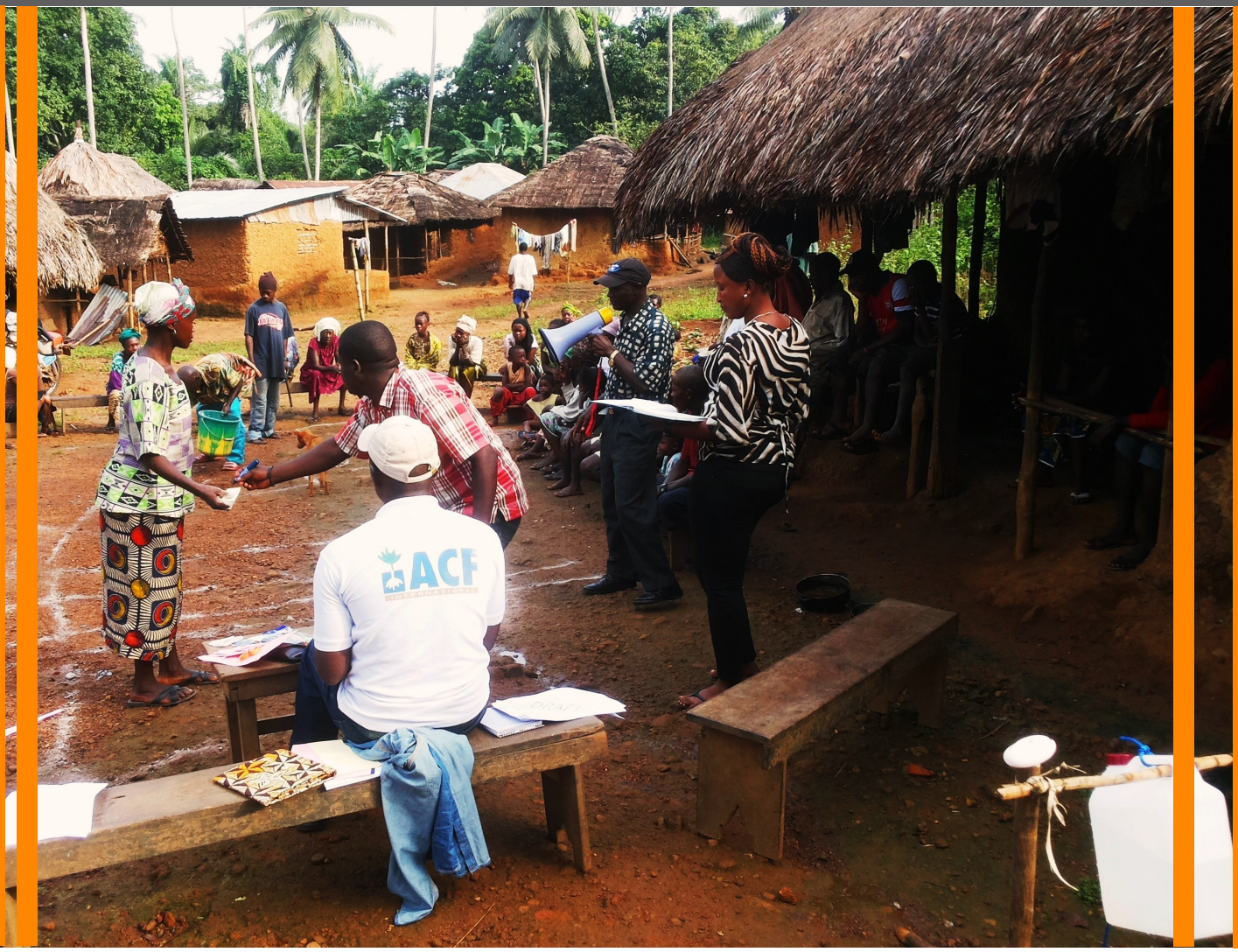
ACF – SIERRA LEONE

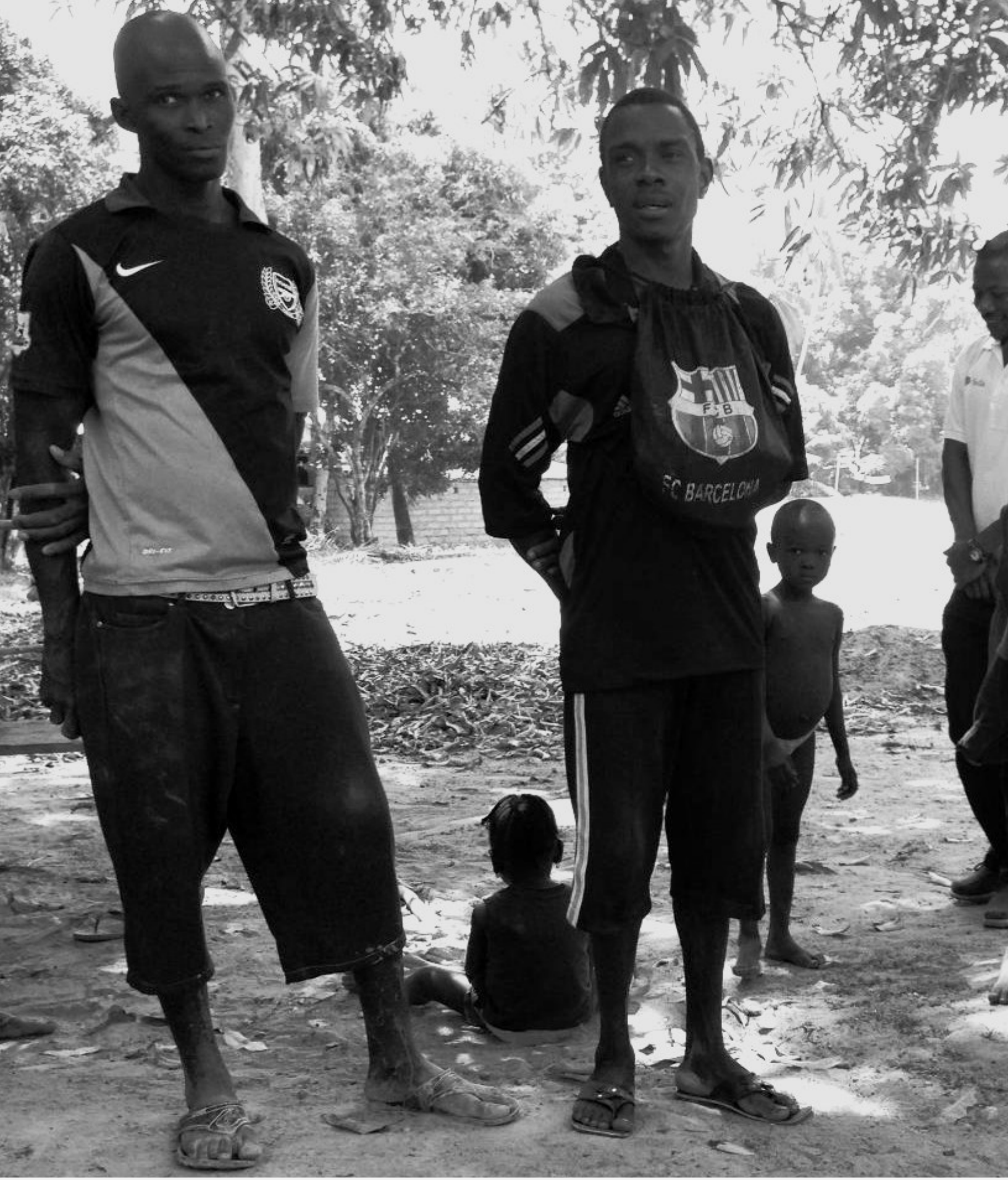
CASE STUDY

COMMUNITY LED EBOLA MANAGEMENT AND ERADICATION (CLEME)

Trigger Behavioral Change to strengthen community's resilience to Ebola Outbreaks



ACF INTERNATIONAL



Mohamed (on the right) is the Burial Advisor of one of the Community Support Groups established in Kambia Districts. Mohamed is an Ebola survivor; he got infected with other 18 people in his family. He survived along with other 3. Mohamed says "I was lucky. As burial advisor I ensure that my fellows practice safe behaviors avoiding touching dead corps and reporting immediately all deaths to the authorities [...] I was infected as I attended the funeral of a family member who died after attending a funeral in another district[...]"

Statement on copyright

Non-responsibility clause

The present document aims to provide access to main information resulting from the implementation of the Community Led Ebola Management and Eradication" (CLEME) approach implemented in Sierra Leone during the Ebola Emergency 2014-2015.

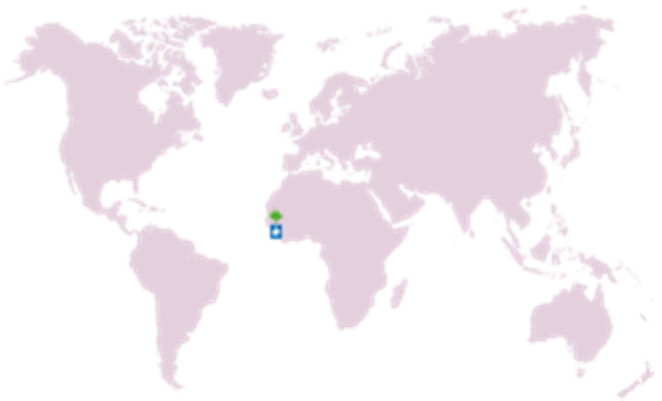
Acknowledgment

This publication is the result of the collaboration between the WASH and the Advocacy Department in ACF Sierra Leone and the Headquarter in Paris. A particular thank is to the WASH Team in the ACF base of Moyamba who designed the CLEME Concept and the initial tools; and to the mission all who believed in the potential success of the project.

The photos in the publications are: © James Senesie—ACF Sierra Leone and @Isotta Pivato—ACF Sierra Leone

Project implemented and funded by:

Content



Sierra Leone: Moyamba and Kambia Districts

Humanitarian context

Background:

Since 2014, an epidemic of the Ebola virus disease (EVD) is ongoing in West Africa. The Government of Sierra Leone has officially declared the beginning of the outbreak on May 26th.

Following the rapid escalation in the number of confirmed EVD cases in the country the President of Sierra Leone His Excellency Ernest Bai Koroma declared the State of Public Emergency on July 31st which entailed the adoption of several emergency measures, including quarantine and limitation in public gathering except the one related to Ebola sensitization. On August 8th WHO declared the outbreak as public health emergency of international concern, and this was followed by the release of a road map to scale up the international response.

As of June 3rd 2015 Sierra Leone counts 8620 confirmed cases of which 3546 deaths.

Since January 2015 the epidemiological trend has improved nationwide; however small pockets of the outbreak are identifiable in the country, particularly in the districts closer to the border with Guinea and Western Area.

Throughout the crisis, the rapid spread of the virus has revealed that case management activities were not sufficient to control the disease, and that social mobilization and community engagement were essential to all aspects of the Ebola response. To stop the human to human transmission, communities and individuals must adapt their social and cultural tradition and practices.

Despite the major role covered by social mobilization in the response, the first "Knowledge, Attitude, Practices" (KAP) study conducted in August 2014 revealed that against a satisfactory awareness on the EVD, communities haven't sufficiently adapted the social practices conducive to EVD human to human transmission.

As a consequence the social mobilization approach in the country shifted from health education and one-way communication to more participatory approaches aiming at behavioral change.

ACF in the Ebola Emergency Response:

Since the outbreak's onset in West Africa, ACF has been actively engaged in the response supporting the Ministry of Health and Sanitation in the design and implementation of social mobilization activities.

Beside social mobilization activities ACF's main activities within the Ebola response have entailed:

- Water, Sanitation and Hygiene (WASH) interventions in communities and health facilities (rehabilitation and construction of facilities);
- Water provision to quarantined households;
- Distribution of hygiene kits, survivors kits and home protection kits;
- Support to MoHS in surveillance activities; Training on "Infection, Prevention and Control" measures at health centres and hospital level, monitoring of the implementation and support in the establishment of triage processes and isolation rooms;
- Support MoHS in the provision of basic package of essential health services at health facility level;
- Provision of consumables to the MoHS at districts level.

In the Ebola response, ACF has been active in the districts of Freetown-Western Area, Moyamba and Kambia with programs reaching a total population of more than 700,000 people.

Quarantine measures: what role for Social Mobilization

Since August 2014 quarantine measures have been enforced by the Government of Sierra Leone at household level, and extended at community, chiefdom and district levels, in the effort of limiting the spread of the disease.

Throughout the emergency the measure was highly criticized by national and international actors. Criticisms were justified by the limited evidence of the effectiveness of the measure in containing the infections; and by the limited control or enforcement of the confinement, initially mostly referred to the population's understanding, and the limited resources available to effectively monitor the implementation.

The MoHS and its partners' social mobilization activities have been key in ensuring the respect of the quarantine measures by the affected individuals and in limiting the infections within the household and the communities. Indeed, extensive attention towards the quarantine affected households, and the adoption of specific messages on the measures aiming at increasing awareness and reducing fear and stigmatization of those affected were provided by the MoHS and its partners.

Yet, social mobilization activities were accompanied by hygiene promotion activities, including the distribution of hygiene kits to encourage the adoption of hygiene practices thus limiting the potential spread of the disease within the household; and provided with specific supports in terms of access to food and water.

Programme Overview and Rationale

In October 2014 ACF has initiated an innovative approach for the social mobilization activities that mobilizes the communities for improving control of the risks of transmission of Ebola at community level.

The CLEME (Community Led Ebola Management and Eradication) programme **aims at triggering the behavioural change needed by the communities to strengthen community resilience to the outbreak and prevent further resurgence by ensuring real and sustainable improvements** through:

- Providing the communities with the means to conduct their own appraisal and analysis of the Ebola outbreak, their safety regarding the disease and its consequence if nothing is done;
- Instilling a feeling of urgency in engaging in community actions that will prevent the community experiencing infections;
- Supporting technically the communities in the implementation of the identified solutions and actions adopted.

The active participation of the communities in the process has been ensured by a methodology that is based on interactive, often visual tools and role games that enable the participation of all members of the community, regardless of the literacy level.

The CLEME approach responded to the need of effectively engage the community in the Ebola response, by reducing the reluctance to the disease and engaging them in effective behavioural change, only partially experienced during the massive sensitization campaigns organized since the beginning of the outbreak.

The behavioural change expected by the communities in order to manage and eradicate the disease are:

- **Early detection of symptoms** and **Seeking early treatment** to health services: as it increase the chances of survival
- **Undertaking and participating to safe and dignified burials:** traditional burials have proven to be one of the most frequent way of transmission of the virus
- **Avoiding any body contact and body fluids** as these are channels for EVD transmission
- **Not to eat bush meat:** to tackle the risks of infection while preparing the meat if the animal is infected
- **Acceptance of Ebola survivors**: survivors have been stigmatized because i.e. the one who brought Ebola in the household; the one who survived;
- **Safe sex with Ebola survivors**: as the virus is still present in semen and vaginal fluids after recovering
- **Compliance to contact tracing and quarantine protocols**: as supports the efforts towards limiting the spread of the disease.

In Sierra Leone the CLEME approach has represented the natural evolution of the experience gained by ACF in the implementation of Community Led Total Sanitation (CLTS) projects. Indeed, the "community led" methodology was responding to the Ebola social mobilization need of adapting the response to each community specific context in order to trigger the necessary changes to reduce the EVD human to human transmission, while building on the community's fear of contracting the disease.

Implementation

ACF CLEME is a process of 5 phases, during which the active participation of the community is ensured by the interactive methodology applied by the facilitators. ACF has implemented the CLEME approach in the districts of Moyamba and Kambia.

1. Selection of the communities: the Pre-Triggering phase

In Moyamba and in Kambia Districts the selection of the communities was based on epidemiological data, identification of hotspots and agreement with the District Health Management Team in order to limit overlaps with other actors working in the same areas. The precise selection of communities in Moyamba was then developed by looking at various criteria including the proximity to other villages, the population, and the presence of other NGOs etc.

The identification of the communities was followed by a community meeting to introduce the ACF programme to the community and key stakeholders. Overall this phase represents a key moment for the programme's success as the ACF facilitators begin building the trust with the communities needed to ensure their commitment and participation throughout the programme.

At this stage Ebola is not specifically mentioned by ACF, instead the community is asked more globally about their health concerns.

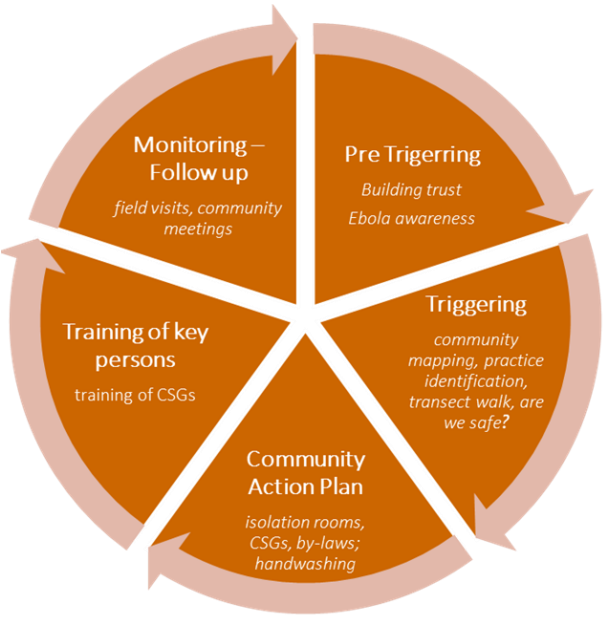
In Moyamba and in Kambia districts, ACF has identified a total of over 400 communities.

2. Towards the community's own assessment of the Ebola outbreak and dangers: the triggering phase

During this phase the ACF facilitators stimulate the collective sense of dangers among the community members. This is facilitated through a set of Participatory Rural Appraisal (PRA) based exercises that allow the community to build up a prioritised picture of their living conditions, and conduct a risk analysis for themselves. The tools applied during the exercise are:

- **Community mapping**: the community is asked to draw a simple map showing the households, health facilities, water points, graveyard, schools, religious sites, households where people have been sick or died in the previous seven (7) days. This allows the facilitator to stimulate the discussion, particularly on sickness and deaths, key moments for the human-to-human transmission of the disease.
- **Identification of common practices for sick people care:** the community members are invited to simulate and identify how they care for the sick people, whether they bring them to health facilities, to traditional healers, etc. During this exercise, led by the facilitators, the communities are able to identify the dangerous practices as well as the potential solution.
- **Simulation of traditional burials:** dead bodies are highly contagious due to the release of infectious body fluids. Along with caring for sick people, traditional burials have been one of the main sources of infections in Sierra Leone. The ACF facilitator encourages the funeral simulation by the community to lead the participants towards understanding where the danger in the practice is and how this could be adapted to minimize the risk of transmission while ensuring the respect to the loved ones.
- **Transect Walk through the community:** It is initiated by the facilitators to confirm what has been drawn in the map, said and simulated by the community, and to identify any discrepancies (i.e. no recent deaths in the community but there are new graves). The triggering process stimulates the understanding by the community members on the unsafe practices they perform and stimulates the discussion on the way to adapt them in order to ensure the community minimizes the risk of infection.

The key event of the triggering is a discussion around the question "are we safe?"



3. Moving forward increased safety: community action plan design

The simple awareness towards signs and symptoms by the population, improved throughout the first period of the emergency (June-October) was found to not be sufficient to lead towards an actual change in behaviour, or a reduction in the infections. In the communities where ACF conducted the triggering phase, the communities have been supported in the design of a community action plan (CAP). The role of the CAP is to define specific activities that are to be implemented by the community as a unique entity to ensure limiting the risk of EVD infections. Few of the actions identified by the communities are the construction of community isolation rooms – particularly in those communities that are in hard to reach areas; and the instalment of hand-washing sites. Further, most of the activities included in the CAP are associated with the establishment of community's by-laws by the community's chief that encourage the community to practice safe behaviours, monitor strangers' visits and sick people, encourage referral of the sick; and prohibit secrete burials. Yet, the miss-respect of the actions included in the CAP by community's members can lead towards the payment of fines that can be utilized by the community to continue carry on preventive measures (i.e. buying soap, cans for hand-washing stations, material for the isolation room, etc.).

The role of ACF in the CAP designing is minimal. Indeed ACF's facilitators are just supporting the community to ensure all members are involved in the exercise limiting the possibility to encounter episodes of discrimination of dominance by the leaders.

4. Ensuring community's safety in the long term: community support group and their training

In the over hundreds of communities where ACF has implemented the CLEME approach, the communities have established "community support groups" (CSG) as part of the activities included in the Community Action Plan. The main role of the CSG is to support the community implementing and respecting the action plan keeping the community safe from infections. The group, usually of about 7 to 8 people, includes the community's natural leaders and others selected by the communities on the basis of the specific capacities needed within the CAP. More in details the group consists of: 1 Chairperson in charge of leading the group, 2 Burial Advisers (male and female), 2 Community Health Workers (CHW), male and female, in care of facilitating the reporting and transferring of sick person with limited risk, 1 Community health monitor (surveillance representative), 1 Hygiene promoter or community social mobiliser and 1 Secretary. This committee is essential to the CLEME approach as its role is to lead, monitor and follow the decisions taken to create an enabling environment that will protect them from Ebola.

Once the CSG is formed by the community, the capacities of the group are strengthened through training and the provision of basic means to perform their duties. Indeed, ACF organizes general training for the whole group aiming at enhancing the awareness and understanding on the Ebola Virus Disease by the members; and the way to prevent the transmission. Further, specific support is provided to each of the CSG's member to ensure they understand their role and they are capable to perform it at the best of their capacities being able to prevent (and control) any infection to happen in their community.

5. Follow up

The CLEME approach includes follow-up activities with the communities where the triggering was conducted. This is an important step of the methodology as it allows ACF to continue the dialogue with the communities; and facilitate the discussion about emerging issues at community level or provide information on the changing environment (epidemiological trend, new activities, new messages, etc.). The follow up visits are also key in monitoring the implementation of the community action plan and in supporting the CSGs in adapting the response to the changes in the context, whether needed. Yet, it also gives the possibility for the communities to provide ACF with key information on the challenges encountered during the implementation of the CAP and on the needs identified at community level.

The follow up visits, and what these entail, contributes also to the monitoring and evaluation of the programme. Indeed, it provides information on how the CLEME methodology is positively impacting on the communities' behaviours. For instance, the construction of isolation rooms is a clear demonstration of the willingness of the communities to keep safe and fight the outbreak by limiting the spread of the disease.

Further, the visits provide ACF also with the opportunity to receive feedback by the communities on the CLEME methodology ensuring its continuous improvement.

Key Findings

The CLEME approach as implemented by ACF in the districts of Kambia and Moyamba has revealed its efficiency in limiting and controlling the spread of the disease at community level. In particular, the CLEME methodology has responded to the need of tailoring the social mobilization activities to address each community's characteristics and needs by triggering behavioural change. Moreover, the CLEME approach, through the establishment of the Community Support Groups, has disclosed to be a methodology that can be easily be adapted to fully complement other elements of the emergency response, i.e. surveillance. Indeed, as beforehand mentioned, one of the key elements of the CSG is the Community Health Monitor who is in charge of surveillance.

Most of the key findings of the CLEME approach are related to the great sense of ownership the approach has triggered in the communities where the methodology was implemented. Indeed, the CLEME methodology is designed to drive, through minimum ACF direct involvement, the communities towards identifying what are their unsafe behaviours and the possible solutions that can support the community in reducing the risk of infection.

Community Engagement

As mentioned, the most important results of the CLEME is the great engagement of the community in community activities. Among the best results:

Isolation Rooms: The 80% of the communities where ACF implemented the CLEME approach have identified as one of the activities to be included in the community action plan the construction of isolation rooms. This need was identified in particular in those communities located in hard to reach areas and far from a Health Facilities. The function of the Isolation room is to welcome sick people in the community who are suspected to have Ebola in order to isolate them as soon as possible from the family by limiting the potential contamination while waiting for the referral to the Ebola holding centre to occur. According to the available land and material, communities have built isolation rooms of different dimensions, from one (1) to four (4) rooms in order to limit, in case of the presence of more than one person, cross-contamination. In consideration of the risk the community isolation room might entail, the role of ACF is to ensure that these rooms respect the minimum safety standards and that communities are provided with the means to protect themselves. Indeed, for those communities where the isolation room was constructed, protective kits were provided along with training on their use to limit the contamination.

Tippy Tap hand-washing: Washing hands with water and soap is a key hygienic practice. Despite the role hand-washing plays in preventing contracting bacterial and virus, ahead of the Ebola outbreak the practice was not widely followed. Since the beginning of the outbreak, massive distribution of hygiene kits including buckets and soap have been conducted by all agencies in an effort towards increasing the hygienic practices of the population, particularly at high risk, i.e. slum areas. In the communities where ACF has implemented the CLEME approach, the need for hand-washing stations was identified however it was left to the community to decide how to ensure the facilities were installed and used. Tippy tap hand-washing facilities were identified and installed at household level and in public areas. Further, in some communities the CSGs have established modalities to collect fines from those members of the community not respecting the hand-washing practice. As result of a community decision, tippy tap hand-washing facilities are actually used and maintained.

Community Support Group: The CSGs have demonstrated to be a modality for the communities to take ownership of the safety of community and of the activities implemented at community level. Further, including in the CSGs elements of the communities who are recognised and respected for their role as natural leaders provides the CSGs with even more leverage on the individuals and communities' behaviours.

By-laws: Since the state of emergency was declared in the country on July 30th 2014, authorities (district, chiefdoms, villages) have been authorized to enforce by-laws to protect people from contracting the disease. These by-laws have demonstrated to be especially effective when adopted at community level and decided by the community natural leaders as communities were recognizing the by-laws as a measure to protect themselves and their loved ones.

CLEME and integration with other projects: Community Event Bases Surveillance

The **community event based surveillance** (CEBS) is a new concept developed by the Ebola Response Consortium (ERC) to be implemented at national level. This was endorsed by the MoHS early this year 2015, and ACF is implementing it in the same districts were the CLEME approach is implemented, Moyamba and Kambia.

CEBS is the organized and rapid capture of information from the community about events that are a potential risk to public health. It has been identified as a surveillance tool that has potential to improve early EVD case identification, reduce Ebola transmission in the community and enhance response efforts in Sierra Leone.

Information generated from this system both informs reporting on emerging Ebola hotspots and simultaneously feed back information to communities. It is also a tool that can be used to improve community sensitization and enhance the rapid Ebola response at the local level. CEBS can serve not only to decrease the Ebola outbreak but also to move toward eradication, preventing Ebola from slipping into the role of an endemic pathogen in Sierra Leone.

In this context, there is a real added value of CLEME, and in integrating the two approaches.

The CLEME approach is an opportunity to improve the quality of the CEBS approach as it has the ability to empower the community towards a common goal: reporting events/ sick people. The CLEME brings the following:

Transparency: By providing accessible and timely information to communities through the CSG on CEBS procedures, structures and processes to ensure that they can make informed decisions and choices, and by facilitating the dialogue between ACF and the community.

Participation: By enabling communities to play an active role in the decision-making processes through the establishment of clear practices and reporting channels to engage them appropriately and ensure that all groups (sex, ages and socio-economic typology) are represented and have influence.

Monitoring and evaluation: By monitoring and evaluating the goals and objectives of programmes with the involvement of the communities, feeding learning back into the organization on an continuous basis and reporting on the results of the process.

Feedback: By actively seeking the views of the communities to improve policy and practice in programming, ensuring that feedback mechanisms are streamlined, appropriate and robust enough to deal with specific issues.

CLEME: Prerequisites

ACF, as most of the humanitarian organizations lacked of experience in dealing with Ebola and had to quickly adapt the conventional emergency response to the rapid and unpredictable spread of the outbreak. Despite the short timeframe of implementation, success factors have been identified that eased the rolling out of the methodology:

Enabled environment:

- **The deny phase was over:** The implementation of the CLEME was supported and facilitated by the awareness campaign that was effective in increasing the understanding of the population on the existence of the Ebola outbreak in the country and on the EVD transmission modalities. Communities were opened for dialogue and seeking for responses. In order to transfer the methodology in other environments where denial is still present or Ebola is not a concrete threat, thus with a poor level of Ebola awareness, organizations are to consider adapting the pre-triggering and triggering phase to respond to the needs of the communities hence including awareness raising in the activities.
- **Existence of Ebola response services:** the CLEME approach was implemented in a period when the services to respond to the outbreak were in place and enhanced compared to the first phase of the response (May-September 2014). These included improved case management and burials capacities, effective contact tracing and surveillance, etc. The existence of the services has played an important role in the success of the approach as the community ownership has consequently increased the level of services requested by the communities.

  In environments where this condition is not present, the effectiveness of the CLEME in influencing the epidemiological trends could be limited. Therefore, community activities shouldn't be implemented as a stand-alone intervention but should be combined with improved service capacities.

Triggering factors:

In the areas and at the time when the CLEME was implemented fear was identified as the key driver to trigger actions by the communities.

However, when extending the implementation of the CLEME to other environment and at other times, it is important to bear in mind that fear could also lead to negative impacts, i.e. stigmatization. It is therefore important to conduct proper analyses of the context of operation and consider associating to fear some positive drivers as love, support, etc. that could support reducing the risks.

Operationalization:

For the CLEME implementation ACF was able, and in the position, to build on the experience and capacities gained through the CLTS methodology as implemented in Sierra Leone.

However, it is relevant to note that the CLEME operationalization might be difficult according to the area of expertise of the organization implementer or the country of operation. Community led methodology indeed require a high numbers of skilled staffs, particularly with regards to facilitation and the topic addressed (in the CLEME case Ebola). Further, it is advisable to have gender balanced team with staff originating from the area of operation that speak the local language and understand the local context. Therefore the implementing agency is to have robust human resources management and knowledge management system to ensure on-going learning process.

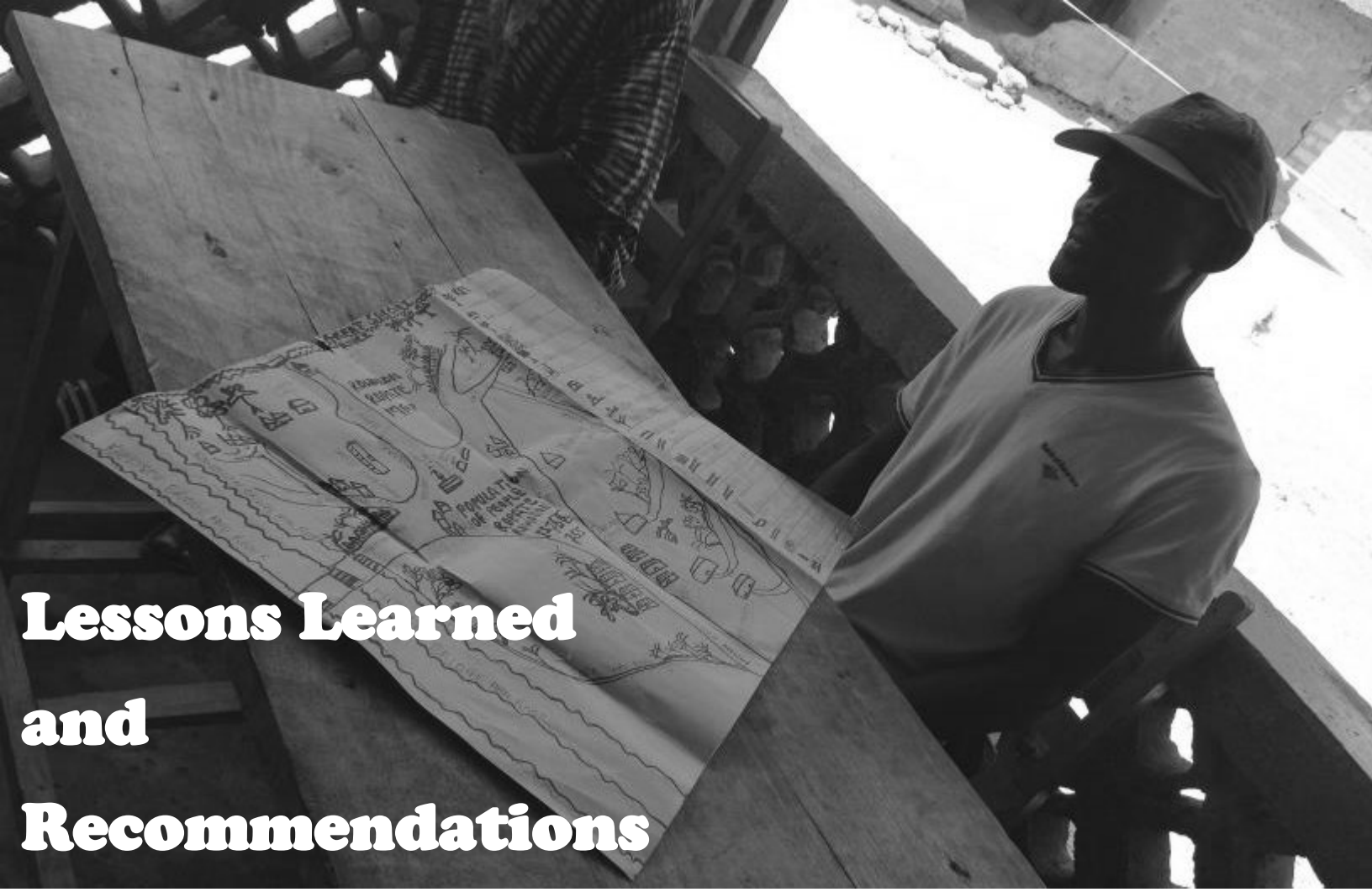
Size and typology of the communities:

- **Size:** Most of the communities where ACF has implemented the CLEME approach communities were of small or medium size. However, some of selected communities were in big settlement. In order to ensure ownership of the community action, and the participation of all members, these communities have divided themselves in sub groups through an accountable and inclusive process.

  When designing and implementing the approach, organizations are to consider the size of the communities in order to ensure that these are empowered and episodes of exclusion are not experienced.
- **Typology:** The CLEME approach was implemented in rural context as the group identity is stronger and community led methodologies are effective.

  Implementing the CLEME in urban context is not advisable as more complicated since the identity is different and the identification of natural leaders could be challenging.

  If organizations aim at implementing such type of approach in urban context they should consider all the sociological and economic factors that exist and influence on the group dynamic; and take them in consideration while designing the programme.



Lessons Learned and Recommendations

The CLEME approach has been designed to respond to the Ebola Emergency in 2014. The methodology has revealed to be effective in improving the communities behaviours towards limiting human-to-human transmission.

The improvements in the epidemiological trend, associated with an increased engagement by the communities in the fight against Ebola have clearly shown that community understanding, ownership and engagement in the response have bee key in contributing to the improvement of the outbreak.

Some key recommendations have been identified as result of the implementation of the approach:

1. **Context analysis:** The CLEME implementation has demonstrated that for a good and effective behavioural change there is the need to ensure continuous analysis of the communities' barriers to safe behaviours is performed to adapt the approach to the actual context. Further, following the trends of the outbreak and analysing the epidemiological data at the level of the targeted population is required to adapt the approach to the needs of the population, and target the most vulnerable communities.
2. **Gender:** gender is to be at the core of the approach whether concrete and long-lasting changes want to be achieved. The tools, in particular the CSG and the action plan are to reflect the different needs of women, men, boys and girls.
3. **Regular update , feedback and adaptation of the approach:** Ensuring continuous follow-up visits are done to the communities is paramount to ensure the regular updates and adaption of the approach to respond to a constantly evolving environment as the one created by the outbreak. The feedback collected and answered at community level should be communicated into the existing coordination system to improve the services to meet the community needs
4. **Programme Integration**:
   - Strengthening the integration between the CLEME and the CEBS is paramount to ensure integration, effectiveness and sustainability of community mobilization and involvement towards an community led health surveillance system.
   - Ebola education and health promotion are to be integrated in all projects at community level to avoid future outbreaks to be of the same intensity
5. **Resilience**: the approach as implemented will need to be adapted to the post-Ebola context in order to respond to the need of building communities' resilience to such type of crisis, this is so in consideration of probable endemic trend of the Ebola outbreak

Mokaikono is one of the communities where ACF has been implementing the CLEME approach. The community is located in Ribbi Chiefdom, one of the most affected chiefdoms by the Ebola Outbreak in Moyamba district . The chiefdom has been particularly prone to Ebola as a result of its bordering position with three districts highly affected (Western Area - Rural, Port Loko and Tonkolili). Yet, in the chiefdom several phenomenon of resistance to the activities of the Ebola response have been experienced, in particular towards case management, burials and social mobilization. All these factors have made Ribbi one of the first chiefdoms to be addressed by ACF through the CLEME approach.

As result of the triggering phase the community has identified as the two main activities to focus on in the community action plan the construction of the Community Isolation Room and the installment of hand-washing facilities at household level to improve the hygiene practices of the community members. The community of Mokaikono has also benefitted from the provision of "protection kits" for the isolation rooms. In consideration of the role played by CHWs within the Community Support Groups, the 2 CHWs of the community have been trained by ACF staff on how to correctly utilize the kit to avoid any infection to occur while supporting the sick people awaiting for the transfer to the holding centre.

Ibrahim Kargbo, one of the members of the community says *"In the last three months of my active participation in the Ebola campaign the capacities of my community have considerably improved on hygiene practices and behavioural change through the number of triggering sessions, sensitizations and capacity building training. Now there is a hand washing facility in each households and we are practicing it at all time".*

Action contre la Faim (ACF) has worked in Sierra Leone since 1991. Currently ACF is working in Freetown-Western Area (urban and rural), Moyamba and Kambia Districts, implementing health and nutrition, food security and WaSH programmes. In strong collaboration with the local and national authorities, ACF has been focusing on prevention and treatment of acute malnutrition by addressing the direct and underlying causes of malnutrition (food insecurity, limited livelihood opportunities and poor access to water and sanitation).

Since the beginning of the Ebola Outbreak in May 2014 ACF has been actively involved in the emergency response, as well as continuing the fight against under-nutrition. By mitigating the secondary impact of the Ebola Outbreak ACF will continue to support the most vulnerable populations in the country in line with the Government of Sierra Leone recovery plans

ACF INTERNATIONAL