GoSL, 6-9 Month Early Recovery Priorities

Independent Evaluation and Assessment- Final Report

Dalan
Development Consultants

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Acronyms

ABC	Agricultural Business Centre
BEmONC	Basic Emergency Obstetrics and Newborn Care
CEmONC	Comprehensive Emergency Obstetrics and Newborn Care
CHC	Community Health Centre
CHP	Community Health Post
CHO	Community Health Officer
DCI	Defence for Children International
DST	District Survey Teams
EPI	Expanded Programme on Immunization
EVD	Ebola Virus Disease
FSA	Financial Service Association
GoSL	Government of Sierra Leone
HH	Household
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
MIS	Management Information System
MOFED	Ministry of Finance and Economic Development
MOHS	Ministry of Health and Sanitation
MSF	Médecins Sans Frontières
MSWGCA	Ministry of Social Welfare, gender and Child Services
NaCSA	National Commission for Social Action
NERICA	New Rice for Africa
NGO	Non-Governmental Organization
NMJD	Network Movement for Justice and Development
ORS	Oral Rehydration Salt
PD	The President's Delivery 6-9 month Recovery Plan Programme (
PDT	President's Delivery Team
PHC	Primary Health Centres
PHU	Peripheral Health Unit
PIH	Partners in health
PPE	Personal Protective Equipment
SLL	Sierra Leonean Leone
SME	Small and Medium Enterprise
RCHD	Reproductive and Child Health Directory
RMNCH	Reproductive, Maternal, Newborn and Child Health
TBA	Traditional Birth Attendance
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNOPS	United Nations Office for Project Services
WASH	Water, Sanitation and Hygiene
WHI	World Hope International
WHO	World Health Organization

Executive Summary

In mid- 2014, Sierra Leone along with Guinea and Liberia, experienced the biggest Ebola Virus Disease (EVD) epidemic ever recorded. By the end of December 2015, over 9,000 Ebola cases had been reported in Sierra Leone, killing an estimated 3,955 people. Across all of the Ebola-affected countries in West Africa, a total of 11,315 Ebola deaths were reported. November 2015, was declared the end of the outbreak as no new cases of the disease had been recorded in 42 days, thereby confirming that the Ebola virus was not being actively transmitted.[1] In an effort to help the country recover from the social, political and economic trauma of the Ebola crisis, His Excellency President Ernest Bai Koroma introduced a four-pronged recovery strategy in March 2015. The strategy focused on:

- Restoring basic health services throughout the country and maintaining a zero rate of Ebola infection;
- Returning children to school safely;
- Protecting vulnerable populations;
- Assisting private sector recovery.

The first phase of the Ebola Recovery Plan implementation ended on 31st March 2016. This assessment was commissioned to verify the efficaciousness of the programmes that have been implemented, to evaluate the degree to which implementation has met the Plan's priorities and to provide an unbiased assessment of the results achieved to date. The assessment also sought to identify challenges, lessons and best practices that can be used to improve the implementation of recovery priorities during the second phase of the Plan (April 2016-June 2017).

The evaluation employed a qualitative methodology, which included a desk review and a series of qualitative interviews. Key Informant Interviews, Focus Group Discussions, Case Studies and Observation were applied. The primary target group for this evaluation is direct beneficiaries of the initiatives implemented for the phase 1 (6-9 months) Ebola recovery priorities. Other targeted groups included indirect beneficiaries (i.e. local level population) as well as other stakeholders. A cluster sampling methodology was used to select study sites, based on level of concentration of 6-9 months early recovery plan activities, and beneficiaries to be surveyed. The target districts selected are: Bo and Moyamba (Southern Region), Kono and Kaiahun (Eastern Region), Port Loko and Bombali (Northern Region), and Western Area (Urban and Rural)[2]

Key results by sector:

Health sector

- Facilities are more likely to have received support for infection prevention control (IPC), malaria, supply chain and immunization. In the case of IPC, frequent assessment of compliance have been done during the recovery period while NGOs have continued further training to improve compliance
- The application of a triage system to curtail the spread of infection seems well grounded. New isolation units have been built in the 6-9 month recovery at some sampled health facilities- Bombali, Kono and Kailahun.
- Even though WASH facilities are widely available, and bore holes have been constructed in some facilities, the pressing challenge is around availability of regular water supply. Some facilities with infrastructure for pipe borne water, lack running water, while other facilities which rely on wells, have to make contingency plans for periods during which wells dry up.

[1] Isa O'Carroll, "WHO officially declares Sierra Leon Ebola Free" *The Guardian* November 7, 2015, accessed March 20, 2016, www.theguardian.com/world/2015/nov/07/world-health-organisation-sierra-leone-ebola-free.
[2] Automatically selected because there are only two districts in the WA

- Supply chain management (or drug availability) has improved, though feedback on drug stock out was also received at facilities visited in Moyamba and Kono, for example. In addition to stock out of some critical drugs, the supplies received during each distribution cycle may be substantially lower than requested for.

Education

- Of The seven indicators assessed, five -WASH in schools, Accelerated Learning, Social Mobilization and School fee waiver- were earmarked for roll out on a national scale, during the early recovery period, while two indicators- special needs initiative for pregnant school girls and the initiative to reduce overcrowding in classrooms were targeted for selected areas.
- Special needs education for returning pregnant girls back to school rated a remarkable success and target far exceeded: Western urban, for example, planned enrolment was 204 girls- actual was 2,165, with > 1,800 already returned to school.
- At sampled schools: i) all have received accelerated learning materials from government, Unicef and NGOs; ii) all teachers have been trained in use of accelerated learning materials and this has helped to get them proficient in using the resources.

Social Protection

- Both NaCSA and the Ministry of Social Welfare, Gender and Children's Affairs, which are the two agencies coordinating Social Protection activities have functional data bases to track support provided to beneficiaries
- Income transfer has taken place as confirmed by household beneficiaries as well as Ebola survivors.
- The amount received per cash transfer differs by respondent, location and organization. Moreover respondents receive cash transfers from different organizations at different intervals.
- MSWGCA social workers are providing support to beneficiaries, including EVD survivors: Beneficiaries are counselled about how and where to seek health services, about personal care, as well as guidance on how to access income support

Private Sector

- 73,000 farming households were supported with seeds; some with fertilizers, as well.
- According to the Ministry of Agriculture, Forestry and Food Security the bulk of the seed supplied to the 73,000 households has been paid back, by farmers given the support was meant to be a
- However, community interviews confirmed that the quantity of seeds supplied varied across locations. The overall view was that quantity of seeds supplied was inadequate.
- Farmers do use local financial institutions and like using them.
- Not much happened in feeder roads since July 2015: only two sampled communities confirmed road work happened this period- KamaKwie and Kakamba, both Bombali district.
- Agricultural Business Centres (ABCs) are functional and they are used.

Lessons Learnt

- Building rapport and persistent engagement with local stakeholders helps to manage unrealistic expectations, and promotes trust and ownership of development interventions. Eg. MEST quickly enlisted paramount chiefs and school management committees, and in the process shared information with them on the programme content. This paid off, as it was the same leaders who turned back to neutralise the misinformation.
- Farmers do use local financial institutions and generally like them
- While external consultants bring in high end expertise to support the development process, the lack of clarity around reporting lines could lead to tension in the partnership process, which may divert energy away from the core focus of the programme as well as undermine local ownership

- Service Level Agreement (SLA) reached with health sector implementing partners (IPs) has helped to minimise the duplication of interventions, build mutual trust and partnership, and above all given a reasonable degree of confidence to MoHS that health IPs are accountable to the Ministry.
- The Presidential Delivery Team has secured pledges and assuming the pledges come through and the cost estimates are also roughly close, the 10-24 month cycle will not face similar financial bottlenecks that unsettled implementation teams, particularly at the kick off phase of the programme.

Key Recommendations

Overarching Recommendation - Create clear and coherent communication strategy for raising public awareness about the Presidential Delivery (PD) Initiatives

Health

- Continued diligence in IPC education and training at the local level; adding an IPC monitor/quality assurance manager will ensure long-term sustainability, and will facilitate repeated trainings and knowledge transmission.
- Intensify sensitization activities to increase immunization coverage especially in hard to reach and among mobile communities
- A systematic evaluation of all WASH facilities must be undertaken in order to provide equal access at all facilities; construction and restoration of water wells, latrines and incinerators is necessary
- Continued and regular training on IDSR, the construction of permanent triage and isolation units, or the provision of grants for health facilities to build these facilities will ensure the maintenance of correct procedures and standards.

Education

- Prioritize the furnishing of all newly built classrooms. Classrooms should be utilized regardless of commissioning status, which can happen at a convenient time
- Supplying schools with more materials, and ensuring that all teachers are trained in the use of materials and relevance of timely usage. This will ensure that educational gains made as part of this programme endure.
- The GoSL to ensure that funds are delivered promptly to all schools across the country. School leadership on their part must put in place strong accountability systems to ensure funds received are properly accounted for and within the recommended reporting schedule. This is necessary to avoid interruption of funding flow to cover school fees.
- The GoSL and local governments must work in concert to build new WASH facilities at all schools.
- There is need to institute a tracking system for the special needs initiatives to monitor dropout and the reasons for dropout. The lessons learnt should be used to improve on expansion plans for the initiative in other schools.

Social Protection

- Continue unconditional cash transfers, but improve on the targeting process.
- NaCSA should maintain an inventory of IPs implementing cash transfers, and should develop guidelines for disbursement given that recipients receive cash transfer from different sources and at different intervals
- Increase local businesses and overall employment

Private Sector

- Conduct an assessment to determine the quantity of seeds and fertilizers actually needed by farmers per community and ensure sufficient and timely supply.
- Prioritize feeder road construction

- Establish new ABCs and delink access/right to purchase seeds, fertilizers and other facilities from ABC membership.
- Provide more loan opportunities for farmers in form of soft loans
- Improve access to community banks

1. Introduction

Sierra Leone is one of the world's poorest countries, ranking 181st of out the 187 countries in the United Nations Development Programme (UNDP) Human Development Index.[3] Adding to existing challenges of poverty and conflict, the country was devastated by an Ebola virus outbreak in 2014, and is now only beginning to recover. The first case of Ebola documented in this most recent outbreak was on May 24, 2014, in Kenema Town, Kenema District – the country's third largest city.[4] While the pace of virus transmission was initially slow, by early June the disease had begun to spread rapidly across communities. The reason for this sudden increase in cases was linked to the funeral of a traditional healer in Kailahun district, near the border with Guinea, who had been treating Ebola patients crossing the border from Guinea; some 365 Ebola cases were ultimately traced back to this healer's funeral.[5] On June 12, 2014 the Government of Sierra Leone (GoSL) declared a state of emergency in Kailahun, which necessitated the closing of schools, cinemas, places of public gathering, the screening of people in vehicles and the setting up of checkpoints along the Sierra Leonean-Guinean border. Kailahun and Kenema to the south constituted the early epicentre of what was to be a nationwide outbreak of Ebola.[6]

The first confirmed case of Ebola in the capital city, Freetown, was documented on June 23, 2014, and President Koroma declared a national state of emergency at the end of July 2014, nearly two full months after the first documented case of Ebola.[7] By the end of December 2015, over 9,000 Ebola cases had been reported in Sierra Leone, killing an estimated 3,955 people. Across all of the Ebola-affected countries in West Africa, a total of 11,315 Ebola deaths were reported in Sierra Leone, Guinea, Liberia and Nigeria.[8]

In November 2015, the end of Ebola outbreak declaration was in Sierra Leone. Sierra Leone was declared Ebola free as no new cases of the disease had been recorded in 42 days, thereby confirming that the Ebola virus was not being actively transmitted.[9] In an effort to help the country recover from the social, political and economic trauma of the Ebola crisis, His Excellency President Ernest Bai Koroma introduced a four-pronged recovery strategy in March 2015. The strategy focused on:

- Restoring basic health services throughout the country and maintaining a zero rate of Ebola infection;
- Returning children to school safely;
- Protecting vulnerable populations;
- Assisting private sector recovery.

[3] UNDEP, "Human Development Reports," n.d., accessed March 20, 2016, http://hdr.undp.org/en/countries/profiles/SLE.
[4] UN Mission for Ebola Emergency Response (UNMEER), "Sierra Leone," n.d., accessed March 20, 2016, http://ebolaresponse.un.org/sierra-leone.
[5] World Health Organisation (WHO), "Ebola in Sierra Leone: A slowly start to an outbreak that eventually outpaced all others," n.d., accessed March 20, 2016, http://www.who.int/csr/disease/ebola/one-year-report/sierra-leone/en/.
[6] Ibid.
[7] Ibid, see also World Health Organisation (WHO), "Ebola in Sierra Leone: A slowly start to an outbreak that eventually outpaced all others," n.d., accessed March 20, 2016, http://www.who.int/csr/disease/ebola/one-year-report/sierra-leone/en/.
[8] BBC, "Ebola: Mapping the outbreak," January 14, 2016, accessed March 20, 2016, http://www.bbc.com/news/world-africa-28755033; World Health Organisation (WHO), "Ebola in Sierra Leone: A slowly start to an outbreak that eventually outpaced all others," n.d., accessed March 20, 2016, http://www.who.int/csr/disease/ebola/one-year-report/sierra-leone/en/.
[9] Isa O'Carroll, "WHO officially declares Sierra Leon Ebola Free" *The Guardian* November 7, 2015, accessed March 20, 2016, www.theguardian.com/world/2015/nov/07/world-health-organisation-sierra-leone-ebola-free.

1.1. Background

1.1.1. Background to Sierra Leone

Sierra Leone has a long history of development challenges. From 1991 through 2002 the country was engulfed in a deadly civil conflict, causing an estimated 70,000 deaths and displacing 2.6 million people. The conflict resulted in the destruction of local political institutions and health infrastructure, weakening of civil society, decreased rates of school enrolment, and increased rates of youth unemployment and illiteracy, in addition to fundamentally undermining protection of women and girls.[10] Partly due to the civil war, Sierra Leone has some of the world's lowest development indicators according to UNDP (as noted above).

According to UNICEF, in 2012 the mortality rate for children below 5 years of age was 182/1,000 live births, as compared to 109/1,000 for West and Central Africa in general. The average life expectancy in Sierra Leone was 45 in 2012, as compared to 54 (2013) for the rest of West and Central Africa. The adult literacy rate in Sierra Leone in 2012 was 43.3% versus 50% for the surrounding region.[11]

These already poor development indicators were dramatically impacted by the Ebola Virus Disease (EVD) outbreak in 2014. As a consequence of the proliferation of EVD in Sierra Leone, schools were closed, and people began to stay away from health facilities in increasingly large numbers due to fear of EVD infection. The GoSL's own research showed that 72% of hospital patients are afraid of being infected by EVD in health care facilities, which has decreased public trust in GoSL health services in general.[12] Indeed, according to analysis conducted by the World Health Organization (WHO), health workers—or anyone working in health services, including drivers, cleaners, burial teams and community-based workers—were between 21 and 32 times more likely to be infected with Ebola than the regular Sierra Leonean population.[13]

1.1.2. Background to GoSL's 6-9 Month Early Recovery Priorities

In March 2015, Sierra Leone's President, Ernest Bai Koroma introduced his 6-9 Month Early Recovery Plan which focused on four core areas of Sierra Leone's recovery from the EVD outbreak. The following is a summary of the four priority areas of the Recovery Plan:

Restoring Basic Health Services: Infection prevention and control (IPC), triage, isolation and integrated disease surveillance and response (IDSR) in all health facilities in the country; providing safe drinking water to a majority of community health centres; restoring and expanding the free health initiative; providing reproductive, maternal, newborn and child health (RMNCH) services; HIV, tuberculosis and malaria treatment provision. Basic health care is necessary for EVD survivors, victims of gender-based violence and pregnant teenagers.

Returning Children to School Safely: New WASH facilities must be built in all of the country's 8,000 schools and tertiary institutions, with 100% protocol compliance; schools fee are to be waived for all students in

[10] Mary Kaldor and James Vincent, "Evaluation of UNDP Assistance to Conflict-Affected Countries: Case Study Sierra Leone," *United Nations Development Programme*, 2006, accessed March 20, 2016, http://web.undp.org/evaluation/documents/thematic/conflict/SierraLeone.pdf.
[11] "At a Glance: Sierra Leone," *UNICEF*, December 27, 2013, accessed March 22, 2016, http://www.unicef.org/infobycountry/sierraleone_statistics.html.
[12] "Recovery and Transition Priorities, Full Deck Explanation." April 2015.
[13] WHO, "Health worker Ebola infections in Guinea, Liberia and Sierra Leone," n.d., accessed March 20, 2016, http://www.who.int/csr/resources/publications/ebola/health-worker-infections/en/.

government supported schools; food will be provided for all primary school children; aim for 100% attendance rates; create special needs programmes; train teachers; reduce class sizes; decontaminate the educational institutions that were used as holding and treatment centres for EVD victims.

Protecting the Vulnerable: Strengthen social protection information systems; provide income support for 150,000 households; develop social protection and support systems focusing especially on EVD survivors and orphans of EVD victims.

Private Sector recovery: Provide seed and fertilizer support for 100,000 farmers; improve market access for farmers by creating and transforming 50 agricultural business centres, refurbishing 20 rice and cassava processors; rehabilitating 1800 km of feeder roads; recapitalizing financial institutions and ensuring access to finance for 125,000 farmers and pretty traders.

1.1.3. Purpose of Assessment &Methodology

The first phase of the Ebola Recovery Plan implementation ended on 31st March 2016. The purpose of this assessment is therefore to verify the efficaciousness of the programmes that have been implemented, to evaluate the degree to which implementation has met with the Plan's priorities and to provide an unbiased assessment of the results achieved to date. Specifically, this evaluation is focused on:

1. Independently verifying the results of the programme initiatives in order to identify challenges and shortfalls that the GoSL and its implementing partners must address.
2. Identify lessons and best practices that can be used to improve the implementation of recovery priorities during the second phase of the Plan (April 2016-June 2017).

2. Aim of Assessment

The findings from this evaluation will:

i. Provide independent adjudication of reported results;
ii. Guide the President's Delivery Team (PDT) to take up any corrective actions necessary to address gaps in the existing programming in order to better achieve its targets;
iii. Identify lessons learned that can be incorporated into the implementation of phase 2;
iv. Strengthen the monitoring and information systems that have been used to verify programme results to this point.

The evaluation seeks to respond to the following questions, which require community level perspectives:

- Do field visits provide evidence verifying the reported status of initiatives?
- What are some of the success factors/challenges this initiative faces?
- Who are the major players at the field level in implementing this initiative?
- What are the reactions of community members and the beneficiaries to this initiative?
- Are there unintended positive and/or negative impacts from the initiatives at the community level?
- What are some of the lessons learned through the implementation of this initiative?

3. Methodology

This evaluation employs a qualitative methodology, which includes a desk review and a series of qualitative interviews. Key Informant Interviews, Focus Group Discussions, Case Studies and Observation were applied with the goal of responding to the questions set above. The primary target group for this evaluation is direct beneficiaries of the initiatives implemented for the phase 1 (6-9 months) Ebola recovery programme. Other targeting groups included indirect beneficiaries (i.e. local level population) as well as other stakeholders. A cluster sampling methodology was used to select study sites, based on level of concentration of president delivery activities, and beneficiaries to be surveyed. The target districts selected are:

- Bo and Moyamba (Southern Region)
- Kono and Kailahun (Eastern Region)
- Port Loko and Bombali (Northern Region)
- Western Area(Urban and Rural)[14]

The chiefdoms selected by district are shown in the table below.

District	Chiefdoms and Areas Selected		
Bo	Kakua	Tinkonko	Bumpe
Moyamba	Fakunya	Kaiyamba	Bumbpeh
Bombali	Bombali Sebora	Sella Limba	Gbanti Kamaranka
Port Loko	Masimera	Marampa	Marforki
Kono	Faima	Nimikoro	Nimiyama
Kailahun	Kissi Kama	Kissi Teng	Luawa
Western Urban	Kissy Kroo Bay	Wilberforce	Lumley
Western Rural	Waterloo	Treeplanting	Newton

A more detailed description of the methodology is provided as annex 1.

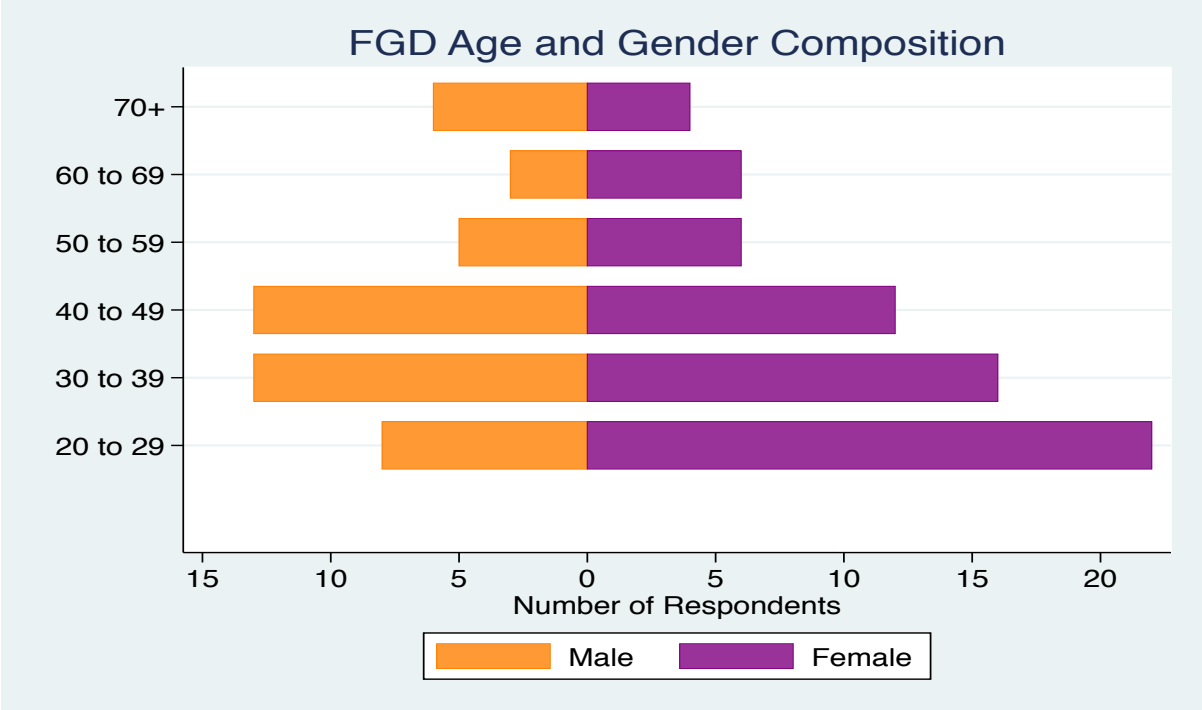
[14] Automatically selected because there are only two districts in the WA

3.1. FGD Respondent Profile

Some basic descriptive and summary statistics are useful to understand the local-level population surveyed for this assessment. In each of the eight districts included in the sample, focus group discussions (FGDs) were conducted with indirect beneficiaries – i.e. members of targeted communities who had the potential to observe and be indirectly affected by the Programme. Respondents were selected purposively in order to maximize the respondent diversity (i.e. variation in gender, ages, and opinions) that would be captured in the sample.

In aggregate, FGD data is derived from 14 focus group discussions comprising 117 respondents – 51 men and 66 women. The genders and ages of FGD participants are summarized in graph 1 (below). The graph suggests that the age and gender composition of FGDs was generally representative of the demographics of the greater population of Sierra Leone, albeit with men from 20-29 years of age being somewhat under-represented in the sample.

Graph 1. Demographic Pyramid



3.2. Limitations

Getting data for this project was a bit challenging. Some of the impediments faced include:

Hesitations of some community members to be interviewed: Some community members because they were not pre-informed about the purpose of the assessments, had doubts about the authenticity and therefore were hesitant about being the Key informant Interviewees and part of the Focus Group Discussions (FGDs). Paramount chiefs and headmen however intervened and this was resolved.

Postponement of interviews: Some interviewees especially the district and central level stakeholders had competing priorities. As a result, interviews had to be shifted a number of times.

Difficult terrains and hard to reach areas: It is difficult to reach some selected sites with bad terrains and poor road networks. Some field researchers rode on motorbikes for long distances while others working in the riverine communities had to rely on canoes to get to their working sites.

Difficulty in tracking down stakeholders and other eligible interviewees: Some eligible interviewees such as farmers and traders have income generating activities that keep them on the move and take them away from their communities for long periods of time. Tracking such people slowed the data collection process.

Unavailability of power supply and inadequate communication networks: Lack of electricity supply and inadequate communication networks affected the transcription pace of the recorded interviews. Laptop batteries ran out and internet modems were usually not used until headquarter towns were accessed.

Coverage for development partners limited to UKaid: Only UKaid was interviewed in the donor community, largely due to oversight. During interviews with MDAs, the World Bank emerged as a major donor to the seeds distribution as well as the cash transfer activities. The agency was not contacted for interviews on this round.

Sub Optimal Coverage of Health Interventions – Even though the assessment of health sector interventions covered a range of interventions, it did not cover all interventions. The interventions excluded were those relevant to HIV, HRH, and TB. These were excluded because of limited time available for data collection, which necessitated prioritization of other key interventions with a direct bearing on maternal and child survival such as IPC, WASH, drug supply chain, BEMOnC) and CEMOnC and immunization, over interventions missed out.

3.3. Layout of the Report

The findings section of the report is presented as five sub sections, corresponding to the requirements in the terms of reference (TOR).

Section 4	Sets the context in terms of programme development and implementation with a focus on conception and design, programme financing and implementation arrangements.
Section 5	Analyzes the programme results and impacts. The sub sections are organized beginning with analysis of the overall impact, followed by a detailed review of results and impact by sector and by outcome indicator.
Section 6	Reviews sector specific challenges at two levels: a) challenges associated with project management arrangement and b) negative externalities, either unforeseen or externalities that were not adequately prepared for at the design stage of the programme.
Section 7	Discusses perspectives about sustainability of the programme in the long term and considerations for scale up
Section 8	Examines key lessons learned and best practices identified during the course of implementation , and ends with the conclusion section
Section 9	Draws conclusions from the findings of the evaluation.

4. The President's 6-9 Month Recovery Priorities: Development and Implementation

4.1 Conception and Design

The President's Delivery (PD)—Early Recovery Programme was first conceived by the Government of Sierra Leone (GoSL) in February 2015, making the initiative country-owned. The initial planning process of what evolved into the President's Delivery Priorities was led by the Ministry of Finance and Economic Development (MoFED), which was mandated by the government to work with other ministries, departments and agencies (MDAs) to identify priority areas and consolidate those into a national early Recovery Programme. As the planning process progressed, the leadership and coordination responsibility was relocated from MoFED to the Office of the Chief of Staff, Office of the President, in part to strengthen interface between the programme development team and the presidency. This relocation was seen as a strategic move that helped to keep the number of priority areas to a manageable size. At the same time, housing the programme within the Office of the President, at the State House, provided the opportunity for the President to be more closely engaged with the planning and design stage.

While the Office of the Chief of Staff led planning, the feedback from MDAs implementing the priorities is that they were also involved in setting out the priorities at an early stage. Civil Society Organisations (CSOs), as well as development partners, including UKaid, were also involved in the consultation process leading to the agreed priorities. Because of the level of involvement, the implementing MDAs reported that they felt an appropriate level of ownership over the initiative and felt a personal responsibility for delivering on the programme results.

4.2. Programme Financing

The early recovery priorities is largely financed by Sierra Leone's development partners, mostly through direct grants or financial aid to the government (depending on the donor), or through third parties, such as NGOs. UKaid has been one of the major funders of the programme, taking on the total staff and operational cost of the President's Delivery Team (PDT), as well as auxiliary costs, including the cost of the consultancy services. Similarly, the World Bank has made significant financial contributions to the cash transfer implemented by NaCSA and the seed distribution carried out by MAFFS.

Stakeholder feedback suggests that PD financing faced some important challenges, including inadequate financial planning for the implementation phase. While the programme priorities, activities and performance targets were sufficiently defined prior to commissioning the intervention, there was no clear price tag placed on the activities. Consequently, the relevant MDAs spent part of the inception phase raising funds rather than rolling out activities. This was particularly the experience of the MoHS and MAFFS.

4.3. Implementation Arrangement

The implementation of programme activities is managed by the sector-relevant MDAs, with education-related priorities being implemented by the Ministry of Education, Science and Technology (MEST), and so forth. The PDT, whose primary role is to provide technical support and monitoring, has one of its members embedded in each ministry, working as the sector coordinator. Similarly, the PDT has representatives in every district council, with one typically working as the district facilitator while the other serves as the district analyst. This model of involvement has helped the PDT to provide hands on support to MDA implementation teams, track progress, as well as identify and respond to many problems that have emerged during the course of

implementation. With support from the donor community, mainly UKaid, McKinsey Limited[15] was also contracted to provide technical assistance to the MDAs. Like the PDT sector coordinators, some of the consultants were also embedded in the relevant MDAs, with the mandate of facilitating implementing entities to develop, implement work programmes and plans, as well as support them in reviewing progress. PDT members and members of the donor community suggested that the involvement of the consultants added value in terms of supporting the immediate implementation process as well as providing an opportunity for skills transfer to key MDA staff, who will ideally be able take over similar functions when the external consultants eventually leave.

Apart from MDAs, both local and international non-governmental organisations (NGOs) have also been involved in implementing PD activities. The model of NGO engagement has been varied, ranging from close partnership and collaboration with the sector-relevant ministry, to what some ministry representatives described as absolute autonomy. At one extreme lies the Ministry of Health and Sanitation (MoHS), for example, which has worked in close collaboration with implementing NGOs. This high level of collaboration and coordination is at least partly attributable to the fact that MoHS has taken strong measures to regulate NGO activities, by effectively requiring them to sign up to a Service Level Agreement before NGOs are allowed to operate.[16] In the middle of the spectrum lies the Ministry of Social Welfare, Gender and Children's Affairs (MSWGC&A), which has relied heavily on NGOs to provide the minimum assistance package for social protection to the population, while the Ministry's staff have aided in monitoring the process. Despite their smaller role, MSWGC&A staff reported that they were pleased with the cooperation from NGOs. At the other extreme, the Ministry of Agriculture, Forestry and Food Security (MAFF) representatives feel strongly that NGOs in their sector have largely implemented interventions without adequate collaboration with the Ministry.

5. Programme Results and Impacts

In this section, the evidence from communities and district level actors on PD results and impacts are presented and discussed. The findings are presented in two parts. First, the overall rating of programme success, from the point of view of communities is presented. This is then followed by a more detailed examination of results for the relevant programme priority areas/sectors.

5.1. Overall Rating of the PD Programme Impact

The data for this rating was obtained from FGDs sessions with recipients that have received one or more type of assistance from the PD programme portfolio.

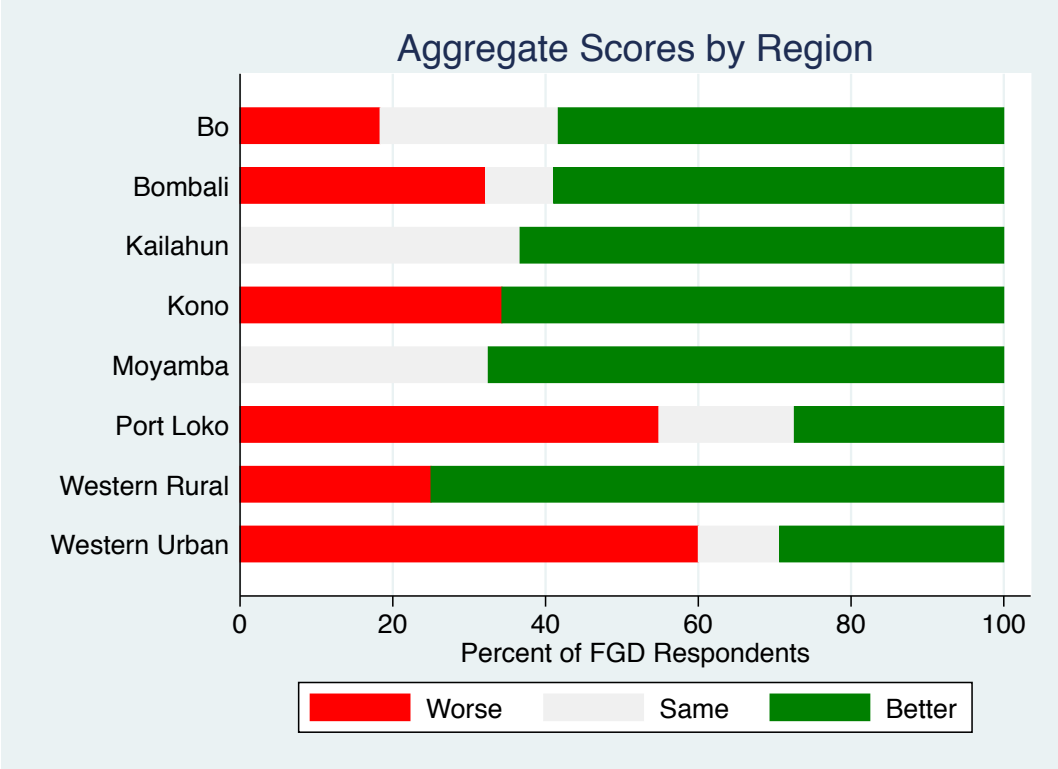
All FGD participants were asked to rate the impacts that they observed in terms of four main beneficiary categories. These questions took the general form "Are [beneficiaries of a certain type] in your community doing better, the same, or worse than they were 6 months ago?" For these questions, the response of each FGD participant was elicited and recorded. The resulting data, while not representative of the entire Sierra Leonean population, provide a useful overview of how ordinary people in Sierra Leone view the impact and efficacy of Ebola Recovery Programmes. Majorities of FGD respondents had lived in their communities for most of (or the entirety of) their lives, and therefore are in a position to speak knowledgably about conditions in their communities.

[15] Mackenzie is a global consultancy firm that is reputed for offering high end management consultancy services.
[16] The agreement commits the NGO to declare what, where, and whom it will reach with its intervention.

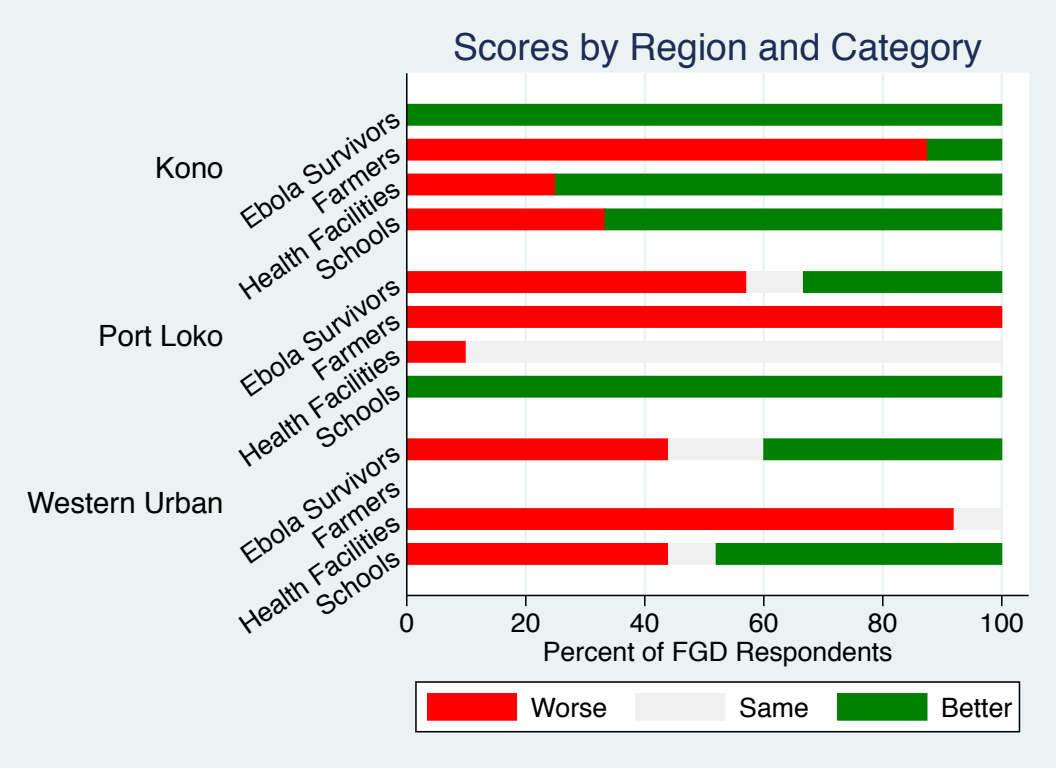
These FGD findings are presented in a series of graphs that help to summarize a vast amount of qualitative information in a small amount of space. All of the graphs summarize findings in terms of the percentage of respondents who expressed a given sentiment when providing their impressions of programme impacts and important changes that have occurred in the past six months.

Examining FGD data by district, large variations occur in the degree to which respondents believe that the 6-9 month Recovery Programme has affected important positive or negative outcomes in their towns and chiefdoms (which are aggregated up to the level of their district for the purpose of reporting). In particular, even with the efforts of the delivery interventions, it would appear that some FGD respondents surveyed in Bombali, Kono, Port Loko, and the Western Urban Area of Freetown are still struggling to see improvements in their general wellbeing.

Graph 2. Perception of Programme Impacts



Graph 3. *Specific Perceptions of Programmatic Impacts*



Graph 3, above, offers a more fine-grained examination of three districts reporting that they believe themselves to be worse off now than before July 2015. FGD participants in Kono and Port Loko believe that farmers are doing much worse now than they were before July 2015, which is negatively impacting the aggregate perception scores for the entirety of Kono and Port Loko districts

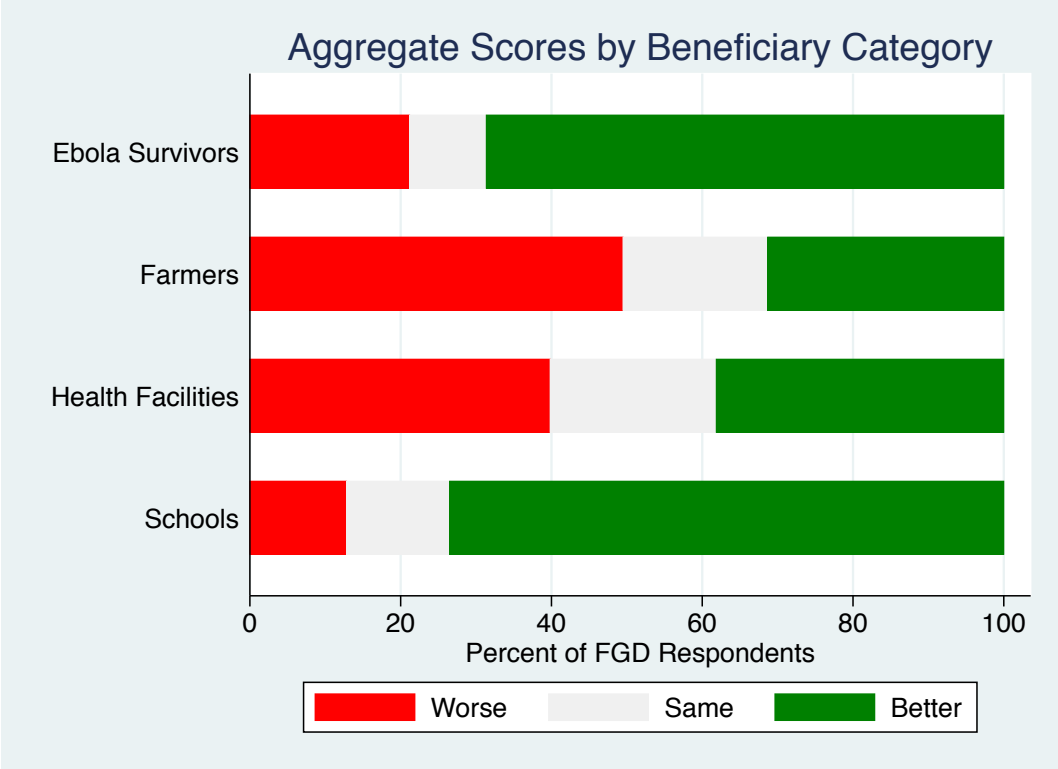
It is also worth noting that the score for Ebola survivors in Port Loko is poor, with over 50% of respondents suggesting that the situation of Ebola survivors has gotten worse over proceeding the last six months

Among problematic districts, urban Freetown stands out because it has the most consistently negative scores across all beneficiary categories. Indeed, in urban Freetown, health facilities have the most negative score, with zero respondents reporting improvement, while roughly 90% of respondents suggest that the situation inside health facilities appears to be getting worse. Moreover, over 40% of Freetown respondents indicated that the situation inside schools was worse now compared to the pre-July 2015 period. These data help explain why the Western Urban area of Freetown has the most negative aggregate score in graph 2 (above), with 60% of respondents suggesting that the situation of key beneficiaries has gotten worse in the past six months.

Examining the degree to which interventions have affected Ebola survivors, farmers, health facilities, and schools, FGD participants suggested that schools have exhibited the most positive changes over the six-month period prior to data collection. Ebola survivors have also benefited significantly from the 6-9 month Recovery Programme. In contrast, FGD participants described the impact on farmers as being much more ambiguous, with nearly 50% of respondents suggesting that the situation of farmers has actually gotten worse over the past six months. A deeper examination of the qualitative evidence suggests that the perception that farmers situation has deteriorated is driven by mixed reasons. In Bombali, FGD respondents surveyed in Bombali Shebora chiefdom expressed frustration about farmers being left out from Government assistance

programmes. When asked about the most important changes they had seen in farming in their community they said "no change at all because even the planation is getting worse, because we did not have seeds or tools"[17] They however praised NGOs for helping out. In the case of FGD respondents surveyed in Kono, their dissatisfaction is not necessarily because of shortfalls in the implementation of the early recovery interventions, but rather due to other factors that are outside the mandate of the early recovery priorities. .FGD participants were troubled about farmers livelihood because of the surge of pests (grasshoppers) which are destroying crops.

Graph 4: *Perceptions of the Impact of the 6-9 Month Recovery Plan on Target Groups*

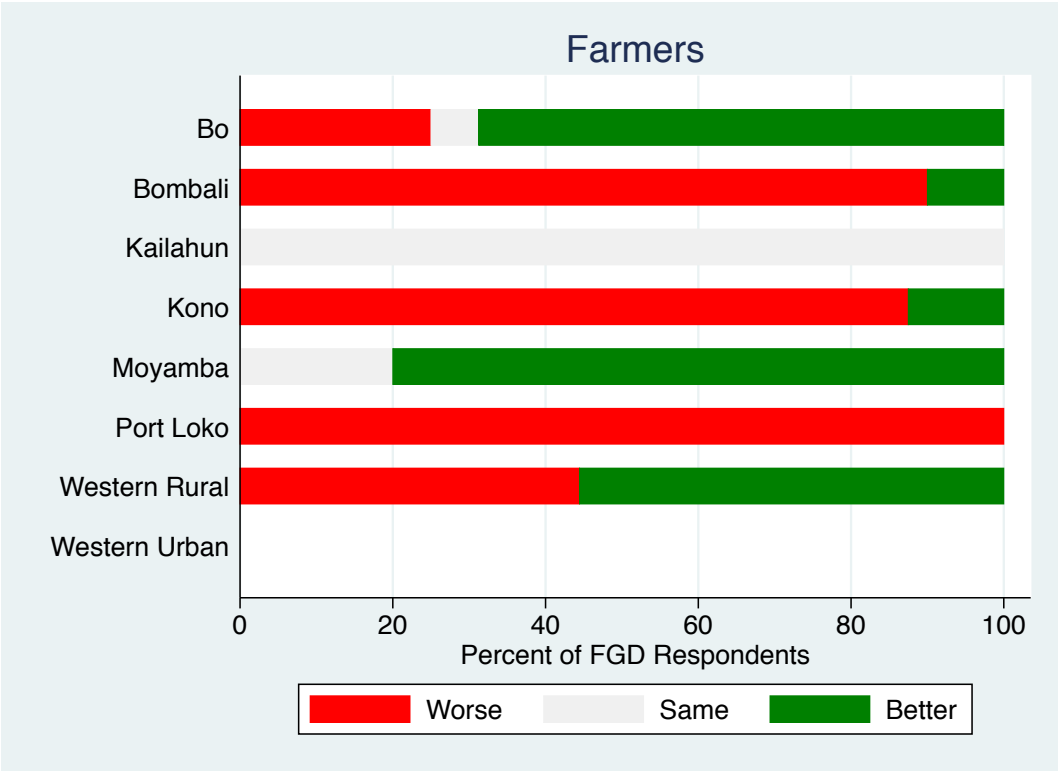


Graph 5, below, illustrates that farmers are perceived to be doing particularly poorly in Bombali, Kono, Port Loko and Western Rural Area on the outskirts of Freetown over the course of the past six months.[18], qualitative responses to questions about farming in Bombali suggest that the situation for farmers in Bombali is also quite bad, and may have been qualitatively similar to the situations in Kono, Port Loko, and Western Rural Area.

[17] Focus Group Discussion – Bombali Shebora Chiefdom – Bombali District i

[18] The Western Urban area of Freetown appears blank on this graph because of the lack of farming; Bombali has significant farming, but appears blank on this graph because respondents in Bombali, which is a product of the respondents in Bombali being unwilling to code their responses (according to the better, same, worse scale) in the same way that respondents in other districts were willing to do.

Graph 5: Perceptions of Farmers Situations, by District



In sum, the 6-9 month Recovery Programme is perceived differently by district and group. While the application and positive impact of the programme, was evident for the education sector, compared to other sectors. In the case of the agriculture sector, one gets the impression that the impact didn't go far enough, to leave people feeling those sectors are in a better state. The uneven impact across sectors is explored in sections that follow. Results and Impact at Sector Level

5.2.1 Health Services

This section presents findings relevant to the *Health Priority: "Restoring Basic Health Services."* The findings are disaggregated by stakeholder groups: i) indirect beneficiaries, including local communities, service providers and paramount chiefs; and ii) implementation team, including the PDT, MDAs and IPs/NGOs. In exploring perspectives of programme results, the evaluation has in large part focused on assessing the effectiveness of interventions-i.e. have programme interventions generated the intended results, the analysis has been done for many of the outcomes defined for the health programme component.

For the purpose of context, Table 1 provides the dashboard ratings for the health sector initiatives as at 31st March 2016.

Table 1. Dashboard Rating Showing Progression towards Outcomes

Human Res. for Health	EPI	HIV	Malaria	IDSR	TB	RMNCH	WASH	EVD Survivors	Triage & Isolation	IPC	Supply Chain

Green indicate 85-100% of target met
Orange indicate 50-85% of target met
Red indicate 0-49% of target met
Blank indicate no data available to evaluate progress

5.2.2 Perspectives of Beneficiaries and Service Providers

Given the wide-ranging impact that the EVD outbreak had on Sierra Leone, it is most critical to assess how the President's 6-9 month Recovery Priorities has met its goals of: improving IPC; increasing the quality of isolation and triage facilities; ensuring the availability of drugs for treatment; improving water sanitation and hygiene (WASH) facilities at medical units; and improving RMNCH. This assessment has been based on feedback from service users/recipients (i.e. communities) and service providers (for example, health workers and teachers).

In general, the qualitative data collected indicates that improvements have been made on all the above-mentioned issues throughout the areas that were surveyed. Indeed, the data suggest that overall awareness of IPC standards has improved and health facilities are complying with IPC standards, as well as passing assessments of their compliance with IPC protocols. Moreover, health facilities have regularly completed their IDSR reports over the preceding 6-9 months (since July 2015). However, health facilities in some areas report limited access to and poor quality of water, drug stock outages, and limited sanitation, isolation and triage facilities. Additionally, in order to expand health facilities' ability to reach populations throughout their catchment areas they require dedicated ground transportation.

5.2.3 Initiative 1- Improvement in Infection Prevention and Control

The section below assessed the recovery Programme's performance at two levels: i) awareness of compliance standard for infection control facilities; and ii) compliance levels of infection control facilities.

1. **Awareness of Compliance Standard for Infection Control Facilities**

Survey respondents ranging from midwives and community health officers in charge of community health clinics to acting medical superintendents all indicated that they were well aware of the compliance standard for infection control facilities. According to the head of a community health post (CHP) in Kono District, IPC is defined as a protective method set up to help prevent health workers, patients and community members from being infected by virulent diseases like the EVD. The respondent noted that the IPC process requires regular hand washing, and the evaluation of a person's temperature.[19]

A community health officer in Waterloo, Western Rural Area noted that health workers must wash their hands prior to and following their interactions with a patient. Washing used instruments as well as disposing of those that cannot be reused is also vital. Sharp instruments like needles must be collected separately from all other

[19]KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.

waste, and disposed of carefully; sharps are disposed of in health facility incinerators. In the labour wards where instruments can be reused, the "four bucket system" is practiced: One bucket has soap and water, another is half chlorine/half water and two hold clean water; "because of the decontamination of those used instruments we just need to wash than in the soapy water then rinse then with clean water then transfer them into the chlorine where it is left for about 15-20 minutes after which we have to wash them again in the clean water to ensure that the chlorine is not left on it."[20] Furthermore, a midwife in Bombali District noted that organizations like GOAL and World Hope International (WHI) have conducted trainings at local health facilities on how to put on and take off personal protective equipment (PPE), and how to do health screening at triage areas prior to admitting people to a health facility. Moreover, nongovernmental organizations (NGOs) also trained local health workers on how to clean the health facilities, i.e. how to dust tables, clean labour rooms, and how to dispose of afterbirth.[21] Therefore, in general, knowledge of infection control compliance has increased.

2. Compliance Levels of Infection Control Facilities

All health facility administrators interviewed for this assessment stated that their facilities had been assessed for compliance to IPC standards in the previous 6-9 months and that their facilities had seemingly passed the assessment. This assessment evaluated how facilities adhered to IPC standards, the use of the four bucket system, the quality of facility infrastructure, and how they operated on a daily basis in terms of treating patients, use of PPEs, cleaning procedures as well as waste disposal methods. Assessors also evaluated how facilities prepared for childbirth and how these procedures were conducted. The WHO in Kailahun examined the isolation and triage areas, the hospital in general for compliance with post-Ebola recovery standards, as well as the WASH facilities.[22] GOAL also helped a Bombali facility rearrange the position of health workers' chairs such that more people could visit health facilities. These assessments occurred at regular intervals (monthly, according to a Western Urban District official over the course of the preceding 6-9 months, and were conducted by organisations such as GOAL, the WHO, ACF, as well as the government.[23] In Kailahun, a representative of the office of the President visited the health facility, and indicated that the facility had satisfactorily complied with the IPC standards.[24]

While no respondents to this survey were given specific data or performance metrics for how effectively they met IPC standards or their understanding of these standards in general, all respondents indicated that their facilities passed their assessments. Indeed, a Western Rural Area community health officer noted that it was unclear what a passing mark on their assessment was, or how passing was measured, but they were told "that we did well."[25]

In Bombali, health facility administrators stated that they worked to improve in the areas in which assessors indicated the facility did not perform well. The health facility worked to increase their staff's health training through internal education and training (with help from GOAL) on "how and where to place things, things that should not be given to patients to be taken home."[26] The Bombali health facility staff indicated that from their perspective compliance with IPC standards was limited by physical space inside the facility, where for example

[20] KII with Health Facility Administrator, Western Rural Area, Waterloo, March 12, 2016.
[21] KII with Health Facility Administrator, Bombali District, Ghanti Kamaranka Chiefdom, Kamaranka community, March 12, 2016.
[22] KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016.
[23] KII with Health Facility Administrator, Western Rural Area, Waterloo, March 12, 2016; KII with Health Facility Administrator, Bombali District, GhantiKamaranka Chiefdom, Kamaranka community, March 12, 2016; KII with Health Facility Administrator, Western Urban Area, Wilberforce community, March 12,
[24] KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016.
[25] KII with Health Facility Administrator, Western Rural Area, Waterloo, March 12, 2016.
[26] KII with Health Facility Administrator, Bombali District, Ghanti Kamaranka Chiefdom, Kamaranka community, March 12, 2016.

the staff dressing room was also used as an under-5 immunization area, as well as by limited knowledge, which is now increasing.[27]

In order to improve compliance with IPC standards, health facility administrators in Western Rural Area recommended that fences be built around the facility to restrict the number of entry and exit points to the facility. This would help limit the spread of potentially infectious diseases. Moreover, the community health officer from this district indicated that a new permanent isolation unit is needed in addition to the provision of larger quantities of personal protective equipment (which is necessary to limit contact with human fluids during childbirth).[28] Similarly, the Kono District Health Facility Administrator suggested that the government of Sierra Leone build a permanent triage unit in all Primary Health Centres (PHCs) and Community Health Centres (CHCs) across all Districts, "because with the construction of a permanent triage unit we will be able to screen and isolate patients that are in critical condition."[29] Administrators also called for more waiting rooms to be constructed, as they would help limit the spread of infectious diseases as people from all over a health facility's catchment areas would not be put in one single area. Moreover, more waiting rooms might help larger number of people feel safe in returning to health facilities to seek treatment.[30]

Health officials from Western Urban Area and Kailahun added that tarring hospital areas will also help meet IPC standards by decreasing the spread of dust, especially in the dry season, which might help increase overall facility cleanliness as well as decrease the spread of infection/bacteria. Additionally, staff from these facilities called for continued increase of facility access to clean water through the construction of boreholes and overhead tanks, as well as the installation of a pump system that will move water from boreholes to overhead tanks.[31]

Finally, staff at the Bombali facility indicated that regular monitoring visits from health experts would help ensure that health facilities continued to implement and comply with IPC standards. According to the Bombali midwife interviewed for this work, monitoring helps keep people alert.[32]

5.2.4 Initiative 2- Increasing the Quality of Isolation and Triage Facilities

Outcome 2 is assessed along two axes: the effectiveness of the patient isolation facilities building programme, and second, the training levels among staff for patient isolation and triage facilities.

1. **Effectiveness of Patient Isolation Facilities Building Programme**

While table 1, below, indicates that no new isolation facilities have been built in three of the districts surveyed, only one health facility in Waterloo, Western Rural Area actually lacks an isolation unit. Indeed, in Waterloo, if Ebola were to recur, a neighbouring health facility (ADRA Hospital) would be asked to assist, as they have an isolation unit that is being used for Ebola.[33] In all other cases, either a new isolation unit had been built in the preceding 6-9 month period, or communities were able to make do with the pre-existing isolation units. Given

[27] Ibid
[28] KII with Health Facility Administrator, Western Rural Area, Waterloo, March 12, 2016.
[29] KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.
[30] Ibid.
[31] KII with Health Facility Administrator, Western Urban Area, Wilberforce community, March 12; KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016.
[32] KII with Health Facility Administrator, Bombali District, GhantiKamaranka Chiefdom, Kamaranka community, March 12, 2016.
[33] KII with Health Facility Administrator, Western Rural Area, Waterloo, March 12, 2016.

the large number of Ebola cases that occurred in the Western Area, the lack of an isolation unit in Waterloo is a gap in future Ebola prevention. It is however notable that in Kailahun and Kono, border districts with Liberia and Guinea, respectively, new isolation units have been built, although the unit in Kono has yet to be completed. These units may well help stem the flow of new suspected cases of Ebola. These new isolation units are especially important given that Médecins Sans Frontières (MSF) closed a local isolation and treatment centre in Kailahun.[34]

Table 2. Isolation Unit Built in the Preceding 6-9 Months?

Yes	No
Bombali	Western Urban Area
Kono	Western Rural Area
Kailahun	Moyamba

2. Training Levels Among staff for Patient Isolation and Triage Facilities

In general, health facility staffs are being trained to use isolation units, except in Moyamba and Western Urban Area, where no new isolation units have been built. Even though Western Rural was not among the target districts for the establishment of a new isolation units, the staff at the health facility surveyed had in fact been trained on how to effectively use isolation units for potential cases of Ebola.[35] In Kailahun, the acting Medical Superintendent reported that all staff members were trained to man the unit, including the porters as well as the cleaners in the unit.[36]

According to a health facility worker in Bombali, all patients in isolation and triage units are carefully evaluated and their temperatures are taken. If a patient's temperature is recorded as being high, the staff will put on their PPE, mix oral rehydration salts (ORS) and administer Panadol until the patient's temperature drops to an acceptable level. . In general, according to the training they received, if a patient is suspected of having the Ebola virus the individual is taken to the isolation unit and the medical official in charge is notified to go see the patient in question.[37]

In terms of treatment, isolation units in Kono (border area with Guinea) and Western Urban Area are the most frequently used. Table 2 contains the treatment figures by isolation unit (no isolation unit exists in Western Rural Area).

[34] KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016; KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.
[35] KII with Health Facility Administrator, Western Rural Area, Waterloo, March 12, 2016.
[36] KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016.
[37] KII with Health Facility Administrator, Bombali District, GhantiKamaranka Chiefdom, Kamaranka community, March 12, 2016.

Table 3. Patients Treated by Isolation Unit – July 2015 to March 2016

Isolation Unit Location	Patients Treated
Kono	1,500 male; 3,000 female
Western Urban Area	3-4 patients per day; 14-16 patients per week
Kailahun	20 suspected cases
Bombali	1 patient since 2015
Moyamba	0

There were no instances of health facilities using their isolation units for any other purpose other than isolating an infectious patient. According to a respondent in Kailahun "we restricted it for screening, triage and isolation of suspected cases… of concern and they have their supplied there that they may need, that is how it has been used."[38]

In terms of potential improvements to the isolations units, outside of building a unit in Western Rural Area, survey respondents indicated that they might need larger units for other diseases like TB; permanent isolation unit structures, continuous training on isolation unit skills, additional staff (such as midwives, Community Health Officers [CHOs] and nurses) and more supplies for isolation units, as well as more cleaning materials.[39] Additionally, a health facility supervisor in Kailahun suggested electrification, as the isolation unit in Kailahun Town did not have power.[40]

5.2.5 Initiative 3- Completion of IDSR Reports

Survey respondents report completing their Integrated Disease Surveillance Reports (IDSR) on a weekly basis over the preceding 6-9 months. IDSRs include information from various local Peripheral Health Units (PHUs) on subjects ranging from EVD to malaria, severe malnutrition, and dog bites.[41]

5.2.6 Initiative 4- Adequateness of Supply of Required Drugs at Medical Centres

A critical point here is that MOHS does not have up to date information on this indicator, based on assessment reports made available to the Central Delivery Team (CDT)[42].

Even so, of the districts surveyed for this assessment only Moyamba and Kono reported any drug stock outages. While no details on this were offered in Moyamba, in Kono the facility is only resupplied on a quarterly basis, which seems to be the root of the problem. In March 2016, the person in charge of the community health post surveyed for this study indicated that his facility had not been restocked since November 2015. The only drugs available at the health facility at the time of the survey were the free health care drugs, with a lack of transportation being the primary cause inhibiting the resupply of the facility. In Kono there was no vehicle

[38] KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016.
[39] KII with Health Facility Administrator, Western Rural Area, Waterloo, March 12, 2016; KII with Health Facility Administrator, Moyamba District, Bumpeh Cheifdom, Rotifunk community, March 15, 2016; KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.
[40] KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016.

[41] KII with Health Facility Administrator, Moyamba District, BumpeCheifdom, Rotifunk community, March 15, 2016.
[42] President Delivery Team , Senior Official

assigned to the health facility; as such, even when drug stocks are available in the store they are hard to obtain. Moreover, the catchment area for the health facility is quite large and many people come to the Community Health Centres based at chiefdom level instead of going to their local PHUs, which drains Community Health Centre (CHC) resources.[43] In short, supply chain management is a core issue with regards to the availability of drugs.[44]

Table 4. List of Drugs Mentioned That Are Not Available at Health Facilities

Lidocaine	Amoxicillin tablets
Quinine tablets and injections	Paracetamol
ORS	Folic Acid
Erythromycin	Doxycycline
Zinc Oxide	Ringer lactate
Alben	Tracer drugs
Gentamicin	Ampicillin
Calcium	Panadol

5.2.7 Initiative 5- Improving Water Sanitation and Hygiene Facilities at Medical Units

Two dimensions were assessed for this outcome:

- Effectiveness of WASH facilities building programme
- Training levels of staff and the use of WASH facilities

1. Effectiveness of WASH Facilities Building Programme

In terms of available WASH facilities in the health facilities under study, all but one in Moyamba has had new water supplies installed in the preceding 6-9 months. WHI helped drill a borehole in Bombali, however it was destroyed.[45] After a new water system was installed in Kono, IRC provided a solar system to transport water from the well to the tank.[46] In Western Urban Area a new borehole was drilled to help augment the already available GUMA water supply, and in Kailahun a new borehole was drilled which will be attached to an overhead tank, which Save the Children provided a pipe for.[47] With the exception of Western Urban Area, where work on a new water supply system is ongoing, all survey respondents indicated that their new and old water systems were working well.[48]

Unfortunately, the quality of water access is uneven across locations. Respondents in Bombali, Moyamba and Western Urban Area all indicated that the overall condition of their water supply was bad. In Bombali, the well

[43]KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.
[44] Ibid; KII with Health Facility Administrator, Moyamba District, BumpeCheifdom, Rotifunk community, March 15, 2016.
[45] KII with Health Facility Administrator, Bombali District, GhantiKamaranka Chiefdom, Kamaranka community, March 12, 2016.
[46]KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.
[47] KII with Health Facility Administrator, Western Urban Area, Wilberforce community, March 12; KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016.
[48]KII with Health Facility Administrator, Western Urban Area, Wilberforce community, March 12.

that existed was damaged and the health facility lacked regular access to it.[49] In Western Urban Area the new borehole does not provide enough water, in addition to the GUMA water supply, to provide the health facility with water 24 hours per day.[50]

Notably, in only one of the districts under study, Kono, had a new sanitation and medical waste system being installed in the previous 6-9 months. The new waste facilities in Kono included an incinerator, placenta pit, general waste bin and a pit dug to dispose of any other waste.[51] In Kailahun an old incinerator was demolished because the United Nations Office for Project Services (UNOPS) constructed a maternity and paediatric complex at the back of the medical facility compound. In Western Urban Area, the construction of a new sanitation and medical waste facility was approved but has yet to be built.

2. Training Levels of Staff and the Use of WASH Facilities

While new sanitation and waste systems had not been constructed, training on the subjects did take place. Staff across the facilities under study had been trained on how to manage different types of waste, waste disposal procedures and traditional birth attendance (TBA). There seems to be a focus on correctly disposing of placenta after childbirth, potentially because these might transmit EVD.[52]

In sum, increasing local access to a steady flow of clean water is the most important WASH improvement necessary at the facilities surveyed. More sources of water, like taps and wells, more storage capacity for available water, and ensuring that the water available is clean are critical according to health facility personnel interviewed.[53]Additionally, several health facility personnel noted that permanent structures for eliminating waste material would also be important; temporary structures in the rainy season become are risky as they can leak hazardous materials into the surrounding community.[54]

5.2.8 Initiative 6- Improving Reproductive, Maternal, Newborn and Child Health

In the previous 6-9 months three of the districts under study (Bombali, Western Rural Area, and Bombali) have not received either Basic Emergency Obstetric and Newborn Care (BEMOnC) or Comprehensive Emergency Obstetrics and Newborn Care (CEMOnC) upgrades. Therefore, their obstetrics routine remains what it was prior to the President 6-9 month recovery plan. However, for those facilities that have been upgraded, maternity staff is better trained, there are more staff members, and the maternity ward larger.[55]

The next steps for increasing the capacity and quality of services provided at health facilities across the country includes provisioning a steady supply of electricity to the facilities through the addition of solar panels for the backup generator. Respondents also indicated the need for additional equipment like an oxygen concentrator,

[49] KII with Health Facility Administrator, Bombali District, GhantiKamaranka Chiefdom, Kamaranka community, March 12, 2016.
[50]KII with Health Facility Administrator, Western Urban Area, Wilberforce community, March 12.
[51]KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.
[52] KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016; KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.
[53]KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.
[54] KII with Health Facility Administrator, Western Urban Area, Wilberforce community, March 12; KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016; KII with Health Facility Administrator, Moyamba District, BumpeCheifdom, Rotifunk community, March 15, 2016.
[5555] KII with Health Facility Administrator, Kailahun District, Luawa Chiefdom, Kailahun Town, March 12, 2016; KII with Health Facility Administrator, Western Rural Area, Waterloo, March 12, 2016..

as well as a standby ambulance. More staff and training were also noted as being important future additions to this outreach programme.[56]

5.2.9 Initiative 7- Improving Expanded Programme on Immunization

All health facilities sampled by the study provide monthly EPI immunizations for children; this programme provides vaccines including BCG, pentavalent, BCV, rotavirus, measles, yellow fever and polio.[57] The number of children per district immunized varies by month, however the data suggest that children are receiving their immunization through this programme. In general, children who come to community health facilities are receiving immunizations. However, as families move from one place to another some children miss their immunizations. Moreover, some of the communities in the health facility catchment areas are quite far away and difficult to reach, especially without any dedicated mode of transportation.[58]

The evaluation further obtained projected and actual vaccination coverage data from the Expanded Programme on Immunization (EPI). Bearing in mind that the 6-9 month early recovery was implemented in the second half of 2015, the mean monthly vaccination coverage for this period was compared with the mean monthly coverage for the first half of 2015, for all districts. Table 5 shows that out of the 17 vaccines captured for the analysis, coverage increased for a total of 13 (which is about 76.5% of vaccine types analysed) during the implementation of the 6-9 month early recovery programme. Vaccination coverage remained more or less the same for one vaccine type-i.e. Vitamin A2 while it declined for two vaccines, mainly TT2 for pregnant and non-pregnant women during the implementation of the initiative. One vaccine, IPV, was not administered in both periods in 2015.

Table 5. Comparison of 2015 Vaccination Coverage, Period before and during 6-9Month Early Recovery Implementation

Vaccines	Period, Mean Half-Yearly Coverage and % Increase		
	Jan-June 2015 (before implementation)	Jul-Dec 2015 (During implementation)	% Increase
TT2+Preg	106.6%	103.4%	-3.3%
TT2+NPRG	6.4%	6.1%	-0.4%
IPV	0.0%	0.0%	0.0%
VIT A2	27.5%	27.5%	0.1%
MEAS	80.6%	84.1%	3.5%
YFV	80.6%	84.7%	4.1%
VIT A1	157.3%	162.0%	4.6%
FIC	78.7%	83.9%	5.2%
OPV3	82.7%	88.0%	5.4%
PENTA3	82.9%	88.3%	5.4%
PNEUMO3	84.1%	89.7%	5.6%
BCG	86.2%	91.9%	5.7%

[56] KII with Health Facility Administrator, Western Rural Area, Waterloo, March 12, 2016; KII with Health Facility Administrator, Bombali District, GhantiKamaranka Chiefdom, Kamaranka community, March 12, 2016.
[57] KII with Health Facility Administrator, Bombali District, GhantiKamaranka Chiefdom, Kamaranka community, March 12, 2016.
[58] KII with Health Facility Administrator Kono District, Nimikoro Chiefdom, Bumpeh community, March 14, 2016.

Vaccines	Period, Mean Half-Yearly Coverage and % Increase		
	Jan-June 2015 (before implementation)	Jul-Dec 2015 (During implementation)	% Increase
ROTA 1	85.4%	93.8%	8.4%
OPV1	91.2%	99.8%	8.6%
PENTA1	91.4%	100.1%	8.8%
PNEUMO1	91.4%	100.6%	9.3%
ROTA 2	84.3%	94.3%	10.0%

5.2.10 Perception of District Level Implementers on the Delivery of Health Sector Programme

At the district level, a range of actors, often collaborating or partnering with one another, implements the PD activities on health. The actors include MDA representatives at the district, the presidential delivery district team, local councils and NGOs.

This section presents findings, as perceived by district level implementers, on the following themes:

- Impact of health programmes
- Community involvement
- Sufficiency of output/outcome monitoring

5.2.10.1. Impact of Health Programmes

The overall feedback from district level stakeholders is that The President's Delivery 6-9 month Recovery Programme (PD) has increased funding and supplies to the local health systems. As a result, three broad improvements have been observed at hospitals and health facilities. Firstly, stakeholders, including representatives interviewed at local councils, district health management teams and NGOs in the sampled districts, all say services delivery has improved in the course of the implementation period. Drug supply is singled out as one of the areas that have improved, to the extent that drugs stock outages have been uncommon in the period under evaluation (since July 2015), although it has to be noted that this feedback is inconsistent with feedback from health facility in-charges interviewed at some locations. Vaccination operation has been restored at the pre-Ebola scale, with mass immunization resumed. A critical improvement is the introduction and continuity of infection, prevention and control (IPC) measures at health facilities. This is an area many stakeholders acknowledged was neglected and in some cases missing in the health system. Many of the IPC practices that were put in place during the epidemic have carried on to this day, including hand washing, use of hand gloves and sanitizers, and at most health facilities patient screening for high body temperature continues.

Through the PD initiative, local health infrastructure has also been upgraded. For example, investments have occurred to improve WASH at health facilities, including the construction and restoration of water wells, latrines and incinerators. At the same time, the human resources situation in the health sector has received some attention. Through this initiative, trained and qualified health workers were recruited to fill vacancies that existed at many facilities. Other IPs also continued working health volunteers and in particular community health workers (CHWs) to support the health system with basic functions, including community mobilisation, monitoring, etc.

While the general feedback was positive, in the Western Area, there was dissatisfaction echoed by some respondents. The perception is that they had not observed any real change in health service delivery. Survey participants referenced the poor state of the infrastructure, poor health worker attitude and the lack of drugs sometimes as the main points of frustration with the health system, even in the post-Ebola context.

5.2.10.2. Community Involvement

Generally speaking, various stakeholders involved in PD implementation at the district level are satisfied with the level of community involvement. One common message from the implementation team is that community involvement was critical, because without it, interventions will not succeed. In the opinion of one local council representative in Kono, they receive frank feedback from the community, and this is helpful for alerting them to weaknesses and actions that must be taken to improve service delivery.

Stakeholders have even built on the positive relationship they have with communities to get the latter involved in frontline service delivery activities. In Moyamba district, for example, one stakeholder said community members have been recruited to monitor service delivery quality at their local health facilities. In Kailahun, community members have also been recruited and trained to support the health system as CHWs.

5.2.10.3. Sufficiency of Output/Outcome Monitoring

The feedback on this is mixed. Generally, stakeholders implementing or providing oversight functions at the district level say they monitor the implementation process. However, in the area of data availability for monitoring purposes the picture is really mixed. Many of the PDT personnel embedded in the districts say they do not have enough data from IPs, and state that IPs rarely cooperate with them to provide necessary data. Interestingly, IPs indicates that they have the data needed for monitoring implementation and decision-making.

5.2.10.4. Validation of Type of Support Received by Health Facilities

The research team explored the opportunity of assessing the specific support received by individual health facilities in regard to the programme indicators in the sampled chiefdoms since July 2015. From the dashboard it is clear that most, if not all, facilities were eligible for support in most key areas including IPC, EPI, and supply chain. However, for some types of support, such as BEmONC /CEmONC, only selected facilities were targeted.

In all, 26 health facilities, including hospitals were interviewed across the 8 districts.[59] The information received from health facility in-charges was validated through observation and by further probing. Table 6 presents the distribution by type of facility and type of support received. Overall, the results from the rapid assessment by interview and observation paint a fairly positive picture of support for selected aspects. Facilities are more likely to have received support for IPC, malaria, supply chain and immunization. Hand-washing facilities in the form of buckets fitted with taps were seen in most facilities. The application of triage system for screening, seem to be well grounded in most facilities visited. In addition, to hand-washing facilities, there was a dedicated space for temperature check. For WASH, surprisingly, the assessment showed more positive findings for the

[59] The 26 facilities included 3 hospitals, 15 community health centres, 2 community health posts and 6 maternal and child health posts.

sanitation component compared to the water component. Over 80% of facilities surveyed had at least one toilet, described as functional and clean.

Table 6: Type of Support Received for Selected Services, by Facility Type

Type of Health Facility	Type of Support									
	IPC	Malaria	Supply Chain	Immunization	WASH	Triage	HIV	Outpatient	CEMONC/ BEMONC	Treatment of EVD
CHC (N=15)	100%	100%	93%	100%	87%	100%	53%	67%	53%	13%
CHP (N=6)	100%	100%	83%	83%	83%	67%	67%	34%	17%	20%
MCHP (N=2)	100%	100%	100%	100%	100%	100%	0	100%	0%	0
Hospital (N= 3)	100%	67%	100%	67%	67%	67%	67%	50%	0%	33%

Even though the Presidential Delivery Team second quarter report (September to November 2015), suggests uncertainty about meeting targets for immunization and supply chain system strengthening, the results from this rapid assessment seem promising. Close to 90% of facility Informants reported receiving support in these two areas. As expected, reported support for EVD treatment was minimal, given that the recovery programme is post Ebola.

Based on the findings in Table 6 above, two critical gaps can be identified with regards to WASH in health facilities and the availability of drugs. To begin, although most facility In-charges[60] gave positive feedback about the support received to enhance WASH, further probing revealed some critical gaps. Access to reliable water supply is a major problem, which is an impediment not only for maintaining high WASH standards, but also for infection prevention and control (IPC). The problems unearthed are not new. Some health facilities had to rely on water sources outside the facility throughout the year, while for others water shortage is more acute during the dry season when there is no running water from taps or wells dry up. Facilities with hand-pumps have no resources for repair, when the pumps get broken. Even though most health facility in-charges seem comfortable with the standard of toilet facilities, one in- charge working at a CHP in Bombali was concerned about drainage issues, while for another at a CHC in Kailahun the concern was about adequacy in terms of number of toilets available for use by clients.

Secondly, facility informants were asked to comment about the availability of essential drugs, tracer drugs and stock outs. Even though the impression from the data is that drug availability may not be a serious issue, a few facilities are experiencing some problems, especially around stock out. The drugs that are more likely to be out of stock are Iron tablets and deworming tablets for pregnant women. Other concerns raised by facility informants are around delay in receiving the expected stock and more importantly about receiving lower quantities of drugs than expected. One CHP in Bo district commenting on the last drug consignment received reported receiving only 10 vials of oxytocin out of the 100 expected.

5.3 Education

[60] This refers to the health personnel that is in charge of a health facility. S/he bears overall administrative responsibility for managing resources and services at the health facility

In this section, evidence is presented relating to the performance of the education services component of the PD programme. As in the previous section, the perspectives of the different stakeholders in terms of the programme achievements will be discussed. These stakeholders include:

- Indirect beneficiaries/local communities, paramount chiefs and education service provider- i.e. school authorities
- District level implementation team, including the PDT representatives, MDAs and IPs/NGOs.

To set the context on accomplishment, table 7 presents the dashboard tracker[61] for education programme outcomes, as at the implementation, 31st March 2016.

Table 7. Dashboard Data for Education Programme Outcomes

Reduce over-crowded classrooms	Accelerated learning	School fees waived	Special Needs	Social Mobilisation	WASH	School feeding

Green indicate 85-100% of target met
Orange indicate 50-85% of target met
Red indicate 0-49% of target met

5.3.1. Initiative 1- Special Needs Education

Several assessment of case numbers and available services in 2014,, uncovered an increase in teenage pregnancy in Sierra Leone during the Ebola crisis.4 Stress and strain on households, restrictions on movement5 , reduced access to basic services and the closure of schools made young girls more vulnerable to abuse during the crisis. The spike in teenage pregnancy is both a result of sexual offences against girls, but also consensual sexual relationships and a severe lack of sexual and reproductive knowledge and services, aggravated by the Ebola crisis[62]. Special learning centres were established in selected schools for pregnant and lactating mothers of school age, as part of the early recovery priorities to support young girls to continue their education.

Three schools surveyed have special learning centres for pregnant girls, called "the third school". In Sewafei Town, Kono, are staffed by teachers with educational training and expertise dealing with teenage mothers. The third school received its name because pregnant girls attend their school after normal hours, so as not to interact with other students.[63] Similarly, in Western Urban Area the special learning needs centre is not attached to the local school, but is located closer to the centre.[64]

Of the 67 girls enrolled at Sewafei Town School, Kono District in March 2016, five showed signs of pregnancy, and may therefore qualify to attend the special learning needs centre. However, according to the school principal, many girls are reluctant to divulge their pregnancies.[65] In Western Urban Area, there are between 25-30 girls enrolled in the school surveyed for this study; there are currently 10 girls who were visibly pregnant at the school, in addition to lactating mothers.[66]

[61] Yellow indicates lack of clarity whether the programme will archive target by end of March 2016. Green indicates the programme is expected to meet target for the outcome by March 2016. Red implies the project will not meet outcome by March 2016.
[62] UNDP (2015)- Ebola recovery in Sierra Leone- tackling the rise in SGBV and Teenage Pregancy during Ebola crises
[63] KII with Head Teacher, Port Kono District, Nimiyama community, Sewafei Town, March 15, 2016.
[64] KII with Head Teacher, Kailahun District, Kiss Teng community, Kangama. March 18, 2016.
[65] KII with Head Teacher, Kono District, Nimiyama community, Sewafei Town, March 15, 2016.
[66] KII with Head Teacher, Western Urban Area, Lumley area March 16, 2016.

5.3.1.1. Effectiveness of the Pregnant Girls' Learning Centre Programme

In terms of effectiveness, it seems that in both Kono and Western Urban Area districts, pregnant girls are in fact using the special learning centres. In both the Sewafei Town and Lumley area (Western Urban Area) schools surveyed for this study there were seven staff member working at the special learning centres for pregnant girls. According to the principal of the Sewafei School, these seven teachers are both male and female.. The female teachers are there to give special counselling to the pregnant girls.[67] Unfortunately, girls are dropping out of these special learning centres as well as the traditional schools, but the schools have been inconsistent in tracking these figures effectively. The senior teacher interviewed in the Lumley area school indicated that 10 pregnant girls have left the school in the last 6-9 month; however the Senior Secondary School Principal in Sewafei Town, Kono district did not know how many girls had dropped out.[68]

Following their pregnancy, girls in Kono do continue using the special learning centre. Being readmitted to the traditional school system depends on the girls; if they have done well in their studies in the special learning centre they should be readmitted to the main school. However, some girls stay in the special learning centre longer as their families may neglect them due to their pregnancies. In these cases girls can only return to the main school once their children are a little older. It is worth noting that only the Lumley area school provides contraception, and this is only for boys.[69]

5.3.2. Initiative 2- School Fee Waiver

As part of the President's Recovery Plan the GoSL has sought to offset the costs of education in the wake of the EVD crisis by paying students' schools fees. However, it seems that the programme's efficacy remains unequal. Respondents in Port Loko Town and in Kangama, Kailahun, for instance, indicated that the government has not provided any money to the schools. In the Port Loko case, the acting principal said the "government is only paying for schools with vouchers and our school does not have a voucher [system]."[70] The Makaiba community, Bombali district school is also not on the voucher system, but the students do not pay any fees at this school. It is worth noting that this school lacks the money to pay a sufficient number of teachers, so most of its teachers are volunteers selected by the community. The lack of school fees and inadequate staffing suggests that that the school receives some government money as part of the fee payment programme, but it is not clear how much, or if what they are receiving is sufficient to operate the school effectively.[71] In Swafei Town, Kono, the government paid students school fees in the previous year but not for the current year.[72]

By contrast, in both Lumley-Western Urban Area and Waterloo, Western Rural Area, the government has paid school fees. In Lumley, the state has paid a portion of schools fees since prior to the EVD crisis, and the current fee payment programme is working well. According to the Senior Teacher there is "no backlog, [the] government paid up to 2015 only, for the 2016 year, which they have not paid but I'm sure they are going to

[67]KII with Head Teacher, Kono District, Nimiyama community, Sewafei Town, March 15, 2016.
[68] KII with Head Teacher, Kono District, Nimiyama community, Sewafei Town, March 15, 2016; KII with Head Teacher, Western Urban Area, March 16, 2016.
[69]KII with Head Teacher, Kono District, Nimiyama community, Sewafei Town, March 15, 2016.
[70] KII with Head Teacher, Port Loko District, MaforkiCheifdom, Kangama community, March 15, 2016.
[71] KII with Head teacher, Bombali District, Gbanti Kama Cheifdom, Makaiba community, March 12, 2016.
[72]KII with Head Teacher, Kono District, Nimiyama community, Sewafei Town, March 15, 2016.

pay, that was what they told the principal."[73] In Waterloo, the GoSL paid half the fees for 850 students, which amounted to 61,200,000 Leones.[74]

It would seem from further consultations that the unevenness in the payment of fee waiver to schools could sometimes be the result of inappropriate and incomplete fulfilment of documentation systems required for the transfer of funds. Stakeholders within MEST, for example, cited instances where heads of schools have submitted personal bank accounts for the transfer of school waivers. As MEST's financial policy dictates, the Ministry is not permitted under any circumstances to make payment intended for a school into a personal/private account.

5.3.3. Initiative 3- Accelerated Learning Programme

Some 1.7 million Sierra Leonean children were left without access to schooling at the beginning of the 2014/2015 school year, when schools did not open in September 2014 as a result of the Ebola crisis. Schools are high-risk areas for the transmission EVD due to poor WASH conditions in many areas and overcrowding. To address the schooling shortfall in a country where prior to Ebola there was a 75% enrolment rate and a 74% pass rate, the GoSL developed an accelerated learning programme. This programme seeks to help kids catch up on the school time they missed and limit how much additional time they would need to be in school as a result of this their missed schooling. Therefore the educational year was compressed from three terms to two, and new consolidated teaching materials were provided to schools.[75] This programme is focused on syllabus design, increased teacher training, classroom upgrades, the provision of educational resources and limiting classroom overcrowding.

In further exploring the effectiveness of the accelerated learning programme activities, the evaluation assessed three dimensions: i) provision of accelerated learning materials at schools; ii) training of staff for using the accelerated learning materials; and iii) staff perception of quality of accelerated learning materials.

1. Provision of Accelerated Learning Materials at Schools

In all schools surveyed for this assessment accelerated learning materials have been provided to schools by the government and NGOs such as UNICEF since July 2015; and teachers have been trained on the accelerated curriculum, and the new syllabus.[76] Table 8 summarizes the supplies provided to schools as part of this programme.

[73]KII with Head Teacher, Western Urban Area, Lumley area March 16, 2016.
[74]KII with Head Teacher, Western Rural Area, Waterloo community, March 14, 2016.
[75]KII with Head Teacher, Western Urban Area, Lumley area March 16, 2016.
[76] KII with Head Teacher, Kailahun District, Kiss Teng Chiefdom, Kangama community, March 18, 2016.

Table 8. Supplies Received as Part of the Accelerated Learning Programme

Chalk	Textbooks (English, Maths, Science, Social Studies, Language Arts)
Pens	Exercise Books
Pencils	Rulers
Geometry sets	Registers
Stationary	Erasers
Plastic School Bag	Game Pack

In terms of the quantity of the materials provided, survey respondents indicate that schools have been supplied unevenly, with some schools reporting that they have received sufficient quantities of educational material, while other report serious shortfalls. Several schools surveyed reported that they are short on the books that teachers use to prepare lesson notes, that registers are in short supply, and that there are insufficient textbooks for students. For example in Kangam, Kailahun district the school has some 445 pupils but has sufficient textbooks for only 100 of those students.[77]

2. Training of Staff on the Use of Accelerated Learning Materials

In each location surveyed teachers in local schools have been trained to use the materials associated with the accelerated learning programme. The number of staff trained to use these materials varies by location, which may itself be a function of school size, and/or the number of teachers available in a given area. Table 9 summarizes the data. In all cases the teachers used these materials in their classrooms every day, especially the core subject materials, according to a respondent in Waterloo.[78]

Table 9. Number of Teachers Trained to use Accelerated Learning Materials, by Location

Location	Teachers Trained
Port Loko Town, Port Loko District	2
Sewafi Town, Kono District	19
Kangama, Kailahun District	11
Lumley Area, Western Urban Area	5
Waterloo, Western Rural Area	3 (who trained others)
Makaiba, Bombali District	1

3. Staff Perception of Quality of Accelerated Learning Materials

In general the teachers at the schools surveyed believed that the materials they have been provided as part of the accelerated learning programme are of good quality and that they are useful. According to a head teacher in Kangama, Kailahun district, children are learning quickly with the new materials, even after a difficult introduction: "like the alphabet, reading and the sounding of letters, recognition of letters, all of this is easy for

[77] Ibid.
[78] KII with Head Teacher, Western Rural Area, Waterloo community, March 14, 2016.

us now," even as the roll of students attending schools is increasing.[79] The core utility of the new materials is that it seems to helping teachers with their method teaching.[80] The most notable recommendations that teachers offered include: continued assistance from the GoSL to local schools, more educational materials, and more assistance to pregnant girls, additional training, and more teachers.

It is important to note that most teachers surveyed suggested that more classrooms be built in order to deal with overcrowding at schools. Unfortunately, no new classrooms had been constructed at the schools surveyed since July 2015. This is one of the major shortcomings of the 6-9 month recovery plan's educational component, as some classes have between 65 and 70 pupils, impacting the quality of learning.[81]

5.3.4. Initiative 4- Water, Sanitation and Hygiene

Part of the President's Recovery Programme was to improve the WASH infrastructure at schools in order to assist in long-term EVD prevention, decrease absenteeism and create a safer environment for girls. The central government must continue to work towards these goals. Of the schools surveyed for this study, only one school in Port Loko town, Port Loko district has had any new water sources constructed. A new mechanical well and three drop hole toilets were constructed in one building, at the start of the most recent academic year. Unfortunately, the school has not yet been able to gain access to these facilities, as the implementing partner (the Evangelical Fellowship of Sierra Leone) has not yet provided the keys to the school, although the new structure has been built. Additionally, the water well that was built was not properly protected with a fence or a door, which would limit the number of people not affiliated with the school that might try to use the facilities.[82]

5.3.5. Perceptions of District Level Implementers on the Delivery of Education Sector Programme

5.3.5.1. Programme Outcomes and Impacts

District level stakeholders indicated the education sector received increased funding for many quality improvement activities, including learning materials and teacher training, thanks to the PD programme. They believe this additional support is one important factor that explains the generally better performance across all public examinations (i.e. NPSE, BECE and WASSCE), albeit the fact that the school system was shut down during the Ebola epidemic. Stakeholders say that student performance exceeded expectations, and as a matter of fact record numbers of students passed the WASSCE with university requirements. In Kono, one respondent said the district got its highest number of passes with university entry requirement in 2015; in Port Loko, it was reported that 17% of all WASSCE candidates passed with university entry requirements while in Bombali district it was 19%.

Besides performance in public examinations, PD has also contributed to positive developments in the sector in other critical ways. The programme financed remedial classes for returning pregnant girls back to school, after they delivered their children. In the opinion of stakeholders, the programme has been such a success that it has far exceeded its enrolment targets. In Western Urban district, for example, the Programme targeted 204

[79] KII with Head Teacher, Kailahun District, Kiss Teng Chiefdom, Kangama community, March 18, 2016.
[80] KII with Head Teacher, Port Loko District, MaforkiCheifdom, Kangama community, March 15, 2016.
[81] KII with Head Teacher, Western Rural Area, Waterloo community, March 14, 2016.
[82] KII with Head Teacher, Port Loko District, Maforki community, Port Loko Town, March 15, 2016.

pregnant girls. However, the actual enrolment was ten times that target, with a total of 2,165 girls participating in the remedial classes; the district education office says it has returned more than 1,800 of these beneficiaries back to the regular schools. The programme also waived tuition fees for school pupils. Some stakeholders say this was a critical assistance for households that were so cash strapped after the epidemic, to the extent that the household could not have been able to afford the fees. In the absence of such a waiver, many of these children would have dropped out of the school system, since the parents would not have been in position to pay up tuition fees.

In another important way, PD has contributed to improving health outcomes for pupils through the extensive hand washing support it has provided to schools, including the supply of veronica buckets, soap, chlorine, etc. schools have adopted the practice even to date, and this is largely credited to the PD support.

5.3.5.2. Community Involvement

All stakeholders responsible for PD implementation at the district level, including local councils, the education department, IPs (or NGOs) and the district PDT members underscored the significance of having the community involved in the implementation process. Without the community, most stakeholders say the chance for the intervention to succeed was zero. It emerged from the data that community involvement is facilitated through engagement with paramount chiefs, headmen, councillors and sometimes ward development committees. Broadly speaking, the role of these elected and appointed community representatives have evolved around social mobilisation, and they have been a vital channel through which actors in the sector have reached communities with their messages.

Through partnership with communities, the course of education was advanced through some innovative approaches. In one community in Western Rural, Bassa Town, for example, because of the appreciation of social mobilising messaging, the community, out of its own volition and resources has constructed a 3-classroom school building and after the construction they visited the education district office to ask them to be involved in managing the facility. In Kailahun, some paramount chiefs and other lower chiefs have been also involved in appealing their subjects to provide financial and other support for teachers that are not on the payroll.

5.3.5.3. Sufficiency of Output/Outcome Monitoring

Generally, the regional and district education offices expressed reasonable level of satisfaction with the monitoring situation. They say they do go out to monitor PD funded education activities being implemented by IPs and others; in some districts, the education office teams up with the local council for some monitoring visits. Education offices also say they do have systems for collecting monitoring data and they did have the service data that was relevant for the sector. IPs/NGOs reported similar confidence in their monitoring systems, including the availability of monitoring data and tracking the progress of implementation.

On the other hand, local councils generally reported that they did not have the monitoring data that will sufficiently inform their planning. Many council representatives attributed this to the fact that IPs were reluctant to share data with them. Some PD team members who work in the districts also expressed this concern.

5.3.5.4. Validation of Type of Support Received by Schools

As part of the process of triangulating the perspectives and information from indirect beneficiaries and district level implementers, the research team further assessed the array of support that have been provided to schools since July 2015 in the sampled chiefdoms. This assessment was done at two levels. Firstly, sample of schools targeted for the classroom construction/expansion initiative under the 6-9 month early recovery programme were interviewed by phone[83], mainly to validate that they were indeed targeted for the activity and also find out the status of the construction. The next level of assessment was broader in scope, mainly to elicit valuable contextual information for informing the general planning processes of the 10-24 month recovery phase. Results of both findings are presented separately.

A) Findings from sampled schools targeted for classroom construction by 6-9 months early recovery programme:

From the feedback from 20 out of 53 (38%) beneficiary school representatives, Table 10 shows that 95% of the sampled schools confirmed that classroom construction activity was commissioned in their respective schools as part of the 6-9 month early recovery programme. 84.2% of schools who said classroom work was commissioned also confirmed the classrooms had been completed by the period of the evaluation. However, none of the schools said the newly constructed classrooms had been furnished. Even though the majority of classroom construction was complete, fewer than 20% of them (or 18.8%)-i.e. 3 of 16 completed classroom construction projects said the new classrooms were in use. School representatives said that the main reason why the new classrooms were not in use was because they have not been commissioned, since the implementing agencies have more or less asked them not to start using the facility until it was formerly handed over to the school. Some school representatives further said they have not started using the newly built classrooms because they did not have the required furniture- desks and chairs.

Table 10. Status of Classroom Construction Activity for the 6-9 Month Early Recovery in Sampled Schools

	Dimensions Assessed				
	Classroom project initiated	Classroom completed at time of evaluation	Number of actual classrooms constructed/improved the same as planned	Constructed classrooms furnished with desk and chairs	New classrooms in use at evaluation
% of sampled schools, as appropriate **(N=20)**	95.0%	84.2%	26.3%	0.0%	18.8%

B) Findings from the gap analysis in educational sector s in sampled chiefdom clusters:

As noted, the next level of assessment entailed a broad sweep of schools located in the cluster of chiefdoms sampled for the 6-9 month early recovery programme evaluation, irrespective of whether they were targeted for any of the early recovery education interventions. Twenty-four schools (15 primary and 9 secondary schools) were visited across all eight districts to collect perspectives from the head and/or a senior teacher about the

[83] These interviews were conducted through mobile telephone interviews with 20 schools in Bo, Bonthe, Kambia and Kono districts. Telephone directory was available for a total of 53 schools targeted for the early recovery classroom construction/improvement initiative. Out of this total, the evaluation team sampled 20 (which is about 37.7% of schools listed in the directory).

type of support their schools received and observe the quality of the output. Schools were selected randomly within targeted clusters to assess the status of all 7 indicators regardless of whether schools were eligible for all seven dimensions of support. The approach was to help shed light on the progress and gaps at schools as a result of the Presidents Recovery Programme.

The following seven dimensions of support were explored: WASH in schools, accelerated core content, social mobilization, school fees waiver, teacher training, reducing overcrowding, special needs for pregnant girls. The results, shown in Table 11, suggest that significant efforts have been invested to upgrade schools especially in the areas of WASH, accelerated core content and in school fees waiver. Primary schools (80%) were more likely to receive support in teacher training compared to secondary schools (33%). The inverse was true for school fees waiver. Eight of the nine secondary schools surveyed (89%) reported receiving assistance with school fees, compared to 10 of the 15 primary schools (67%).

Table 11. Type of Support Received, by School Type

School Type	**Type of Support Received**						
	WASH in schools	Accelerated Core Content	Social Mobilization	School Fees Waiver	Teacher Training	Special needs for pregnant girls	Reducing overcrowding in classrooms
Primary (n=15)	87%	93%	87%	67%	80%	27%	20%
Secondary (n=9)	89%	89%	89%	89%	33%	11%	11%

The relatively low coverage for meeting special needs for pregnant girls and reducing overcrowding in schools is not unexpected, given that these were limited initiatives targeting selected schools. For example only about 150 schools were targeted nationwide for classroom expansion. By chance, two of the four schools visited in Bo district were among the 150 classroom expansion beneficiary schools. The new classrooms in both schools are still not in use for different reasons. In one school, the delay is because arrangements are yet to be made for an official opening ceremony, while in the other school, the head teacher attributes the delay to structural issues which need further attention, in order not to put children at risk.

The observations made at these two schools even though not generalizable provides some insight as to the status of classroom projects.

5.4. Social Protection

Performance of the social protection component was similarly evaluated from the perspectives of the indirect beneficiaries, as well as district level implementers. For the purpose of understanding the trajectory of implementation progress, table 10 illustrates the dashboard tracking of programme activities as at 10th February 2016.[84]

[84] Green indicate the programme will achieve target by completion in March 2016 while red indicates the target will not be achieved by the end of implementation.

Table 5. Dashboard Data on Social Protection Programme Activities

Income Support	Min. assistance packages	Social Protection	CMIMS	Strengthen SPRINT

Green indicate 85-100% of target met
Red indicate 0-49% of target met

5.4.1. Perspectives from Indirect Beneficiaries

5.4.1.1. Outcome 1- Income Support

Part of the President's 6-9 month Recovery Plan is to provide direct assistance in the form of cash transfers to vulnerable households and people directly affected by the EVD crisis. The goal of this programme is to raise income levels and stimulate job creation by injecting money into local economies. Over the long term, this cash transfer programme is part of establishing a sustainable national-level social protection programme. As part of this income support initiative, the GoSL also seeks to develop a social worker training programme with an eye towards supporting EVD survivors as well as to strengthen the social welfare system from "cradle to grave."[85]

Effectiveness of the Cash Transfer Programme

Recipients of cash transfers have received their cash allotments anywhere from once to 5 times since July 2015, based on their location and the number of organizations in their area offering cash transfers. Most respondents indicated that they have received cash transfers 2-3 times since July 2015. However, an Ebola survivor in Joe Town, Kono district indicated that he had gotten cash from the Network Movement for Justice and Development (NMJD) on several occasions, "DCI (Defence for Children) one time, PIH (Partners in health) one time, NIMRIGHT gave me… SLL [Sierra Leonean Leone] 50,000 another NGO gave me SLL 500,000… WHO also gave me SLL 300,000?"[86] By contrast, a widow from Yuikor Town, Kono district received a cash transfer 3 times from the same NGO, the National Commission for Social Action (NaCSA). It is not clearly whether there is a centralized oversight agency to regulate cash transfer mechanisms. This raises the need to improve on the functioning of the cash transfer industry.

Notably, the majority of respondents indicated that they receive their cash transfers monthly, which does not seem to fit with the foregoing. Notable exceptions to the monthly discernment of cash transfers include: a widow in Yuikor Town, Kono district, a trader in Waterloo, Western Rural Area, and a female household head in Kamakoni, Bombali district, who said they received their cash transfers once quarterly and between September 2015 and February 2016, respectively.[87]

The amount received per cash transfer differs by respondent, location and organization. It seems that respondents receive cash transfers from different organizations at different intervals. Table 13 summaries the data.

[85] Recovery and Transition Priorities, Full Deck Explanation." April 2015.
[86] KII with Cash Transfer Programme Beneficiary, Kono District, Nimkoro Chiefdom, Joe Town, March 15, 2016.
[87] KII with Cash Transfer Programme Beneficiary, Bombali District, Sella Lima Chiefdom, Kamakoni Community, March 12, 2016.

Table 13. Amount and Number of Cash Transfers Received, by Location- Since July 2015

Female Household Head	Kamakoni, Bombali District	1. 300,000 SLL 2. 700,000 SLL
Female Survivor	Kailahun Town, Kailahun District	1. 1,000,000 SLL 2. 250,000 SLL
Male Survivor	Joe Town, Kono District	1. 250,000 SLL 2. 100,000 SLL 3. 100,000 SLL 4. 50,000 SLL 5. 50,000 SLL 6. 1,000,000 SLL
Male Survivor	Rotifunk, Mayomba District	1. 265,000 SLL (per month/4 months) 2. 740,000 (January 2016)
Widow	Yuikor Town, Kono District	1. 740,000 SLL (lump sum)
Female Trader	Kangama, Kailahun District	1. 900,000 SLL 2. 900,000 SLL
Seamstress	Kiss Community, Western Urban Area	1. 265,000 SLL /month
Female Trader	Benguma Road, Western Rural Area	1. 250,000 SLL 2. 1,600,000 SLL 3. 265, 000 SLL /month
Female Trader	Tree Planting, Western Rural Area	1. 195,000 SLL /every 3 months
Mechanic/Survivor	Kiss Community, Western Rural Area	1. 265,000 SLL /month

All respondents indicated that the cash transfer programme is positively improving their lives. Cash transfer funds are used for: conducting petty trading (business); settling children's' school affairs; purchasing food for oneself and one's family; purchasing clothing; buying a mobile phone; buying bicycles/transportation; and/or paying off debts.[88] It is important to note that four respondents indicated that they paid school fees or bought school materials for their children with the cash transfer money they received. It is possible that those beneficiaries who reported paying school fees may have children enrolled in the 25% or so schools that are yet to benefit from the school fees waiver programme. This is a counterintuitive finding as the government has committed to paying children's schools fees.[89]

[88] KII with Cash Transfer Programme Beneficiary, Bombali District, Sella Lima Chiefdom, Kamakoni Community, March 12, 2016; KII with Cash Transfer Programme Beneficiary, Kono District, Nimkoro Chiefdom, Joe Town, March 15, 2016; KII with Cash Transfer Programme Beneficiary Kailahun District, Luawa Chiefdom, Kailahun Town, March 17, 2016; KII with Cash Transfer Programme Beneficiary Kono District, Flama Chiefdom, Yuikor Town, March 16, 2016; KII with Cash Transfer Programme Beneficiary Moyamba District, Bumpe Chiefdom, Rotifunk Community, March 15, 2016; KII with Cash Transfer Programme Beneficiary Kailahun District, KissiTeng Chiefdom, Kangama Community, March 12, 2016; KII with Cash Transfer Programme Beneficiary Western Area Rural, Kissy Community, March 17, 2016.

[89] KII with Cash Transfer Programme Beneficiary Western Rural Area, Tree Panting Community, March 16, 2016; KII with Cash Transfer Programme Beneficiary, Bombali District, Sella Lima Chiefdom, Kamakoni Community, March 12, 2016; KII with Cash Transfer Programme Beneficiary, Kono District, Nimkoro Chiefdom, Joe Town, March 15, 2016; KII with Cash Transfer Programme Beneficiary Moyamba District, Bumpe Chiefdom, Rotifunk Community, March 15, 2016.

Effectiveness of the Cash Transfer Programme for EVD-Affected Population

Of the 10 cash transfer programme beneficiaries, 7 (70%) were directly affected by EVD: either the respondents lost family members or community members to the disease or they themselves survived the infection. All EVD-affected respondents report receiving assistance packages in the form of money and/or goods as a result of being affected by the Ebola crisis. In all cases survey participants indicated that the assistance they received had a positive impact on their situations. A 14-year-old male survivor said that the food aid he receives allows him to cook and eat when he returns from school.[90] Another 14-year-old survivor from Rotifunk, Moyamba district reported a positive impact that a foam mattress and decent clothes were having on his day-to-day life.[91]

Unfortunately, EVD-affected cash transfer beneficiaries must deal with several challenges in order to receive their assistance packages. In Kamakoni, Bombali district, a respondent said that people treat EVD-affected beneficiaries poorly: "they will look at us as different people sending us here and there. Sometimes they will not give us the full supply we deserved and we don't have anything to do or any place to complain."[92] Additionally, as with other cash transfer programme beneficiaries, EVD-affected individuals reported that they waste time travelling to collect their money, as in some cases the money is not available when they were told to collect it.[93]

In order to enhance the quality of the cash transfer programme respondents suggested bringing the assistance packages to beneficiaries' houses or to the local Chairman for distribution, in order to limit the time and money spent on travel.[94] Another recommendation was to send assistance packages through local councillors because "many things that are going through social welfare is not reaching us."[95]

5.4.1.2. Outcome 2- Social Protection/Social Work Services

As part of the President's 6-9 month recovery plan the GoSL seeks to build the foundation for a social welfare system. As part of this longer-term objective the GoSL seeks to train social workers to work with EVD-affected individuals to strengthen the social welfare system. Both EVD survivors and heads of households receiving income support were the respondent groups surveyed. Sixty percent of those targeted for social protection, , regardless of whether they have been affected by EVD or not, indicate that they have used the services of a government social worker since July 2015. Social workers encourage the people they interact with, provide counselling on cash transfers, and offer knowledge on how to care for one's family as well as themselves in order to avoid contracting Ebola in the future.[96] However, the number of times that respondents used the services of a government social worker varies significantly. One respondent from the Benguma Road area of Western Rural Area indicated using a social worker only once while respondents in Kono said that social workers have come to visit their areas many times: in Joe Town a respondent said he has used a social worker 7 times, while in Yukor Town the participant said over 5 times (every two weeks).[97]

[90]KII with Cash Transfer Programme Beneficiary, Kono District, Nimkoro Chiefdom, Joe Town, March 15, 2016.
[91]KII with Cash Transfer Programme Beneficiary Moyamba District, Bumpe Chiefdom, Rotifunk Community, March 15, 2016.
[92]KII with Cash Transfer Programme Beneficiary, Bombali District, Sella Lima Chiefdom, Kamakoni Community, March 12, 2016.
[93]KII with Cash Transfer Programme Beneficiary Western Rural Area,Benguma Road, March 14, 2016.
[94]KII with Cash Transfer Programme Beneficiary, Kono District, Nimkoro Chiefdom, Joe Town, March 15, 2016.
[95]KII with Cash Transfer Programme Beneficiary Western Area Rural, Kissy Community, March 17, 2016.
[96]KII with Cash Transfer Programme Beneficiary, Kono District, Nimkoro Chiefdom, Joe Town, March 15, 2016;KII with Cash Transfer Programme Beneficiary, Bombali District, Sella Lima Chiefdom, Kamakoni Community, March 12, 2016.
[97]KII with Cash Transfer Programme Beneficiary, Kono District, Nimkoro Chiefdom, Joe Town, March 15, 2016; KII with Cash Transfer Programme Beneficiary, Kono District, Nimkoro Chiefdom, Joe Town, March 15, 2016.

Overall, respondents view the work of government social workers positively. Respondents noted that social workers help with their overall stress levels, and provide advice.[98]Indeed, most respondents stated that if social workers were to come to their communities they would meet with the social workers. "They have never been rude to us, they know how to talk to people who are depressed. They have respect not only for adults but for everyone. We will not want them to be changed, let them be with us as we have known them."[99]

To improve social work services respondents suggest that local social worker call meetings in order to update communities of their activities.[100] Furthermore, respondents suggested that the GoSL pay social workers well and train them to support community programming for Ebola survivors in the long-term. As mentioned above transportation is a major issue in the communities surveyed for this assessment, as a consequence survey participants noted that social workers should be given a vehicle or a motorcycle in order to help them reach communities on a regular basis.[101]

5.4.2. Perception of District Level Implementers on the Delivery of Social Protection Services

5.4.2.1. Programme Outcomes and Impacts

Feedback indicates that social protection assistance has had an array of positive effects on community life in targeted areas. For all the impact, the programme has contributed the most to improving access to basic needs for beneficiaries. Individuals and households that have received cash transfers have generally used them to purchase food and pay for education. One respondent in Kailahun district also indicated that some beneficiaries use the funds to improve their housing, by replacing their thatch roof with corrugated iron sheets.

The social protection intervention has also impacted beneficiaries' lives in other ways. It was evident in some interviews that beneficiaries were forced into debt during the Ebola epidemic and repayment issues continue to be a problem. Consequently, some of the funds that have come through the cash transfers have been used to repay loans.

In addition to cash, this component of the programme has also worked on social reintegration of Ebola survivors as well as household members affected Ebola-i.e. households affected by the virus. For instance, Ebola survivors faced stigmatisation when they initially returned to their communities. There are accounts of family members refusing to accept survivors into their homes, usually as a precaution against contracting the virus. IPs in the social protection domain did a lot of work to reverse the stigma and reassure families and the community at large that survivors were absolutely safe to return to their normal community lives.

5.4.2.2. Community Involvement

The level of community engagement has been similar to that in the other programme sectors. Stakeholders underscored the critical importance of having community involvement, because this helps increase the efficiency of Programme implementation. For example, some on the implementation team said they work with

[98]KII with Cash Transfer Programme Beneficiary, Kono District, Nimkoro Chiefdom, Joe Town, March 15, 2016.
[99]KII with Cash Transfer Programme Beneficiary Western Rural Area, Tree Planting, March 16, 2016
[100]KII with Cash Transfer Programme Beneficiary Kailahun District, Luawa Chiefdom, Kailahun Town, March 17, 2016
[101]KII with Cash Transfer Programme Beneficiary Moyamba District, Bumpe Chiefdom, Rotifunk Community, March 15, 2016;KII with Cash Transfer Programme Beneficiary Kono District, Flama Chiefdom, Yuikor Town, March 16, 2016.

survivor networks to mobilise beneficiaries. When it came to targeting, the decision across districts was to work with local leaders to identify and screen beneficiaries.

5.4.2.3. Sufficiency of Output/Outcome Monitoring

Overall, MDAs implementing social protection activities (NaCSA and MSWG&CA) say they have monitoring mechanisms in place and they are able to collect the programme data that they require for monitoring purposes. Unfortunately, PDTs embedded in districts continue to face challenges in accessing data, particularly from IPs/NGOs.

5.5. Private Sector Programmes

Ebola caused the Sierra Leonean economy to contract dramatically, with a 30% decline in household income, a 30% drop in agricultural outputs, in addition to raising countrywide levels of food insecurity. Moreover, the Ebola crisis halted many infrastructural development and maintenance projects.[102] Therefore, the final component of the President's 6-9 month Recovery Programme is assistance to the private sector, including farmers, youth and petty traders. The targeted impacts of the GoSL's private sector programmes include:

- Enhancing farmer incomes and productivity as well as promote food security by providing seeds and fertilizer for 1 hectare of rice cultivation;
- Helping small trader's business returns recover to pre-Ebola levels;
- Providing bank accounts and financial services to farmers;
- Strengthen 100 Agricultural Business Centres (ABCs)to improve processing/marketing of Famers' goods (target was continuously revised) ;
- Creating new jobs, as well as driving up worker skill through exposure to new technologies and equipment;
- Upgrading 500 km of feeder roads linking farmers and traders to markets.

The progression towards the private sector targets, as at 10th February 2016, is illustrated in Table 14.

[102]Recovery and Transition Priorities, Full Deck Explanation. April 2015.

Table 64. Dashboard Data on Private Sector Programme Performance

Seeds & Fertilizer	Feeder roads	SME Agency created	Access to Finance (MTI)	ABC Transformation (MAFFS)	(MAFFS)

Green indicate 85-100% of target met
Orange indicate 50-85% of target met
Red indicate 0-49% of target met

5.5.1. Perspectives from Indirect Beneficiaries

5.5.1.1. Initiative 1- Seeds and Fertilizer

Agricultural cultivation represents 66% of Sierra Leone's employment opportunities, and it accounts for 46% of the country's GDP as well as 22% of its exports.[103] As a consequence, the President's recovery plan delivered subsidized agricultural inputs to small farmers through the direct distribution of improved seeds and fertilizer to cultivate 1 hectare (ha) of rice. Of the respondents to this assessment all said that they have received rice seeds, while several noted that the seeds were good quality because "it is a short duration variety," which was new to farmers and grows quickly; this government-provisioned rice allows for a harvest 3 times per year.[104] However, not all areas received fertilizer. Respondents in 5 districts (Bumpeh, and Njaigboima, Bo district, Tokobenahun, Kailahun district, and Babaya, Kono district, Kamakwie community, Sella Limba, Bombali District) reported not receiving fertilizer at all.[105]

In terms of what farmers received, all received NERICA (New Rice for Africa) L19 rice, that increases the total yield of rice per hectare planted, has a shorter growth cycle, and can tolerate various types of soil toxicity.[106] In addition, farmers reported receiving okra seeds, cucumber seeds, krain krain (corchorus) seeds, garden egg seeds, and pepper seeds.[107] Since July 2015, respondents reported that they received seeds once, in the 2015. According to survey participants, the rice they received provided a higher yield, with larger grains, which was sweet tasting, and was able to survive in the swamps where it was planted, even with its shorter growth time. In Kailahun one farmer noted that the krain krain (corchorus) seeds they received would however not germinate, even when nursed.[108] Table 15 summarizes the amount of seed rice received by participants.

[103] Ibid.
[104] KII with Farmer Bombali District, Stella Limba, Kamakwie Community, March 12, 2016.
[105] KII with Farmer Bo District, Bumpeh Chiefdom, Bumpeh Community, March 12, 2016; KII with Farmer Bo District, Kakua Chiefdom, Njaigboima Community, March 15, 2016; KII with Farmer Kailahun District, Luawa Chiefdom, Tokobenahun Community, March 18, 2016; KII with Farmer Kono District, Fiama Chiefdom, Babaya Community, March 16, 2016; KII with Farmer Bombali District, SellaLimba Chiefdom, Kamakwie Community, March 12, 2016.
[106] AfricaRice, *New Breeding Directions at AfricaRice: Beyond NERICA*, 2010, Benin: Africa Rice Center, accessed April 3, 2016, http://africarice.org/publications/Beyond_Nerica.pdf.
[107] KII with Farmer Moyamba District, Bumpeh Chiefdom, Magazine Community, March 18, 2016.
[108] KII with Farmer Bo District, Bumpeh Chiefdom, Bumpeh Community, March 12, 2016; KII with Farmer Kailahun District, Luawa Chiefdom, Tokobenahun Community, March 18, 2016.

Table 75. Quantity of Seed Rice Received, by Location[109]

Kamakwie, Bombali	1 bag of seed grain, 1 bag for eating
Kakamba, Bombali	1 bag of seed rice
Tokobenahun, Kailahun	10 bags of seed rice
Babaya, Kono	15 bags of seed rice (30 bushels of seed)
Njaigboima, Bo	5 bags of seed rice (10 bushels of seed)

In terms of the perceived impact of the seeds (and fertilizer that was received), this rice seed was generally viewed positively because the rice adapted to the soil/swampy areas in which it was planted, and it's short germination time. This later issue is particularly important because the rice was able to mature fast enough such that birds could not negatively impact its harvesting.[110]Additionally, the delivery of this rice was accompanied by training on how to effectively plant rice. This training helped farmers move from a scatter planting method to a systematic row planting method, which has further increased yield.[111]

Unfortunately, the majority of survey respondents do not believe that the amount of seed or fertilizer provided (if they received the latter) was sufficient. It seems to be the case that rice was distributed to farmer associations at the community level, which then distributed the rice to farmers. This sequence of rice distribution then accounts for the variation in the quantity of seeds that where reported (i.e. some respondents reported what their associations received). This distribution sequence also accounts for why the amount of rice was seen as insufficient: individual farmers were only getting a percentage of the total amount, and if they have large farms the amount of rice they were given was not sufficient to plant on the entirety of their lands. Indeed, farmers in Kakamba, Bomabli and Magazine, Moyamba reported that they have large plots of land and they had insufficient rice to plant the entirety of their fields.[112]

Two other issues with the rice distribution programme were reported. First, in one case a farmer was obligated to travel a few miles to collect the seed rice, and transportation is expensive.[113] Secondly, there was a delay in receiving the seeds in two cases, but ultimately the seeds arrived.[114]

Thus, in terms of improving the seed and fertilizer delivery programme, actually delivering the fertilizer is something respondents requested. Furthermore, greater supplies of seeds, timely delivery of these seeds, providing tools for farming, as well as storage and drying facilities in order to prevent depredation of harvested rice by animals. Finally, respondent suggested sending monitors to villages to see if rice and fertilizer are in fact delivered, as well as if the amount provided is sufficient.[115]

[109] KII with Farmer Bo District, Bumpeh Chiefdom, Bumpeh Community, March 12, 2016; KII with Farmer Bo District, Kakua Chiefdom, Njaigboima Community, March 15, 2016; KII with Farmer Kailahun District, Luawa Chiefdom, Tokobenahun Community, March 18, 2016; KII with Farmer Kono District, Fiama Chiefdom, Babaya Community, March 16, 2016; KII with Farmer Bombali District, SellaLimba Chiefdom, Kamakwie Community, March 12, 2016.

[110] KII with Farmer Bombali District, SellaLimba Chiefdom, Kamakwie Community, March 12, 2016;
KII with Farmer Bombali District, SellaLimba Chiefdom, Kakamba Community, March 12, 2016.

[111] KII with Farmer Kono District, Fiama Chiefdom, Babaya Community, March 16, 2016.

[112] KII with Farmer Moyamba District, Bumpeh Chiefdom, Magazine Community, March 18, 2016; KII with Farmer Bombali District, Stella Limba, Kamakwie Community, March 12, 2016.

[113] KII with Farmer Bo District, Bumpeh Chiefdom, Bumpeh Community, March 12, 2016.

[114] KII with Farmer Kono District, Fiama Chiefdom, Babaya Community, March 16, 2016; KII with Farmer Bo District, Kakua Chiefdom, Njaigboima Community, March 15, 2016.

[115] KII with Farmer Bo District, Bumpeh Chiefdom, Bumpeh Community, March 12, 2016; KII with Farmer Bo District, Kakua Chiefdom, Njaigboima Community, March 15, 2016; KII with Farmer Kailahun District, Luawa Chiefdom, Tokobenahun Community, March 18,

5.5.1.2. Initiative 2- Access to Finance

As mentioned above, the 6-9 month Recovery Plan is also focused on providing financial services and bank accounts to all farmers in order to ensure that farmers are brought into the formal economy in a sustainable and secure fashion. A majority of farmers surveyed for this assessment reported that they both have a bank of financial services association in their villages or larger communities, and that they use the financial services association or bank to deposit money and take out loans when necessary. According to a respondent in Kamakwie, Bombali district "the service is good, the community bank charges minimum interest rate for all farmers and as such we really appreciate the community bank."[116] Indeed, only respondents in Bumpeh community and Njaigboima community, Bo district indicated that they have neither a bank nor a financial services association in their areas. It is worth noting that all communities with local financial services that were surveyed for this work had banks prior to the Ebola crisis, with the exception of Magazine community, Moyamba. In Magazine, both the financial services association and the bank were established after July 2015.[117]

It does however seem that banking remains a concept that community members are still growing accustomed to. Thus, in some areas famers are banking regularly, after an initial period of uncertainty, farmers are depositing their money locally, somewhere in the community, knowing that they can access it when they have business in Freetown. "This is very simple now for us the farmers."[118] In other areas however it seems residents lack access to the bank due to high illiteracy rates. However, illiterate farmers are willing to try banking if someone led them through the process.[119] Therefore, access to finance is uneven across the communities under study.

Respondents suggested that more loan opportunities in the form of 'soft loans' that are easily repaid would be a method by which to improve financial services locally.[120] Moreover, building community banks in each community would improve access to and the quality of banking services throughout Sierra Leone. In Kailahun town there is no bank, so farmers must travel to Koindu where there is a Financial Service Association (FSA). Unfortunately, the FSA is not capable of making the same number and size loans that a bank could. Also, transportation is expensive. As a consequence building banks in communities would benefit farmers and the financial sector.[121]

5.5.1.3. Feeder Roads

In addition to bringing farmers into the formal economy, the President's 6-9 Month Recovery Plan seeks to link farmers and traders to markets by upgrading the quality of 1300 km of feeder roads. This assessment collected views from beneficiaries residing in who two locations included in this study which have had new feeder roads built since July 2015: Kamakwie and Kakamba, Bombali district. According to the Chairperson of farmers in Babaya, Kono district, the community was skipped because it has easy access to the district headquarter town,

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2016; KII with Farmer Kono District, Fiama Chiefdom, Babaya Community, March 16, 2016; KII with Farmer Bombali District, SellaLimba Chiefdom, Kamakwie Community, March 12, 2016.

[116] KII with Farmer Bombali District, SellaLimba Chiefdom, Kamakwie Community, March 12, 2016.

[117] KII with Farmer Moyamba District, Bumpeh Chiefdom, Magazine Community, March 18, 2016.

[118] KII with Farmer Bombali District, SellaLimba Chiefdom, Kakamba Community, March 12, 2016; KII with Farmer Moyamba District, Bumpeh Chiefdom, Magazine Community, March 18, 2016.

[119] KII with Farmer Bo District, Kakua Chiefdom, Njaigboima Community, March 15, 2016.

[120] KII with Farmer Bombali District, SellaLimba Chiefdom, Kamakwie Community, March 12, 2016.

[121] KII with Farmer, Kailahun District, Luawa Chiefdom, Tokobenahun Community, March 18, 2016.

they were too close to Koidu town. The GoSL "are targeting the villages that are far away from the district town. They constructed feeder roads from Njabema to Woama because those villages are very far from Koidu town and they need to transport their goods from their villages to the district headquarter town for sale."[122] However, in the areas where feeder roads have been built, they are perceived to benefit communities because farmers can more easily move large quantities of produce. Moreover, fewer goods are lost or destroyed in transit to markets now.[123]

As should be expected, all respondents indicated that they believe more feeder roads should be built in their communities. Feeder roads will allow more access to farms, give supervisors and monitors more access to local communities, as well as allow more access to specific swamps.[124] Farmers report that as a result of the poor quality roads surrounding their communities produce is lost and as a result farmers lose income. "If a farmer has a pepper, rice and other items, [a] vehicle will be able to pick them up and send them to either Makeni or Freetown, if there are [sic] no road access from those villages then it might be very difficult for them to have a reward after their harvest."[125]

In sum, based on the known added value of feeder roads and the collective views of beneficiaries more feeder roads will stimulate increased economic activity for farmers; roads will increase their incomes and livelihoods, as well as local food security. Moreover, feeder roads will decrease overall costs of transportation for people and goods.

5.5.1.4. Agricultural Business Centres

Much like feeder roads, agricultural business centres (ABCs) are tools for improving the private sector incomes. ABCs work to help with the processing and marketing of farmers' goods, in addition to overseeing harvest and market prices. The communities surveyed represented a mix of those with and without ABCs; Bumpeh, Bo district, Magazine, Moyamba district, Tokobenahun, Kailahun district all lack ABCs. In Sella Limba Chiefdom there are three Agricultural Business Centers, yet a farmer interviewed indicated that he did not believe these centers were functioning as they were designed to. That is, the farmer noted that there were no machines to help farmers, and as a result most farmers were harvesting their produce manually. None of the three centres have a water well, toilet facility or drying floor. More importantly, no work is being done in these centres.[126]

Contrastingly, in Fiama chiefdom, Kono district, the centre is used to manage all farming business. All planting is seemingly coordinated in these ABCs and local crops are processed at the centre. Moreover, the ABC is used as a meeting point for farmers in the chiefdom. Babaya village was chosen for the construction of the ABC "because it has easy access to the district headquarter town."[127] This ABC also has a drying floor for rice as well as a milling machine. Monthly meetings are held at the ABC where farmers from different villages come to discuss ways in which the centre can be improved.[128]

A farmer from Kakua chiefdom, Bo district also notes that the local ABC will not supply rice to farmers that are not members of the ABC. Indeed, it seems that ABCs serve as a middleman between the government and farmers (as noted above), as the government's priory is on supplying ABC-member farmers. "It is only when we

[122] Ibid.
[123] KII with Farmer Bombali District, SellaLimba Chiefdom, Kamakwie Community, March 12, 2016.
[124] Ibid.
[125] KII with Farmer Bombali District, SellaLimba Chiefdom, Kakamba Community, March 12, 2016.
[126] Ibid.
[127] KII with Farmer Kono District, Fiama Chiefdom, Babaya Community, March 16, 2016.
[128] Ibid.

have been supplied that we will in turn look for other farmers and sorry for them and give them, but is not Government's priority –Government only cares for those under the ABC… and the Government wants all farmers to be in an association so that they will be cared for. So if one says he is independent, things will be difficult for him."[129]

Members used ABCs regularly in the areas in which they exist. It is however important to point out here that members seem to be obligated to pay into their ABCs. The ABC in Fiama chiefdom, Kono district has a standard well with a tap system that people are made to pay a small amount for using, in order to pay for maintenance.[130]Similarly, a farmer in Luawa chiefdom, Kailahun district told an interviewer that in order to register with the local ABC his organization was obligated to pay 300,000 LE. Without this sum he was told his organization could not join the ABC. It is unclear if others were also obligated to pay a similar sum of money to join their local ABCs.[131]

Effectiveness of ABCs

In terms of the effectiveness of the Agricultural Business Centres, respondents are split. While some believe that the ABCs are effective and equitably run, other survey participants do not believe it is fair to force farmers to pay money to join the ABCs, especially if a farmer is very poor.[132] Indeed, this seems like it would undermine the entire goal of the 6-9 month Recovery Programme's private sector support to farmer component. Moreover, it seems that leadership of these ABCs can be hard to maintain, as in two cases, Sella Limba chiefdom, Bombali district and Kakua chiefdom, Bo district the chairman of the ABC has died and the community has not been able to replace him. In the former case the ABC has closed, and in the latter case a group within the ABC, those that are milling rice, seem to be dominating the ABC's operations. Moreover, the death of the ABC chairperson in Kuka chiefdom has limited the ABC's ability to repair their machines. The parts for these machines (most notably the milling machines) are hard to find, and there is no leader to charge of the repair.[133]

In terms of improving the ABC component of the follow on 12-24 months, building ABCs in strategic areas is a necessary first step. Secondly, supplying spare parts for the machines at ABCs is vital, as these seem to be unavailable.[134] Third, one respondent suggested letting communities run their own ABCs; communities "need to take responsibilities of those centres so that the community people will think that those centres belong to them."[135]

[129] KII with Farmer Bo District, Bumpeh Chiefdom, Bumpeh Community, March 12, 2016.
[130] KII with Farmer Kono District, Fiama Chiefdom, Babaya Community, March 16, 2016.
[131] KII with Farmer Kailahun District, Luawa Chiefdom, Tokobenahun Community, March 18, 2016.
[132] Ibid.
[133] KII with Farmer Bo District, Kakua Chiefdom, Njaigboima Community, March 15, 2016; KII with Farmer Kailahun District, Luawa Chiefdom, Tokobenahun Community, March 18, 2016.
[134]KII with Farmer Bo District, Kakua Chiefdom, Njaigboima Community, March 15, 2016.
[135]KII with Farmer Bo District, Bumpeh Chiefdom, Bumpeh Community, March 12, 2016.

5.5.2. Perception of District Level Implementers on the Delivery of Private Sector Programmes

5.5.2.1. Programme Outcomes and Impacts

The private sector component financed two activities: seed distribution to farmers, and business grants to petty traders. Feedback from the district level implementation teams indicates the seed distribution helped to relieve the seed shortage in the farming community. Moreover, due to the increased quality of the seeds distributed—foundation and certified seeds—yields were generally high in the last farming year. Also, farmers who received foundation seeds were supplied fertilizers, which also improved yields.

5.5.2.2. Community Involvement

There is limited data on community involvement in the implementation process. From the available evidence, however, there seems to be a mixed picture on this parameter. For the seeds component, for example, those who have received supplies were said to be very supportive and appreciative of the intervention. Other farmers who were not fortunate to get the seeds have shown limited enthusiasm and support for the programme, and this is understandable, since the benefit has not reached them yet.

With the grant component, the data shows some tensions in district like Port Loko, between the population and the IP. Communities had alleged that bribes were sometimes requested in order to make it onto the beneficiary list. According to investigations undertaken by the district representatives, there was lack of credible evidence to confirm the allegations.

5.5.2.3. Sufficiency of Output/Outcome Monitoring

On the sufficiency of monitoring data, the findings from the different stakeholders, including IPs and MAFFS district offices indicate they were satisfied with the data management systems in place. The different agency representatives said they had the data that was required for tracking the performance of implementation.

6. Implementation Challenges and Negative Externalities

While much of the PD implementation has progressed on course, there are several critical challenges that project implementation has faced. Challenges were related to gaps in project management arrangement, while others were largely negative externalities. These challenges were either unforeseen or inadequately prepared for at the design stage of the programme. Some of the challenges have already been covered in previous sections of the report.

For coherence, this section presents those challenges at two levels: level one focuses on cross-cutting challenges, which relate to management gaps, and level two addresses sector specific challenges.

6.1. Cross-Cutting Implementation Challenges

There are several implementation challenges that require attention. ***Funding gaps-***To begin with, across all priority areas, demand for programme benefits exceeds feasible supply. As a result of funding limitations, various MDAs have had to scale back their initially planned programmatic outputs, sometimes by as much as half the initial planned target. In the agriculture sector, for example, the PD sought to supply an estimated 100,000 farming households for seed distribution. The eventual target reached was 73,000 households because of limited funds. It was a similar story for NaCSA, which also wanted to target 100,000 households, but eventually scaled its target to target to 50,000 households, because of financing constraints. These basic funding limitations appear to have been present across all programme areas, resulting in scaling-down of activities from the levels originally planned.

Some MDAs criticized the consultants from McKinsey suggesting that the team was often pushing forward without adequately considering the views of Ministry staff. There were also countervailing views amongst the consultants that the Ministries were not always sufficiently sensitive to the time-bounded nature of performance and payment milestones. In particular, Mckinsey staff members struggled to meet milestones in order to receive their payments through UKaid. It is clear that there were conflicting incentives, which occasionally engendered tensions between Mckinsey and the MDAs that Mckinsey supports. On one side, Ministries are obligated to participate and own the process; on the other side, there is the potentially conflicting imperative for Mckinsey to reach its own contractual targets within a specified time period.

Members of ***GoSL Ministries expressed dissatisfaction with the limited accountability that some NGOs had to government Ministries***. Members of Ministries claim that some NGOs behave as though they are only accountable to their donors, rather than to the government, or to the people of Sierra Leone. Similarly, Ministry officials also complained about occasions on which donors allocated funds by handpicking their favoured NGOs rather than engaging in a more open process to identify the most appropriate implementing partners.

Some stakeholders suggested that the ***government did not create a clear and coherent communications strategy for raising public awareness of the PD programme***. As a result, public awareness may currently be focused on implementing NGOs rather than on the shared responsibility of the NGOs and the Sierra Leone Government for jointly administering and delivering the PD initiatives.

6.2. Sector Specific Challenges

In addition to implementation challenges each sector faced a unique set of obstacles during Programme implementation. This section details the sector-specific obstacles that the PD faced since implementation.

6.2.1 Challenges in Health Sector Programme

First and most importantly, ***gaps in water and electricity supply at health facilities remain throughout Sierra Leone***. Community feedback indicates that some health facilities either have a water supply system that is dysfunctional, or one that does not supply adequate water to meet the needs of the facility. On a much larger scale, the lack of electricity supply at most facilities was also highlighted as a major challenge to the quality of health service delivery, including complicating health worker's capacity to provide effective treatment to patients at night.

Second, there has been a ***delay in the completion of WASH***. The component is reportedly behind schedule in the health sector. The delay has been attributed to a lack of funds to pay contractors.

Third, there has been a ***delay in TB programme activities***. This target is effectively unachievable because the donor for this component, Global Funds, has not yet disbursed necessary funding to begin activity implementation.

Fourth, ***buildings have been constructed but are not being used by communities***. Indeed, an eight-bed health facility was constructed in Bumpeh, Bo district, as part of the PD intervention; the facility is said to be good, and has functioning mosquito nets, as well as other medical tools. The original expectation was for the community to use this facility, rather than other local health facilities. This is however not the case; to date the building remains idle or under used.

Moreover, incompetent assessors were hired for health facility assessment. An important quality assurance activity in the health system during this PD implementation cycle was the completion of regular assessments to evaluate the readiness of health facilities to deliver service. However, ***one local health manager noted that sometimes poorly trained people had been fielded to health facilities to conduct these assessments***, and as a result of their incompetence health facility received poor evaluation scores.

Several more challenges at health facilities deserve attention. Health facilities have significant ***volunteer workforces on whom they rely to perform essential tasks. Because they are not paid, some survey respondents note that they sometimes act inappropriately to earn some money and some were even accused of insubordination to in-charges***.

There are ***reports from health facilities of the unlawful sale of free health care drugs, thereby denying pregnant women, lactating mothers and children under-five their right to healthcare***. This statement directly contrasts with the health objective of the PD programme to improve health outcomes in under-five children and pregnant women.

Further challenges in regard to ***drugs stock out were mentioned at some health facilities***. One facility said the stock out sometimes occurred at the facility not for the lack of drugs. Rather, the lack of transportation to deliver them from the district town to the health facility was the challenge.

Finally, there are ***unrealistic public expectations***. Some survey respondents from the local councils and IPs noted that there were high public expectations of service delivery in the aftermath of the epidemic. The perception of communities was that the health sector had received massive injections of cash, and this was supposed to reflect in the quality of service delivery.

6.2.2 Challenges in the Education Sector Programmes

There are five major challenges with education sector programming. First, it seems that ***some head teachers may be withholding textbooks***. Inadvertently, some head teachers decided to keep textbooks supplied for pupils, rather than actually dispersing them to use as intended. District officials made this discovery during visits to some schools.

Second, there have been ***delays in the GoSL's payment of school tuition fees***. Although the government has promised schools that it will pay tuition fees on behalf of pupils, these payments have been delayed for some schools. As a result of these delays, schools are starved of funds to buy consumables, such as chalks, pens, dusters, etc. that they usually purchase with the revenue generated from school fees, and this has negatively affected learning, as it puts the school administration under a lot of pressure to find administrative cost from elsewhere.

Learning materials are also not reaching rural communities. Some respondents expressed concern that learning materials supplied by the government do not always reach schools outside towns and cities. A paramount chief echoed this view: "Most of the learning materials provided by government do not reach our communities; they stop at big towns like Lunsar"[136].

Limited access to schools in rural communities and further limitation of qualified teachers also remains a serious issue. One paramount chief noted that rural communities are acutely short of qualified teachers. This shortage can be attributed to many factors, including a lack of financial incentives in taking up a teaching post in a village. "Students trek several miles to access school in some communities. We need more qualified teachers, when we asked they said that teachers will not leave Kenema or Freetown to come here because they cannot organize extra classes here. Majority of the people will not be willing to pay, even if you ask for 10, 000 Leones, a lot of parents will not be willing to pay." The only person who takes decision is the deputy director of education. Whatever he says about education here is final. I don't think this is right, we should have another person to consult."[137]

Finally, there is a ***continuing delay in the completion of WASH facilities at schools***. The WASH component is reportedly behind schedule in many schools. This delay can be attributed to lack of funds to pay contractors.

6.2.3 Challenges in the Social Protection Programme

There are three core challenges to the social protection sector of the PD. ***The first major challenge is elite capture***. A core strategy for promoting ownership and enhancing effective programmatic targeting was to involve local community leaders in recruiting beneficiaries for the social protection component of the PD. However, some community leaders, who are in a relatively better financial situation than the intended programme beneficiaries, attempted to influence the selection process for either themselves or their associates. Although the programme did what it could to minimize this risk, there are possibilities that some unintended beneficiaries were actually enrolled.

Relatedly this type of ***cash assistance increases the possibility of a dependency effect***. The obvious basis for targeting participants in the social protection intervention was because they lacked the financial capacity to provide for their basic needs. However, programme implementers are realizing that many beneficiaries are beginning to show evidence of dependency on the programme and the government for their economic needs. In other words, there are many more demands coming through for assistance as the programme progresses.

Finally, transportation costs are high. ***Some cash transfer beneficiaries report the cost of transportation being the most important barrier to accessing payment***. In many cases, recipients travel to pick up their cash transfers, and the cost of the travel is prohibitively expensive. "The money given to me by the Ministry of Social

[136] .KII Paramount Chief, Port Loko District
[137] KII Paramount Chief, Kailahun District

Welfare did not make any impact in my life because most of the money was spent on transportation."[138] Similarly, several cash transfer recipients report that it can be hard to go and pick up their money because they are to visit several offices several times, and in some cases they must do this during work hours.[139]

6.2.4 Challenges in the Private Sector Programme

The ***grant component of the private sector support, which was intended to refinance small businesses (or petty traders), was generally delayed, and was in fact completely stalled in a few districts***. Taking Port Loko as an example, recruitment of beneficiaries for private sector grants was halted because local stakeholders, including paramount chiefs, sent a letter protesting what they saw as the implementing partner (IP) having a severe lack of experience in targeting local communities.

There are three additional problems with the private sector component. First is the ***late distribution of seeds***. In some communities, including Moyamba, it was reported that seeds were supplied late, prompting some farmers to put them into storage for the next planting season. While in storage, however, many seeds were consumed by pests.

Second, is ***pest and disaster-affecting farming***. In Kono district, one paramount chief reports that pests such as cows—who can graze on rice crops—affected farming activities, including productivity, which limited farmers' yields. This chief also mentioned that fire accidents occurred at some farms, gutting away production.

Finally, there is an ***on-going contest for agricultural land in urban locations***. In Freetown some farmers that received seed supplies at one location quarrelled with other claimants of the same farmland. Land ownership is still contested after the EVD crisis, and the claim of ownership by the rival party can disrupt farming.

7. Sustainability and Scaling Up

There is genuine concern among national-level stakeholders that the outcomes delivered by the 6-9 month phase, as well as those which will be achieved in the second phase, will be difficult to sustain. First and foremost, there are doubts as to whether or not the government will be able to maintain the progress it has achieved if shortfalls in donor funding occur. There are also significant concerns about the internal capacity of MDAs to continue to pursue PD goals after technical assistance from external consultants comes to an end.

Despite these concerns, some MDAs are already finding ways to sustain the gains made thus far. MEST has developed a school integration strategy that provides an institutionalized framework for readmitting pregnant girls into the school system after childbirth. At MAFFS, the team has assembled a plan for sustaining the seed distribution programme and continuing to scale over time. In essence, it has given current seeds as "loans" that will be paid back after harvest. Stakeholders suggested that, so far, most of what was given out to farmers has been recuperated and can be used again in the future. The plans are for another 73,000 farmers to be targeted at the next farming cycle, and then, a new cohort the following year, and so on. If this plan can be implemented and successfully maintained, the Ministry projects that they will be able to reach 300,000 or more farmers in five years.

[138] KII with Cash Transfer Programme Beneficiary Western Rural Area, Benguma Road, March 14, 2016.
[139] KII with Cash Transfer Program Beneficiary Western Rural Area, Kissy Community, March 17, 2016.

In making the broader argument for sustaining the gains achieved by the PD programme, national level stakeholders widely referenced the impact that the intervention has had on beneficiaries as well as on the functional capacities of institutions. This perspective is important to understand for two fundamental reasons. Firstly, the MDAs at the central level, including policymakers at MEST and at other participating Ministries understand their core competency is service delivery. So, any intervention that enhances that role is welcomed. Secondly, the intervention, as already noted, has enhanced the functionality of participating MDAs in some important domains.

In Health, the feedback from MoHS and other stakeholders is that the intervention has begun to restore a health system that was on the brink of collapse following the Ebola outbreak. Through the intervention, hospitals and peripheral health units have gained a regular supply of drugs; coverage for vaccination of children under-five has improved across all districts; emergency health transportation is more widely available (in contrast to the severe shortage of ambulances before the outbreak); and infection prevention and control (IPC) supplies are now a standard part of the health system. MoHS has also used the partnership momentum fostered by the PD to deepen collaboration and accountability from NGOs. It has introduced the Service Level Agreement (SLA), which basically require NGOs to share their implementation plans with MoHS, including operational areas, programme targets, etc.

In Education, stakeholders reported that the intervention has addressed some of the critical gaps that affected the quality of learning and performance. For example, new classrooms have been built and existing ones have been improved to ease over-crowding. The waiver programme for tuition fees has facilitated the return of thousands of children to school – children who would have otherwise been unable to attend due to the financial situation of their families. In addition, the programme has facilitated the return of pregnant girls after childbirth. Special needs education, which caters to teenage mothers, was initially planned for 3,000 girls, but due to its popularity, it has reached 10,000 girls—three times more than the planned target. In all, thousands of teenage mothers have returned to the regular school system as a result of the programme.

In the Social Protection domain, the National Commission for Social Action (NaCSA) reports that it has effectively increased the number of poor households served by the safety net programmes. It has also reportedly doubled its monthly cash transfers to households, from $15 to $30 per month. Similarly, MSWGCA, which is also implementing the social protection programme, reports reaching a total of 36,500 individuals with its minimum assistance package for Ebola survivors.

Finally, in the area of Private Sector support, seed distribution has successfully reached 73,000 farming households that had lost seedlings for the next planting season, due to the Ebola epidemic. The business grant to revive or start small businesses is reported to have assisted 29,000 households.

2. Programme Impact MDA Institutional Capacity

Most of the institutional strengthening benefits offered by the PD have been shared across all of the MDAs involved in the planning and implementation of the PD. The following list summarises the main benefits cited:

MDA feedback suggests that the PD intervention significantly improved Ministries' information management capabilities. In MoHS they have developed what they believe to be efficient and effective mechanisms for disease surveillance and other health-systems data requirements, along with the ability to efficiently collect data and store it centrally in order to provide timely analysis and decision making. The NaCSA has cited similar

progress, involving the SPRINT information management system that holds a database on the poorest members of the national population. MSWG&CA has also established a new information management system called the Communications Management and Information Management System (CMIMS), for collecting and storing nationwide information on social protection clients.

Stakeholders have reported increased coordination and information sharing between the NaCSA and MSWG&CA, both of which are leading social protection services providers. These bodies had not previously coordinated on social protection operations. The PD has reportedly bridged this gap, with an emphasis on interoperability of information management systems.

Representatives of the MSWGC&A said that their acute staff shortage has been (at least temporarily) alleviated by the PD intervention. The programme has hired a total of 228 staff, including 200 social workers, 14 monitoring and evaluation officers and 14 data management analysts. Every district effectively now has reasonable number of social workers, one M&E officer, and one data management analyst. The boost in human resources has enabled them to reach more locations and serve more people.

MAFFS reported being able to freshly supply farmers with certified seeds.[140] The Ministry says the farmers who were issued the foundation and certified seeds realised a much better harvest in the most recent farming season.

8. Lessons Learned, Best Practices and Conclusion

8.1. Lessons Learned

Key lessons that have emerged from the implementation include:

- The Service Level Agreement (SLA) reached with health sector IPs has helped to minimise the duplication of interventions, build mutual trust and partnership, and above all give a reasonable degree of confidence to MoHS that health IPs are accountable to the Ministry.

- The PDT has learned from lapses in the 6-9 month early programming, where funding mobilisation was not given the same level of attention as the programme content at the development stage. It has adopted a parallel approach to the 10-24 month cycle, by fully costing activity implementation for this period. It has further convened a donor forum in the office of the president, and even before the start of implementation, there was a 100% funding commitment from the donor community. Assuming the pledges come through and the cost estimates are also roughly close, the 10-24 month cycle will not face similar financial bottlenecks that unsettled implementation teams, particularly at the kick off phase of the programme.

- Building rapport and persistent engagement with local stakeholders helps to manage unrealistic expectations, and promotes trust and ownership of development interventions. For example, MEST said there were several unrealistic demands from communities when it initially started implementation. Rather than dismiss these, it quickly enlisted the paramount chiefs and school management committees, and in the process shared information with them on the programme content. This paid off, as it was the same leaders who turned back to neutralise the misinformation.

[140] Foundation seeds are breeds produced from the original trials while certified seeds are breed from foundation seeds.

- While external consultants bring in high end expertise to support the development process, the lack of clarity around reporting lines could lead to tension in the partnership process, which may divert energy away from the core focus of the programme as well as undermine local ownership. This phenomenon was at play in the phase that just concluded. The perception is that the reporting line for the consultants was UKaid, as such it was the principal client to whom they were accountable.

- There is no culture of NGO accountability to the government, primarily because NGOs do not perceive the government as their funder. This breeds a lack of trust and may also cause retaliation from MDAs who want to make the point that the funds NGOs receive are disbursed in the name of the people of Sierra Leone, and that the government represents this constituency.

8.2. Best Practices

MDAs have found a way of improving the effectiveness and efficiency of their operations at the same time as navigating through the risks that they had identified. This required innovative measures and examples of successful practices that worked, such as:

- NaCSA was always aware of the risks associated with cash transfer programmes, such as payments being illegally obtained by rogue persons even before they reached the intended beneficiary. In order to deal with this problem, it has put a few practical but effective approaches in place. First, it chose to make payments through an electronic cash payment service provider, SPLASH, which effectively meant payments would go straight to the phone contacts provided by the beneficiary, which could be cashed anywhere in the country; NaCSA even absorbed the service fee charged for making the payments. Additionally, it recognised that mobile phone reception was not always available across the country. So, further arrangements were made with SPLASH, where they had a mobile payment team that went to communities to pay beneficiaries. To prevent fraud, every beneficiary that is paid by the mobile SPLASH team is photographed at every payment, and that photograph is subsequently reconciled with the existing beneficiary photograph that NaCSA has in its database. In addition, the mobile team travels with Anti-Corruption Commission (ACC) staff, who are there to attend to any incidence of fraud. Although they acknowledge that the system may not be perfect, they say that it has largely worked, ensuring that rightful claimants do access payments.

- MAFFS effectively used its existing decentralised structure to complete beneficiary recruitment quickly. Each district is divided into six to eight agricultural blocks, depending on the size of the district. Each block has four frontline extension workers, who are supervised by one block extension officer. These staffs reside in the local communities and are at the doorstep of farmers. The senior management at MAFFS therefore decided to empower the block extension teams to work with local communities and identify farmers for the seed distribution programme. This targeting approach has largely worked, even in the face of excess demand for the intervention.

- MEST recognised that it did not have the manpower to adequately monitor implementation of its priority activities. Moreover, it realized that it needed a lot of community awareness to achieve uptake of its programme. It therefore worked on a social mobilisation strategy that put paramount chiefs and the school management committees at the centre of sensitising communities, as well as supporting the Ministry with monitoring functions.

- The PDT emphasised programme coordination meetings to review progress and address challenges, and it got high-level government officials to facilitate the meetings. There are two high level coordinating bodies.

First, there is the presidential forum, which meets every fortnight and is chaired by the President. This forum brought together ministers and key stakeholders in the implementing MDAs to review progress of the Dashboard and agree on actions. The other high level forum is chaired by the Chief of Staff of the Office of the president, and is also attended by ministers.

9. Conclusions

Overall, The President's Recovery Programme can be viewed as a success, as local individuals, paramount chiefs, district officials, and national level stakeholders agree that significant progress has been made on health, education, social protection and private sector growth. However, several gaps remain, which must be addressed as the programme continues.

While national level officials note that health indicators have improved over the last 6 months, the data from local communities suggest that the improvements are not as far-reaching as national level officials would have hoped. Indeed, it seems that the quality of health facilities remains problematic for local communities: Medicines are still in short supply in several areas surveyed; many areas do not have permanent isolation and triage facilities; there are an insufficient number of hospital beds; the supply of clean water remains limited; more nurses are needed; and health workers still do not receive their salaries on time.

It is, however, important to note that all government and local individuals surveyed agree that more people are returning to use health facilities as IPC standard are met, WASH conditions are improving, and child immunization is occurring regularly and is available for all children.

In terms of education the national and district level officials interviewed offer sanguine views with regards to improvements in education and learning infrastructure. However, at the local levels, school teachers indicate that while they are receiving educational materials, these materials are in short supply. Moreover, few new classrooms have been built and, as a result, classroom overcrowding remains a problem. Additionally, the payment of fees by the GoSL to local schools has been delayed in many cases. Finally, few new WASH and clean water facilities have been built at local schools. At the same time, teacher training is taking place, and these teachers are in turn training others.

There is also a notable discrepancy between the district and local level views of the provision of educational supplies. At the local level, teachers indicate that they are not receiving sufficient supplies for all their students (but recognize the improved quality of these educational supplies, especially the accelerated syllabus). Meanwhile, at the district level there is some indication that teachers are actually withholding educational supplies from their students. This tension between district and local level perceptions must be addressed.

From the perspective of social protection, all individuals surveyed seem to agree that the cash transfer programme is having a positive impact on local communities and EVD survivors. According to national-level data 51, 000 people have received cash transfers, and the value of these transfers has increased from £15 to £35. Issues with this section of the Recovery Programme include the uneven distribution of funds, as some people are receiving much more than others, and the differing periods of distribution by location. Additionally, recipients are obligated to travel to receive their cash transfers in some cases, which is costly and time consuming, and deter some from accessing their grants.

Improvements to this area of programming must include additional social workers, higher wages for social workers, and limiting the potentiality for elite capture of the programme, as well as the potential issue of long-term dependency.

With regards to private sector reforms there seem to be major disagreements between local communities and paramount chiefs, as well as district and national stakeholders. At the local level communities report dissatisfaction with the benefits farmers are receiving, namely the lack of fertilizer, insufficient quantities of rice seeds, and delays in the receipt of these goods. Moreover, the requirement to become a member of ABCs in order to receive GoSL farm subsidies seems to be an issue for individual farmers due to the expense of the membership. This is especially problematic given that seeds and fertilizer are distributed through ABCs, several of which do not seem to operate effectively or efficiently. It is also important to note that few feeder roads have been built in the communities assessed for this report.

A core objective of the private sector portion of the Recovery Programme is the distribution of grants, and providing farmers access to finance. It seems that while money is available for farmers according to national-level stakeholders, the use of financial institutions is still uneven at the local level.

Thus, while the President's Recovery Programme has not yet achieved all of its goals, it has affected positive developments in local communities. The key, moving forward, is for the GoSL to systematically address the gaps and shortfalls in the Programme in order to help local populations, increase levels of education, rebuild the economy, and prevent future Ebola crises.

10. Conclusions and Recommendations

Indicator	Conclusion	Recommendation
	HEALTH	
IPC	The quality of IPC has risen at all health facilities surveyed for this assessment, and as a result community members are returning to health facilities for treatment	Continued diligence in IPC education and training at the local level; adding an IPC monitor/quality assurance manager will ensure long-term sustainability, and will facilitate repeated trainings and knowledge transmission.
	The use of standardized performance matrix to assess IPC standards, generates credible results. The setback is with the delay in providing feedback to facilities, to trigger timely actions in order to address weak aspects.	Share assessment results immediately with facilities.
EPI	The immunization data suggest fairly high coverage for children under five, as well as pregnant. However the coverage rate is still below the desired 100% for most vaccines. Still coverage was higher for the early recovery period (July to December 2015 compared to the earlier months (January – June 2015)	Intensify sensitization activities to increase coverage especially in hard to reach and among mobile communities
WASH	WASH facilities including access to clean water are improving at all health facilities, but the quality of water access is uneven across locations.	A systematic evaluation of all WASH and waster access facilities must be undertaken in order to provide equal access at all facilities; construction and restoration of water wells, latrines and incinerators is necessary.
IDSR, Triage and Isolation	The capacity of health workers to conduct integrated disease surveillance and response (IDSR) has increased, as has their systematic and correct use of available triage and isolation facilities.	Continued and regular training on IDSR, the construction of permanent triage and isolation units, or the provision of grants for health facilities to build these facilities will ensure the maintenance of correct procedures and standards.
	EDUCATION	

Indicator	Conclusion	Recommendation
Classroom Overcrowding	Even though new classrooms have been built, targeting four districts, the classrooms are not in use as yet. Non - use is attributed to the need for officially commissioning classrooms and also due to lack of furniture	Prioritize the furnishing of all newly built classrooms. Classrooms should be utilized regardless of commissioning status, which can happen at a convenient time
Accelerated Learning	According to all respondents the accelerated learning syllabus is effective, although it took some time for teachers and students to get accustomed to it. Unfortunately there seems to be an insufficient supply of learning materials as part of this programme. In other instances, school recipients may tend to store the materials in the name of safe keeping instead of making use of the materials.	Supplying schools with more materials, and ensuring that all teachers are trained, in the use of materials and relevance of timely usage. This will ensure that educational gains made as part of this programme endure.
School Fees Waived	Most respondents do not report paying school fees, and school administrators report receiving funds to offset fees from the GoSL. However, there do seem to be delays in the delivery of these fund to some schools	The GoSL must ensure that funds are delivered promptly to all schools across the country. School leadership on their part must put in place strong accountability systems to ensure funds received are properly accounted for and within the recommended reporting schedule. This is necessary to avoid interruption of funding flow to cover school fees
WASH	The school surveyed for this assessment which has had new WASH facilities built as part of the Recovery Programme, still cannot access this facility.	The GoSL and local governments must work in concert to build new WASH facilities at all schools. These facilities will mitigate the spread of disease and infection and can help young girls on their menstrual cycles stay in school.

Indicator	Conclusion	Recommendation
Special Needs	Pregnant girls are using the special learning centres. However, the risk of drop out is high.	There is need to institute a tracking system to: a) Measure drop- out rate b) Find out reasons for drop out Make use of the lessons learned to improve on expansion plans for special needs initiatives in other schools
	PRIVATE SECTOR	
Seeds & Fertilizer	Seeds have been distributed to communities through ABCs, however the extent of fertilizer delivery is limited. The rice seeds provided seem to be useful and adaptable to local soil conditions, and are contributing to greater and more stable yields for farmer	Farmers indicate that the amount of seeds they have received is insufficient. A study must be undertaken to assess how much rice the average farmer is specific locations requires in order to calibrate the correct amount of rice seeds necessary for each community.
Feeder Roads	Very few feeder roads have been built to date (only 2 towns in this study have had new feeder roads built), and those that have been constructed work to link remote communities to local headquarter towns.	More focus must be put towards feeder road construction. Transportation remains an issue throughout Sierra Leone, particularly in rural areas. More feeder roads will increase farmer livelihoods as more crops can be moved to market in less time. Moreover, it will allow more people to more freely, thereby facilitating the movement of health personnel, and government officials.
ABC Transformation	ABCs do not exist in all communities surveyed for this assessment, and those that do exist are of mixed quality and effectiveness in terms of how they operate. For example ABCs can only supply or sell seeds to members.	ABCs require specific attention, as these bodies play a key role in the distribution of seeds and fertilizer and in organizing farm life in communities. However accessing seeds and fertilizers and other facilities should be delinked from the

Indicator	Conclusion	Recommendation
		ABC membership so as to improve equitable distribution to the services. Establish new ABCs in strategic areas
Access to Finance	The grant component of the private sector support, which was basically intended to refinance small businesses (or petty traders) was delayed and in some cases has not taken off in few districts because of management issues. Moreover, local farmers do not yet all have access to banks of FSA, which means access to finance is uneven across the	More loan opportunities in the form of 'soft loans' that are easily repaid would be a method by which to improve financial services locally. Moreover, building community banks in each area would seemingly improve access to and the quality of banking services throughout Sierra Leone.
	SOCIAL PROTECTION	
Income Support	All survey respondents agree that this element of the Recovery Programme is working effectively, and is positively impacting communities. The sole limitation is that in some cases beneficiaries must travel to receive the cash transfers;	Maintaining cash transfer programme is key to short-term economic welfare for communities. Continue unconditional cash transfer but improve on the targeting mechanism NaCSA should maintain an inventory of IPs implementing cash transfers, and should develop guidelines for disbursement given that recipients receive cash transfer from different sources and at different intervals Increase local businesses and overall employment

11. Annex 1- Detailed Methodology

METHODOLOGY

This evaluation employs a qualitative methodology, which includes a desk review, a series of qualitative interviews at field level, and phone interviews.

a) Desk Review

Dalan Consulting worked interactively with the President Delivery Central level Team (PDT) to access reference information and background documentation necessary for this assessment. The documents and reference materials reviewed are listed, categorized by type.

Background Documentation

- Recovery Priorities – Full Deck Application[141]
- Mapping of Interventions by Sector, district and chiefdom
- Central/ National Level stakeholder list

Beneficiary Listings (File names as received from source)

- Health sector (IPC)
- Survivors list- Nationwide
- Trader beneficiaries
- FBO- Summary (IP seeds and fertilizers)
- Households supported by chiefdom
- List of schools targeted for classroom expansion
- List of 20 UNICEF supported health facilities
- UNFPA list of BeMONC and CeMONC facilities

Progress Reports

- 6-9 months priorities and KPI (Dashboard)
- GoSL 1st Quarter Report
- GoSL2ND Quarter Report
- February 2016 – Regional tour Data

b) Qualitative Research

This field component of the evaluation was designed specifically to employ a qualitative methodology, which uses key informant interviews (KIIs) and focus group discussions (FGDs) to gather the required data. The study instruments and sampling considerations are described below.

i) Study Instruments and Respondents

Forcier Consulting developed the instruments required for district and community level engagement as well as for implementing partners and MDAs. Dalan Consulting developed the instruments administered to national level stakeholders. The target respondents by type are listed below:

[141] "Recovery and Transition Priorities, Full Deck Explanation." April 2015.

Community Level

- Key informant interviews
  - Health facility officials
  - Teachers
  - Farmers
  - Beneficiaries receiving cash transfers (Household Heads receiving Income support, and survivors,)
- Case Studies – targeting beneficiary groups, especially survivors
- Focus group discussion with indirect beneficiaries
- Observation of available facilities at selected schools and health facilities

Implementing Partners and MDAs

- Key informant interviews with implementers and MDA representatives at district

National Level Stakeholders

- Key informant interviews with MDA representatives at central level
- Key informant interview with President's Delivery central level team
- Key informant interview with Development Partners

ii) Sample Design and Respondent Selection

The primary target group for this evaluation is direct beneficiaries of the initiatives implemented for phase 1 (6-9 months) of the post-Ebola Recovery Programme. A cluster sampling methodology was used to select study sites and beneficiaries to be surveyed.

Selection of Districts and Chiefdoms– The following four steps were applied to select districts and chiefdoms to be surveyed

- ***Step 1*** – Update the available map provided by the PDT in order to create a comprehensive sample frame, showing interventions, by sector, district and chiefdoms.
- ***Step 2-*** Create a summary output table that indicates the distribution of intervention activities by chiefdom and by district.
- ***Step 3*** - Select two districts showing the highest concentration of intervention activities in each region.
- ***Step 4*** - In the selected districts, select a cluster of three chiefdoms located along the same axis.

The target districts selected are:

- Bo and Moyamba (Southern Region)
- Kono and Kaiahun (Eastern Region)
- Port Loko and Bombali (Northern Region)
- Western Area (Urban and Rural)[142]

[142] Automatically selected because there are only two districts in the WA

The chiefdoms selected by district are shown in the table below.

District	Chiefdoms and Areas Selected		
Bo	**Kakua**	**Tinkonko**	**Bumpe**
Moyamba	**Fakunya**	**Kaiyamba**	**Bumbpeh**
Bombali	**Bombali Sebora**	**Sella Limba**	**Gbanti Kamaranka**
Port Loko	**Masimera**	**Marampa**	**Marforki**
Kono	**Faima**	**Nimikoro**	**Nimiyama**
Kailahun	**Kissi Kama**	**Kissi Teng**	**Luawa**
Western Urban	**Kissy** **Kroo Bay**	**Wilberforce**	**Lumley**
Western Rural	**Waterloo**	**Treeplanting**	**Newton**

Selection of Sections at the District Level

The selection of sections and communities to be surveyed was compiled at the district level at the time of the fieldwork. Each district survey team was supported by the Presidential Delivery District Facilitator and or District Analyst to identify sections in each chiefdom with the highest level of activity.

Selection of Beneficiaries across Three Chiefdom Clusters

Key Informant Interviews

Ten beneficiaries were interviewed across each three selected chiefdom clusters in each district:

- Health worker/ Facility In-charge - 1
- Head Teacher-1
- Household receiving support -2
- Survivor-2
- Farmer 2 or (1 farmer and 1 trader)
- Indirect Beneficiaries -2

Case Studies

Three case studies were completed by every district survey team:

- One case study with a survivor (KII with the other survivor)
- One case study with a farmer (KII with the other farmer)
- One case study with a household (HH) receiving income support (KII with other HHs)

Observation

- Each district team also selected one additional school and health facility at random, within the selected chiefdom clusters, to find out about the type of support received over the early recovery period and also observe the quality of the output.

c) Phone Interviews

At the end of the field component, phone interviews were conducted with about a third (20 of the 52 schools in Kono, Kambia, Bonthe and Bo districts which had received support for classroom expansion by World Vision to validate the status.

Forcier Consulting

Forcier Consulting is a development research firm that operates in challenging post-conflict environments. Established in 2011 in South Sudan, Forcier Consulting has invested in developing methodologies and approaches to research that are contextually appropriate and feasible, whilst adhering to international standards for social science research and utilizing the latest data collection technology available. Our core services include population and social science research, project evaluations, market assessments for livelihoods and vocational trainings, private sector and market research for feasibility studies, strategic planning and representation, and training and capacity building
workshops.

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Dalan Development Consultants Profile: History and Expertise

Dalan Development Consultants (DDC) Limited is a Sierra Leonean owned Management and Development Consultancy firm established in 2003, with a national reach. Dalan provides technical assistance and engages in social science research, programme delivery, monitoring and evaluation in development related fields. We specialize in five areas: Health and social programmes, Programme Management, Environment and Natural Resources, Enterprise Development and Facilitation. Cross-sectorial programmes include, providing support to strengthen health, water and sanitation, environment and natural resources and pro poor systems.

Our public sector clients include governmental agencies, such as the Ministry of Health, Ministry of Water, National Commission for Privatisation (NCP) and the National Commission for Social Action (NaCSA). Our clients in other sectors include non- governmental, bilateral and multilateral institutions, to whom we have offered research and analytical services to suit their needs.

The assessments we have been engaged with across sectors, involve the collection of quantitative data using standardized questionnaires and/or qualitative data using variety of methods including focus group discussion and/or In-depth interview methods.

Our team is made up of 10 core staff and more than 50 Associates from different cultural and professional backgrounds. Our Associates are carefully selected and assigned to respond to the cultural, language diversity and literacy uniqueness of each district in Sierra Leone.

For further information, please visit www.dalanconsult.com