EVALUATION OF DISASTERS EMERGENCY COMMITTEE AND AGE INTERNATIONAL FUNDED: RESPONDING TO THE EBOLA OUTBREAK IN SIERRA LEONE THROUGH AGE-INCLUSIVE COMMUNITY-LED ACTION

EVALUATION REPORT FOR AGE INTERNATIONAL

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ABBREVIATIONS

ABC – avoiding body contact

ACAPS – Assessment Capacities Project

CHO – Chief Health Officer

CLEA – community-led Ebola Action

CLTS – community-led total sanitation

DEC – Disasters Emergency Committee

DERC – District Ebola Response Centre

DMHT – District Medical Officer

EVD – Ebola Virus Disease

FAO – Food and Agricultural Organization of the United Nations

FGD – Focus group discussions

HDI – Human Development Index

iCMM – integrated community case management

KAP – knowledge, attitudes, and practices

M&E - monitoring and evaluation

MNCH – maternal, newborn, and child health

MoGD – Ministry of Gender and Development

NERC – National Ebola Response Centre

OECD-DAC – Organization for Economic Co-operation and Development – Development Assistance Committee

SMAC – Social Mobilisation Action Consortium

SPSS – Statistical Package for the Social Sciences

UK – United Kingdom

UN – United Nations

USD – United States dollars

WASH – water, sanitation, and hygiene

WFP – World Food Programme

WHO – World Health Organization

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EXECUTIVE SUMMARY

As part of the response to the Ebola Virus Disease (EVD) outbreak in Sierra Leone, Age International and Restless Development implemented the Disasters Emergency Committee (DEC) and Age International funded project entitled: Responding to the EVD outbreak in Sierra Leone through Age-inclusive Community-led Action. This project focused on EVD prevention through community-led social mobilisation and EVD-related inclusion activities targeted towards the elderly and of vulnerable groups. The project consists of three phases, the first of which is considered in this evaluation. The expected outcomes for phase one the project were twofold:

A. 176,640 people in 1,368 communities in four districts in Sierra Leone practice EVD-safe and non-discriminatory behaviours to reduce EVD-related morbidity and mortality and stigma
B. Humanitarian actors responding to the EVD outbreak in Sierra Leone and Liberia integrate the specific needs of older people in their own response activities

The primary objective of this evaluation is to assess the effectiveness of the community-led approach in stopping the spread of EVD, the extent to which this approach has been inclusive of older people and other vulnerable groups, and the effectiveness of the Inclusion Advisor in supporting members of the Food Security Cluster in Liberia to integrate older people in their response programmes.

The fieldwork that informed this report occurred 24 June – 19 July 2015, with data collection taking place 6-11 July in the following four districts: Kono, Portloko, Bonthe and Pujehun. The evaluation relied on project documents and monitoring data, as well as key informant interviews (KIIs) and focus group discussion (FGDs). A mixed methods approach was used to provide measurable quantitative information about the progress towards key evaluation criteria, as well as to provide qualitative insights into the underlying causal and explanatory factors related to the objectives and indicators of the project.

Relevance

The WHO's *Ebola Response Roadmap*[1] identifies social mobilization as a 'priority activity' for tackling EVD. As part of its response, the *Roadmap* calls for "full community engagement in contact tracing and risk mitigation" as a necessary step to achieving the full geographic coverage with complementary EVD response activities in countries with widespread and intense transmission. In addition, social mobilization is a key pillar/cluster of the National Ebola Response Centre (NERC) in Sierra Leone,[2] and an important component of Sierra Leone's fight against the spread of EVD. Thus, the project's community-led Ebola Action (CLEA) approach was aligned with the type of approach called for by the WHO and implemented nationally through the NERC. Further, community-led approaches are increasingly being used globally in high-impact interventions to prevent and manage diseases such as pneumonia, malaria and diarrhoea.

Effectiveness

Though, overall, the project was implemented effectively, there were some challenges. Perhaps most importantly, throughout qualitative data it was indicated that most communities were, at first, resistant to mobilization work. Transportation was also said to

[1] WHO, 2014, *Ebola Response Roadmap*, 28 August, p. 7.

[2] Government of Sierra Leone, NERC, http://www.nerc.sl/?q=nercpillartexo/socialmobilization (12 September 2015).

be a problem, with access to remote communities presenting a particular challenge. In these areas, the timely implementation of the project was hindered, and a lack of transportation exacerbated difficulties in scheduling community visits. But as the relationship between mobilizers and the communities grew, the scheduling of project activities improved.

Moreover, many communities had expectations that financial assistance would be provided through the project. In these instances, financial expectations impeded project implementation, as communities refused to cooperate in the early stages of mobilization, delaying its implementation. As well, as the project progressed community members were included into mobilization and some were incentivized financially.

A significant issue throughout the project was timely monitoring and evaluation (M&E). It seems as though, at all levels of M&E there was a backlog of data, which was not processed in a way as to inform project review and revision. Because there was limited feedback from field level activities to Age International, it was challenging to track the implementation of elderly-specific programming. An alternative would have been to utilize a system that better balances M&E capacities with information needs – foregoing analytical depth for the type of a dynamic feedback mechanisms required in an emergency. Also, a plan was made for Inclusion Advisor in Liberia to provide regular remote feedback and/or training to the volunteers based on the feedback Restless Development provided from mobilisers. However, because feedback was not sustained, such an interaction was not possible, leaving the Age International to rely on anecdotal information for monitoring and advocacy work.

In Liberia, despite notable achievements, the work of the Inclusion Advisor was hindered by a number of challenges. One particular challenge was the infrequent and inconsistent cluster meetings, making it difficult to form relationships with cluster members, and promote inclusion through cluster activities. Another key constraint was that, with the change of leadership within the Food Security Cluster, there was an overwhelming focus of the cluster on the Food Security Assessment. In the opinion of the Inclusion Advisor, this came at the cost of activities, for example, that were focused on examining the programming of specific partners, as well as potential programming gaps within the cluster.[3] Further, three months had passed of phase one before the Inclusion Advisor commenced her work. As result, when she did arrive in Liberia, there had already been a significant change in circumstances on the ground, which created the necessity that activities of the Inclusion Advisor were shifted from the EVD response to EVD recovery.

Impact

Since the commencement of the project, rates of EVD in the four districts Age International supported through this project had undoubtedly gone down. Social mobilization "activities were critical to ending the epidemic."[4] Importantly, using on-the-ground mobilizers played "an important role in turning the tide against Ebola."[5] While it is not possible disaggregate project-specific effects on knowledge, attitudes, and practices (KAP), surveys conducted throughout the EVD outbreak suggest that there has been important positive changes to behaviours in terms of EVD prevention. Restless

[3] KII, Age International Inclusion Advisor, 15 August 2015.

[4] USAID, "Q&A: How Changing Behaviors is Helping Stop Ebola's Spread in West Africa," Posted by Clara Wagner on Wednesday, June 10th 2015, https://blog.usaid.gov/2015/06/qa-how-changing-behaviors-is-helping-stop-ebolas-spread-in-west-africa/ 18 September 2015.

[5] Snyder, David, "Social Mobilization Helps Turn the Tide in Sierra Leone," CDC Foundation, http://www.cdcfoundation.org/blog-entry/social-mobilization-helps-turn-tide-sierra-leone (18 September 2015).

Development's monitoring data was ambiguous in terms of the effects of mobilization activities on influencing important behaviours, but qualitative research appears to support opinions related to the impact of mobilization in the EVD response within this project. Amongst all types of actors interviewed as part of this evaluation, and across all project-supported districts, there is a belief that project activities contributed to reducing EVD.

Firstly, FGDs reported that there were changes to health-seeking behaviours, where individuals moved away from traditional medicine towards public health for EVD treatment. Qualitative data also suggests that, in fact, unsafe burial practices were another specific behaviour that was reduced through mobilization, which had a positive impact on reducing EVD rates. There is evidence that such behavioural change may have been particularly impactful for the elderly, whose socially-prescribed roles often necessitated that they tend to bodies after death. Finally, project activities also contributed positively to increasing proper hygiene practices.

Through qualitative research it was suggested that the implementation and monitoring of community action plans had an important impact on behavioural changes. In addition to the behavioural changes identified above, other important changes included: screening and registering of visitors entering communities, prohibitions on the consumption of bush meat, and strict adherence to the principles of ABC (avoiding body contact). Despite generally positive changes in all behavioural areas it was suggested that the eating of bush meat was most difficult to alter, due to a neglect of this issue, within the context of other issues.

In Liberia, the Inclusion Advisor was able to record many important achievements, despite the challenges listed in the effectiveness section. For instance, she provided inputs on issues related to the elderly and other vulnerable groups into a multi-sectorial assessment led by the Assessment Capacities Project (ACAPS) and a nationwide comprehensive Food Security Assessment. Further, she led a half-day workshop for World Food Programme (WFP) staff in Gbarnga County and its partners on safe and dignified distributions and the risks faced during such distributions by vulnerable groups. Save the Children International also responded positively to an offer to conduct an observation of a cash distribution to 140 beneficiaries in Montserrado County, with the objective of providing recommendations for improved inclusion of older people and persons with disabilities, increased safety, dignity and accountability. A second observation was carried out to a WFP food distribution as part of their assistance to communities previously quarantined due to EVD cases in that community.

According to key stakeholders consulted for this evaluation, the main impacts of the Inclusion Advisor's work were described to be: improved awareness about the situation and needs of vulnerable groups, increased awareness and information to raise interest and encourage actions to improve support and facilitation of older and disable people to obtain food assistance, and improved safe delivery of cash to people with vulnerabilities and better targeting of most vulnerable households and individuals for cash assistance.

Accessibility

As stated, the intervention included training community mobilisers on the inclusion of vulnerable groups, including older people. Pre- and post-test questionnaires were randomly administered to the mobilisers before and after training. The average score for pre-tests was 59.5 per cent. This average score improved to 87.6 per cent for post-tests. All test questions showed an improvement between the pre- and post-tests.

However, qualitative data collected as part of this evaluation revealed a widespread belief that youth were believed to have benefited most for the project. Qualitative research also indicated that the project was reported to have had considerable overall impacts in many communities, and vulnerable populations shared the benefits of these impacts; though in many instances, benefits to vulnerable populations were reported to have been limited to 'universal' broader impacts. In this sense, "the vulnerable only participate practically in the information they get from the sensitization such as frequent hand washing, no body contact. They were not participating in the sensitization because they are not active."[6] As put by another FGD, "the vulnerable people were included in the holding of meetings, and their participation was accepted in the discussion by giving out different ideas towards [fighting] the Ebola virus."[7]

But there were also opinion amongst many key informants and focus group participants that the inclusion of vulnerable persons in project activities was reported to have been imperfect in many respects. For instance, vulnerable people were often not incorporated directly into implementing mobilization activities, because of a belief that the elderly and disabled unable to cope with the physical demands of community mobilization and sensitization. Though it was not the expressed design of the project to include vulnerable groups in mobilization, such a strategy should perhaps have been considered as part of an integrated intergenerational approach to mobilization.

Partnership and Way of Working

In Liberia, Age International worked with HelpAge, a key delivery partner that shares values, priorities, and approaches to programming. As a result, there were no challenges in the work undertaken together in Liberia. Yet, in Liberia, the Inclusion Advisor experienced some partnership-related problems within the Food Security Cluster – including: infrequent meetings and a limited focus on the Food Security Assessment. These challenges were mitigated by leveraging other working groups and forming bilateral relationships, as previously described.

At the outset of the project in Sierra Leone, its design attempted to draw on an intergenerational approach – in particular, sensitising and training young people to work together with older people to stop the spread of EVD. However, it was expressed in KIIs that, as partners, Age International and Restless Development did not explore sufficiently what such an intergenerational approach might entail and require – especially the possible challenges that such an approach my pose. In retrospect, more resources could have been devoted to developing a better understanding how an intergenerational approach might be leverage for programming in an emergency situation.

While it is true that Age International's partnership with Restless Development leveraged the latter's social mobilization capacities and networks (a key rationale for the partnership), it can be seen from the analysis above that, in spite of the training and support offered to social mobilisers on the needs of older people and vulnerable groups, social mobilization activities focussed more on young people. As mentioned above, the elderly and other vulnerable groups were largely left out of being direct implementors in social mobilization, and were treated as a beneficiary group rather than becoming the focus of an integrated intergenerational approach. Again, though the programme design did not specifically call for including the elderly directly as mobilizers, it is conceivable that an intergenerational approach could have included the elderly and other vulnerable populations directly in mobilization.

[6] FGD, community leaders, Bendu, Bonthe, 13 July 2015.
[7] FGD, community leaders, Masam Kpaka Pujehun, 10 July 2015.

Accountability

At an international level, mechanisms were in place to manage the relationship between Restless Development and Age International; these included: Memorandums of Understanding drawn up between Age International, HelpAge, and Restless Development, a contract agreement drawn up between Age International and Restless Development, regular meetings between Age International and Restless Development UK, regular communication between the Age International Training Advisor and Restless Development in Sierra Leone, and regular communication between Restless Development UK and Restless Development in Sierra Leone.

As stated previously, this evaluation found that challenges in M&E included a lack of systematic feedback of monitoring data from mobilisers, as well as the lack of timely availability of pre- and post-training surveys to provide updates regarding the efficacy of trainings. Lacking this data, Age International's ability to ensure accountability and effective project implementation was reduced. This also reduced the ability of the organization to draw on data to support its advocacy for the needs of the elderly and other vulnerable groups in the context of the EVD outbreak.

Conclusions and Recommendations

Though the impact of the EVD outbreak in Sierra Leone has been great, from the analysis above it can be seen that the project had a positive impact in reducing EVD in the country. In addition, the project also promoted the needs of vulnerable populations in both Sierra Leone and Liberia. The lessons learned also offer an opportunity to inform future programming – both in Sierra Leone and Liberia, and elsewhere. The following are recommendations associated with this evaluation:

- Behavioural change is a long-term process. There may be an opportunity to leverage experiences within the EVD epidemic to consolidate and improve on gains made in behavioural changes in areas such as water, sanitation, and hygiene (WASH) and maternal, newborn, and child health (MNCH).
- Subsequent project activities should utilize a system that better balances M&E capacities with information needs. Such a system would forego some analytical depth in favour of the type of a dynamic feedback mechanisms required in an emergency, improving the tracking the implementation of elderly-specific programming.
- The work done by the Inclusion Advisor in Liberia to form relationships and create awareness about issues related to the elderly – and other vulnerable populations – presents an opportunity to advocate for more inclusive recovery programming. Working with implementing partners during the early stages the recovery can help ensure that their programming is equitable and sensitive to the needs of the most vulnerable.
- The project could have benefited from an Inclusion Advisor in Sierra Leone during phase one. Such a position should be created in the recovery phase of the project.
- A continued partnership with Restless Development is logical in the recovery phase. However, more needs to be done to at the outset of the next phase partnership to define and design an intergenerational approach – making sure young and old are working together in post-EVD recovery.
- There is still a need to scale up short-term food security operations to answer the immediate food needs of the most vulnerable people, and especially to address food supply gaps, particularly among most-affected demographics.

- The key concern noted was the need for the provision of financial support for households headed by the elderly and disabled. With the high numbers of EVD orphans, older people will take on greater care roles and therefore have increased financial needs for themselves and orphans in their care. This may be a particularly acute need in those instances where a grandparent has taken on added parenting responsibilities, as they have adopted children whose guardians have died.
- As part of a potential partnership with Restless Development – or other partners – in the recovery phase, explore the potential to implement livelihood recovery activities for older people and other vulnerable groups.

1 INTRODUCTION

In May 2014, the Ebola Virus Disease (EVD) epidemic spread to Sierra Leone from the neighbouring countries of Guinea and Liberia. Since the beginning of the outbreak, there have been over 13,000 cases in Sierra Leone, which have resulted in almost 4,000 deaths. As part of the response to the EVD crisis, the World Health Organization (WHO) developed the *Ebola Response Roadmap*,[8] which calls for an increased coordinated international response in Sierra Leone and other affected countries. Within the *Roadmap*, there is a focus on social mobilization to reduce the number of cases of EVD. This is seen as a key response requirement, along side the identification and treatment of EVD cases. As the outbreak progressed, it was further recognized that there was a need to move from the awareness-raising approach that marked the first stages of the response – where communities necessitated sensitization regarding the authenticity of the EVD outbreak – to a community-specific and community-led approach that was both well-coordinated and responsive to the constantly evolving outbreak.

In line with these needs, Age International established a partnership with Restless Development to respond to the EVD in Sierra Leone in November 2014. Age International is the only United Kingdom (UK) charity working for, and with, older people in developing countries, and is the UK member of the global HelpAge network. The organizational vision is a world in which women and men everywhere can lead dignified, healthy and secure lives as they grow older. Conversely, Restless Development works to place young people at the forefront of change and development, in order to promote young people's taking of leadership roles in addressing the most urgent issues facing their countries and the world. Age International identified that Restless Development was well-connected to the social mobilisation pillar of the EVD response, had capabilities in volunteer mobilisation and training, and was able to operate in almost all of the districts of Sierra Leone.

From these two different perspectives, the resultant Disasters Emergency Committee (DEC) and Age International funded project – entitled: Responding to the EVD outbreak in Sierra Leone through Age-inclusive Community-led Action – focused on community-led social mobilisation and inclusion activities, with technical support provided by HelpAge International and an Age International commissioned technical consultant. In February 2015 Age International seconded an Inclusion Advisor to the Food Security Cluster in Liberia, managed by HelpAge International. This six-month placement until 31 July, and was evaluated as part of phase one of the response. Phase one of this response ended 30 April. Phase two started on 1 May and involves a further four months of social mobilisation until 31 August 2015. Phase three, focussing on early recovery, is expected to start in the last quarter of 2015.

The expected outcomes for phase one the project were twofold:

A. 176,640 people in 1,368 communities in four districts in Sierra Leone practice EVD-safe and non-discriminatory behaviours to reduce EVD-related morbidity and mortality and stigma
B. Humanitarian actors responding to the EVD outbreak in Sierra Leone and Liberia integrate the specific needs of older people in their own response activities

For outcome B, humanitarian actors targeted in Sierra Leone are principally Restless Development staff and volunteers, with members of the Special Needs Working Group targeted to a lesser extent. Humanitarian actors targeted in Liberia are limited to members of the Food Security Cluster.

[8] WHO, 2014, *Ebola Response Roadmap*, WHO/EVD/Roadmap/14.1
http://apps.who.int/iris/bitstream/10665/131596/1/EbolaResponseRoadmap.pdf?ua=1

1.1 Evaluation Purpose

An evaluation is required as part of the project. As per the evaluation terms of reference, the primary objective of this evaluation is to assess the extent to which the project has achieved its outcomes, including:

- The effectiveness of the community-led approach in the social mobilisation drive in stopping the spread of EVD
- The extent to which this approach has been inclusive of older people, amongst other vulnerable groups, within the communities
- The effectiveness of the Inclusion Advisor in supporting members of the Food Security Cluster in Liberia to integrate older people in their response programmes

Further, the conversations with Age International and Restless Development Sierra Leone suggest that the evaluation should also examine:

- The relevance and effectiveness of the new partnership between Age International and Restless Development, especially considering remote partnership between Age International, UK, and Restless Development Sierra Leone
- Relevant opportunities for programming during the post-EVD recovery, or phase three of the project

The lessons learned and recommendations from this evaluation can be leveraged by Age International and its partners for the purposes of accountability and organizational learning. The criteria of relevance, effectiveness, efficiency, impact, and sustainability will serve as the foundation for the evaluation framework outlined in this proposal. These "Criteria for Evaluating Development Assistance"[9] have been designed for evaluating international development projects. Other key criteria for evaluation will include: accessibility, coordination, connectedness, accountability, transparency, impartiality and equity, and partnership and way of working. The 'quality criteria for partnership assessments' outlined by Coordination SUD[10] can serve as a guide for measuring many of the criteria just mentioned. Additionally, the evaluation will be designed and implemented according to established good practices in the areas of monitoring and evaluation (M&E), as outlined in the Organization for Economic Co-operation and Development – Development Assistance Committee's (OECD-DAC) *The Principles for Evaluation of Development Assistance*[11] and accepted standards for M&E in humanitarian contexts.[12]

This evaluation report is comprised of the following sections: the preceding introduction; a context section that outlines the effects of the EVD outbreak, so as to provide a setting for the project and to provide a starting point for identifying opportunities for phase three of the project; an outline of the methodology; the main evaluation findings; and conclusions and recommendations.

2 CONTEXT

Even before the EVD outbreak, Sierra Leone already ranked near the bottom on the United Nations (UN) Human Development Index (HDI). Poverty in the country was widespread, with more than 60 per cent of the population living on less than USD 1.25 a day. Sierra Leone's

[9] OECD-DAC, "DAC Criteria for Evaluating Development Assistance," http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm (1 May 2013).
[10] Coordination SUD. *A Practical Guide to be Used by Partners from the North and the South.* http://www.coordinationsud.org/document-ressource/guide-partenariat
[11] OECD-DAC, 1991, *Principles for Evaluation of Development Assistance*, Paris: OECD.
[12] See, for example: OECD-DAC, 1999, *Guide for Evaluating Humanitarian Action Complex Emergencies:* and, ALNAP, 2006, *Evaluating Humanitarian Action Using the OECD-DAC Criteria.*

HDI value for 2013 was 0.374 – which is in the low human development category – positioning it at 183 out of 187 countries and territories.[13] In terms of issues affecting vulnerable people, the percentage of older people having access to pensions is very low, leaving a majority of older people without any social security and in danger of poverty. Estimates of the population size of persons with disabilities in Sierra Leone ranges from 2.4 per cent to more than 20 per cent of the population. Disabled people often live on the fringe, marginalized and ostracized by the wider community. As will be detailed below – the already precarious socioeconomic status of Sierra Leone – and in particular of vulnerable groups in the country – was exacerbated by the outbreak of EVD.

As of 9 August 2015, Sierra Leone had experienced 13,494 cases of EVD – the most of all countries affected by the outbreak – 3,952 of which were fatal.[14] Studies point to higher fatality rates by age for EVD. For instance, patients with EVD under the age of 21 years had a significantly lower fatality rate than those over the age of 45 years – 57 per cent versus 94 per cent, respectively.[15] Older people are usually prone to have a weak immune system, poor hydration, and co-morbidities that make them more prone to infections. Moreover, caring and burial practices were important transmission routes during the EVD outbreak. In many cases, the elderly are responsible for caring for the sick immediately before the moment of death, and body preparation practices immediately after death. In this way, community-led mobilization aimed at older people targets key transmission routes of EVD.

But measures of the impacts of the EVD outbreak extend far beyond just total cases and mortality rates. The outbreak, for instance, had a serious negative effect on economic development. Official forecasts for growth in Sierra Leone in 2014 were revised downwards by 6.4 percentage points since the onset of the outbreak.[16] Though these have been lifted, restrictions on travel and public gatherings, implemented as part of the government response to EVD, severely impeded many economic activities since the outbreak started.[17] Other control measures instituted to control the emergency – for example the closure of businesses, quarantining of homes and communities, and destruction of property – also had significant economic costs, the effects of which are still being felt. Surveys conducted during the last quarter of 2014 found increased unemployment levels, particularly in urban areas and amongst those employed in wage work and non-agricultural self-employment, compared to reference survey data collected earlier in 2014.[18] A more recent assessment of the impacts of EVD in Sierra Leone conducted by BRAC – Sierra Leone in May 2015, revealed that 68.3 per cent of all respondents ranked less income and/or employment as one of the top-three effects of the outbreak.[19]

According to the same study, an even larger percentage of respondents – 73.8 per cent – indicated that less food and/or less farming was a top effect the EVD epidemic. Indeed, the

[13] UNDP, 2014, *Human Development Report 2014 Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience*, Explanatory note on the 2014 Human Development Report composite indices for Sierra Leone, p.1.
[14] WHO, "Ebola: Current Situation," http://apps.who.int/ebola/en/current-situation (accessed 24 August 2015).
[15] Schieffelin, JS, et al., 2015, "Clinical Illness and Outcomes Patients with Ebola Sierra Leone," *The New England Journal of Medicine* 371 (22): 2092-2100.
[16] UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. 17.
[17] ACAPS, 2014, *Briefing Note: Potential Impact of Ebola on Food Security*, 10 November.
[18] Government of Sierra Leone, the World Bank, and Innovations for Poverty Action, 2014, *The Socio-Economic Impacts of Ebola Sierra Leone Results from a High Frequency Cell Phone Survey Round 1*, 12 January, p. 7.
[19] BRAC – Sierra Leone, 2015, *Assessment of The Impact of EVD Five Districts Sierra Leone*, May, p. 10.

EVD outbreak resulted in a serious shock to the agriculture and food sectors in 2014.[20] For instance, restrictions on gathering and movement discouraged many farmers from harvesting their fields.[21] The epidemic started spreading when many crops were being planted and expanded, and when staple crops rice, maize, and cassava were to be harvested. The imposition of quarantines and restrictions on social gatherings hindered the sowing period of the agricultural production cycle. According to Assessment Capacities Project (ACAPS), food insecurity was an important issue during the crisis, and will likely continue to be so until agricultural production resumes.[22]

Disruption to agriculture and food production as a result of EVD were reported to have had particularly strong adverse effects on food security. The Food and Agricultural Organization of the UN (FAO) and World Food Programme (WFP) estimated that about 450,000 people – or 7.5 per cent of the population of Sierra Leone – were severely food insecure as of December 2014.[23] The impact of EVD accounted for more than a quarter of the food insecure. About 76 per cent of the EVD related food insecure individuals were said to live in rural areas. For the elderly, low nourishment from a poor diet can be aggravated by loss of teeth and reduced saliva, leaving the individual less able to cope with the activities of daily living. In an emergency like the EVD crisis, the capacity of older people to survive is already seriously compromised by the ageing process.

Inflation also rose during the crisis, as a result of reduced supply of labour and goods.[24] The increased cost of living compounded vulnerability among many Sierra Leoneans. The resultant reduction in household purchasing power caused poor households in much of the country to be unable to cover essential non-food expenditures and face food insecurity.[25] Making matters even worse, social safety nets were also in disrepair. The devotion of increased expenditures to fighting the EVD outbreak, coupled with declining government revenues, expanded fiscal deficits and reduced expenditures on activities not directly related to EVD response.[26]

In particular, the already fragile Sierra Leonean health system was further weakened by cuts in expenditures on non-EVD related health services. A dramatic fall in the use of services – for instance: health agency visits, assisted childbirths, antiretroviral therapy drugs, home visits – was reported during the height of the crisis, owing to fears of infection. If either the supply of, or the demand for, health services do not return more people may die from childbirth, malaria and AIDS.[27] In instances such as this, access to healthcare and other services became even more difficult for older people due to mobility problems.

Moreover, the loss of family members meant that children, women, and the elderly found themselves taking on the roles and responsibilities as the heads of household or additional

[20] Food and Agricultural Organization of the UN (FAO) and World Food Programme (WFP), 2014, *FAO/WFP Crop and Food Security Assessment – Sierra Leone*, Special Report I4279E, 17 December, p. 4.
[21] ACAPS, 2014, *Briefing Note: Potential Impact of Ebola on Food Security*, 10 November.
[22] ACAPS, 2014, *Briefing Note: Potential Impact of Ebola on Food Security*, 10 November.
[23] FAO and WFP, 2014, *FAO/WFP Crop and Food Security Assessment – Sierra Leone*, Special Report I4279E, 17 December, p. 4.
[24] UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. vii.
[25] FEWS NET, 2015, *Guinea, Liberia, and Sierra Leone Special Report*, January, p. 1.
[26] World Bank, 2014, *The Economic Impact of the 2014 Ebola Epidemic: Short and Medium Term Estimates for Guinea, Liberia, and Sierra Leone*, Report No. 90748, 17 September.
[27] UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. vii.

childcare responsibilities.[28] As this happened, older people were pushed into the role of primary caregivers for grandchildren, while lacking the financial resources to assume such responsibility. Further, changing family structures resulting from the EVD crisis – for example, older people headed households, female or widow headed households, and households with large numbers of dependent children – created specific protection risks for older people and their families.

The epidemic is also reported to have broken down social ties. Longstanding traditions of community support and care giving were disrupted, EVD victims were stigmatized and social gatherings cancelled[29]. Many people have come to fear contact with strangers and sometimes even with their own family. Lack of access to support and social relationships compounded the isolation felt by older people, as does the high level of help required in daily activities.

Although EVD had significantly declined to the point that the objective of Sierra Leone being declared EVD-free is within reach, it must be emphasized that many of the impacts of the EVD outbreak outlined above are persistent and on-going. These may continue for years, or even decades, if appropriate measures are not taken by the Government of Sierra Leone and its national and international partners. Interventions implemented over the coming years will play a major role in determining the prospects for national, community, and household development.

3 EVALUATION METHODOLOGY

The fieldwork that informed this report occurred 24 June – 19 July 2015, with data collection taking place 6-11 July. The evaluation methodology utilized both primary and secondary sources, as well as quantitative and qualitative data. A mixed methods approach provided measurable quantitative information about the progress towards key evaluation criteria such as impact and effectiveness, while at the same time providing qualitative insights into criteria of relevance, efficiency, and sustainability, as well as explaining underlying causal and explanatory factors related to the objectives and indicators of the project. The methodological composition was chosen because it provided for a holistic evaluation of both impact- and process- variables, maximizing organizational learning from the intervention.

Although both quantitative and qualitative methods were used for the evaluation, primary research focused on the qualitative. A largely qualitative approach to research was better able to disentangle project-specific changes to knowledge, attitudes, and practices (KAP). This method also allowed for a step-by-step understanding of the processes of change. This was not possible with quantitative methods. In addition, a quantitative-focused primary research design would have required a large-n representative survey. Such a survey would need to be compared to a baseline (and counterfactual) in order to quantify project-attributable change. Data from KAP studies relating to EVD was unavailable.[30]

Project documents and monitoring data were used as the main form of secondary sources. Primary research relied on key informant interviews (KIIs) and focus group discussions

[28] Inter-agency Standing Committee (IASC), 2015, *Humanitarian Crisis West Africa (Ebola) Gender Alert: February 2015*.

[29] UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. vii.

[30] See: Catholic Relief Services, FOCUS 1000, and United Nations Children's Fund (UNICEF), 2014, *Study on Public KAP Relating to EVD Prevention and Medical Care Sierra Leone*, September; Government of Sierra Leone, Center for Disease Control (CDC), Focus 1000, UNICEF, 2014, *Follow-up Study on Public KAP Relating to EVD Prevention and Medical Care Sierra Leone*, KAP-2, Final Report; and Government of Sierra Leone, CDC, Focus 1000, UNICEF, 2015, *Follow-up Study on Public KAP Relating to EVD SL, KAP 3, Preliminary Findings*.

(FGDs). KIIs were conducted at the international, national, district, and community levels, while FGDs were conducted in every community. More information on each method used is provided below. To choose participants in primary research, the study relied on a combination of two forms of purposeful sampling: convenience and maximum variation sampling. Those key informants and focus group participants that were available for the research project were accessed through convenience sampling. However, convenience samples were stratified by key characteristics to ensure maximum variation facilities and persons sampled.

Because time and logistical constraints did not permit an evaluation of all project-supported communities, a sample of four districts was taken, focusing on four communities in each district. The districts chosen included all four districts supported under project Outcome A – Kono, Portloko, Bonthe and Pujehun – as these are all also included under activities related to Outcome B. The selection of the number of districts and communities balanced time in-field relative to an estimate of how many communities would have to be visited to evaluate project-wide indicators. Communities were selected according to the following criteria:

- In different directions from the capital
- Within travelling distance of the district capital, to facilitate travel of research teams
- Had health facilities within the community, or close to the community
- Two communities that were deemed to be more affected by the EDV outbreak – as determined by Restless Development field staff, based the perceived number of EVD cases and deaths – and two communities deemed to be less affected by the EVD outbreak
- Still had Restless Development staff or mobilisers living within them, so as to facilitate community entry and research activities

Unlike with representative quantitative research, there are no set rules for the number of total communities chosen for the type of qualitative research design used for this evaluation. The final number chosen balanced the time and resources available for fieldwork with the need to generate meaningful qualitative data from a number of different perspectives. Based on the consultant's experiences with similar evaluations, this is a suitable number of communities to visit. One must also remember that all community-focused research is also complemented with additional research at the international, national, and district levels and with Age International and Restless Development representatives within the project, allowing for additional triangulation. Further, triangulation is also possible through monitoring data and other secondary data.

The evaluation for the Liberian portion of Outcome B was conducted remotely. It required a KII with the Inclusion Advisor, and emailed questionnaires to representatives of the Food Security Cluster. Such questionnaires provided a diverse array of perspectives on inclusion-related issues and allowed for some quantifiable evidence to be generated regarding the extent and quality of inclusion among group members during the EVD response in Liberia; see Annex A for FGD and KII question sets and see Annex B for a copy of the Liberia stakeholder survey.

3.1 Secondary Data

There were three types of secondary sources used for the purposes of this evaluation. Firstly, the evaluation required an initial desk review of relevant secondary sources to situate it within the appropriate social, political, economic, programming, and policy context, including the: *EVD Outbreak Response Plan in West Africa* drafted by the WHO and the

governments of Guinea, Liberia, and Sierra Leone,[31] which also contains the WHO's *Strategic Action Plan for Ebola Outbreak Response*, and *Liberia Operational Plan For Accelerated Response to Re-occurrence of Ebola Epidemic* and the *Sierra Leone Accelerated EVD Outbreak Response Plan.* Secondly, project documents that were used to better understand the project, including: grant agreement, logframe, DEC supporting documents, *DEC Ebola Crisis Appeal – Response Review,*[32] project narrative reports, project budget, plans, etc. Important secondary data included monitoring data from mobilization activities, as well as pre- and post-test data from inclusions trainings. While data from KAP studies was not made available for analysis, or for follow-up through further quantitative research, KAP reports provided key information the KAP relating to EVD.

3.2 Key Informant Interviews

KIIs focused on determining the underlying causal and explanatory factors affecting project performance. KIIs targeted a broad spectrum of stakeholders at the international, national, and sub-national levels. Interviews with key informants in Liberia were conducted remotely. International and national level KIIs focused on analysing higher-level elements of the key evaluation criteria mentioned above, especially project partnership and coordination. Other interviews looked at the on-the-ground implementation and context related to the project. In this regards to the latter, issues related vulnerability were accounted for; not only by including vulnerable populations in the research, but by examining the impact that the project had on relations between vulnerable populations and the communities in, and beyond, the EVD response.

International or national level key informants

- Age International: Executive Director, Project Officer, Monitoring and Learning Manager, Liberia Inclusion Advisor, and Training Advisor
- Restless Development UK: Senior Partnerships Manager
- Restless Development Sierra Leone: Country Director, Social Mobilisation Action Consortium (SMAC) National Coordinator, SMAC Regional Coordinators, and M&E Officer
- EVD response partners: WFP, FAO, Save the Children, Welthungerhilfe, Ministry of Gender and Development (MoGD), Mercy Corps, and ACDI/VOCA

District level key informants

- SMAC District Coordinators and Assistant Project Coordinators in selected districts
- District Liaison Officers in selected districts
- District Medical Officer (DMHT) in selected districts
- District Ebola Response Centre (DERC) Coordinator in selected districts

Community level key informants

- Chief Health Officers (CHOs) and nurses in for selected communities
- SMAC community mobilizers in selected communities

At the international and national level a total of seventeen key informants were interviewed. As can be seen from the following table, there was a total of fifteen key informants interviewed at the district level, and 41 at the community level.

[31] UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease Guinea, Liberia and Sierra Leone – The Road to Recovery*, December

[32] Oosterhoff, Pauline, 2015, *DEC Ebola Crisis Appeal – Response Review*, March.

Table 1: Key Informants at The District and Community Levels

	Male	Female
DERC	4	0
APC	3	1
DMO	3	1
DLO	0	3
	10	***5***
	Male	**Female**
Health	7	9
Mobilizers	20	5
	27	***14***

KIIs and FGDs were semi-structured and utilized standardized open-ended questions to collect data. A semi-structured interview format allowed for non-standardized follow-up questions that varied between key informants, so as to conduct an in-depth analysis of key issues as they arose. In this way it is possible to produce a deep and detailed understanding of the project. Further, analysing specific cases of community-driven change – or cases where change was not forthcoming – offered insight into the process of change, not just its end result. This interviewing technique was used, for example, to map information flows, and how these do or do not result in improvements expected project outcomes.

3.3 Focus Group Discussions

Outside of KIIs, qualitative data was collected through FGDs. These were used to examine key evaluation criteria, to determine causal factors related to quantitative data, to examine key strengths and challenges of project implementation, and to add context to and validate quantitative data. FGDs were semi-structured, and allowed for follow-up questions in order to develop deep descriptions of the effects of EVD and to map the processes of cause, effect, and response. FGDs all relied on proportional piling, which is a simple method that helps to obtain data from participants about relative values or relative importance of comparable items. This technique is especially useful low-literacy settings to obtain non-representative quantitative estimates. Participants take ten stones to distribute into relative proportions for a particular question. For instance, the relative effects of a particular project on different groups can be gauged according to how many stones out of ten are allocated to each effect group.

Three FGD categories were included in research: vulnerable groups, community leaders, and community members. FGDs with vulnerable groups included a mixture of elderly and disabled persons. Community leaders FGDs included representatives of groups such as: youth group, women's group, religious leaders, chief, etc. Community member FGDs were segregated by sex, with two male discussions and two female discussions being conducted per district. Selection of FGD participants relied on a combination of two forms of purposeful sampling: convenience sampling and maximum variation sampling. Using convenience sampling for FGDs, the evaluation leveraged focus group participants that were available at the time of data collection. However, convenience samples were also stratified by key characteristics to ensure maximum variation within groups; that is, heterogeneity of persons sampled. As mentioned, community member FGDs were segregate by sex, but sex composition was deliberately considered in all FGDs, to ensure, as much as possible, representation of both males and females.

FGDs were made up of 6-8 persons and those included as participants were chosen according to a combination of convenience and maximum variation. Using 6-10 persons per discussion is standard practice when conducting FGDs. The lower end of this spectrum was chosen to allow for a deeper analysis of the project through discussion. In total there were twenty FGDs conducted, with a total of 332 participants – 183 males and 149 females. Within this number there were at total of fifteen FGDs undertaken with vulnerable persons, including 55 males and 47 females.

3.4 Data Entry, Analysis, and Reporting

Evaluation data was captured through paper-based notetaking forms. Conclusions from all research are drawn from the identification of generalizable patterns and trends through the analysis of quantitative and qualitative data. For quantitative data, analysis was done using the statistical application Statistical Package for the Social Sciences (SPSS). For qualitative research, analysis was specifically undertaken through content analysis. Coding for content analysis was done *a posteriori*, by identifying key commonalities in responses between FGDs. Preliminary research results were presented to Age International for feedback and incorporated into an initial draft report, which then required another round of extensive commentary. All comments and feedback resulting from this process were considered for this final evaluation report.

3.5 Limitations

One limitation is that the evaluation lacks a control group and appropriate quantitative data to compare to the treatment group of programme participants and measure changes resulting form mobilization and inclusion efforts. Therefore, evaluation measures perceptions of impact rather than quantified 'attributable change' or 'impact.' That being said, every possible effort was made through available secondary quantitative data and qualitative research to determine project impact, and identify factors external to the project are playing a role in changes to project indicators. Another key limitation was lack of access to KAP survey data. Without KAP data as a baseline, it was not possible develop a quantitative baseline to measure changes to KAP in project communities.

3.6 Ethical Considerations

Broadly, research activities were directed by principles of voluntariness-of-participation, anonymity, and confidentiality. All participants were given the opportunity to opt out of participating in interviews or discussions – or out of specific questions. Confidentiality of respondents was protected by using identification codes rather than names and by safe storage of data after collection. Moreover, research assistants were trained in appropriate research techniques, including how to ask questions about sensitive topics and were provided with relevant security training, in order to keep their respondents and themselves secure at all times. Through this training, research assistants were made aware of the potential types of the physical and emotional harm that respondents could face by participating in the research. Importantly, it was deemed the role of research assistants to promote a secure and comforting environment, but to proactively appraise situations for potential sources of insecurity. Maintaining the security of all persons participating in the research was prioritized ahead of any other research activity. Therefore, if the security of any person was threatened as a result of research, research assistants were instructed to terminate evaluation activities and report situations of insecurity to the team supervisor and/or research consultant. Throughout the research activities, and in all aspects of the research, regular contact was maintained between the research consultant and each research team. Regular contact and monitoring activities acted as a safeguard to ensure that the safety and security protocol discussed during training were followed appropriately.

4 RELEVANCE

The WHO's *Ebola Response Roadmap*[33] identifies social mobilization as a 'priority activity' for tackling EVD. As part of its response, the *Roadmap* calls for "full community engagement in contact tracing and risk mitigation" as a necessary step to achieving the full geographic coverage with complementary EVD response activities in countries with widespread and intense transmission. Accordingly, the WHO suggests that achieving real community understanding, ownership and implementation of EVD response requires sustained mobilization, engagement and dialogue with communities to build collective trust and confidence in the response efforts and community action. For this purpose, establishing robust, community-led approaches to EVD prevention that built on existing local networks and organizations in each affected and at-risk district were essential to full implementation, effectiveness, and sustainable results of the *Roadmap.* Within this strategy, there was an impetus to use community-based approaches to enhance understanding of the disease, risks and risk mitigation measures, putting people at the centre of the response. In addition, social mobilization is a key pillar/cluster of the National Ebola Response Centre (NERC) in Sierra Leone,[34] and an important component of Sierra Leone's fight against the spread of EVD.

It can be said that the project's community-led Ebola Action (CLEA) approach was aligned with the type of approach called for by the WHO and implemented nationally through the NERC. Specifically, CLEA emphasised peer-to-peer learning, in a model that was community-driven rather than one that was forced from outside by external actors. This helped to ensure that communities were responsible for their own actions and ownership of these actions. Community-led approaches are also increasingly being used globally in high-impact interventions to prevent and manage diseases such as pneumonia, malaria and diarrhoea. For instance, integrated community case management (iCCM) is used as a tool to reduce illness and mortality, and it is also being incorporated into community health packages. The water, sanitation, and hygiene (WASH) sector has also relied upon community-led total sanitation (CLTS) to trigger a change of mindset and social norms to encourage entire communities to abandon open defecation. Using this approach, community workers have proved pivotal to communicating messages related to proper hygiene and sanitation practices, as well as other messages aimed at improving knowledge, attitudes, and practices around community health.[35] Thus, the CLEA model is well aligned with a model of community-led development that prevents unnecessary suffering and death from sickness and disease.

Looking at community perceptions of EVD-related needs, as well, it can be said that the project was relevant. The main problems affecting communities, as identified through qualitative research, were reported to be:

- Continued reluctance to accept the EVD was real, especially at the start of the crisis
- Persons were afraid to visit health facilities, and were resorting to traditional medicine or self-care
- Unsafe burial practices in communities
- Social contact between persons as spreading the virus
- Poor hygiene practices, especially in terms of handwashing

[33] WHO, 2014, *Ebola Response Roadmap*, 28 August, p. 7.
[34] Government of Sierra Leone, NERC, http://www.nerc.sl/?q=nercpillartexo/socialmobilization (12 September 2015).
[35] UNICEF, "Water, Sanitation, and Hygiene," UNICEF ESARO http://www.unicef.org/esaro/5479_water_sanitation_hygiene.html (accessed 6 September 2015).

- Lack of regulation of visitors to communities

In general, qualitative research revealed that the project was well-suited towards addressing these problems. In particular, the community-led social mobilisation aspect of the project was well designed in helping to ensure that project communities had sufficient knowledge on EVD and EVD transmission, so as to change attitudes and practices and prevent further spread of the virus. It was noted that where this model of behavioural change was ineffective and Restless Development staff and mobilisers were unable to change behaviour, they intervened at community level – for example, raising alerts of EVD-cases or unsafe burials directly to the district authorities.[36] Thus, the model was not only constructed in such a way as to address the key needs of communities, in such a way that fit with the overall strategic approach to the EVD response, but it also allowed for the flexibility required to adapt to a dynamic emergency response situation.

As identified above, the elderly and other vulnerable populations were at even greater risk during the EVD crisis. Consequently, there was a need to reach older people, through a project that provided them with the knowledge to change behaviours related to transmission. In addition, work with Handicap International incorporated another key group of vulnerable – persons with disabilities – into project activities. In Liberia, patterns of transmission and fatality were the same, though the Inclusion Advisor and KIIs with partners reported that many actors were not considering the needs of vulnerable populations. In partner assessments, all stated they need further training on age, gender and disability issues.[37] Thus, incorporating these important vulnerable groups in the EVD response was relevant in ensuring that the EVD response was not only effective, but was conducted in an equitable manner that considered the needs of all affected – especially the most vulnerable.

5 EFFECTIVENESS

5.1 Sierra Leone

Though, overall, the project was implemented effectively, there were some challenges that were mentioned through qualitative research. In the interests of time and for the sake of organizational learning, this evaluation will focus on those areas of project implementation that can be improved. Perhaps most importantly, throughout qualitative data it was indicated that most communities were, at first, resistant to mobilization work. Indeed, in many cases there was significant pushback to mobilization activities and even the presence of the mobilization teams themselves. “These problems were overcome by the perseverance and commitment of the community mobilizers and through collaboration with the local stakeholders.”[38] In instances where mobilizers were directly prevented from accessing communities, they were able to leverage relationships with other response actors – mostly notably DERC – to get access into the communities. Such experiences signify that behavioural change is a long-term process that must be deeply embedded in community understandings of, and experiences with, society, economy, politics, and culture. Therefore, effective and sustained behavioural change requires deep anthropological understandings of how behaviours are constructed in the first place. Moreover, changing behaviours is a contextual process that can be driven by shifting understandings of emergency situations. In the case of EVD, as the outbreak worsened, communities were more inclined to mobilize in the interests of response and prevention. Similarly, as the outbreak subsides, it should be

[36] KII, Age International Project Officer and M&E Officer, 15 July 2015.
[37] KII, Age International Project Officer and M&E Officer, 15 July 2015.
[38] FGD, community leaders, Bendu, Bonthe, 10 June 2015.

understood that such an inclination will likely decrease, creating problems with the sustainability of positive results achieved through programming.

Transportation was also said to be a problem. Access to remote communities presented a particular challenge. In these areas, the timely implementation of the project was hindered, and a lack of transportation exacerbated difficulties in scheduling community visits. Thus, an additional implementation challenge was organization of proper timing for mobilization visits so that they aligned with the schedules and activities of communities, especially in the early stages of the project. As the relationship between mobilizers and the communities grew, the scheduling of project activities also improved. Mobilizers worked with communities to plan activities in advance, so that residents would be prepared, and did their best to work around community schedules. "Mobilizers came, people used to go to their business places. So that was a difficult problem for the mobilizers, because it was difficult for us to leave our work or business places to come for meeting."[39] A related logistical problem was communication. Some mobilizers lacked mobile phones to communicate to one another, resulting in the delays to implementation. In these cases, mobilizers could not communicate well with project coordinators to inform them about developments in the crisis and adaptations to programming. In addition, some remote areas had limited network coverage, further impeding the flows of communication.

Moreover, many communities had expectations that financial assistance would be provided through the project. In these instances, financial expectations impeded the project, as communities refused to cooperate in the early stages of mobilization, delaying its implementation. "The expectation of community people was high. They were expecting Restless [Development] to give the money and food supply instead of distributing buckets, soap and the rest."[40] Where expectations of communities were unmet, the result was often frustration and an unwillingness to cooperate with mobilization efforts. This was overcome by communicating with community leaders and providing sensitization about how the project was to be conducted and incentives were to be distributed. As well, as the project progressed, community members were included into mobilization and some were incentivized financially. In this way, financial expectations were assuaged – as they saw project benefits coming to their fellow community members.

Another challenge was that materials such as soap and rubber buckets tended to get misused, and could often not be accounted for by communities. While such problems did not pervade all communities, they were reported with significant frequency. Two measures were put in place to address the problem.[41] First, youth volunteers were given stipends, removing the incentive to pilfer project materials. Second, many communities reported identifying this problem and addressing it by increasing oversight – either through community leaders or elderly persons.

A significant issue throughout the project was timely monitoring. This both undermined the monitoring of project activities in-country, as well as the communication of project results outside of Sierra Leone. The latter, in particular, may have impeded the effective oversight of inclusion activities. Without clear feedback on the effectiveness of the project's inclusion component, Age International was unable to determine if trainings were carried out effectively, or if these required some form of revision or adaptation. In addition, further challenges were experienced with pre- and post-training testing, the results of which were only provided while this report was being finalized. As a result, it was difficult to gauge the

[39] FGD, community leaders, Lauwa, Bonthe, 9 July 2015.
[40] FGD, community leaders, Kayinbor Port Loko, 11 July 2015
[41] FGD, community leaders, Kayinbor Port Loko, 11 Jully 2015.

impact of trainings given in a timely way, though it is reported to have progressed as planned.[42] Problems with M&E also affected mobilization activities. Specifically, M&E data collection systems that were developed required a level of capacity that was difficult to reach for mobilization staff.[43] The low capacity to process monitoring data on the ground created a backlog of data, which was still being processed at the time of this evaluation. An alternative would have been to utilize a system that better balances M&E capacities with information needs – foregoing analytical depth for the type of a dynamic feedback mechanisms required in an emergency. Also, a plan was made for Inclusion Advisor in Liberia to provide regular remote feedback and/or training to the volunteers based on the feedback Restless Development provided from mobilisers. However, because feedback was not sustained, such an interaction was not possible. As a result, little monitoring data was communicated to Age International, leaving the organization to rely on anecdotal information.

5.2 Liberia

As can be seen from the table below, the main means of engagement between the Inclusion Advisor and Liberia-based partners was through the provision of training. All partners interviewed as part of the evaluation stated this as a form of engagement. Other important types of engagement that were noted included: presenting information, providing project-specific technical support, and offering advocacy-related support.

Table 2: Means of Engagement with Partners

Method of Engagement	Number of Partners
Inclusion Advisor provided training	7
Inclusion Advisor provided presentation	4
Inclusion Advisor provided project-specific technical support	3
Inclusion Advisor provided advocacy-related support	2
Other	1

While there were challenges in the activities of the Food Security Cluster, this forum was still a primary form of activity for the Inclusion Advisor, as can be see from the table below. However, many partners also engaged with the Inclusion Advisor in the Social Cash Transfer Working Group, implying a multidimensional engagement.

Table 3: Forum of Engagement with Partners

Forum of Engagement	Number of Partners
Food Security Cluster	7
Social Cash Transfer Technical Working Group	5
Other multilateral forum	1
Bilateral meeting	1

The following table illustrates that the main direct and indirect beneficiaries of the Inclusion Advisor's activities were the elderly.

[42] KII, Age International Executive Director, 13 July 2015.
[43] KII, Restless Development, SMAC Regional Coordinators, 15 August 2015.

Table 4: Beneficiary Types Directly and Indirectly Benefiting from Inclusion Advisor

Beneficiary Types	Direct	Indirect
Elderly males	6	5
Elderly females	6	5
Male youth and children	5	4
Female youth and children	5	4
Other adult males	4	4
Other adult females	5	4
Disabled populations	3	4
Other	0	1

Despite the achievements mentioned above, the work of the Inclusion Advisor was hindered by a number of challenges. One particular challenge was the infrequent and inconsistent cluster meetings of the Food Security Cluster. There have been only four meetings between the beginning of February and the end of May, posing a challenge in terms of reaching out to all partners to give updates, and share information, tools, and lessons learned from the work being carried out. This made it difficult to form relationships with cluster members, and promote inclusion through cluster activities. In response, some of the Inclusion Advisor's work was shifted to the Social Cash Transfer Working Group and other multilateral venues, as well as bilateral engagements. Through such a multifaceted approach to engagement, the Inclusion Advisor was able align with the organizations that were already heavily involved in the EVD response.

Another key constraint was that, with the change of leadership within the Food Security Cluster there was an overwhelming focus of the cluster on the Food Security Assessment. In the opinion of the Inclusion Advisor, this came at the cost of activities, for example, that were focused on examining the programming of specific partners and identifying potential vulnerability-related programming gaps within the cluster.[44] Further, three months had passed of phase one before the Inclusion Advisor commenced her work. As result, when she did arrive in Liberia, there had already been a significant change in circumstances on the ground, which created the necessity that activities of the Inclusion Advisor were shifted from the EVD response to EVD recovery. While the Inclusion Advisor was coming from a humanitarian perspective, the organizations she was working with were said to be coming from a development perspective. Admittedly, this resulted in a situation were the Advisor felt to some extent "out of place" in her role.[45]

However, despite these challenges, in general, qualitative data reveals that key informants were satisfied with the work of the inclusion advisor. As put by one key informant, "her quality of presentation through practical illustrations was great and enhanced our capacities to now define Age and disabilities."[46] As will be described below, the primary impact of the Inclusion Advisor's activities was raising awareness about vulnerability issues and sharing information about how these can be incorporated into the EVD-related activities. Out of the seven key informants, four said that the work of the Inclusion Advisor could be improved in some way. Suggestions for improvements were targeted mainly to expanding the work being provided. For instance, key informants suggested that presentations made during cluster meeting were insufficient for proper uptake of information provided. Further, others

[44] KII, Age International Inclusion Advisor, 15 August 2015.
[45] KII, Age International Inclusion Advisor, 15 August 2015.
[46] KII, FAO, 19 August 2015.

also made the point that inclusion advice was necessary outside of Monrovia; though it is unclear if this indeed would have been possible given the timeframe and the context of the crisis.

6 IMPACT

6.1 Sierra Leone

Since the commencement of the project, rates of EVD in Sierra Leone – including in the four districts Age International supported through this project – had undoubtedly gone down. While it is impossible to precisely attribute causation to the project, Age International staff believe that this impact is, at least, "partly attributable to the Restless Development response."[47] In particular, in meetings with donors, social mobilisation is said to have been a well-recognised approach that has worked to help reduce the EVD crisis. Further, there is significant anecdotal evidence, as well as some empirical evidence, that social mobilization was important in halting the spread of EVD.

There are numerous reports from the most EVD-affected countries, as well as news reports that social mobilization "activities were critical to ending the epidemic... And while health facilities and health care workers are absolutely essential in responding to an Ebola outbreak, the behaviours of individuals, families and communities are key to stopping it entirely."[48] Importantly, on-the-ground mobilizers played "an important role in turning the tide against Ebola."[49] While empirical studies of the impact of social mobilization on the EVD response are still limited, there is emerging evidence of the importance of social mobilization. For instance, a study of the role of social mobilization in controlling EVD in Liberia, analysed the dynamics of the disease transmission with and without population behaviour change. The study found that that "education and awareness-induced behaviour change in the population was instrumental in curtailing the Ebola outbreak in Lofa County and is likely playing an important role in stopping the West Africa epidemic altogether."[50]

KAP surveys conducted throughout the EVD outbreak also suggest that there were important positive changes to behaviours in terms of EVD prevention. Between the first KAP survey and the third there was knowledge that EVD is caused by a virus increased from 41 per cent, to 68 per cent.[51] The surveys found that knowledge on EVD prevention and treatment increased in many areas – for instance, with more respondents agreeing that: persons with EVD have a higher chance of survival if s/he immediately goes to a health facility, avoid funeral or burial rituals that require handling the body of someone who died of EVD, and avoid contact with blood and body fluids. At the same time, as knowledge about EVD increased, misconceptions about the virus declined in the following areas: beliefs that traditional healers can treat EVD, beliefs that spiritual healers can treat EVD, beliefs that EVD is transmitted through mosquito bites, beliefs that EVD is transmitted through air, and beliefs that bathing with salt and hot water can prevent EVD. In terms of behaviours, there was decreased resistance to foregoing traditional burial and funeral rituals and proportionally more people called to report deaths and suspected EVD cases.

[47] KII, Age International Project Officer and M&E Officer, 15 July 2015.
[48] USAID, "Q&A: How Changing Behaviors is Helping Stop Ebola's Spread in West Africa," Posted by Clara Wagner on Wednesday, June 10th 2015, https://blog.usaid.gov/2015/06/qa-how-changing-behaviors-is-helping-stop-ebolas-spread-in-west-africa/ 18 September 2015.
[49] Snyder, David, "Social Mobilization Helps Turn the Tide in Sierra Leone," CDC Foundation, http://www.cdcfoundation.org/blog-entry/social-mobilization-helps-turn-tide-sierra-leone (18 September 2015).
[50] Fast, Shannon, et al., 2015, "The Role of Social Mobilization in Controlling Ebola Virus in Lofa County, Liberia," *PLOS Currents Outbreaks*, 15 May 15, Edition 1.
[51] CDC, Focus 1000, UNICEF, 2015, *Follow-up Study on Public KAP Relating to EVD SL, KAP 3, Preliminary Findings*.

Although radio was identified as the most important source for receiving EVD information, the remaining four sources of information were community level sources of communication and mobilization. These included mosques and churches, community talks, house-to-house visits, and megaphones. Based on these findings, it seems as though community level mobilization was important in changing knowledge, attitudes, and practices in relation to EVD.

Restless Development's monitoring data was ambiguous in terms of the effects of mobilization activities on influencing important behaviours. As can be seen from the table below, the percentage of referrals, as a proportion of seriously sick persons went up from 59.6 per cent to 70.9 per cent between triggering and follow-up. On the other hand, safe burials as a proportion of deaths seem to have decreased from 84.7 per cent to 74.4 per cent. The latter indicator contradicts qualitative findings outlined later in this report. It is unclear why these discrepancies exist. One possibility is that monitoring data was not collected or entered properly.

Table 5: Monitoring Data for Certain Behaviours

	Referrals within 24 Hours per Seriously Sick Persons	Safe Burials per Deaths
Triggering	59.6%	84.7%
Follow-up	70.9%	74.4%

The ambiguity of monitoring data notwithstanding, qualitative research appears to support opinions related to the impact of mobilization in the EVD response, generally, and of this project, specifically. Amongst all types of actors interviewed as part of this evaluation, and across all project-supported districts, there is a belief that project activities contributed to reducing EVD. For instance, this statement from one FGD was typical of others captured throughout fieldwork: "the main impacts of the project in this community is the reduction of the new infection cases, decrease in death rate, and awareness of community people."[52] As put by another FGD, "the project was very valuable to our community because with the sensitization by the mobilizers we were able to protect our community from the Ebola virus."[53] Similarly, in another discussion it was mentioned that "with community action plans, the by-laws been were formed, there was referral of the sick to the health centre, good hygiene practice, [and] house-to-house sensitization, the project [had] an impact and value as far as the community as a whole is concerned."[54] Moreover, according to the DERC Coordinator in Pujehun, "mobilization guiding the process of setting community by-laws was important to seeing rapid change in the fight against Ebola."[55]

A typical mechanism used within community action plans was to institute by-laws prohibiting certain types of actions, and associate a fine to violating those by-laws. For example, one community set up the following by-laws:

- "Always wash hands with soap and clean water
- Do not eat bush meat or fruit partly eaten by bush animal
- Report sick person if anybody refused to do that he/she will pay a sum of SLL 500,000
- Any who caught washing and burring dead bodies will pay the sum of SLL 500,00

[52] FGD, community leaders, Kayinbor, Port Loko, 11 Jully 2015.
[53] FGD, women, Melekulay, Port Loko, 9 July 2015.
[54] FGD, women, Potaine, Pujehun, 10 July 2015
[55] KII, DERC, Pujehun, 8 July 2015.

- Anybody that allow strangers without that stranger be checked he/she will pay the sum of SLL 500,000"[56]

Additional issues related to older people that were suggested by mobilizers for community action plans included:[57]

- Older people and other vulnerable groups should be supported and trained to serve as vocal people in their communities and help mobilisers to work effectively
- Older people and other vulnerable groups should be helped with food, medical and other basic stuffs
- Wheel chair or armchairs should be provided for the vulnerable to ease their movement in the community
- Restless development should develop a database to record numbers of old and vulnerable groups in various communities in the country
- There should be a committee of old and vulnerable people where they are given the opportunity to meet and discuss their views

Though implementation of by-laws varied between communities, in some instances it was mentioned that the elderly and disabled played an important role in enforcing laws. For example, on FGD of vulnerable persons mentioned that "with these by-laws, we work as a team so that [they] will be effective, and because of that our community became Ebola-free."[58] An effective model for sustainability reported in a number of communities was that funds paid for violation of by-laws were used to buy materials for EVD prevention; for instance: soap, buckets, and chlorine. Ultimately, by-laws were key for prompting and monitoring behavioural change.

Sensitization was another key within the project. After initial delays in up-take of project messaging, the sensitization work was generally implemented effectively. Information provided through sensitization helped "communities understand and know the causes, effects and prevention methods against the Ebola. This information includes: avoiding body contacts of any kind with people, whether they are sick or not, washing hands with chlorine, soap, and water regularly, and avoiding eating bush meat."[59] Mobilizers worked to ensure that triggering and follow-up meetings became common practice for community people, so that communities would be in a position to handle their own problems. "The main impact is the triggering and follow-up activities was that targeted communities did not do harmful practices that made them in danger of Ebola save. The community group that benefitted from project activities is right across, such as children, adult, and women."[60]

6.1.1 Health-seeking

There are a number of key behavioural mechanisms by which EVD-related behaviours changed, after the initial period of distrust by the community during which the community was sceptical towards the project. Firstly, FGDs reported that there were changes to health-seeking behaviours, where individuals moved away from traditional medicine towards public health for EVD treatment. In community level discussions, such behavioural changes were specifically linked to the work done by community mobilizers. As suggested by one discussant, "awareness was raised in the area of getting people to seek earlier treatment [at health facilities, which] increased the chances of survival. This contributed to increasing

[56] FGD, community leaders, Karlu, Pujehun, 9 July 2015.
[57] Restless Development, 2015, *Mobiliser Feedback Report*, p. 7.
[58] FGD, vulnerable people, Karlu, Pujehun, 9 July 2015.
[59] FGD, vulnerable persons, Bumpeh, Kono, 10 July 2015.
[60] KII, APC, Pujehun, 11 July 2015.

hospital attendance."[61] Behavioural changes likely also decreased transmission rates of EVD, as infected persons were removed from communities and into care.

Also, as result of community engagement, SMAC mobilisers have contributed in creating demand for people to access health services. One unintended positive impact of the project was that it is also reported to have increased health-seeking behaviours in other areas of the health system. For example, in the area of maternal, newborn, and child health (MNCH), "Suckling mothers to take their children for treatment as a result of the sensitization from the projects."[62] Discussants suggest that this may have had a positive impact on reducing maternal mortality in project communities. Moreover, engagement of communities by SMAC social mobilization also contributed to the large turnout of communities in national immunization campaigns in this district.[63] There was a fear in the community members that the vaccines might have been EVD trial vaccines that can lead to the spread of new EVD infection in the district. This was strategically handled by SMAC social mobilization in all the communities in the district.

However, though mobilization efforts were important in increasing demand for health services, these positive changes in demand were bound by structural variables. In particular, a dearth of health staff and health supplies mitigated the potential impact that mobilization activities may have had. Simply, supply of health services was inadequate to meet increased demand at the peak of the crisis. It was reported that in some cases where patients sought care at health facilities, they were turned away due to lack of resources. This was especially true in during the height of the crisis, as the health system struggled to cope with demand for services. As more resources were targeted towards fighting EVD, demand for public health was reported to generally have been met with adequate supply.

6.1.2 Burial Practices

As shown in Table 5 above, Restless Development's monitoring data indicates that safe burials as-a-percentage-of-deaths decreased between triggering and follow-up. However, qualitative data suggests that, in fact, unsafe burial practices were reduced through mobilization, which had a positive impact on reducing EVD rates. In particular, washing of dead bodies by community members was prevalent at the outset of the outbreak and was cut through project activities. "The traditional practice of washing dead bodies was common among the community people but due to all sensitization made through drama and the display of posters these problems were address."[64] As with other activities, improvements to burial practices took time to be seen. Because of the "problem of denial, people were still touching the sick and the dead as a way of sympathizing.[65]

There is evidence that such behavioural change may have been particularly impactful for the elderly. As was mentioned above, the socially-prescribed roles of the elderly often necessitated that they tend to bodies after death. It was said that, as a result of the project, "the elderly they no longer wash or prepared bodies for burial, but call 117 for safe and dignified medical burial."[66] Unfortunately, in some instances, a lack of capacities within the health system impeded safe burial practices – for instance, in the event of late response, or non-response, of burial teams. While "mobilizers were sending alert messages but the

[61] KII, APC, Bonthe, 10 July 2015.
[62] FGD, community leaders, Mamandu, Kono, 11 July 2015.
[63] KII, Restless Development, SMAC Regional Coordinators, 15 August 2015.
[64] FGD, men, Lauwa, Bonthe, 9 July 2015.
[65] FGD, women, Bumpeh, Kono, 10 July 2015.
[66] FGD, community leaders, Makump, Port Loko, 10 July 2015.

respond from burial team for some communities where slow in taking move. The burial team sometimes even refuse to go bodies."[67]

6.1.3 Hygiene

Project activities also contributed positively to increasing proper hygiene practices. According to one FGD, the project was "very valuable, as mobilisers to helped to share about the proper hand washing method… These activities came out in the community by the Restless SMAC project, [and] has made the community to be Ebola by recording about 138 days of zero cases."[68] Other communities shared similar experiences. There are hopes within many interviews and discussions that improved handwashing practices will be sustained beyond the life of the project. For instance, according to one key informant, "the changes from the project made in the lives of community people will be sustained after the Ebola crisis is over, especially the training about proper hygiene.[69] However, in reality it there is likely to be a considerable drop-off in practices related to proper handwashing – and other aspects of proper hygiene – without follow-up sensitization efforts. As the area of hygiene is often difficult in terms of behavioural change, the post-EVD period may present an opportunity for programming. This may be particularly true if messaging around good hygiene is tied directly to experiences people had with EVD.

6.1.4 Other Positive Behavioural Changes from Community Action Plans

As mentioned, it was indicated that the implementation and monitoring of community action plans had an important impact on behavioural changes. In addition to the behavioural changes identified above, other notable changes included: screening and registering of visitors entering communities, prohibitions on the consumption of bush meat, and strict adherence to the principles of ABC (avoiding body contact). Despite generally positive changes in all behavioural areas it was suggested that the eating of bush meat was most difficult to alter. In some instances, qualitative data indicated that this was due to a neglect of this issue, within the context of other issues. For instance, as identified by one key informant, "most of the information shared to some of the communities were mainly information on the ABC method, no burying of the dead, and frequent washing of hands, [whereas] not much information against the eating of bush meat was shared properly in some communities and as a result, cases raising due to this practice increases."[70]

6.2 Liberia

Despite the challenges listed in the effectiveness section, the Inclusion Advisor was able to record many important achievements.[71] For instance, she provided inputs into a multi-sectorial assessment led by ACAPS, ensuing that questions on disability and chronic illness were integrated into key informant questionnaires, as well as questions on specific vulnerable groups who face the most difficulties, namely older people, persons with disabilities, widows, single female headed households and those with chronic disease.

She also provided input into a nationwide comprehensive Food Security Assessment, ensuring that tools included sex and age disaggregated data relating to household composition, employment, food consumption, agricultural production, income sources as well as information on disability and chronic illness. The FAO project entitled UN Trust Fund

[67] KII, DLO, Pujehun, 11 July 2015.
[68] FGD, community leaders, Bumpeh, Kono, 10 July 2015.
[69] KII, mobilizers, Karlu, Pujehun, 9 July 2015.
[70] KII, DMO, Kono, 9 July 2015.
[71] Caffarelli, Luciana, 2015, Mission Report by the Inclusion Advisor to the Food Security Cluster Liberia, February to July 2015.

for Human Security equally benefited from mainstreaming of gender, age and disability in its baseline survey.

The advisor also led a half-day workshop on safe and dignified distributions for WFP staff in Gbarnga County and its partners. Through the workshop, participants gained knowledge and practical advice on the importance of safe and dignified distributions, the risks faced by vulnerable groups such as older people and persons with disabilities during distributions, and positive strategies that can be incorporated to mitigate the risks. As a result of the workshop, a safe and dignified distribution checklist was drafted by participants, and is to become a standard tool in WFP operations.

WFP and Save the Children International also received consistent participation in Food Security Cluster and bilateral meetings. As a result, Save the Children International responded positively to an offer to conduct an observation of a cash distribution to 140 beneficiaries in Montserrado County, with the objective of providing recommendations for improved inclusion of older people and persons with disabilities, increased safety, dignity and accountability. A second observation was carried out on a WFP food distribution as part of their assistance to communities previously quarantined due to EVD cases in that community. The observation took place in Grand Cape Mount County and a report was drafted with recommendations for improved inclusion of older people and people with disabilities sent to senior management. The report was also sent to relevant field staff members and will support the need for improved distributions across operations.

In addition, the Inclusion Advisor was able to work with the Health Cluster to increase members' understandings and awareness of the gaps in support to older people and persons with disabilities in health services. For example, a presentation was delivered at a Health Cluster meeting, during which WHO data on the numbers and status of EVD cases of people aged fifty and above was shared.

Finally, sixteen practitioners from government and non-governmental organizations also participated in a one-day inclusion workshop. The workshop was aimed to increase knowledge and understanding of participants about the needs and capacities of older people and persons with disabilities in emergency settings and to provide practical knowledge on how to make programmes more age and disability sensitive.

According to key stakeholders consulted for this evaluation, the Inclusion Advisor's "contribution was timely and useful to ensure that project activities are taking into consideration protection issues for beneficiaries particularly the aged."[72] The main impacts of the Inclusion Advisor's work were described to be: improved awareness about the situation and needs of vulnerable groups, increased awareness and information to raise interest and encourage actions to improve support and facilitation of older and disable people to obtain food assistance, and improved safe delivery of cash to people with vulnerabilities and better targeting of most vulnerable households and individuals for cash assistance. Further, the participation of the Inclusion Advisor in promoting the response needs of vulnerable persons and the need to revise data collection to accommodate issues related to vulnerability may have positive impacts during the EVD recovery – as this data is transformed into programming. As described by one key informant, "we did not know much about our beneficiaries before. Hence, our programmes were not taking the specific needs of our beneficiaries into consideration. With adjusting the data collection, we hope to get to

[72] KII, ACDI/VOCA, 14 August 2015.

know our beneficiaries better and especially adjust our food and nutrition training, social mobilization and WASH activities to the needs of elders and people with disability."[73]

7 ACCESSIBILITY

As stated, the intervention included training of community mobilisers on the inclusion of vulnerable groups, including older people. The training enabled the mobilisers to ensure that older and vulnerable persons are given the relevant information and support to allow them to live safely in hotspot areas. Pre- and post-test questionnaires were randomly administered to the mobilisers before and after training. Of this sample, 83 per cent rated the topic of older people and other vulnerable groups to be either important or very important.[74] Further, 89 per cent found the training to be either relevant or very relevant to their work as social mobilisers and 93 per cent found the training to be useful or very useful for the social mobilisation work.

The average score for pre-tests was 59.5 per cent. This average score improved to 87.6 per cent for post-tests. These improvements can be seen in Table 6, which shows that there was an improvement in correct responses for both males and females. Taking both sexes into account there was an average overall improvement in correct answers of 2.8 responses per respondent. This resulted in an overall 71.7 per cent positive change[75] in correct answers between pre- and post-tests.

Table 6: Changes in Performance between Pre- and Post-tests

	Males	Females	Overall
Average Difference in Correct Answers	2.8	2.9	2.8
Percentage Change	63.2%	81.9%	71.7%

As illustrated by the following table, all test questions showed an improvement between the pre- and post-tests. The question that returned the lowest overall post-test score was that 'older people can make little contribution during EVD crisis as they are compromised by their health and age,' suggesting that this may be an area that required further sensitization.

[73] KII, Welthungerhilfe, 11 August 2015.
[74] Restless Development, 2015, *Mobiliser Feedback Report*, pp. 7-8.
[75] Percentage change is calculated using the following formula: (post-test – pre-test)/pre-test.

Table 7: Changes in Performance between Pre- and Post-tests, by Question

Question	Pre-test	Post-test	Percentage Change
Vulnerability cuts across all ages	57.2%	94.4%	65.0%
It is ok to make decision on behalf of vulnerable people without consulting with them	51.0%	85.0%	66.8%
Vulnerable people refer to people with physical disability only	62.1%	80.7%	30.0%
Older people can make little contribution during Ebola crisis as they are compromised by their health and age	42.8%	72.2%	68.9%
There is need to take into account the needs of vulnerable and older people during social mobilization activities	52.2%	93.0%	78.2%
Engaging with older people can help us to encourage safe burial practices as they are one of the key influences in the community	70.0%	89.6%	27.9%
Vulnerability includes the social constraints and barriers imposed by a society that takes little or no account of people with disabilities' needs	66.4%	82.4%	24.0%
The most vulnerable in society tend to be invisible and are often excluded	62.1%	93.2%	50.2%
Vulnerable people often have positive contributions and capacities	72.0%	94.9%	31.9%
To be young or old, a woman or an individual with a disability or HIV does not of itself make a person vulnerable or at increased risk. Rather, it is the interplay of factors that does so	59.7%	90.6%	51.8%

According to Restless Development's *Mobilizer Feedback Report*, mobilisers used the training they had received when handling issues relating to older people and other vulnerable groups.[76] With the posters given to them during the refresher training, they engaged children in schools on issues such as vulnerability, teenage pregnancy, stigmatization, etc. They also relayed information to parents on how to take care of vulnerable and older people. Within this work the report also indicated a number of challenges when dealing with older people and other vulnerable groups;[77] these challenges included:

- Some of the older people in the community were physically impaired so mobilisers have to pass information to these old people through their family members or the community
- Another key challenge faced by mobilisers in dealing with older people was to overcome the reluctance to adapt to changes or accept new information
- Vulnerable people found it very difficult to attend meetings
- Vulnerable people required more face to face engagement – in order to convey messages for example – which limits time available for activities with other community members or activities
- Older people found it difficult to understand the EVD prevention messages

[76] Restless Development, 2015, *Mobiliser Feedback Report*, p. 6.
[77] Restless Development, 2015, *Mobiliser Feedback Report*, pp. 3-4.

Such challenges are evidence that mobilization work that is focused on the elderly and other vulnerable groups has important challenges that must be specifically incorporated into the design of mobilization activities. As such, an adapted mobilization approach is likely needed to reach such populations.

Primary data also examined questions related to accessibility. Typically, it said that vulnerable populations were not adequately included in district level response planning. For example, in Bonthe Distrct, the DERC Coordinator stated that "there was no specific provision made for vulnerable people. The elderly people were not reached so they were not included in the [implementation of the] Ebola response plan."[78] A CHO in Pujehune indicated that "in relation to the vulnerable like the old people, no provision was made for vulnerable in the Ebola response plan. They only benefited from the home-to-home visit and the health talk. They get messages through radio discussion and the display of posters in the community."[79]

Based on the results of proportional piling, in which FGD participants voted for those groups that they believed benefited most from the project, youth were found to have benefited the most at community level. Though community experiences no doubt varied, according to one key informant, "the group that benefited most were the young males and females. The simple reason is that youths are mostly in good attendance during community engagements, and they are mostly travelling from one place to other due to their presence during the community action days, and they have followed the procedures that are contributing gradually to the success of the country. However older people were included in community decision making processes and health personnel were trained to provide special care for vulnerable groups in the communities."[80]

FGD participants indicated that the community-as-a-whole is the second most likely group to benefit. As can be seen from the table below, vulnerable persons are perceived to have benefited the last out of all four groups.

Table 8: Perceptions of Project Benefits according to All FGD Participants

	Youth	Vulnerable	Community	Health
Number of respondents	1,197	518	819	589
Percentage	38.3%	16.6%	26.2%	18.9%

Results from proportional piling conducted by vulnerable persons mirrored those conducted by FGD participants taken as a whole, with vulnerable people being perceived as the least likely to have benefited from the project.

Table 9: Perceptions of Project Benefits according to Vulnerable Persons Participating in FGDs

	Youth	Vulnerable	Community	Health
Number of respondents	388	179	263	147
Percentage	39.7%	18.3%	26.9%	15.0%

Benefits were also generally attributed to communities as a whole. In this regard, the project was reported to have had considerable overall impacts in many communities, and vulnerable populations shared the benefits of these impacts. In this sense, "the vulnerable

[78] KII, DERC Coordinator, Bonthe, 9 July 2015.
[79] KII, CHO, Potaine, Pujehun, 10 July 2015.
[80] KII, Restless Development, SMAC Regional Coordinators, 15 August 2015.

only practically participate in the information they get from the sensitization such as frequent hand washing, no body contact. They were not participating in the sensitization because they are not active."[81] One discussant said that the "project was of value to the vulnerable people because they were involved in washing of dead body. But the sensitization, educate them of these and when they practice it prevent them from Ebola."[82]

But there were many instances were qualitative research suggested that vulnerable groups did not adequately participate in mobilization activities. According to one FGD composed of elderly and disabled persons, "vulnerable people's participation was not considered. We forced ourselves to project by serving as volunteering supervisors to community mobilizers. At first they were not doing their work but when we change their behaviours. We participated forcefully and at the end some of us were considered by the field officers. They assist us by sending our names to social welfare ministry and they come to our aid."[83] Though it was not within the project design to specific include the elderly into mobilization activities, it is conceivable that an intergenerational approach to mobilization should do so. Qualitative data also reveals considerable dissatisfaction that vulnerable people were often not incorporated directly into implementing project activities. Because vulnerable groups did not generally participate in implementation, "no financial provision was made for the vulnerable, excluding them in this way."[84] In many discussions, it was mentioned, however, that the elderly and other vulnerable groups were able to participate by providing input into planning and providing oversight during the implementation of community action plans.

In terms of mobilization, females were also limited in their participation due to domestic obligations. In Bonthe, however, females were included in burial teams as a result of consultations with community mobilizers. "Every community were allowed to send a females to join the burial team because the community people were not happy that their female dead bodies had been buried by the male burial team."[85] In addition, in some areas a strategic plan was made to include women that were involved in *sande* society.[86] Where women were included, it helped in disseminating the message of EVD to other women in the district.[87] Women "also in the door-to-door sensitization on Ebola protection and prevention method and about hand washing."[88] In another community, "the women were employed as surveillance officers to check and report and activities that involves cultural secret societies. Other women were employed as surveillance officers checking house on regular basis for a sick person."[89]

With sensitization, inclusion of the blind and deaf was particularly problematic. According to one key informant, the "blind, deaf, and lame were restricted from accessing vital information with regards to Ebola prevention and control."[90] When such opinions were voiced, the reason was that special provisions were not made to provide information to such groups, implying that training on the specific needs of vulnerable people did not have a sufficient influence on EVD response.

[81] FGD, community leaders, Bendu, Bonthe, 13 July 2015.
[82] FGD, women, Bendu, Bonthe, 13 July 2015.
[83] FGD, vulnerable persons, Kayinbor Port Loko, 11 July 2015
[84] KII, health workers, Karlu, Pujehun, 9 July 2015.
[85] KII, APC, Bonthe, 10 July 2015.
[86] *Sande*, also known *bondo*, is a women's secret society West Africa.
[87] KII, DERC Coordinator, Bonthe, 9 July 2015.
[88] FGD, women, Karlu, Pujehun, 9 July 2015.
[89] FGD, community leaders, Bumpeh, Kono, 10 July 2015
[90] KII, health workers, Baiama Gbonda, Pujehun, 9 July 2015.

8 EFFICIENCY

The project was underspent at the end of phase two, implying overall project efficiency.[91] In particular, it can be said that the project generally used human resources efficiently.[92] Salaries to international staff are consistent with other international non-governmental organizations, and in some cases towards the lower end of the salary scale. The salary scale of the national staff was said to be in line with salaries offered by international partners were. Further, activities and expenses typically matched the project budget and it was reported that all project spending was necessary. Though in some instances, some budget lines had little spending, as these were already covered under other aspects of SMAC, allowing for efficiencies to be leveraged across funding sources in Sierra Leone. In Liberia, accommodation costs were lower than expected, offering some savings in this area. As was mentioned above, there were instances where some project materials – for instance, buckets, soap, etc. – went missing during programming. As this happened, safeguards were put into place in order to help ensure that these materials were used properly. In terms of adapting the project to the changing nature of the EVD outbreak, as the number of cases of EVD decreased, the number of mobilizers was also dropped in those districts where this was necessary. For instance, in Pujehun District, "the number of mobilizers dropped due to the reduction of the number of cases with in the district – from 128 to 32."[93]

9 PARTNERSHIP AND WAY OF WORKING

From the outset of the project, its design attempted to draw on an intergenerational approach – in particular, sensitising and training young people to work together with older people to stop the spread of EVD. However, it was expressed in KIIs that, as partners, Age International and Restless Development explored sufficiently what such an intergenerational approach might entail and require – especially the possible challenges that such an approach my pose. Indeed, as was mentioned above, youth, the elderly, and other vulnerable populations were not expressly incorporated in a joint project strategy for mobilization and sensitization. In retrospect, more resources could have been devoted to developing a better understanding how an intergenerational approach might be leverage for programming in an emergency situation. Specifically, more could have been done in the lead-up to the project to define exactly how an intergenerational approach would be manifested within the project; rather than simply incorporating training and issues related to older people into an existing youth-led programme. The key to such an approach would be to integrate youth and the elderly into the project in a way that both see themselves as working towards a common goal in a mutually dependent and reinforcing way. Indeed, it was mentioned in correspondence related to the DEC response review that it was "unclear how the CLEA programme specifically targeted the elderly community."[94] Instead, the suggestion was made to work with groups who the elderly are known to listen to within the specific social context of West Africa.

While it is true that Age International's partnership with Restless Development leveraged the latter's social mobilization capacities and networks (a key rationale for the partnership), it can be seen from the analysis above that, in spite of the training and support offered to social mobilisers on the needs of older people and vulnerable groups, social mobilization activities focussed more on young people – as was intended by the programme design. However, as was just stated, an integrated intergenerational approach to mobilization and

[91] KII, Restless Development, Senior Partnerships Manager, 30 September 2015.
[92] Restless Development Finance Plan May - August 2015.
[93] KII, DERC, Pujehun, 8 July 2015.
[94] Personal correspondence, Chris Roles and Pauline Oosterhoff, 14 June 2015.

sensitization should have given more consideration to directly including the elderly and other vulnerable groups, instead of treating them as a beneficiary group.

In Liberia, Age International worked with HelpAge, a key delivery partner that shares values, priorities, and approaches to programming. As a result, there were no challenges in the work undertaken together in Liberia. Yet, in Liberia, the Inclusion Advisor experienced some partnership-related problems within the Food Security Cluster – including: infrequent meetings and a limited focus on the Food Security Assessment. These challenges were mitigated by leveraging other working groups and forming bilateral relationships, as previously described.

10 ACCOUNTABILITY

At an international level, mechanisms were in place to manage the relationship between Restless Development and Age International; these included: Memorandums of Understanding drawn up between Age International, HelpAge, and Restless Development, a contract agreement drawn up between Age International and Restless Development, regular meetings between Age International and Restless Development UK, regular communication between the Age International Training Advisor and Restless Development in Sierra Leone, and regular communication between Restless Development UK and Restless Development in Sierra Leone. There was little direct contact between Age International and Restless Development Sierra Leone after February, as it was agreed that this relationship would be managed by Restless Development UK. As the project progressed, it was also established that more regular contact between Restless Development and Age International by telephone or Skype, rather than email would improve communications.[95]

It was reported by Restless Development that the organization used its M&E systems to measure progress against agreed outcomes and indicators, and reported against these as per the terms and conditions of the project grant.[96] Just the same, as was mentioned above, this evaluation found that challenges in M&E included a lack of systematic timely feedback of monitoring data from mobilisers and real-time feedback of pre- and post-training tests. Lacking this data, Age International's ability to ensure accountability and effective project implementation was reduced. This also reduced the ability of the organization to draw on data to support its advocacy for the needs of the elderly and other vulnerable groups in the context of the EVD outbreak. It was also reported that lack of clarity on expectations regarding the capacity of Restless Development's in-country staff to conduct ad-hoc evaluations, provide communications materials, and conduct beneficiary and mobiliser feedback evaluations posed challenges during phase one.[97] This was compounded by lack of clear communication lines via which Restless Development UK could respond to urgent queries from Age International on behalf of Restless Development Sierra Leone. These issues have since been resolved through clear communication on reporting requirements, and systems strengthening on grant management by Restless Development.

Age International did not place an Inclusion Advisor in Sierra Leone during this project. Efforts to identify and place an advisor within the time frame, in a challenging operating environment, were unsuccessful. This meant that opportunities for advocacy work, for example within the social mobilisation cluster, in relation to the needs of older people, were lost. Restless Development could not be expected to conduct such advocacy work when issues related to age were new to an organization that has historically focused on

[95] KII, Restless Development, Senior Partnerships Manager, 30 September 2015.
[96] KII, Restless Development, Senior Partnerships Manager, 30 September 2015.
[97] KII, Restless Development, Senior Partnerships Manager, 30 September 2015.

programming related to youth issues. The project could have benefited from an Inclusion Advisor in Sierra Leone during phase one. Such a position should be created in the recovery phase of the project.

11 COORDINATION, CONNECTEDNESS, AND SUSTAINABILITY

Overall, key informants at district level suggested that the project was well integrated into the EVD response. Restless Development was well connected to the social mobilization pillar of the EVD response, and therefore able to influence other actors based on the training provided.[98] As a key actor within the response, they were able to access the most current information and respond in a coordinated approach, avoiding duplication of resources and actions. As said by one DERC Coordinator, the "integration of SMAC mobilizers in to the Ebola response was very swift as there was a proper flow of communications between DERC and Restless Development within the district."[99] Further, another opined that "Restless SMAC mobilizers had strong coordinating skills, which impacted positively in the drastic reduction of infections with in the district."[100]

A key project strength was that Restless Development is one of the few organization that can operate in almost all of the districts in Sierra Leone,[101] with a presence that extends into even the most remote chiefdoms.[102] At community level, it was reported that project mobilizers were able to contribute in other areas of the EVD response. In particular, mobilizers were able to liaise with other response actors to help solicit transport for infected persons and the safe disposal of dead bodies. As put by one FGD participant, "before the project the burial team took long time to come for dead bodies in the community."[103] Additionally, according to the community leaders in one community, "one of the many impacts of the project is the good working relationship between the health workers, contacts tracing team and the community people."[104] Before the project, the relationship between the community and EVD responders was strained, undermining response efforts.

As stated above, there are hopes among focus group participants and key informants that behavioural changes achieved through the project will be sustained over time. But behavioural change is notoriously difficult to bring about, and requires considerable time to do so. Application of the theory of change of this project showed that positive outcomes were not automatic, and it took time for behavioural changes to come about. As the EVD outbreak subsides, there will be additional questions regarding whether changes will be sustained. "In a do-or-die context people change, because they have to. But when that context changes, what happens then? Already see a lot of behaviours backsliding."[105] The knowledge-imparted and behavioural-changes-achieved are positive accomplishments. But whether they can be maintained requires constructive analysis of how past successes can be leveraged in the future. It is possible, for example, that future projects can focus on behavioural aspects of WASH, using peoples' experiences with EVD to amplify messaging around his important topic.

[98] KII, DERC, Kono, 9 July 2015.
[99] KII, DERC, Pujehun, 8 July 2015.
[100] KII, DERC Coordinator, Bonthe, 9 July 2015.
[101] KII, DERC, Kono, 9 July 2015.
[102] KII, DMO, Kono, 9 July 2015.
[103] FGD, vulnerable persons, Bendu, Bonthe, 13 July 2015.
[104] FGD, community leaders, Potaine Pujehun, 10 July 2015.
[105] KII, Restless Development, Country Director, 11 July 2015.

11.1 Recovery Needs

Sierra Leone is at a critical period. Interventions implemented over the coming years will play a major role in determining the prospects for national, community, and household development. In terms of services being provided, qualitative research suggests that that the programmes that currently exist in most communities are predominately health-oriented; others were oriented on supply of household goods, food, or financial assistance – especially for EVD survivors and orphans and vulnerable children (OVCs). Health-related activities include: provision of chlorine and sanitizer, training of burial teams, supply of protective equipment, provision of ambulances, building of community care centres, training of community health workers, EVD sensitization and contact tracing, and supply of anti-malarial drugs. Supply of household goods, food, or financial assistance included: provision of financial grants or micro credit, supply of staple foods, provision of buckets, soap, blankets, school materials, etc. Troublingly, many FGDs reported that they were receiving no programmes or services.

According to a May 2015 assessment of the impacts of EVD in five districts[106] clean water, education, food, and healthcare are the main concerns after EVD – as listed in order of perceived magnitude of the problem; see table below. The largest change between concerns today and concerns from before EVD were that food increased significantly as concern for all groups, but especially for those households that reported a case of EVD. Education also grew as a concern for all groups since before EVD, whereas water has decreased as a concern from before EVD.

Table 10: Most Important Development Concerns*

	Before EVD	After EVD
No concerns	0%	0%
Education	42.3%	54.8%
Healthcare	44.4%	41.5%
Transportation	4.9%	4.3%
Employment	22.5%	21.2%
Clean water	63.3%	55.6%
Food	23.3%	42.6%
Housing	3.4%	2%
Electricity	27%	19.4%
Sanitation	12.1%	8.7%

Qualitative data collected for this evaluation echoed key results of the findings just presented. According to KIIs and FGDs, the key recovery concerns are: health, employment, and WASH. In terms of health, the rehabilitation of the health system requires training of doctors and nurses, as well as the provision of medical supplies. Health workers also expressed the need for sensitization to encourage demand for health services in the wake of the EVD outbreak.

Additionally, there is a need of for employment creation and support for agriculture. Key among these concerns is the need to capacitate business people and farmers with credit to revive selling and agricultural activities. Respondents also mentioned the needs of farmers for agricultural inputs such as: seeds, tools, and fertilizer. Savings had been used up or sold by many people during the EVD outbreak as economic activities collapsed and prices rose. Many business and agriculture inputs were sold also to generate income at the same time.

[106] BRAC – Sierra Leone, 2015, *Assessment of The Impact of EVD Five Districts Sierra Leone*, May, p. 31.

Access to clean water and sanitation is another important development concern in many communities that predates the EVD outbreak.

Qualitative data was also collected on the specific development needs of vulnerable groups. The key concern noted was the need for the provision of financial and food support for households headed by vulnerable persons – in particular the elderly and disabled. This was said to be a particularly acute need in those instances where such persons – often a grandparent – have taken on added parenting responsibilities, as they have adopted children whose guardians have died. Food and financial assistance is needed for such families, as is assistance for the children they are supporting. Regarding the latter, assistance with funding for school was said to be paramount. There may also be a need for the provision of non-food household items, as many such items have been sold, or otherwise lost, during the EVD crisis.

It was also noted that vulnerable persons require vocational training in order to increase income-generating opportunities among this group, as the elderly and disabled are generally not in a position to take advantage of other work opportunities – for instance, labour work in agriculture and resource extraction. For the same reason, financing should also be provided to promote income-generation through small business activities amongst vulnerable populations. Finally, FGDs and KIIs indicated that the elderly and disabled require financial support for, or free access to medical facilities and medications, which often account for a disproportionate portion of expenses for these groups.

12 CONCLUSIONS AND RECOMMENDATIONS

Though the impact of EVD outbreak in Sierra Leone has been great, from the analysis above it can be seen that the project had a positive impact in reducing EVD in the country. In addition, the project also promoted the needs of vulnerable populations in both Sierra Leone and Liberia, despite some challenges promoting inclusion in mobilization activities and in monitoring the impact of inclusion training on the awareness and behaviour of social mobilisers. The lessons learned from this evaluation offer an opportunity to inform future programming – both in Sierra Leone and Liberia, and elsewhere. The following are recommendations associated with this evaluation.

Continue Behavioural Change Activities Post-EVD

Behavioural change is a long-term process that requires deep anthropological understandings of how behaviours are constructed. Moreover, changing behaviours is a contextual process that can be driven by shifting understandings of situations – both within emergency contexts, and between emergency and recovery. As the EVD outbreak worsened, communities were more inclined to mobilize in the interests of response and prevention. Similarly, as the outbreak subsides, such an inclination is decreasing, undermining the sustainability of positive results achieved through programming. Still, there may be an opportunity to leverage experiences within the EVD epidemic to consolidate and improve on gains made in behavioural changes in areas such as WASH and MNCH. Indeed, experiences with EVD may provide a practical example for the types of health benefits that proper healthcare and/or effective hygiene or sanitation practices can have. In this regard, the CLTS model can be employed as a useful mechanism for change, and may be adapted to also promote community-driven health development.

Balance M&E Capacities/Needs with Other Programming Needs

Subsequent activities should utilize a system that better balances M&E capacities with information needs. This system would forego some analytical depth in favour of the type of a dynamic feedback mechanisms required in an emergency, improving the tracking the

implementation of programming. Such needs are especially acute in a situation were Age International does not have inclusion representation on the ground to oversee programming.

Follow Up on Work of Inclusion Advisor in Liberia
In many ways, the work of the Inclusion Advisor in Liberia required considerable lead up – especially in the context of changing conditions on the ground. The work done to form relationships and create awareness about issues related to the elderly and other vulnerable populations presents an opportunity to advocate for more inclusive recovery programming. Indeed, recovery in both Liberia and Sierra Leone over the next years will be dictated by the actions taken by the respective governments of these two countries and their international and national partners. Continuing to raise awareness about the needs of the elderly and other vulnerable groups can be a key value-added within the recovery. Further, working with implementing partners during the early stages the recovery can help ensure that their programming is equitable and sensitive to the needs of the most vulnerable.

Ensure Proper Inclusion Representation during Recovery in Sierra Leone
Though Restless Development has gained valuable insights into programming targeted towards elderly populations, it would be difficult to expect the organization to effectively conduct advocacy on such issues. The project could have benefited from an Inclusion Advisor in Sierra Leone during phase one. Such a position should be created in the recovery phase of the project.

Use EVD Experience to Better Define Intergenerational Approach
A continued partnership with Restless Development is logical in the recovery phase. However, more needs to be done to at the outset of the next phase partnership to define and design an integrated intergenerational approach – making sure young and old are working together in post-EVD recovery in a mutually dependent and reinforcing way. In advance of future partnerships with youth-focused organizations, more resources should be devoted to developing a better understanding how an intergenerational approach might be leverage for programming – whether in an emergency situation, or in a subsequent recovery.

Food Support for Households Headed by Vulnerable Persons
A key concern noted was the need for the provision of food support for households headed by the elderly and disabled. There is still a need to scale up short-term food security operations to answer the immediate food needs of the most vulnerable people, and especially to address food supply gaps. To be effective, the food security response should assess, redevelop, and protect local institutional infrastructure – for example, farmers' associations, cooperatives, savings and loan schemes, local government structures, etc. – and strengthen the access of vulnerable populations to existing food supplies.

Financial Support for Households Headed by Vulnerable Persons
With the high numbers of EVD OVCs, older people will take on greater care roles and therefore have increased financial needs for themselves and orphans in their care. This may be a particularly acute need in those instances where a grandparent has taken on added parenting responsibilities, as they have adopted children whose guardians have died. For example, special grants should be considered for the families and relatives that take them in. Regarding the latter, qualitative data identified assistance for schooling as paramount, though many forms of assistance are likely to be needed. As was mentioned, there may also be a need for the provision of non-food household items, as many such items were sold, or otherwise lost, during the EVD outbreak. For those of adolescent age, measures should be taken to ensure their enrolment in, for instance, vocational training programmes, allowing them to join the labour market. Early childhood development programmes focused on OVCs

may also make it possible for children that have lost one, or both parents, to grow and develop to their full potential. This will reduce the need for remedial services to address stunting, developmental lag and social problems later in life.[107]

Livelihoods Support for Vulnerable Populations

As part of a potential partnership with Restless Development – or other partners – in the recovery phase, Age International should explore the potential to implement livelihood-recovery activities for older people and other vulnerable groups. There may, for example, be an opportunity to integrate older people into Restless Development's livelihoods programmes. It was noted in qualitative research that vulnerable persons require vocational training in order to increase income-generating opportunities. Microfinance may also be provided to promote income-generation through small business activities amongst vulnerable populations.

[107] Republic of South Africa and UNICEF, 2006, *Guidelines for Early Childhood Development Services*, Pretoria: Department of Social Development and UNICEF, p. 13.

ANNEX A: FGD AND KII INTERVIEW GUIDE FOR EVALUATION

INTRODUCTION

Hello. Thank you for meeting with us today. My name is _____ and I am working with Restless Development, an organization working in Sierra Leone. We are conducting discussions in this community for a project we are carrying out. We would very much appreciate your participation in this discussion.

The discussion will last about one hour. Your answers will be kept strictly confidential and will not be shown to other persons and we will not link your name to any answers. We cannot provide you with any direct benefits for you or promise any specific development for your community. We can give you some refreshments for your participation today.

We are gathering data to better understand the effectiveness of this project in your community and in this district. We will make sure that what you tell us today will be communicated to Restless Development and its partners so that they can try to help communities such as this one.

Do you have any questions about any of the things that I just mentioned?

- If **YES**, answer all participants' questions and continue.
- If **NO**, continue to **CONSENT**.

CONSENT

Participation in this discussion is completely voluntary. If I ask any question you do not want to answer, let me know and you will not have to answer. You can end your participation in the discussion at any time.

However, I hope you will participate since your views are very important to understanding how we can improve the lives of young children in this community and others like it.

Did the respondents give consent?

YES ⟶ **GROUND RULES**
NO ⟶ **END**

★★ *At the end of each discussion, please check the notes with both the notetaker and facilitator, to fill in any missing information.* ★★

FURTHER INTRODUCTION AND GROUND RULES FOR PRAs and FGDs

Facilitator should introduce themselves and the notetaker, and explain why they are taking notes and what is being noted.

- Participants should introduce themselves and set ground rules.
- Remind individual/group that you are speaking about the Restless mobilization (Social Mobilization Action Committee) SMAC/CLEA project.

NOTES

District level key informants

- One person interviews
- DMO and DERC Coordinator done by team with supervisor
- DLO and Project Coordinators / Assistant Coordinators by other team
- Go to DERC Coordinator first

Health key informants

- 1-2 people interviews, with CHOs and nurses
- One per community, for each team

Community mobilizers informants

- 1-2 person interviews, community mobilizers
- One per community, for each team

FGD

- 6-8 person discussions, vulnerable groups, community leaders, and community members
- **All persons in the FGD should have knowledge of the Restless Development SMAC / SMAC/CLEA project**
- Vulnerable groups PRA: elderly and disabled
- Community leaders: youth group, women's group, religious leaders, chief, etc.
- Community members: two with only men, and two with only women.

COMMUNITIES

No	*Community/Location*	*Chiefdom*	*Comm. Members FGD*	*District*
1	Massabendu	Nimiyama	Men	Kono
2	Sukudu	Kamara	Women	
3	Moimandu	Goraqma kono	Men	
4	Bumpeh	Nimikor	Women	
5	Luwa	Jong	Men	Bonthe
6	Bendu	Sogbini	Women	
7	Lawana	Kpanda kemo	Men	
8	Janagalor	Imperri	Women	
9	Baiama Gbonda	Kpanga Krim	Men	Pujehun
10	Potaine	Malen	Women	
11	Masam Kpaka	Kpaka	Men	
12	Karlu	Yakemoh Kpukumu Krim	Women	
13	Kayinbor	Debia	Men	Port Loko
14	Melekuray	TMS	Women	
15	Mafengben	TMS	Men	
16	Makump	Debia	Women	

DISTRICT LEVEL KEY INFORMANTS

District Coordinators / Assistant Project Coordinators, District Liaison Officer, District Medical Officer (DMHT), and DERC Coordinator

1. Communities had many problems during the Ebola crisis, how well did the Restless SMAC/CLEA mobilization address the most important problems of communities in this district during this crisis?
   (What problems were met well?)
   (What problems were not met well?)

2. How well were the activities of Restless' SMAC/CLEA mobilizers project integrated in the district Ebola response?
   (What were the strengths of this integration)
   (What were the challenges of this integration)

3. What were the impacts the Restless SMAC/CLEA mobilization in the district level response to Ebola?
   (What were the main impacts?)

4. Which community groups benefitted most from the Restless SMAC/CLEA mobilization?
   (Were there any groups that did not benefit?)

5. How well were vulnerable people (e.g., elderly, disabled, and women) included in district level Ebola response plans?
   (How valuable was the project to vulnerable people (e.g., elderly, disabled, and women)?)

6. Were there any significant problems experienced during the implementation of the Restless SMAC/CLEA mobilzation?
   (How did these problems impact the effectiveness of the project?)
   (Were these problems overcome, and how?)

7. What are the main needs of communities in this district in their post-Ebola recovery?
   (What are the main needs of vulnerable people (e.g., elderly, disabled, and women) in post-Ebola recovery?)
   (How can the work done during the Restless SMAC/CLEA project be used to help in post-Ebola recovery?)

8. Based on what we have discussed here today, is there anything else that you would like to add or tell me more about?

HEALTH KEY INFORMANTS

1. What were the impacts the Restless SMAC/CLEA project in the response to Ebola?
   (What were the main impacts?)
   (Where there any unforeseen impacts?)

2. What were the impacts the Restless SMAC/CLEA project on vulnerable people (e.g., elderly, disabled, and women) in the response to Ebola?
   (What were the main impacts?)

3. How well were vulnerable people (e.g., elderly, disabled, and women) included in Ebola response plans?

4. Were there any significant problems experienced in including vulnerable people (e.g., elderly, disabled, and women) in Ebola response plans?
   (How did these problems impact the lives of vulnerable people?)
   (Were these problems overcome, and how?)

5. What are the main needs of communities in this district in their post-Ebola recovery?

6. What are the main needs of vulnerable people (e.g., elderly, disabled, and women) in post-Ebola recovery?)

7. Based on what we have discussed here today, is there anything else that you would like to add or tell me more about?

COMMUNITY MOBILIZERS INFORMANTS

1. Communities had many problems during the Ebola crisis, how well did the Restless SMAC/CLEA project address the most important problems of the communities you are working in during this crisis?
   (What problems were met well?)
   (What problems were not met well?)

2. What were the impacts the Restless SMAC/CLEA project in the district level response to Ebola?
   (What were the main impacts?)
   (Where there any unforeseen impacts?)

3. Which community groups benefitted most from the Restless SMAC/CLEA project?
   (Were there any groups that did not benefit, or benefited less?)

4. How valuable was the project to vulnerable people (e.g., elderly, disabled, and women)?
   (How did vulnerable people participate in the project?)

5. Will the changes from the Restless SMAC/CLEA project made in the lives of vulnerable people (e.g., elderly, disabled, and women) be sustained after the Ebola crisis is over?

6. Were there any significant problems experienced during the implementation of the Restless SMAC/CLEA project?
   (How did these problems impact the effectiveness of the project?)
   (Were these problems overcome, and how?)

7. Are there any ways that the money spent for this project could have been used more effectively?

8. What are the main needs of communities in this district in their post-Ebola recovery?
   (What are the main needs of vulnerable people (e.g., elderly, disabled, and women) in post-Ebola recovery?)
   (How can the work done during the Restless SMAC/CLEA project be used to help in post-Ebola recovery?)

9. Based on what we have discussed here today, is there anything else that you would like to add or tell me more about?

FGD QUESTIONS

Vulnerable groups (including: elderly and disabled), community leaders, and community members (one per community, disaggregated for males, females, and youth)

1. Communities had many problems during the Ebola crisis, how well did the Restless SMAC/CLEA project address the most important problems of is community during this crisis?

2. What were the main impacts of the Restless SMAC/CLEA project in this community?

   <<Introduce proportional piling to group using food example>>

3. Who has benefitted from the project?
   a. Young People
   b. Vulnerable people (e.g., elderly, disabled, and women)
   c. The Community
   d. Health workers

4. How valuable was the project to young people?
   (How did vulnerable young people participate in the project?)
   (Will the changes from the Restless SMAC/CLEA project made in the lives of young people be sustained after the Ebola crisis is over?)

5. How valuable was the project to vulnerable people (e.g., elderly, disabled, and women)?
   (How did vulnerable people participate in the project?)
   (Will the changes from the Restless SMAC/CLEA project made in the lives of vulnerable people be sustained after the Ebola crisis is over?)

6. How valuable was the project to the community as a whole?
   (Will the changes from the Restless SMAC/CLEA project made in the lives of community people be sustained after the Ebola crisis is over?)

7. Were there any significant problems in implementing the Restless SMAC/CLEA project?
   (How did these problems impact the effectiveness of the project?)
   (Were these problems overcome, and how?)

8. Who has benefitted more from the work of Restless Development in your community in the last 12 months?
   a. Adult men
   b. Young women (18 and below years)
   c. Adult women
   d. Young men (18 and below years)
   e. Please explain and discuss the ways in which each group has benefited.

9. Based on what we have discussed here today, is there anything else that you would like to add or tell me more about?

SUMMARY AND CONCLUSION

At the end of each focus group, the facilitator should:

- Summarize MAIN points of the focus group discussion
- Reiterate confidentially

"Thank you for your time. Your help in this research is very important. We will do our best to ensure that these results are communicated to Restless Development and its partners."

★★ *At the end of each session, please check the notes with both the notetaker and facilitator, to fill in any missing information.* ★★

ANNEX B: EVD RESPONSE INCLUSION ACTIVITIES QUESTIONNAIRE

Information about this Questionnaire

- This interview is part of an evaluation of Age International's contributions to Ebola response activities in Liberia and Sierra Leone.
- As part of Age International's work in Liberia, Inclusion Advisor Luciana Caffarelli provided training, technical support and advocacy related to issues affecting older people and other vulnerable groups during the Ebola response.
- This work was conducted with humanitarian organizations working as part of the Ebola response in Liberia; for instance, those organizations participating in the Food Security Cluster and the Social Cash Transfer Technical Working Group, as well as in multilateral and bilateral structures.
- The questions in this questionnaire relate to the work of the Inclusion Advisor.

Information about the interview

- The interview collects information about (a) the respondents and his/her organisation, (b) the nature of the organization's collaboration with the inclusion advisor, (c) the specific programme effects of that collaboration.
- Filling out the questionnaire should require about 20-25 minutes.
- Please highlight appropriate multiple-choice answers.
- Please complete this questionnaire by **Tuesday, 21 July 2015**.
- For further information please contact Dariusz Dziewanski, by email at dariusz_dziewanski@soas.ac.uk.

(A) RESPONDENT DETAILS	
1. Name(s) of the respondent(s) and e-mail	
2. Name of your organization	
3. Contact details of your organization (incl. address, telephone number, website)	
4. Name of Ebola response project(s)	
5. Description of Ebola response activities	
6. Did the Age International Inclusion Advisor work with your organization?	(Please highlight answer:) - Yes - No (If no, move on to question 17)
7. In what way did the Age International Inclusion advisor work with your organization?	(Please highlight all that apply:) - Inclusion Advisor provided training - Inclusion Advisor provided presentation - Inclusion Advisor provided project-specific technical support - Inclusion Advisor provided advocacy-related support - Other (specify):
8. Please specify the forum of the work occurred in	(Please highlight all that apply:) - Food Security Cluster - Social Cash Transfer Technical Working Group - Other multilateral forum (specify): - Bilateral meeting (specify):

9. Please describe the nature of the work provided by Age International Inclusion Advisor
10. Please describe the impacts of the work provided by Age International Inclusion Advisor on the Ebola response activities your organization is engaged in
11. Please describe the impacts of the work of the Age International Inclusion Advisor work on other activities your organization is engaged in
12. Please describe the direct and indirect benefits of the work of the Age International Inclusion Advisor to the beneficiaries your organization works with
13. Please specify total number of beneficiaries that directly benefited from the work Age International Inclusion Advisor

14. What groups of beneficiaries benefited directly from the work Age International Inclusion Advisor?	(Please highlight all that apply:) - Elderly males - Elderly females - Male youth and children - Female youth and children - Other adult males - Other adult females - Disabled populations - Other (specify):
15. Please specify total number of beneficiaries indirectly benefited from the work of the Age International Inclusion Advisor	
16. What types of beneficiaries benefited indirectly from the work Age International Inclusion Advisor?	(Please highlight all that apply:) - Elderly males - Elderly females - Male youth and children - Female youth and children - Other adult males - Other adult females - Disabled populations - Other (specify):
17. Could the work of the Age International Inclusion Advisor could have been improved in some way?	(Please highlight answer:) - Yes - No (If no, move on to question 19)
18. Please describe the ways in which the work of the Age International Inclusion Advisor could have been improved	

19. Please provide any other information that you think would be beneficial to this evaluation