THE UNITED METHODIST CHURCH

SIERRA LEONE CONFERENCE

POST EBOLA RECOVERY RESPONSE STRATEGIC PLAN (PERSP) 2015 – 2017

January 2015

INTRODUCTION

News of Ebola outbreak in Sierra Leone was first reported in May 2014. From May to date, the disease has spread with such devastating consequences that it is now found in every political district in the country. A recent WHO report estimated the total number of Ebola cases (as of January 12, 2015) at over 21,329, including 8,444 deaths from the three most affected West African countries— Guinea, Liberia and Sierra Leone, with Sierra Leone bearing the heaviest toll. WHO estimated that in Sierra Leone alone, over 3,000 people had died of the disease including 11 medical doctors and 120 other health workers. Who also reported that while cases in Guinea and Liberia seemed to stabilize, the numbers in Sierra Leone kept rising, leaving the country in the grip of the disease.

IMPACT OF EBOLA

The disease has caused such devastating social and economic consequences that today everyone lives in a state of fear and intimidation. The whole nation has been largely isolated by the international community as countries imposed travel band on Sierra Leoneans for fear of spreading the disease. Sierra Leoneans now live in a state of shame and embarrassment, loss, pain, grief, panic, suspicion and superstitions

The nation's economy has been seriously affected as prices of essential items continue to hike every day. Some of our people are lost their jobs as institutions close down. Others are receiving less working hours and therefore less salaries while others have been asked to stay home without salary.

The educational system has been affected. Since the outbreak of the disease, a nationwide closure of all educational institutions was imposed by government in an effort to contain the spread the disease. Schools and colleges would have reopened in September 2014 which is usually the beginning of the new school year but five months on, it is still not clear when schools and colleges will reopen. This places our children's education at risk. However, Government's announcement of reopening schools in March brings some hope that there is light at the end of the tunnel.

Ebola made serious negative impacts on religious and social activities including the cancellation of pilgrimage to the holy land, ban on huge church gatherings and ban on public gatherings such as cinemas and foot ball matches.

Until November 2014, Ebola treatment centers were overwhelmed with the influx of Ebola patients. Inadequate care and food supply for quarantine families

forced people to escape from these quarantine homes and holding centers to go in search of food thereby mingling with the population and spreading the disease to other persons in the communities.
But perhaps most scary of it all is the alarming rate of health workers who lost their lives to the disease. As of December 2014, the country has lost eleven medical doctors to Ebola. In a country with less than 150 doctors, this was certainly a huge blow to our health system.

By July 2014, WHO, MSF, the U.S. CDC, and other international health organizations who are on the "front lines" of the Ebola epidemic contented that the situation was out of control, and without major engagement from the international community, the situation would only get worse. Every attempt to curb the virus including, isolation of patients, isolation of whole regions, suspension of international flights etc. yielded very little result. Border closures, flight bans and mass quarantines proved ineffective. The alarming rate of spread of the disease and death due to Ebola placed our ailing and fragile health system into serious disrepute. According to WHO report, Sierra Leone "lacks the health care workers it needs to monitor potential carriers and train communities in how to avoid catching the disease. People in contact with the sick evaded surveillance, moving at will and hiding their illnesses until they infected others in turn. Whole villages, stricken by fear, repeatedly shut themselves off for days or weeks, giving the virus more opportunities to whip around and skip to other places". At the initial stage of the outbreak, there was only one Ebola testing and treatment center in the the country. Patients and blood samples from suspeted Ebola patients were moved across the country to this one testing Center in Kenema each day. The limited number of trained and skilled testing staff in the country became overwhelmed with the magnitude of tests they have to do each day. As a result, patients had to wait for days for them to know their status. This period of waiting was argonizing and the fear of a positive result often caused patients to escape the rather loose "isolation units"

The Sierra health infrastructure completely collapsed and threw the government into a massive confusion as the country had no idea how to handle the situation. It was only after the declaration of Ebola as a health emergency and an appeal to the international community by the President Ernest Bai Koroma that a more intentional and robust international assistance started trickling in.

Challenges

Ebola broke out in the country when no one was prepared for it. In its attempt to respond to the outbreak, government inadvertently sent out conflicting and often counterproductive information at the initial stages of the outbreak. Some of the media Ebola messaging created fear, panic, and confusion that lead to an atmosphere of hopelessness and denial among the people. In Kailahun, the epicenter of the disease where whole families were being wiped out, there was a massive loss of trust in the government health personnel and the police. Most of the people became hostile to both the health personnel and police whom they thought were more of a threat to their lives than the disease itself. Others fearing forced arrest fled into the forests.

A major psycho-social imapct of the Ebola Virus Disease is that once patients tested positive, their social status immediately droped. They were more or less treated like mere criminals. In the vast majority of cases, relatives of suspected patients hardly ever set eyes on their loved ones from the day they were taken into isolation until their death and burial, most often in mass graves where family members would never know. These are the hard realities with which Sierra Leoneans had to contend with.
Repackaging the Ebola prevention and containment messaging is therefore a critical tool if the fight to eradicate Ebola must be won.

Eight months since the outbreak of the disease, there are still huge pockets of the population that deny the reality of Ebola often ascribing the high death rate to witchcraft and other factors.

Perhaps, the greatest challenge in the fight against Ebola is that vast portions of the population still adhere to traditional and cultural practices especially in the burial of their loved ones. Washing of bodies of the dead is a practice that cuts across every tribe in Sierra Leone and this places our people at high risk since this is the stage that the virus actually becomes virulent.

In its Accelerated Ebola Virus Response plan (July 24, 2014), the government presented several reasons why the virus has continued to spread with such alarming speed;

- Inadequate understanding within the communities of the EVD as this is the first major outbreak reported in Sierra Leone.

- Lack of experience among healthcare workers and limited capacities for rapid response.
- High exposure to Ebola virus in the communities through household care and customary burial procedures. This has resulted in a high level of community deaths leading to panic and anxiety.
- Denial, mistrust and rejection of proposed public health interventions arising from misinterpretation of the cause of the new disease.
- Fear of the disease by frontline health workers leading to either suboptimal care for patients or substandard implementation of protective measures.
- Close community ties and movement within and across borders has led to difficulties in tracing and following up of contacts for the three countries.
- This outbreak poses serious challenges in terms of human capacity, financial, operational and logistics requirements and threatens national and international health.

The United Methodist response to Ebola

Through the *United Methodist Church Ebola response Initiative* funded by the United Methodist Committee on Relief (UMCOR), an interfaith response - the *Religious Leaders Task Force on Ebola* was initiated on July 16, 2014. This Task Force provided an opportunity for an interfaith response to the disease in ways that had never being conceived.

The Religious Leaders Task Force on Ebola immediately adopted a "quick impact response" that have had a wider and more positive impact on the nation. In fact, the Religious Leaders Task Force was the first faith based organization that actually rang the alarm bell signaling the seriousness of the EVD. At a press conference, attended by the only TV station in the country-SLBCTV and the major local tabloids in the country, the Religious Leaders Task Force on Ebola called on government to urgently put in place intentional measures to address the issues posed by the disease including and most importantly, a declaration of Ebola as a national health emergency.

The work of the Religious Leaders Task Force focuses primarily on the following initiatives;

1. Aggressive and nationwide media Ebola messaging

- Intentional radio and TV programs aimed at creating awareness, sensitization and education of all Sierra Leoneans on the causes,

symptoms and prevention of Ebola. These were done through panel discussions, announcements, songs and jingles in many major radio stations in the country.

- Recorded messages on Ebola prevention for dissemination to all district Headquarters and major towns and villages throughout the country on CDs. Engage volunteer young people and provide them with T-shirts bearing the slogan "Ebola can be prevented" vehicles with CD players, microphones and loud speakers.

- Work with Paramount Chiefs and other community leaders to propagate Ebola prevention message throughout their chiefdoms

- Printing and distribution of T-shirts, banners, stickers with Ebola prevention messages in all 14 political District headquarter towns targeting the literate population so they in turn would teach the illiterate members of their communities.

2. Aggressive training of religious leaders and health workers of faith based Health facilities. We organized two nation-wide regional trainings on Ebola awareness, sensitization and Education. First training Session was held in Bo July 16 and 17 for 100 religious leaders and health workers from Faith based health institutions in the South and Eastern Regions. The second leg of training took place in Freetown August 5 and 6 for 120 religious Leaders and health workers in faith based health institutions in the West region.

3. We engaged in intentional advocacy and networking programs with other stake holders to urge government to:

- Declare Ebola an emergency in the country so the international community could come in and help the country develop a more robust response to the epidemic.

- Develop a nationally coordinated, accurate, credible, consistent and effective approach in responding to the threat posed by Ebola.

- Intensify training of religious leaders and health staff on Ebola and provide adequate protective gears for vulnerable health workers throughout the country.

- Expand Ebola testing centers to all District Headquarter towns and provide adequate infrastructure such as ambulances to facilitate the free and expeditious movement of suspected cases to the nearest testing/treatment centers.

- Momentarily restrict free movement of people from infected to non - infected areas and verse versa.

- Our work focused on increasing community awareness and education especially at the grass root level. Our goal was to teach our people not to come in contact with infected and suspected infected individuals.

- In partnership with World vision and the Religious Leaders Task Force on Ebola, we lobbied with government to ensure that "last respect" (dignified burial) for all who die of Ebola go hand in hand with "safe burial".

- In partnership with World Vision, CRS, the Religious Leaders Task Force on Ebola, we distributed 300 bags of rice, 300 gallons of cooking oil, 300 gallons of liquid soap and quantities of assorted items including sugar, milk etc. to over 300 families in quarantine homes and persons with disabilities in the most Ebola infested areas – Freetown (rural and Urban), Port Loko and Moyamba districts.

In addition to the above, the United Methodist Church Ebola Response Program also adopted a number of response strategies that tremendously helped to reduce Ebola infection and transmission in our ten Health facilities in the country. These include;

- Two sessions of intensive training of our more than 200 health workers (doctors, Nurses and support staff) in Ebola awareness, prevention and psychosocial education focusing primarily on the use and removal of sanitary gloves and PPE kits.
- Provision of adequate PPE kits and other Ebola consumables to all our health centers throughout the country.
- Maintenance of a sanitary environment through routine cleaning, and fumigation of four of our health facilities that had incidences of Ebola cases, namely, Manjama health center Mercy hospital, Rotifunk hospital and Kissy General hospital.
- Follow up trainings and surveillance through a case by case unannounced visits to ensure that basic prevention procedures were being practiced in all our health centers.

- Provision of ambulances in two of our hospitals – Mercy and Kissy general hospital to swiftly transfer suspected Ebola patients to testing and treatment centers.
- Provision of regular supply of essential drugs to all our health facilities that remained opened throughout the Ebola epidemic so that they could ably respond to both Ebola and other non-Ebola health problems.
- Provision of Bio medical test equipment and other essential Ebola and non Ebola related drugs and consumables to seven (7) major government health facilities in the country.
- Provided salary support for all our health workers as health facilities lost the capacity to raise sufficient income to pay staff salaries.
- Provided food support to all health workers in our ten health institutions in the country.
- Maintained a high level of best practices which resulted in one of the lowest Ebola deaths (three health workers and one patient) compared to other health facilities in the country.
- Through support from our various Mission partners, we are able to provide food to congregations and staff working in all United Methodist institutions across the country:
  - The United Methodist Women's Department and the United Methodist Women Regional Missionary initiative distributed substantial quantities of food items rice, cooking oil, onions etc. to women and children in the most vulnerable communities in the country.
  - The Community Empowerment for Livelihood and Development (CELAD) distributed food items to all communities serviced by the project.
  - The Department of Youth and Young Adults Ministry in collaboration with the United Methodist Women's Regional Missionary initiative for young people carried out a nation-wide Ebola sensitization and education including distribution of food to quarantine and other vulnerable families.
  - The Department of children's ministry conducted seminars on Ebola prevention among children for Sunday school teachers in the Western district to prevent spread of Ebola among children in the church.
  - Through the "Church to Church Ebola Talk" the Bishop engaged the whole church in a conference wide preaching and teaching mission on Ebola prevention focusing on places where Ebola infection and death toll was having the greatest impact on the lives of people.

The good news is that while many health facilities (both private and government) closed down during the peak Ebola infection period, six of our health facilities

have remained opened throughout the epidemic providing needed health care services to a population that had lost every hope of survival. In the midst of what became a hopeless situation, our health facilities became the hope for the people.

The United Methodist Post Ebola Recovery Strategic Plan (PERSP)

As of date, we have more than a dozen international Governmental and Non-governmental organizations operating in the country. They include, WHO, UNICEF, MSF, World Vision, CRS, UMCOR, ECOWAS, AU, United States of America, Britain, Cuba, China etc. and other National non-government organizations. As a result of the expertise and huge resources invested by these organizations, the rate of infection and death has shown dramatic reduction in the last four months (October 2014 to January 2015). Many Ebola patients are now being discharged from treatment centers. This is good news and certainly a reason to believe that with political willingness and intentional efforts from all concerned, the disease will soon be history not only in Sierra Leone but in West Africa as a whole.

However, while treatment continues to be the focus of government and other key stake holders, care for children orphaned by Ebola and many of the sick in quarantine homes remain largely neglected. More emphasis is being placed on prevention and treatment than on care for these vulnerable group of people. Cracks in the food distribution system organized by the National Ebola Response Committee (NERC) have resulted to some quarantine communities getting more and regular food supply than others. In the quarantine homes, basic needs such as food and water are in short supply. This is the reason why many Ebola patients break bounds and sneak from the quarantine homes to seek food and other basic needs, and in the process, spread the disease even more.

The case of children orphaned by Ebola and the many girls who are now becoming mothers because they are not going to school are certainly major post Ebola concerns.

It is clearly evident that, like the decade long rebel war, Sierra Leone will be faced with endemic challenges when Ebola is eventually eradicated as is already the case now.

As a result of the above, the United Methodist Church has visioned the following post Ebola initiatives to be implemented in the next three years (2015 2017).

During the height of the Ebola epidemic, when bodies of Ebola victims were dumped in mass graves, the much attention was paid to ***"Safe and dignified burial"***. With "safe and dignified burial now behind us, focus should now be placed on ***"Safe and Dignified life***".

In line with this, the United Methodist post Ebola recovery strategy will focus on the following four key words; ***Prevention, Advocacy, Restoration, and Care (PARC). The goal is to protect, honour, uphold and restore the dignity and value of every human being affected and unaffected by Ebola.***

The key catch word will be ENGAGEMENT. We will work towards engaging every facet of the Sierra Leone community- grassroots, village, religious leaders, the school system and relevant NGOs operating in the country.

1. Health Care One major learning experience from the Ebola epidemic is that it opened our eyes to the serious cracks in our national health system. As a church, our first priority in this area is to transform our ongoing health care delivery system into a robust first class health care system in the country based on the principles of best practices, accountability, transparency and sustainability.

Our first goal is to reopen the four other health clinics that we shut down during the heat of the Ebola epidemic as a way of protecting our vulnerable health workers in these facilities. The plan is for the conference health team to visit and make on the spot assessment of the needs in these facilities and work towards equipping these centers so they are well positioned to handle any health challenge that may occur when they are finally reopened.

We plan putting in place an effective and efficient ambulance service in three of our major health facilities that will provide for the swift movement of patients from home to hospital and from hospital to referral health centers.

We will also engage improving on the current staffing levels through intentional recruitment/training of qualified, efficient, committed, dedicated and compassionate health workers including primarily doctors, Nurses and pharmacy and laboratory technicians; provide high quality, accessible and affordable drugs; maintain a sanitary and professional patient friendly health care environment (physical and administrative); upgrade all our four major hospitals with effective diagnostic laboratories, radiology, surgical and physiotherapy units; provide efficient and high quality water supply and

electricity, and empower local health management Boards to function more efficiently and effectively

A major change in our current health priorities will involve the Mercy hospital. Instead of relocating the hospital to Manjama, the new vision we are proposing to our HCW partners is to build an all in one three story hospital complex building opposite the present Mercy hospital at the Urban Ministries compound in Bo, fully equipped with surgical, radiology, clinical laboratory, physiotherapy unit, pharmacy, offices and admitting wards. An alternative will be to adopt a more cost effective rehabilitation and expansion of the current hospital building towards the laboratory to house the various units mentioned above as well as create additional and separate admitting wards for children, male and female admitting wards.

With MSF now closing down most of its operations in the country, especially the Gondama health center, the need to improve the facilities and services at Mercy becomes even more compelling.

We are also in the process of establishing a School of Nursing on the same premises. The Mercy hospital will provide students with the much needed hands on practical skills and experiences required of professional health workers. The goal is to work with HCW and UMCOR to seek financial support from ASHA (American Schools and Hospitals Abroad) and other partners through an appropriate grant proposal.

2. Integrated Community based Health Care program (CBHC) The Missions and development program and the health program will work together to develop an integrated Community Based program that will ensure water and environmental sanitation, food security, nutrition and continuing Malaria/Ebola prevention, education and treatment. While Ebola infection rates appear to be leveling off in the country, Sierra Leone has already started experiencing the long term post Ebola challenges as evidenced in the current food (rice) shortage and economic hardship in the country. The Food & Agriculture Organization (FAO) and the World Food Program (December 17) estimate that 120,000 Sierra Leoneans are already “food insecure” as a result of Ebola. This means Sierra Leoneans neither have the food they need nor are able to buy it. By March, the report predicts, the number will rise to 280,000.

The Ebola outbreak has taken the greatest human toll in Sierra Leone compared to the other neighbouring countries of Liberia and Guinea. Like in the decade long rebel war, most of those who have died constitute the farming/agricultural community. And in a country where peasant agriculture continues to be the dominant means of livelihood and where human beings provide more than 90 percent of the agricultural labour force, Sierra Leone is likely to face a huge food crisis in the coming years.

Closely related with food security is the high rate of malnutrition amongst children. About 80% of the food generally eating in Sierra Leone comprises carbohydrate. The goal is to work with rural communities to empower parents especially mothers to grow protein rich food stuff such as Bennie seed, maize and vegetable crops that can be locally processed into baby and children's food.

Our goal is to work with the United Methodist Committee on Relief (UMCOR and other international agencies to develop a robust agricultural development plan that will seek to address this looming food insecurity crisis. Included in this plan will also be the production of health providing crops and animal products such as Moringa and honey.

3. The United Methodist University Providing high quality accessible and affordable post-secondary education through the establishment of the United Methodist University. The goal is that by 2016, at least three schools of the university – Theology, Nursing and Agriculture will be established. It is hoped that the school of Agriculture will play a major and leading role in our food security development goal. Infrastructure for housing these schools are near completion. Aggressive efforts are now in place for furniture and other equipment and teaching/learning resources.
   Plans for accreditation of the University from the Tertiary Education Commission of Sierra Leone are almost complete and the infrastructure for the Schools of theology and Nursing are near completion.

4. Primary and Secondary education Improving on our current primary and secondary educational system through construction of a few primary schools in the most needy communities, rehabilitation and equipping of

existing structures, establishment of school libraries, teacher training, school feeding program (in the poorest rural communities), chaplaincy and counselling programs. We will continue our ongoing emphasis on Girl Child education.

With the pronouncement by Government of reopening of schools in March 2015, our goal is to engage the key stake holders in our primary and secondary education system – heads of schools, teachers, pupils, parents and government to engage in a massive Ebola Prevention Preparedness Education program (EPPE). The goal is to provide teachers and pupils with basic knowledge and skills in Ebola prevention including, but not limited to health education/sanitation, advocacy and the basic principles of prevention. Beginning March 2, 2015, intensive and intentional Ebola prevention training involving primary and secondary school teachers will be organized at both district and regional levels to get the school administrations adequately prepared to detect and handle any likely case of Ebola in the school system.

5. Engaging in radical evangelism, church planting and Lay and Clergy leadership development. In the last six years, the United Methodist Church has engaged in a radical expansion program that has led to the creation of new congregations in all the fourteen political Districts in the country. This expansion includes places of worship, schools, health facilities and various community development projects. However, such an expansion requires a robust cadre of trained and qualified personnel to provide ongoing leadership for these new initiatives. The goal is to equip lay and clergy with the needed skills and expertise that will enable them keep these ministries going through community participation and ownership. Leadership training opportunities will be provided through formal college and university training as well as seminars and workshops at home and abroad. For the next three years (2015-2017) our leadership development goals will focus on theological education, teacher education, health education (Nurses and doctors) and social work (communication, community development and advocacy work).

   In addition, we will also vigorously pursue the construction of four new places of worship in the following communities – Lunsar, Kambia, Boijibu

and Ma Siaka. Two of these places of worship are already under construction with plans to complete them by end of this year.

The need for a boat to service the Bothe District is urgent. Bonthe is an Island and ministry to this district and the many united Methodist village communities which can only be assessed by sea has been a great challenge. It is our hope that by the end of this year, we will be able to buy a sea worthy boat that enhance evangelism and administration in the district.

6. Children, youth and Young Adults In addition to our ongoing ministries to children and youth, we shall seek to develop other life transforming ministries for children, youth, young men and young women. These will include ministries to children orphaned by Ebola, improve our current Sunday school programs, develop an intentional child protection policy/program, organize the United Methodist youth/young adults volunteer corps (UMYVC), Youth internship programs (YIP) and a United Methodist technical/vocational training program. Advocacy programs targeting child trafficking, child labour, and access to education will be integral components of our children's ministry.

With schools closed for almost one year (May 2014 to February 2015), there has been a high rate of teenage pregnancy all over the country. This is due to two main factors;

- Many of the children lost their parents and had no one to care for them. The female teenagers therefore became victims of neglect and abuse resulting to the high rate of pregnancy among them.
- With the long period out of school and with many parents living their children unaccompanied, the female teenagers became vulnerable to abuse by both adults and their own peers often leading to pregnancy.

Our goal is to design an appropriate program that will get these children back to school when the deliver their babies as well as take care of the babies.

With regards to children orphaned by Ebola, our goal is to establish an Orphanage in Kailahun to cater for orphans in Kailahun and Kenema. The service may be extended to orphans in other districts depending on financial resources and need. This will be the second orphanage established by the United Methodist Church in Sierra Leone. The first orphanage –Child Rescue Center in Bo - was established in 2000 to address the issue of war orphans.

Kailahun was the first and most hard hit district by Ebola. The United Methodist Church is well positioned to establish this life- saving ministry because we have already established a new mission station in Kailahun three years ago with an ordained elder who serves as our Associate Director of Evangelism and Church planting.

It is estimated that there are about 800 children orphaned by Ebola in Sierra Leone right now. Many of these children have no relatives to care for them because of the stigma of the disease. They fend for themselves and they are in desperate need of food shelter, education and health care. Their plight is compounded by the fact that adult sex offenders and even their peers take advantage of their vulnerability and sexually abuse them leading to the high increase in Teenage pregnancy in any communities in Sierra Leone.

The goal is to establish an orphanage or a temporary care/transit center for one year during which it is hoped the children will be reunified with relatives. However, those children who will not have relatives to care for them will be retained in the orphanage. A project proposal is already being developed for submission to prospective partners for the establishment of the Orphanage. We invite interested partners to journey with us in this life saving and life changing ministry.

The following data shows the geographical spread of Ebola orphans in Sierra Leone as at November 2014. As stated above, Kailahun and Kenema account for the most number of affected children who have lost either a single parent or both parents. The figures present a compelling reason for the church to rise and act by developing a life-saving ministry for these vulnerable children.

Ministry of Social Welfare, Gender and Children's Affairs/Partners Summary Report on the Rapid Registration of Ebola Affected Children **<u>Cumulative Ebola Affected Children Status Report as of 11/11/2014</u>**

District	Affected Children			Quarantined			Confirmed			Confirmed Cases: Deceased			Confirmed Cases: In Treatment			Confirmed Cases: Discharged			Single Orphan			Double Orphan		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Bo District	220	119	101	190	105	85	20	8	12	18	6	12	0	0	0	2	2	0	14	4	10	18	9	9
Bombali	156	86	70	89	56	33	66	30	36	14	5	9	1	1	0	51	24	27	0	0	0	12	7	5
Kailahun	478	234	244	38	14	24	123	59	64	43	23	20	2	1	1	78	35	43	13	10	3	228	106	122
Kenema	402	182	220	121	57	64	50	22	28	29	12	17	0	0	0	21	10	11	0	0	0	227	101	126
Kono	78	34	44	77	34	43	1	0	1	1	0	1	0	0	0	0	0	0	2	2	0	13	6	7
Moyamba	128	60	68	70	32	38	42	23	19	17	10	7	14	7	7	11	6	5	2	0	2	8	3	5
Port Loko	382	194	188	307	160	147	17	7	10	0	0	0	6	4	2	11	3	8	3	1	2	88	54	34
Pujehun	204	100	104	186	92	94	1	0	1	0	0	0	1	0	1	0	0	0	9	4	5	15	10	5
Tonkolili	533	270	263	465	241	224	60	26	34	13	8	5	8	3	5	39	15	24	17	10	7	91	46	45
Western Area Rural	195	109	86	115	63	52	36	19	17	11	9	2	8	3	5	17	7	10	10	8	2	31	21	10
Western Area Urban	480	237	243	383	187	196	64	33	31	22	9	13	11	7	4	31	17	14	19	5	14	38	22	16
Bonthe	51	25	26	51	25	26	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kambia	176	99	77	173	96	77	3	3	0	2	2	0	1	1	0							26	13	13
Grand Total	**3483**	**1749**	**1734**	**2265**	**1162**	**1103**	**483**	**230**	**253**	**170**	**84**	**86**	**52**	**27**	**25**	**261**	**119**	**142**	**89**	**44**	**45**	**795**	**398**	**397**

7. Internet facility One of our major priorities in the next one year is to create an internet capable infrastructure throughout the conference. Our first priority is to provide all our ten District Superintendents with lap tops

and an internet modem so they are able to connect with their pastors and congregations and with the conference head office.

Second, by the end of the year (2015), the UMC headquarters office will be relocating to a very spacious facility in the West end of Freetown. The plan is to make this building internet capable by installing a very effective Wi-Fi internet service. Our plan is to work with the United Methodist Communications to bring the dream to fruition.

8. New Government policy on Employment The recent minimum wage rate policy imposed by government will have a crippling effect on the already fragile financial position in the conference. The minimum wage rate announced by Government which came into effect January 1, 2015 is LE 500,000 ($100) per month). This has completely thrown our budget over board and with the value of the US dollar rapidly rising over and above the Leone, the situation might lead us into a serious crisis. For example , with the new salary raise;

- Pastors' salaries have jumped from LE 36,506,000 ($8,000) to LE 79,906,000 ($17,000) per Month an increase of about 100%.
- Staff salaries at the UMC headquarters have jumped from LE 11,609,000 ($2,500) to LE 23,838,000 ($4,500) per month resulting in an increase of about 100%.
- Evangelists/Lay pastors' salaries have jumped from LE 5,075,000 ($1,127) to LE 16,500,000 ($3,600) per month, an increase of about 300%.

With our sources of income remaining the same, this is certainly huge financial burden that conference cannot cope with.

Our conference finance committee has proposed some recommendations including termination of service of workers so that we can only employ workers who we can pay at the end of the month. This will mean putting people out of job. It will also mean closing down some of our new mission areas where ministries are already flourishing. This is the last thing we would want to do as a church but we may be forced by circumstances beyond our control to do so.

In pursuant of these goals, we hope to engage every United Methodist congregation, heads of various ministries/programs/departments and our international mission partners in developing strategies for effective implementation of the above goals. It is hoped that the above goals will

serve as a working document during our Sierra Leone Partners Conferences in Germany and Norway (May 2015) and in the US (August 2015).