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EVALUATION OF THE EBOLA RECOVERY COMMUNITY TRUST PROJECT

SIERRA LEONE

Swedish Red Cross

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RESEARCH & EVALUATION

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Acronyms

CBHP	Community-Based Health Programme
CEA	Community Engagement and Accountability
CHO	Community Health Officer
DHMT	District Health Management Team
EIA	Environmental Impact Assessment
ETC	Emergency Treatment Centre
EVD	Ebola Virus Disease
FGD	Focus Group Discussion
IFRC	International Federation of Red Cross and Red Crescent Societies
KII	Key Informant Interview
MOHS	Ministry of Health and Sanitation
PPE	Personal Protective Equipment
PSS	Psychosocial Support
RCRC	Red Cross Red Crescent
SLRCS	Sierra Leone Red Cross Society
SRC	Swedish Red Cross

Executive Summary

Introduction

On 6 August 2014 Ebola Virus Disease (EVD) was declared a national emergency in Sierra Leone. The Swedish Red Cross (SRC) responded to the disaster and worked with Sierra Leone Red Cross Society (SLRCS), to provide clinical, managerial and financial support.[1] The primary focus of SRC activities was in the two districts of Kailahun and Kenema. Since 2016, SRC has been involved in Ebola recovery activities in Sierra Leone. In 2016, in partnership with SLRCS, SRC developed the Ebola Recovery Community Trust Project, a three-year project to address environmental concerns of the EVD disaster response, with appropriate messaging for communities. The project used a community engagement and accountability (CEA) approach that focused on *information as aid* and did not provide any hardware, such as well or latrine construction.

The Ebola Recovery Community Trust Project was developed in three phases:

- Phase 1 (year 1, 2016) – Environmental impact assessment (EIA)
- Phase 2 (year 2, 2017) – Pilot in 12 communities in Kailahun
- Phase 3 (year 3, 2018) – Extended to a further 56 communities in seven districts (Kenema, Kambia, Western Area, Bombali, Moyamba, Koinadugu and Kono).

The project was managed and delivered by SLRCS with technical support from SRC.

Purpose and scope of the evaluation

The purpose of this evaluation is to provide an independent evidenced-based assessment of the three-year project, which finished in May 2019. This report provides the results of an evaluation conducted in November–December 2019. The focus of the evaluation was to assess the relevance, effectiveness, coverage and sustainability of the project, and identify key lessons and recommendations for future projects.

The evaluation collected primary data from Kailahun, supplemented by secondary data including baseline and endline surveys previously undertaken in the seven other districts. A representative sample of six communities was selected, and interviews and focus group discussions (FGDs) were conducted with key individuals, community members, volunteers, SLRCS staff and stakeholders.

Findings

Relevance

The first phase of the three-year project was designed as a retrospective EIA, to establish if there was any environmental impact as a result of the emergency response. Discussions with communities identified persistent fear and misunderstanding about EVD. These findings were also supported by the SRC Listening Study, a project providing psychosocial support to volunteers. The EIA was able to recommend the project should continue into a second year. While the overall design remained the same, the findings from the EIA led the project to change the focus of messages from environmental concerns to EVD, target whole communities and recruit new volunteers.

Messages on EVD were developed in consultation with communities, tested with volunteers and endorsed by the Ministry of Health and Sanitation. In the third year messages on health and hygiene were developed, and disseminated without being piloted affecting accuracy and quality. Many of the volunteers had low literacy levels. Volunteers in the pilot had more training than their counterparts in the third year. This coupled with the clarity of health message led to misunderstanding for both volunteers and recipients of the messages.

At the start of the second year of the pilot, 70 volunteers were recruited and trained from 12 communities in Kailahun. The project developed recruitment criteria for volunteers, but in practice community leaders used their own criteria. In Kailahun, SLRCS staff supported recruitment and communities were well informed about who was recruited. This was not the case some of the other districts.

Recruitment and retention of volunteers overall was not difficult: SLRCS has an enviable volunteer support base, with over 16,000 volunteers. All volunteers signed an agreement with SLRCS and volunteered approximately 6–8 hours per week of their time, with no financial incentives. Some communities provided volunteers with agricultural land, although there was no provision for tools or seeds. The ability of SRLCS to recruit volunteers in hard-to-reach areas is a unique selling point, which can be used as an incentive for other stakeholders to partner with SLRCS. Future projects could consider assisting volunteers with non-financial incentives through income-generating

schemes, supported with training in marketing and micro-finance initiatives to help with initiatives such as drama groups and market gardens.

SRC successfully integrated gender and diversity into the project, which ensured women, children, people with disabilities and older people were targeted along with men, community and faith leaders. Through the project, SRC strengthened the operational capacity of SLRCS staff and introduced the CEA approach, which ultimately changed working practices both of SRC delegates and SRLCS staff.

Effectiveness

A total of 26 messages were developed: 16 messages on EVD during the pilot and a further 10 messages on health (breastfeeding, malaria and immunisation). Overall, 315 volunteers were recruited, 43% of whom were female. Although this was less than planned, the project was still able to target and address gender-specific information. A total of 144,510 people were reached through household visits, 13% higher than the original target. However, with just six months of implementation in the final year, some targets on behaviour change were perhaps overly ambitious, especially when there was a lack of access to latrines, clean water or appropriate health facilities to facilitate change.

Messages were delivered by volunteers in their local language through drama performances, FGDs and household discussions. The clarity of the message and duration of training received by volunteers directly affected their ability to understand and effectively deliver messages. Radio discussions were also broadcast in local languages. The majority of respondents indicated that drama performances were the best method, as they were engaging and informative. FGDs and household visits were considered good at targeting specific messages and groups, as well as to check understanding. Radio was least favoured, although it was considered trustworthy. Radio was able to gain coverage beyond the target communities, but effectiveness was limited to those who had access to a radio – in most cases men, and not all areas were able to receive the relevant radio station. Overall, the four channels for communicating the messages were applicable to recipients and to the context and where appropriate can be applied to other projects. However the use of radio broadcasts may need reviewing if specifically targeting women and children.

The evaluation demonstrated that through using *information as aid* communities had increased their understanding of EVD and were less fearful of going to health providers. As a result, communities had changed their practices. Communities reported a reduction in traditional medicine, increased use of health facilities and improved hygiene practices, resulting in better health outcomes: reduction in malaria, sleeping under bed nets, reduced diarrhoea, women attending antenatal clinics, and reduction in miscarriage and maternal deaths. However, the issue of eating bushmeat still prevailed and rather than stating they ate no bushmeat, communities reported they did not eat 'dead bushmeat' – domestic or wild animals – which have died from an unknown cause. Changes in behaviour were supported and helped through communities developing their own by-laws.

The CEA approach identifies a feedback mechanism as an important element to facilitate dialogue and provide solutions to issues. The project did not effectively implement a feedback mechanism with open dialogue with a range of stakeholders, leaving volunteers and SLRCS staff powerless other than to collate requests and complaints from communities, which primarily focused on hardware and provision of health services. The project could have been further strengthened if an advocacy component had been introduced to enable volunteers and communities to identify and target appropriate actors to address their concerns about hardware and services.

Coverage

In Kailahun, target communities were identified through the criteria developed by the EIA: high incidence of EVD, close to border areas, hard to reach and close to an emergency treatment centre or cemetery. It is unclear how rigorously this criteria was applied when recruiting communities in the seven other districts. Target groups were identified by age, gender and disability.

In Kailahun, volunteers informally extended their reach to a further eight communities and self-recruited a further 24 volunteers, who did not receive any formal training. All but two of the 68 communities reported they had heard the messages. Retention and performance of volunteers can be attributed to the number and type of supervision visits made by SLRCS branch-level staff. In the third year, due to the increased size of the project and geography, all districts received less managerial support than was delivered during the pilot.

Although standardised tools were developed, no handheld technology was used to collect data and the majority of information was collected on paper forms. A household survey was not conducted at baseline or endline,

therefore no statistical data was available and the findings are based on qualitative data. Data quality and collection could be improved by collecting quantitative date to monitor behaviour change and introducing handheld technology.

Sustainability

The project built the skills and capacity of volunteers, communities and SLRCS, particularly with those who had been involved since the pilot. SRC technical experts and staff provided support remotely and through country visits. However, an in-country presence from SRC might have strengthened this further, particularly when reviewing the project and addressing challenges.

In Kailahun, volunteers have remained in their communities and continue to deliver messages, even after the project has closed. Communities expressed that they are now more resilient to disasters, no longer fear EVD and will continue with the changes in their behaviour.

A number of SLRCS staff have been trained in CEA and it is being mainstreamed within the National Society and included in the new five-year strategy.

There was no specific exit strategy, although sustainability planning was undertaken in the final year.

Conclusion

The overall design of the three-year project remained the same, although the project was flexible enough to respond to the needs and requests of communities and focus on addressing concerns on EVD rather than the environment as originally planned. The Red Cross is unique in being able to recruit and retain volunteers without incentives. The recruitment of volunteers from local communities facilitated 1) an openness among communities to learn and 2) sustainability. The channels of communication were relevant to the context and well received by communities, particularly the drama performances. Teaching of messages and skills to deliver messages cannot be rushed, particularly when training people with low literacy levels. There were challenges to monitoring the project in the third year, due to increased size and limited staff.

The approach of information as aid was successful and there was good coverage of messages across the eight communities, many reporting improved health through changes in health and hygiene practices. The introduction of the CEA approach has facilitated SLRCS with a more systematic approach for engaging with communities. However, the project did not have a feedback mechanism, therefore it was unable to effectively respond to community feedback nor systematically engage with potential partners. Future projects need to have a systematic feedback mechanism from the inception and throughout the project's duration. The quality of the project could have been improved through regular supervision of volunteers and by collecting household survey data to measure changes in health status. In conclusion, the project was successful in using information as aid to address fears and reduce myths about EVD; and helping communities overcome their fears about accessing health services. However, the project's results could have been improved with more effective communication with a range of stakeholders, an advocacy component and the introduction of hardware, to help facilitate ongoing behaviour change.

Key recommendations

- Strengthen future projects by building an effective feedback mechanism at the inception phase, which also includes appropriate testing and piloting.
- SLRCS should look beyond its own resources and capabilities and identify other partners to help engage and respond to community needs, such as hardware and upskilling.
- Develop an advocacy component for volunteers and communities, and link with local governance.
- Strengthen results through identifying and implementing appropriate monitoring and evaluation methods – train staff on the monitoring and evaluation approach, including the logframe.

1. Background

The first confirmed case of Ebola virus disease (EVD) in Sierra Leone was reported in Kailahun district in May 2014. This was followed by the declaration on 6 August of a national state of emergency. By the time Sierra Leone was officially declared Ebola free for the second and final time on 17 March 2016, 14,089 people had contracted the disease and 3,955 had died from it, although it is likely that the actual figures could be much higher.[2]

The Swedish Red Cross (SRC) supported projects in Sierra Leone up to 2012, when it made a strategic decision to support projects in fewer countries. Consequently, SRC phased out cooperation with some of its sister National Societies, including the Sierra Leone Red Cross Society (SLRCS). SLRCS is the National Society in Sierra Leone, established in 1962, with headquarters in the capital Freetown.[3] It has branches in 14 administrative districts of Sierra Leone, with district branch managers leading day-to-day administration and management of volunteers and activities.[4]

In 2014, when EVD was declared an emergency in Sierra Leone, SRC supported SLRCS in response to emergency appeals by the International Federation of Red Cross and Red Crescent Societies (IFRC) by sending delegates to Sierra Leone to support the IFRC operation in that country, providing clinical, managerial and financial support.[5] Since 2016, SRC has been involved in Ebola recovery activities in Sierra Leone.[6] The Green Response was an approach that emphasised 'stronger accountability [by RCRC] towards affected populations by actively promoting alternative, more environmentally beneficial solutions in addressing needs'[7] by improving particular practices during a disaster and preparing for future disasters. In Sierra Leone, the three-year Ebola Recovery Community Trust Project, initially called the Green Response project, aimed to re-establish community trust by reducing myths about the spread of Ebola. In the final year of implementation, this was extended to cover re-establishing trust in healthcare providers and services. The project finished in March 2019.

In early 2015, the IFRC engaged with a range of stakeholders and communities to conduct a recovery assessment to identify recovery needs and options for the health sector and for disaster risk management.[8] Post-EVD, SRC continued to support the Ebola recovery process through psychosocial support for survivors and volunteers and community-based surveillance to detect cases of disease in communities at an early stage. In 2016, SRC introduced the Ebola Recovery Community Trust Project. In the first phase, a stakeholder analysis was conducted with partners and national health experts, which identified that: 1) there had been little community engagement as part of the national Ebola recovery phase; 2) there had been no new messaging on EVD to reflect the change in disease status; and 3) fears and myths persisted about EVD, and communities lacked trust in external people and agencies.[9] The findings were also supported by an SRC Listening Study that focused on volunteers affected by EVD. This confirmed the relevance of the project. Therefore, it was decided to continue with the second phase of the project – the community engagement and trust phase – that was subsequently piloted in Kailahun in 2017.

Although the project was planned for three years, funding was only provided on a yearly basis and the project had to adapt to the resources available for each year.

1.1 Ebola Recovery Community Trust Project

The Ebola Recovery Community Trust Project focused on community-level behaviour change, through the RCRC community engagement and accountability (CEA) approach. The CEA aims to ensure communities are engaged in the process, '[putting] communities at the centre, by integrating communication and participation throughout the programme cycle or operation' and '[helping] them speak out about the issues that affect them and influence decision and policy-makers to implement positive changes'.[10] The CEA has four components: 1) participation and feedback; 2) information as aid; 3) behaviour and social change communication; and 4) evidence-based advocacy.

Together, the EIA initial consultation with communities in Kailahun and the Listening Study established there was:

- Uncertainty over which rules and behaviours regarding EVD should be practised now the epidemic was over;
- Concern about risk of infection and the likelihood of Ebola returning, especially from neighbouring countries;
- A demand by communities for information on preparedness for future outbreaks; and
- Persistent concerns about unhappy or restless spirits caused by the use of body bags and absence of traditional or religious burial rites, most strongly expressed by people living near Ebola cemeteries.[11]

In the second year, after the findings of the EIA had been shared, the project was piloted in Kailahun in 12 communities. In the third year, the project was extended to a further seven districts: Kenema, Kambia, Western Area, Bombali, Moyamba, Koinadugu and Kono (comprising 56 communities).

Specific activities involved working with the communities to firstly establish what myths and fears about EVD needed to be addressed, then developing appropriate messages accordingly. Initially, 16 messages about EVD were developed and tested with Red Cross volunteers from the targeted communities before being disseminated in communities. After the pilot in Kailahun, community feedback asked for messages to include information on health and hygiene,[12] which continued to be delivered through four communication channels: drama performance, household visits, community consultations and radio discussions.

The project was to be managed and delivered by SLRCS, with technical support from SRC experts. The project would be coordinated and overseen by a SLRCS CEA programme manager and in each branch supported by a CEA officer. SLRCS was responsible for recruiting both staff and volunteers.

Initially, 70 volunteers – men and women[13] – were recruited from the 12 target communities, rising to 315 after the project had been rolled out in other districts. The project addressed fears and myths surrounding EVD, later expanding to ensure greater trust in healthcare providers and services. Its initial objectives were to increase knowledge about: 1) EVD; and 2) environmental issues within SLRCS.[14] This was revised in the third year to: 1) increasing knowledge about key messages on EVD and malaria; and 2) targeting communities to adopt and consistently practise key recommended health behaviours.

Table 1: Outline of Ebola Recovery Community Trust Project activities

Year	Activity	Description
2016	- EIA	- Insight into potential concerns about environmental and ecosystem services - Provided a lessons learnt guide for future operations
	- Listening study and community consultations	- Listening study with volunteers and community consultations allowed people to express their concerns and fears - Provided knowledge about rumours that needed to be contained and managed
2017	- Developed messages on EVD and recruited volunteers	- 16 messages developed based on findings from EIA, listening study and community consultations - Messages developed by SLRCS, with technical support from SRC CEA specialist - Volunteers recruited from target communities to ensure local ownership and sustainability – ideally, they had been previously engaged with SLRCS/Red Cross - Messages tested with volunteers in Kailahun, adjusted as appropriate and approved by Ministry of Health and Sanitation
	- Piloted messages and ran campaign	- 12 communities in total targeted in Kailahun district
2018	- Increased coverage, disseminating project to total of 8 districts	- 7 more districts targeted: Kenema, Kambia, Western Area, Bombali, Moyamba, Koinadugu and Kono (56 communities in total) - Messages included EVD as well as an additional 10 messages on health and hygiene (e.g. malaria, immunisation, breastfeeding, sex and breastfeeding)

2 Overview

2.1 Objective

The purpose of the final evaluation is to provide an independent assessment of the Ebola Recovery Community Trust Project over the three years of implementation, providing an evidence-based analysis of any changes in the target communities that can be attributed to communication messages developed for the project. The Terms of Reference seek to evaluate the relevance, effectiveness, coverage and sustainability of the project to identify key lessons and recommendations, and inform future projects.

The primary audience for this report comprises SLRCS, SRC, IFRC and Icelandic Red Cross. The deliverables were developed with a view to providing information beyond the main audience, including the Sierra Leone Ministry of Health and Sanitation (MOHS), NGOs and other implementing partners, and the wider Red Cross movement. It is anticipated that the report will be made public so that others may learn from the intervention.[15]

2.2 Assessment questions

Table 2: Evaluation questions

Question area[16]	Suggested questions	Sub-criteria
Relevance and appropriateness – The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor	1. What aspects of the project were aligned with the findings of the initial research of the Green Response (SRC EIA and Listening Study) and why did changes occur to the project design? 2. To what extent did the project align with SRC/SLRCS policy and strategy?	What, if any, were the changes to the original project design?
		How were the key messages determined and delivered to the communities?
		How were volunteers recruited and promoted?
		Did the project support gender and diversity perspectives?
Effectiveness – A measure of the extent to which an aid activity attains its objectives	3. To what extent were the project's specific objectives achieved? 4. Which was the most effective method in communicating messages?	What were the project's actual vs intended results?
		What were the unintended results?
		What community-level feedback mechanisms were put in place and/or strengthened?
		What was the most effective communication method to improve knowledge among target groups?
		How effective was the project in improving knowledge and reducing myths about EVD?
		Was community trust in health providers re-established?
Coverage	5. What criteria were used to identify target groups and communities? 6. How effective was the project in targeting different groups within communities?	How were the target groups and communities determined?
		To what extent were the target groups and communities reached, according to the planned project?
		What, if any, have been the key challenges to extending the project beyond Kailahun?
		How relevant were the monitoring and evaluation methods?
Sustainability – Measures whether the benefits of an activity are likely to continue after donor funding has been withdrawn	7. How sustainable are the results of the project?	How did the project help to build the capacity of volunteers, communities and SLRCS?
		What was done to build and mainstream CEA within SLRCS and partners?
		What activities are likely to continue and why?
		To what extent was an exit strategy developed and implemented?

2.3 Approach and methodology

The scope of the evaluation was to collect primary data from the pilot district, Kailahun. The primary data would then be supplemented with secondary data in the form of the baseline and endline data from the seven other districts. The evaluation selected a representative sample of communities and individuals to reflect the 12 communities selected in the pilot study. The evaluation was conducted in six communities, selected according to the original project criteria: a high incidence of EVD; close to border areas or close to an emergency treatment centre (ETC) and/or cemetery (see Table 3: Communities selected for the evaluation). Individuals selected for key

informant interviews (KIIs) and focus group discussions (FGDs) lived in communities, were volunteers from the communities, had worked with the communities or been involved with the pilot.

Table 3: Communities selected for the evaluation

Name of community	Criteria
Pondu, Foundu	Border community/hard-hit community
Jalla	Hard-hit community
Belu, Kpelamu	Close to ETC/cemetery
Gbanyalwallu	Hard-to-reach/hard-hit community

Before the field visit, a systematic desk review of the available literature was undertaken. The insight gained from this was used to identify information gaps and focus areas for stakeholder-based data collection in-country. The country visit focused on obtaining qualitative data through semi-structured KIIs and FGDs with selected communities and other relevant stakeholders. The data collection methods and tools are listed in Table 4.

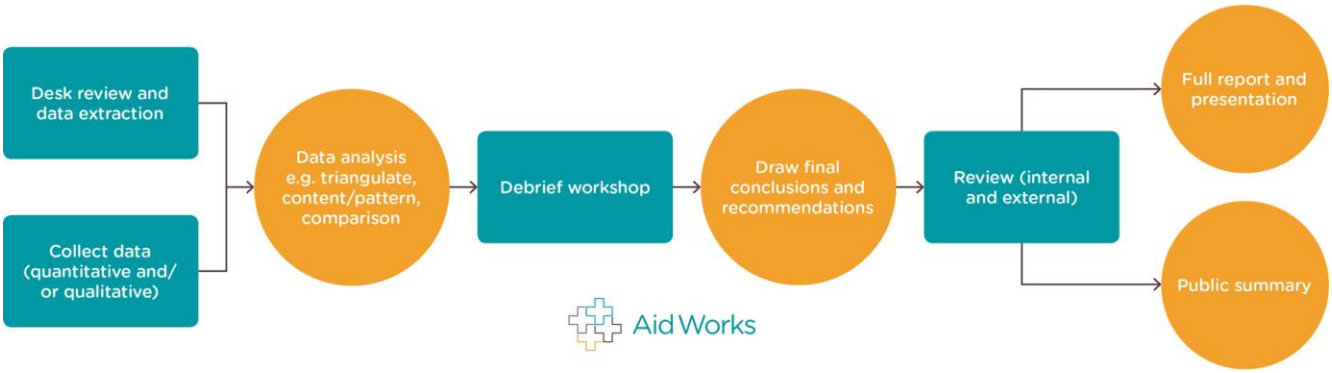
On completion of the primary data collection, a validation workshop was held with the SLRCS to outline the main findings and preliminary recommendations. Then, in-depth analysis and interpretation were conducted and a final report produced, outlining the evaluation's conclusions, lessons learnt and recommendations.

Table 4: Summary of data collection methods and tools

Activity	Completed	Data collection tools
Document review	- All relevant project documents - Red Cross documents	Key findings template
KIIs	17 KIIs covered:[17] - SRC staff and delegates - Health facility staff in Jalla and Foidu - Volunteers from selected communities - Finnish Red Cross - SLRCS staff - District Health Management Team (Kailahun)	Semi-structured interview guidelines
FGDs	15 FGDs (around 167 participants): - 4 men's groups - 4 women's groups - 1 youth group - 2 community leaders - 2 schoolchildren - 1 Red Cross volunteer - 1 CEA officer and district branch manager	Focus group guidelines
Community visits	- Pondu, Foidu, Jalla, Belu, Kpelamu, Gbanyawalu - 2 health facilities in Jalla and Foidu communities	–

2.4 Analysis and reporting

Figure 1: Aid Works standard evaluation process



Standardised KII and FGD guides were developed to capture data systematically. An overall analysis framework was populated for each question to support triangulation of data from different sources. Findings were presented to and validated by the National Society team during a debrief presentation at the end of the visit.

2.5 Limitations

The evaluation was primarily qualitative, collecting information on the project's relevance, efficiency, coverage and sustainability. Limitations of the evaluation included:

- Lack of quantitative data and therefore reliance on qualitative data at both primary and secondary levels. The baseline and endline data did not include any household surveys, and the evaluation was unable to: 1) make comparisons pre-/post-intervention; and 2) verify qualitative responses with MOHS data.
- Reliance on memory of past experiences, potentially leading to recall bias.
- Significant staff changes at the National Society during the project's implementation.
- Information being lost during the translation process (e.g. from Mende to Krio to English).
- Kailahun, was the only district visited, therefore reliant on secondary data for the seven other districts.
- Kialahun had a longer implementation period, therefore unable to make direct comparisons with the other seven districts.

A large evidence base was used, systematically recording and analysing information across sources. Where possible, information was triangulated with secondary sources to reduce bias and cover gaps. Secondary sources included: the EIA report; project baseline and endline documents; a review of the Kailahun pilot; the project's monthly reports; and case studies (see Appendix I). At the end of the field visit, the validation meeting with SLRCS was an opportunity to confirm field observation generalisations were correct and comment on preliminary findings, conclusions and recommendations.

3 Research Findings

3.1 Relevance

Project design

The Ebola Recovery Community Trust Project was designed to be a three-year project. The initial stage was to conduct a retrospective EIA to identify potential long-term environmental impacts resulting from Red Cross activities in Kailahun and Kenema during the EVD emergency. As far as is known, this was the first EIA to be conducted on EVD in Sierra Leone.[18] The EIA team, which comprised two SRC delegates and two SLRCS staff, took soil samples and conducted community consultations to act as proxies for communities. The EIA team identified its main environmental concerns: 1) the impact of burning large amounts of personal protective equipment; 2) the large number of body bags used during the Ebola response for permanent burial; and 3) significant quantities of chlorine used as disinfectant. The EIA concluded there was no significant long-term environmental impact from RCRC's Ebola response. But, its recommendations included reviewing the use of body bags for long-term disposal of bodies.[19]

During interviews conducted as part of the Listening Study it became apparent that psychosocial (PSS) volunteers were not representative of communities due to their experience during the emergency and at the time had been ostracised. This resulted in the team going directly to communities for consultations. Community feedback showed myths and fears persisted, and that there was a lack of knowledge and understanding about EVD. Crucially, however, interviewees expressed a desire to know more.

Therefore, the messages developed focused primarily on EVD rather than the environment.[20] The initial design had identified PSS volunteers to deliver messages to particular groups in the second year. However, this was also changed and new volunteers were recruited directly from communities. The flexibility of SRC, SLRCS and project funding permitted changes that better suited the communities' expressed needs and the EIA findings (see Table 5).

Table 5: Changes in project design

Ebola Recovery Community Trust Project – Original project objectives:	Changes and why they occurred
Produce scientifically proven knowledge on the Ebola response's impacts on environmental functions	- No change
Improve knowledge on environmentally friendly emergency responses within Sierra Leone and across the RCRC movement	- Messages devised to focus on EVD rather than environment – EIA found communities lacked knowledge and understanding about EVD - No change – learning was disseminated in Freetown, Stockholm and Nairobi
Improve knowledge among local stakeholders and PSS volunteers on environmental consequences of the Ebola response	- No longer considered necessary – EIA assessed there was no environmental impact
PSS volunteers to deliver environmental messages to selected groups	- Recruited volunteers from communities instead of PSS volunteers - Delivered EVD messages to whole communities – EIA found whole communities needed correct information, not just particular groups
Planned for three years	- No change

Volunteers

During the EVD emergency, messages were not always translated into local language and were delivered by outsiders. Volunteers were therefore recruited from the 12 selected communities (see 3.3. Coverage), because they were from those communities, could speak the same language and would remain in the communities. The Red Cross was perceived as trustworthy because it had remained after the emergency when other actors had left. (across Sierra Leone, the Red Cross has a good reputation and over 16,000 volunteers are registered).[21]

During the pilot phase, 70 volunteers were recruited and trained. Volunteers interviewed identified wanting to participate in the project to support their communities and also to develop skills.[22] Volunteers worked in groups, overseen by a team leader. Although volunteer team leaders were expected to be able to read and write, many of the volunteers recruited had low literacy levels.

The project developed criteria for recruiting volunteers (see Appendix IV), but feedback from six communities in Kailahun stated that they had selected volunteers using their own criteria,[23] based on individuals being trustworthy, reliable and from the community.[24] The SLRCS CEA officer encouraged communities to recruit male and female Red Cross volunteers. Community leaders held a community meeting to select volunteers. The volunteers were then promoted through community meetings. This was not the case in other districts. The endline assessment found that some communities were unclear on how volunteers were selected and the role of the Red Cross.[25]

All volunteers received training on messages, drama skills, community engagement, accountability skills and being part of the Red Cross. Many volunteers enjoyed the training and learning new skills,[26] which have the potential to be used in other projects. All volunteers were asked to sign an agreement and to work without financial incentives or remuneration for the duration of the project. Some communities gave volunteers agricultural land, although the

benefits were limited as they did not have the relevant tools or seeds. Volunteers from Kailahun attended several training sessions, compared to those in the third year who only had one training session. Volunteers in Kailahun worked around 6–8 hours a week and were still engaged in activities even after the project had finished.[27] Future projects could consider assisting volunteers with non-financial incentives through supporting volunteers with income-generating schemes - such as developing drama groups and market gardens - with training in marketing and micro-finance initiatives.

How the project aligned with SRC and SLRCS policy and strategy

SRC did not have a permanent in-country presence and provided support through country visits (see Appendix III). Visiting SRC staff and SRC delegates provided SLRCS project staff with technical support in planning and designing the project, including introducing CEA methodology, refining messages, designing and implementing baseline and endline assessments, and training volunteers. SRC delegates were encouraged to use a participatory approach in supporting SLRCS staff with planning and funding proposals, monitoring and evaluation, documenting results, and building staff capacity and ownership of the project.[28]

Table 6: SRC and SLRCS policies and strategies

Policy/strategy	Purpose	Achieved
Humanitarian Strategy of the SRC 2016–19	Build capacity of National Societies and strengthen operational capacity	✓
	Develop capacity in health, water and sanitation	✓
	Support SLRCS in resilience activities	✓
	Provide strong connection between disaster response, recovery and long-term support	✓
	Measures for risk reduction/climate change adaptation	✓
	Integrating gender and diversity	✓
SLRCS Strategy Road Map 2014–18	Strengthen partnerships with other organisations	✓
	Strengthen SLRCS	✓
	Increase awareness of SLRCS nationally	✓

During the project, SLRCS was encouraged to attend cluster meetings and liaise with other actors and stakeholders at national and district levels – such as the MOHS, WHO and UNICEF – to inform people about and promote the project, and get consensus on message development. SLRCS staff reported attending relevant cluster meetings in Kailahun and Freetown.[29]

SRC was keen to ensure gender and diversity were integral to the project, recruiting female volunteers and specifically targeting groups of men, women, young people and children. Religious leaders were recruited as volunteers, enabling messages to be delivered in mosques and churches.[30] People with disabilities and older people were given access to the same information. Volunteers and communities said they made sure these groups were informed through household visits and helped people with disabilities get to health facilities when they were ill.[31]

According to feedback from the staff consulted in this evaluation, SRC has built the capacity of SLRCS staff and raised awareness about the need to systematically engage with communities.[32] Although not a specific outcome of CEA approach, the introduction of CEA has led to programming being more integrated, rather than working in silos. CEA has also been included in the next SLRCS five-year strategy.[33]

3.2 Effectiveness

Objectives achieved

The pilot was successful in developing and testing key EVD messages within the community. In Kailahun, each community was reached through a systematic plan of activities. However, the endline assessment found that two communities in Western Rural and Kenema were not clear about the messages or volunteer activities.[34] In the third year, 10 more health messages on breastfeeding, malaria and immunisation were developed based on

findings from the baseline study.[35] All 26 messages were developed and shared with the MOHS and relevant partners. However, SRC delegates expressed concern about the health messages, saying that that they should have been reviewed by specialists in health and gender as some were not clear, particularly around sex and breastfeeding, and how malaria is transmitted.[36] The lack of clarity on some health messages, coupled with low literacy levels and only one training session for volunteers recruited in the third year, affected the volunteers' ability to learn and understand messages, which directly affected the quality of messages delivered to communities.

During the project, 315 volunteers were recruited and trained (43% were female).[37] Although there were fewer female volunteers, the project was able to deliver gender-specific messages, which were well received by both men and women. One women's FGD stated it was the first time they had received gender-specific information.[38]

SLRCS had previously managed a child advocacy project to train children on messages. One community FGD stated '[the children were] very good and helped to reduce sickness in community'.[39] SLRCS also managed a community-based health programme (CBHP) project across Sierra Leone and had been operational in some of the 68 project communities prior to the Ebola Recovery Community Trust Project. While the CBHP was not operational in the 12 pilot communities, it is unclear whether the CBHP ran alongside the project in the seven other districts. Even if CBHP was not operational during the project period, the results on health and hygiene practices may not be solely attributable to the project, due to previous interventions.

Overall, a total of 144,510 people were reached through household visits, 13% more than the endline target. While the outcomes were relevant to the context, not all targets in the logframe were met – particularly on behaviour change – but some were perhaps overly ambitious (see Appendix IV). Given that the roll-out to the additional seven districts in 2018 was only operational for six months, some targets on behaviour change[40] were unlikely to be achieved and could have been amended accordingly. Although communities have reported behaviour change, now that the project has finished the lack of access to hardware such as latrines and clean water or appropriate health services will present challenges for sustained change, even for motivated individuals or communities.

Methods of communicating messages

In Sierra Leone, there is a strong oral tradition, and a history of theatre for development dating back to the 1970s.[41] Messages were delivered through drama, FGDs, household visits and radio discussions. Crucially, all messages were delivered in local languages by community volunteers. EVD significantly affected all communities in Kailahun. They reported drama as being particularly good for delivering EVD messages, as it was entertaining as well as being informative:[42]

> *The message passed through drama [is the best]. Before, I did not have the courage to pass by the cemetery and ETC, but through the performance and messages I can boast that I now have a garden at the ETC. That's why I prefer drama to anything else*[43]

However, respondents acknowledged that FGDs and household visits were also important. FGDs allowed for further discussion on a smaller scale and helped target specific groups (e.g. discussing women's health with women only) and household visits allowed volunteers to see and address practices that had been misunderstood.[44] Radio discussions were mentioned least often. This is perhaps to be expected, as not everyone has access to a radio, and some can only pick up stations from neighbouring countries. In general, men own the radios and more men than women reported hearing the radio messages.[45] They considered the messages to be 'factually accurate' because they were on the radio.[46] SLRCS has now integrated drama into other projects.[47]

In Kailahun, communities considered information to be trustworthy because they had helped develop the messages, the messages were delivered in their own language, and they trusted the volunteers – who they referred to as 'their own children' – and the Red Cross.[48]

Improved knowledge about EVD

All the communities surveyed,[49] apart from two, reported increased understanding and knowledge about EVD and having changed practices as a result.[50] For example, people no longer avoid passing cemeteries; survivors are accepted in communities; and ETCs are used for farming, playing football or as health centres.[51] One message focused on not eating bushmeat. In the six communities visited in Kailahun, all stated that they no longer ate 'dead meat', referring to both domestic and bushmeat whose cause of death was unknown: 'Before, we saw a dead animal as a blessing but now we don't eat it'.[52] During the project, all communities developed by-laws on

consumption of dead meat, either about not eating it or not bringing it into the community to eat: 'Do not bring dead bush meat into the community'; 'Avoid eating a dead animal in the community'; 'Avoid eating a dead animal, including bats' (see Appendix VI).[53]

As a result of the project, all six communities in Kailahun felt they were now more resilient to future shocks and disasters because of the information provided, and because volunteers were still living in the community and they could call the Red Cross in future emergencies. This was also a finding of the endline assessment.[54]

Re-established trust in health providers

During the Ebola response there was a deep mistrust in health providers. Community members saw their loved ones go to health facilities but not return, resulting in some communities hiding their sick and self-treating.[55] The project aimed to encourage communities to increase their use of health facilities for both curative and preventative reasons. In Kailahun, all six communities reported an increased use of health facilities to treat sickness, for antenatal checks and delivery, and for child immunisation. As a result of going to the health facility, children said that they now slept under mosquito nets, which some of the families had received for the first time.[56]

All communities reported reductions in malaria, and sickness including vomiting and diarrhoea. Two communities, Kpelamu and Gbanyawalu, reported reductions in miscarriages and maternal deaths.[57] The practice of using traditional herbs and healers, and self-prescribing drugs, were also reported to have been significantly reduced. A community health officer at Jalla health facility said he had seen an increase in footfall and a reduction in traditional medicine: 'The use of traditional medicine has reduced. More people come to the health facility and bypass traditional medicine.'[58]

From observation, the communities visited were tidy, with drying racks for clothes and cooking utensils. Overall, communities reported less sickness and malaria, and that handwashing was important. However, there was little evidence of soap and water readily available at latrines. And both health facilities at Jalla and Foidu in fact reported an increase in cases of malaria. However, it may be that as a result of the project more people are presenting with malaria because they are aware they can get treatment at the health facility.

Community feedback mechanism

Figure 2: IFRC outline of how feedback and complaints should be integrated into projects

> Establish a system to listen [to], collect, analyse, respond to and act on feedback and complaints. This should be designed with input from the community and staff and volunteers properly trained to manage it.[59]

During the EIA and pilot, communities provided feedback on findings and were involved in developing messages on EVD. As a result two SRC delegates said that they had changed their future practices to include feeding back to participants. CEA is also focused on feedback mechanisms from communities about their concerns; and on how to improve projects and increase trust among all involved. IFRC CEA Guide identifies feedback as being a two-way dialogue to act and respond to feedback and complaints (see Figure 2). However during the project, it appears that feedback was informal and ad hoc, rather than being systematised.[60] The project was designed as information as aid with no provision of hardware; as a result of the type of messages delivered, feedback from communities was directly related to and focused on requests for help around hardware and health facilities. Volunteers collated and reported feedback to the CEA officer, who in turn would report back to SLRCS in Freetown. But there was no provision in the budget for hardware. The CEA officer in Kailahun liaised with other agencies at cluster meetings, but only one well was built in in Kpelamu through SLRCS/CBHP funding. In one instance, the community did not believe volunteers were passing on their requests for help and went directly to the Kailahun branch office.[61] Volunteers and SLRCS district staff were powerless to do anything about requests for help other than collate and report to either the district offices or Freetown respectively: 'The community requested so much, but we couldn't meet their expectations – we were just told to document requests and send it to CEA officer, who then sent it to Freetown'.[62]

In addition the project did not appear to have a specific advocacy component. Therefore, neither volunteers nor communities were given training to help develop advocacy skills to enable them to identify and target appropriate

local authorities and/or other organisations regarding the construction of hardware and appropriate health services. Not only might it have helped to secure further support, but it could also have reduced pressure on volunteers and SLRCS staff and empowered communities to be proactive regarding future developments within their communities.

Unintended outcomes
The project had several unexpected outcomes:

- Communities developed by-laws related to EVD and good health practices, with fines if people broke them.
- In Kailahun, volunteers continued their activities after the project had finished.
- Volunteers increased in confidence, gained respect and standing within their communities, and acquired new skills, which led to some – who lived in or near urban areas – gaining employment.
- Cleaning groups were established in some communities.
- The use of traditional medicine and self-medication was less accepted and promoted less by communities.
- In Kailahun, volunteers extended their target area to surrounding villages and communities, leading some to change their practices.
- Delays to project implementation in the third year reduced the coverage and quality of messages – many volunteers recruited were illiterate and had little or no health knowledge, and the project training did not allow for proper assimilation of information, which meant some volunteers delivered incorrect information.
- Project results might have improved if they had aligned with other SLRCS activities.

3.3 Coverage

Target communities
The EIA identified target communities through four criteria: they were hard to reach; had a high incidence of EVD; were close to border areas; and were close to an ETC and/or cemetery. In Kailahun, the criteria were adhered to, but it is unclear how strictly this was done when extending the project to seven districts, as there was little technical supervision during this period.[63]

In Kailahun, volunteers increased coverage by going beyond their target communities, informally extending their reach to a further eight communities (20 in total). They increased their capacity by self-recruiting 24 more volunteers, bringing their number to 94. However, the new volunteers did not receive formal training from SLRCS. Delays in the third year, [64] which were beyond the control of the project, reduced the project delivery time and slowed the expansion of project activities. Therefore, the coverage in seven districts was not as comprehensive as in the pilot area.

Target groups
A range of target groups were identified (e.g. community and religious leaders, women's groups, teachers, young people and schoolchildren). The project disaggregated target groups to ensure all sections of the community received the correct messages and the most appropriate communication method. For example, women were targeted with maternal and child health information through household visits and FGDs. Schoolchildren were targeted with messages through drama and singing. Volunteers were recruited from different faith groups, including traditional healers. Messages were also delivered in religious meetings at churches and mosques.[65]

In Kailahun, the CEA officer supervised volunteers. EVD and health messages were delivered by volunteers, as well as over the radio. Respondents in all six communities visited said they were aware of all the messages and were certain the whole community had heard them. The endline assessment reached a similar conclusion. The majority of respondents had seen the volunteers' activities. But this was not the case in two communities – in Western Rural and Kenema – where respondents were barely aware that Red Cross volunteers had been in the community. The endline concluded that the volunteers needed much closer monitoring at branch level.[66]

Monitoring and evaluation methods
Tools were developed and standardised to collect information disaggregated by gender, age and disability. In Kailahun, a monthly work plan was developed for each of the 12 communities and visited monthly by the CEA officer.[67] The CEA officer was also supported with regular visits by the CEA programme manager.[68] In the third

year, the same level of supervision by CEA officers was not as consistent across all districts, leaving volunteers to manage themselves or not engage with activities.[69] Due to increased geographical coverage, logistics and seasonal rains, the CEA programme manager could not provide the same level of support to branch officers as had been possible during the pilot.

No handheld technology was employed and volunteers collated data manually on paper and reported to a team leader, who was literate. Every month, the team leader, who was provided with mobile phone credit, would report the findings to the CEA officer. The CEA officer would collate all the data in a spreadsheet and send it to the programme manager, who produced monthly reports. A lot of information and paperwork were collected during the second and third years, with little support to address any issues raised in the reports.[70] CEA officers interviewed were also apparently unfamiliar with the logframe.[71] Monitoring of communities was also limited in the third year due to 1) limited access in the rainy season and 2) untimely disbursal of funds to help with monitoring of activities (e.g. fuel and mobile top-ups).[72]

One of the weaknesses of the project is that it did not collect quantitative data. No quantitative baseline or endline surveys were conducted in Kailahun, nor were any household surveys conducted in any of the eight districts. The findings are heavily reliant on qualitative data. Data collection in Sierra Leone is difficult to access though formal channels, so a household survey both at the start and the end of the project would have provided accessible data and more robust findings to support feedback from communities on behaviour change.

3.4 Sustainability

Building capacity of volunteers, communities and SLRCS

The project succeeded in empowering and increasing confidence among staff and volunteers, particularly among those who had been involved with the project since the pilot phase, as they had more time and support to assimilate information and develop skills. This, perhaps, happened to a lesser degree in the third year. However, the majority of volunteers will remain in the target communities, as will the knowledge and skills obtained. In Kailahun, volunteers continue to deliver the messages. The sense of community cohesion has increased, particularly among volunteers who received agricultural land and have worked together to grow crops as an income-generating scheme.

Overall, communities have a greater sense of control over their health and no longer fear EVD, as correct knowledge and practice have replaced myths and misunderstanding. Communities report being more resilient and better able to cope with future disasters.[73]

SLRCS and volunteers are now aware of how important liaising and partnering with community leaders and other stakeholders are to the success of a project.[74] Through the project, SLRCS has promoted the work of the National Society, and proved that it can deliver appropriate projects. Consequently, Freetown City Council has asked SLRCS to co-ordinate the council's community engagement branch with Catholic Relief Services; and SLRCS has helped the District Health Management Team with distributing mosquito nets and a polio campaign.[75] Other NGOs also want to work with Red Cross volunteers.[76]

SLRCS already had a good volunteer base, but the project has increased volunteer numbers and improved their reputation in communities. Sustainability of volunteers could have been enhanced if the project had identified non-financial incentives such as agricultural tools, seeds and marketing skills on how to develop co-operatives to sell agricultural produce or drama performances.

Mainstreaming CEA

Through the project, SRC wanted to embed CEA within SLRCS. A number of SLRCS staff have been trained in CEA and have cascaded their training to branch members. CEA is now being mainstreamed as part of the National Society's recently developed five-year strategy.[77]

Exit strategy

There was no specific exit strategy for the project and some communities were unaware the project had ended.[78] However, in the final year sustainability planning was conducted among SLRCS staff, as was a learning exercise with volunteers during the endline assessment.[79]

4 Conclusions and Recommendations

4.1 Conclusions

Relevance

The project was relevant and appropriate and followed the overall project design, although some changes were implemented. The changes that occurred resulted from the EIA findings, which identified the need to change the messages' focus from the environment to EVD and who would deliver the messages. The EIA also confirmed there was a need for the project to continue to phase 2. Key EVD messages were identified and developed with communities and piloted with volunteers in Kailahun. The health messages were less rigorously tested and piloted, affecting both their quality and how well volunteers and community understood them.

Volunteers were recruited and promoted by community leaders from target communities. This was a transparent process in Kailahun, but it was not always the case in other districts. The messages were delivered by volunteers in the local language after being trained in drama; during FGDs and household visits; and through radio discussions. Overall, the type of communication channels selected as part of the project were relevant and appropriate. Volunteers learnt new skills and gained confidence in delivering messages to their communities.

The project aligned with SRC and SLRCS strategies and policies, including integrating gender and diversity perspectives into project activities. It also highlighted the uniqueness of the Red Cross in being able to recruit and retain volunteers without financial incentives. In the future, there is a real opportunity and great potential to work with other partners and support initiatives that are struggling to recruit volunteers in hard-to-reach areas.

Effectiveness

The project was successful in developing messages on EVD to address communities' concerns and fears about EVD, and re-established trust in health providers. As a result of the project, intervention communities are cleaner and report behaviour changes in the use of mosquito nets, handwashing, breastfeeding and avoiding eating bushmeat. Communities also report improved health and reduction in disease and malaria. Correct understanding of EVD among communities in Kailahun can be attributed to the project. This also directly correlates with a reduction in fear of the disease. Re-established trust and use of health providers mean that use of traditional medicine and self-prescribing have reduced, and use of health facilities for both curative and preventative services has increased.

The volunteers' ability to learn and understand messages can be attributed to the length of time they attended training and quality of messages developed. The focus of the project was to give *information as aid* and was not designed to include any hardware elements. While there have been positive changes, the lack of hardware affected results, as it is difficult to make long-term changes without appropriate hardware to support the necessary changes. However, an unexpected outcome was the introduction of by-laws by community leaders, which has ensured certain behaviour changes persist.

Overall the project did not develop a formal feedback mechanism, resulting in communities predominantly making requests for hardware and health services. Project staff and volunteers did not have the resources or the training to be able to respond to requests from communities, which disempowered staff and volunteers and caused frustration for communities, as their requests did not appear to be addressed. Future projects could be strengthened by building in an effective feedback mechanism, as well as an advocacy component, with a specific focus on supporting communities to engage with other actors. However, the project was successful in engaging with communities to identify the need for messages on EVD during the pilot to provide feedback on developing the messages.

The approach of using drama, supported by FGDs, household visits and radio discussions worked well. Overall, drama was the most effective means of communicating messages, particularly in delivering sensitive messages on EVD. FGDs and household visits were useful in targeting specific groups and addressing misunderstanding. Although the use of radio had a wide coverage beyond target communities, it was limited as not all areas received a radio signal, and the majority of those who had access to radios were men. Future projects should continue to use the methodology to deliver messages – especially messages of a sensitive nature – while recognising that radio has its limitations.

Coverage
The EIA developed criteria to select target communities, which were used effectively in community selection during the pilot phase. It is less clear if the criteria were applied as rigorously when identifying communities in the other seven districts. Target groups were identified through community consultation, as well as by employing a gender and diversity focus.

Coverage was greatest in Kailahun and extended its reach beyond the target communities due to volunteers' diligence, recruitment of more volunteers and the length of the project. However, delays in the third year, which were beyond the control of the project, reduced the project delivery time and slowed the expansion of project activities. Therefore, the coverage in seven districts was not as comprehensive as in the pilot area.

Data collection could have been improved by, using technology for data collection, introducing a household survey at both the start and end of the project and timely disbursement of project funding.

Sustainability
The project succeeded in building the capacity of volunteers, SLRCS staff and communities, ensuring the sustainability of the project's benefits, particularly in the target communities. SRC provided support remotely and by visiting delegates. Had there been a permanent presence, this could have been strengthened even further, particularly when reviewing monthly reports, planning activities in the third year and reviewing the project after delays were incurred.

Project activities have been sustained by the policy of recruiting volunteers without financial incentives. This policy should continue, but volunteers could be supported with alternatives to cash based incentives such as income-generating activities and micro-finance training.

The CEA approach has now been mainstreamed by SLRCS as a result of the project and is now part of the National Society's five-year strategic plan. There was no specific exit strategy. But, in the final year sustainability planning was delivered that identified recruitment of volunteers into other Red Cross activities and engaging with other stakeholders as ways of promoting the work of the Red Cross.

4.2 Learning and recommendations

The project was successful and effective in delivering *information as aid*. Information as aid can be more than a one way process. It has the potential to communicate as a network - to help facilitate dialogue and partnerships not just with communities, but with volunteers, staff, local government structures, stakeholders and partners. The potential information network should be mapped prior to the project implementation to be inclusive of the various actors and therefore strengthening the approach of *aid as information*.

Key recommendations

- Strengthen future projects by building an effective feedback mechanism at the inception phase, which also includes appropriate testing and piloting.
- SLRCS should look beyond its own resources and capabilities and identify other partners to help engage and respond to community needs, such as hardware and upskilling.
- Develop an advocacy component for volunteers and communities, and link with local governance.
- Strengthen results through identifying and implementing appropriate monitoring and evaluation methods – train staff on the monitoring and evaluation approach, including the logframe.

Table 7: Key learning from the project

Project component	Key learnings	Recommendations for future projects
Messages	*Message development* - Developing messages with communities was good practice and increased trust between Red Cross and communities - Communities engaged in message development are more likely to engage with project activities *Methodology for delivering messages* - Drama is an excellent format for delivering messages – especially topics of a sensitive nature, such as EVD – to all groups, regardless of age or gender - FGDs and household visits targeted specific groups and provided essential checks on quality of knowledge attained - Radio is more likely to be accessed by men, especially in rural areas	- Strengthen projects by building message development into feedback mechanisms, making sure suitable time is built into projects to develop and refine messages with target groups and communities - Methodology to continue in future projects - Develop pictorial checklists to ensure key messages have been learnt by households/individuals - Review use of radio if specifically targeting women and children
Volunteers	- Recruitment and retention of volunteers (without incentives), particularly in hard-to-reach areas, is a unique selling point of the Red Cross - Volunteers were given agricultural land by communities, but did not have the tools or seeds to cultivate the land - Volunteers could develop and establish drama groups as an income-generating scheme - Criteria developed for volunteer selection were not used	- National Society can use unique selling point to engage and partner with other stakeholders who find it difficult to access hard-to-reach communities and recruit volunteers - Identify funding for income-generating schemes (e.g. agricultural tools and seeds) - Provide training to volunteers on marketing skills and micro-finance - Develop volunteer recruitment criteria with community leaders and support decision makers
CEA approach	- Approach worked well and provided systematic way of engaging and working with communities - Use of *information as aid* would have been strengthened by integrating relevant hardware - Approach ensured that delegates went back to communities after initial consultation to verify findings, helping to change practice of SRC delegates in working with communities - Communities developed by-laws, which sustained behaviour change - Feedback needs to be planned, systematic and a two-way process - Need to have a clear action plan on how to give and who will address feedback - Even in an emergency/post-emergency it is important to have feedback mechanism	- Strengthen future projects by embedding CEA into future project designs - Identify partners for future projects that can provide hardware - Publicise how CEA has changed practice of SRC delegates and national staff - Include policy-level advocacy component in future designs for community information work - Manage community expectations about what projects can/cannot provide - Ensure proper communication back to communities on what project staff and volunteers are doing to address community concerns - Develop and design a feedback mechanism policy at the inception phase of projects, with guidelines and training to staff on how to implement - Develop case study (2–3 pages) to promote work of SLRCS
Strengthened monitoring and evaluation	- Handheld or mobile device technologies would have improved data collection, reduced paperwork and helped with more timely reporting - Reporting of project results could have been strengthened with quantitative data	- Use technology to improve data collection and help with internet access - Strengthen projects by using quantitative data such as household surveys at both baseline and endline - Train staff on project rationale and Logframe

	- Project staff may have better understood project if they were more familiar with logframe - Unexpected delays directly affected delivery and results of project in seven districts in third year	- Continue to support project staff to stop, reflect and review logframe against timelines and capacity of staff
Surveys and evaluations	- Communities readily engaged with survey and evaluation process - EIA assessment is only one known to have been conducted on EVD – findings and recommendations may be of use to emergency in Democratic Republic of Congo	- Feedback evaluation findings to communities - Review findings and recommendations of EIA, particularly in relation to correct disposal of PPEs and long-term impacts in places of burial of body bags containing EVD victims.
Exit strategy	- Lack of specific exit strategy potentially weakened project's sustainability	- Develop exit strategy before implementation and update document regularly - Build advocacy component into exit strategy

Appendices

Appendix I: Project documents

- Results Assessment Memo for Sierra Leone 2017
- SRC Project Management Report, Jan 2017–Mar 2019
- Monthly Project Reports
- List of Annexes for Final Report on CEA for Post-Ebola Recovery in Sierra Leone
- SRC Project Management Report, Jan 2017–Mar 2019
- Monthly Reports
- SRC Funding Proposal, Jan 2016
- SRC Funding Proposal, Oct 2016
- Environmental Impact Assessment Report, Feb 2017
- Environmental Impact Assessment Report (Appendices), Feb 2017
- CEA for Post-Ebola Recovery in Sierra Leone, Report on Pilot Programme in Kailahun District, January 2018
- SRC Funding Proposal, May 2018
- CEA for Post-Ebola Recovery Programme Baseline Assessment Report, June 2018
- CEA for Post-Ebola Recovery, Endline Assessment Report, March 2019
- Views of and Attitudes towards Ebola, Listening Study Findings, SRC, 2016
- A Red Cross Red Crescent guide to Community Engagement and Accountability (Pilot Version), ICRC, 2016
- Sierra Leone Red Cross Society Strategy Road Map, SLRCS, May 2014–2018
- Humanitarian Strategy of the Swedish Red Cross for 2016–2019, SRC, 2015

Appendix II: Key informants

Organisation	Title	Name
DHMT, Kailahun	IPC supervisor, previously District Social Mobilisation 2	Justin Tambawa
Finnish Red Cross	Regional programme delegate for West and Central Africa	Sophia Itämaki
Gbanyawalu community	Red Cross volunteer	Margaret Tsaffa
Jalla community	Imam and Red Cross volunteer	–
Kpelamu community	Red Cross volunteer	Margaret James
MOHS	CHO, Jalla Community Health Facility	Martin Brima
MOHS	State-enrolled community health nurse, Foidu Community Health Post	Mohamed Sillah
SLRCS	CEA officer, Kailahun	Augustine Amara
SLRCS	CEA programme manager	Stella Tucker
SLRCS	Director of programmes	Nelson Nyandemoh
SLRCS	Director of resource mobilisation and communications	Yusuf Kamara
SRC delegate	WASH specialist/EIA consultant	Erik Pettersson
SRC delegate	M&E specialist/CEA baseline survey	Lydia Atiema
SRC delegate	M&E specialist/CEA endline survey	Maika Skjonsberg
SRC delegate	M&E specialist	Lauren Smith
SRC staff member	Desk officer, West Africa/Organisational development delegate, Liberia	Malin Bohlers
SRC delegate	Environmental specialist/EIA consultant	Gavin Reynolds

Appendix III: SRC delegates and duration of visits to Sierra Leone

Year	SRC technical support	Duration of visit to Sierra Leone
2016	Environmental impact assessment team leader (delegate)	10 months – 2 separate missions Some months were done remotely
2016	Environmental impact assessment delegate	4 months
2017	CEA delegate	4 months – divided between two missions
2018	Baseline delegate	1 month
2019	MEAL delegate	3 months
2016–19	SRC desk officer for West Africa SRC CEA advisor	Short visits carried out throughout the project period

Appendix IV: Volunteer selection criteria developed during pilot phase

Required criteria	Preferred criteria
• Must be an active SLRCS volunteer (have received Red Cross volunteer training and/or will be debriefed by senior volunteer before training, with plans to be included in next planned Red Cross training to allow for requirement of community-based volunteers in targeted communities) • Must be community based and preferably former EVD SLRCS Social Mob or Beneficiary Communication volunteer and/or PSS • Must not have criminal record • Must have basic community engagement skills (such as drama) • Must understand and speak the local language of the community, including Krio • Must be flexible • Must understand the norms of the community • Must be available to volunteer 3 hours, 3 days per week	• Active SLRCS volunteer • Drama experience • SLRCS beneficiary communications experience

Appendix V: Logframe and results

Community engagement and accountability for post-Ebola recovery logframe						
Objectives	Indicators	Means of verification	Assumptions	Baselines	Targets	Endline results
Goal: Contribute to re-establishing community trust	% of community members that trust healthcare providers in the facilities and communities	Baseline and endline assessment reports	Communities will overcome myths related to healthcare workers	74%	100%	100%
	% of community members that believing that an Ebola patient can get well			66%		88%
Outcome 1: Increased knowledge of key messages on Ebola, malaria	% of community members that correctly identify at least three ways that Ebola is transmitted	Baseline and endline assessment reports	Interest from community members to participate in the session	86%	100%	100%
	% of community members that would buy food items from Ebola survivors			68%		85%
	% of community members that would welcome survivors to their home			85%		96%
Output 1.1: Key health messages developed	Number of key health messages developed	Messages in Temne, Kono, Mandigo, Limba, Fula, Korako and Susu available	Translations into local languages are done accurately and timely (Mende, Krio and Kissi already available from 2017)	16	26	26
Output 1.2: Volunteers in the selected districts are recruited	Number of signed agreements with volunteers in 2018	The Agreements with volunteers are signed and entered in the volunteer register	The volunteers are available for planned activities including training	70 (female 37, male 33)	315 total (female 173, male 142)	315 (138 female, 177 male)
Output 1.3: Community-based volunteers trained in CEA and Forum Theatre.	Number of male and female volunteers trained on CEA and Forum Theatre in 2018 in 8 districts	Participant lists and training reports from each district	Volunteers completed training in CEA and Forum Theatre. Note: refresher training in Kailahun	70 (female 37, male 33)	315 total (female 173, male 142)	316 (138 female, 177 male)
Output 1.4: Focus group discussions conducted by CEA volunteer team	Number of focus group discussion conducted by CEA volunteer team leaders for target groups by December 2018	Completed monthly report form from volunteers	FGDs successfully carried out	25	50	680

leaders	Number of males and females reached during FGD by December 2018	CEA district officer report		268 (male 133, female 135)	500 (male 200, female 300)	15,619 (male 3,852, female 4,819, boys 3,063, girls 3,887)
Outcome 2: Target communities adopt and consistently practise key recommended behaviours	% of community members avoiding bushmeat (monkeys and bats)	Baseline and endline assessment report		39%	90%	88%
	% of community members reporting all suspicious deaths and illnesses to a health worker	Monthly report from volunteers – observation in communities during HH visits		50%		–
	% of communities utilizing mosquito nets			50%		81%
	% of women in communities that breastfed their babies up to six months			70%		89%
	% of women in communities that take their children for vaccination			70%		–
	% of community members that have known on proper hand-washing.			70%		–
Output 2.1: Community Forum Theatre performances conducted in each community regularly	Number of Forum Theatre performances conducted where messages were shared and discussed, addressing concerns and attitudes/beliefs	Completed monthly report form from volunteers CEA district officer report	Forum Theatre performance successfully carried out	227	590	1,330
Output 2.2: Focus group discussions conducted by CEA volunteer team leaders	Number of focus group discussion conducted by CEA volunteer team leaders for targeted groups by December 2018 Number of males and females reached during focus group discussion by December 2018	Completed monthly report form from volunteers CEA district officer report	Focus group discussion successfully carried out	25 Male 133,female 135 (total 268)	50 Male 200,female 300 (total 500)	–
Output 2.3: Community radio shows broadcasted	Number of radio spots and interactive programmes produced and broadcasted (no. of emissions).	Support supervision report outlining text messages and call-ins during programming	Radio station signed MOU and pre-recordings completed	1	8	9

	Number of community radio talk shows, soap opera broadcasted			1	8	9
Output 2.4: House-to-house sensitization visits conducted.	Number of households visited by CEA volunteers by December 2018	Volunteers report form CEA district officer report		7,577	20,000	30,800
	Number of males, females, and children reached through house to house sensitization.			41,063 (men 13,394, women 13,690 and 13,979 children)	125,000 (male 40,000 female 45,000 children 40,000)	144,510 (male 39,753, female 44,405, children 60,352)
Outcome 3: Community members can provide feedback on the programme, which is acted upon and responded to.	% of feedback received, addressed and communicated to the community within two weeks	Feedback register		N/A	100%	No
Output 3.1: Feedback mechanisms set up	Presence of guidelines highlighting feedback channels and functioning of the mechanisms	The Guidelines		N/A	Feedback handling guidelines	Guidelines updated

Appendix VI: By-laws developed by communities in Kailahun

Community name	By-laws developed by communities
Gbanyawalu **Fines ranged from 15,000–30,000L**	- Do not keep someone sick in the house – should refer to health facility; if do not, there is a fine - If there is a stranger in the community, this must be reported to the chief - Need to empty child stool - If asked to clean the community by the chief and we don't, then there is a fine - If seen eating a dead animal, including bats
Belu **By-laws have a fine of 50,000L**	- Strangers in village must be reported to the chief – if there is no relation to anyone in village, then should not stay - Avoid dead animals and do not bring them into the village – if going to eat go into the bush and eat by yourself - Sick man, woman or child refer to hospital – if take drugs not prescribed by medical person, will be fined - If someone dies, then authorities need to be called - All pregnant women should go to health facility – mandatory - Keep environment clean - Stool for children, if don't take care and anyone sees it, will be fined - Children must be immunised
Kpelamu **Fines originally started at 10,000L, but it was too low and increased to 50,000L**	- Allow strangers into the village, but leaders need to be informed - Do not eat dead animals - When sick, refer to health facility for treatment – if keep sick person at home there can be a fine - Keep environment clean – first Saturday of every month there is cleaning, but we are monitored every day on clean environment - When someone dies, must call health authority - If child does a stool and it's not removed, then get a fine
Jalla	- If animals die, even a rat, should use a shovel to get rid of it - Pregnant women must go to the health facility - Treat water before drinking - When child does a stool, should clean it immediately - If some is sick, must report to the health facility - Should not eat any animal that died on its own: goat, sheep, beef – all meat, including bushmeat - When someone dies, don't bury them until seen by medical person - If a stranger comes to the community they should be reported to the chief - Handwashing – before/after toilet wash hands
Pondu	- Keep community a clean environment – last Saturday of the month to clean the area - Avoid bushmeat – don't eat dead animals - Proper use of bed nets – don't misuse mosquito nets (i.e. not for fishing) - When someone is sick, go to the hospital
Foidu **50,000L fine**	- If stranger comes into home, must inform community leader - Keep environment clean and attend cleaning last Saturday of the month - Do not bring dead bushmeat into the community

Note: L = Leone

Endnotes

[1] SRC, Funding Proposal, October 2016

[2] http://kslp.org.uk/about-kings-sierra-leone-partnership/ebola

[3] https://en.wikipedia.org/wiki/Sierra_Leone_Red_Cross_Society

[4] http://sierraleoneredcross.org/about-us-who-we-are/management-of-slrcs/

[5] SRC, Funding Proposal, October 2016

[6] Ibid

[7] https://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2018/08/Green-Response-Snapshot-March-2018.pdf

[8] SRC, Funding Proposal, October 2016

[9] SRC, Report on Pilot Programme Kailahun District, January 2018

[10] https://media.ifrc.org/ifrc/what-we-do/community-engagement/

[11] SRC, Funding Proposal, May 2018

[12] Although the project outcomes for the third year indicated messages were for EVD and malaria, in practice these were extended to diarrhoea, immunisation, breastfeeding, sex and breastfeeding.

[13] In June 2017, 70 volunteers were trained (41 men, 29 female).

[14] SRC, Funding Proposal, October 2016

[15] To be discussed with SRC and SLRCS.

[16] Definitions from: www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

[17] See Appendix II for list of key informants.

[18] KII EIA lead delegate – an internet search did not find any other EIA similar to this study.

[19] EIA Report of the Red Cross Response to the Sierra Leone Ebola Virus Disease Epidemic, February 2017; KII SRC delegate

[20] Although some questions remained in relation to environment, which focused on safe farming (e.g. if it was safe to farm on land where there has been ETCs, cemeteries, etc.).

[21] KII SMT staff, SLRCS

[22] For example one interviewee said “We work for our community, because they are part of us”, FGD volunteers, Kailahun.

[23] FGDs Kailahun; FGD CEA officers and district branch managers

[24] FGDs in six communities in Kailahun

[25] CEA for Post-Ebola Recovery, Endline Assessment Report, March 2019

[26] FGD volunteers, Kailahun, KIIs volunteers

[27] FGDs, KIIs in six communities in Kailahun

[28] KII SRC; Results Assessment Memo For Sierra Leone 2017

[29] During KIIs it was stated by the CEA programme manager, CEA officer, Kialahun, DHMT, Kialahun they attended cluster meetings

[30] KIIs volunteers Jalla, Kpelamu

[31] KII female volunteer, Kpelamu; FGDs men’s group and youth group, Gbanyawalu

[32] KIIs CEA programme manager, SMT SLRCS; FGD CEA officers and district branch managers

[33] Ibid.

[34] CEA for Post-Ebola Recovery, Endline Assessment Report, March 2019

[35] CEA for Post-Ebola Recovery Programme, Baseline Assessment Report, June 2018

[36] CEA For Post-Ebola Recovery, Endline Assessment Report, March 2019; KII SRC delegates

[37] CEA for Post-Ebola Recovery, Endline Assessment Report, March 2019

[38] FGD women's group, Pondu

[39] FGDs men's and women's groups, Kpelamu

[40] See behaviour change targets in Logframe: outcome 2.

[41] CEA for Post-Ebola Recovery in Sierra Leone, Report on Pilot Programme in Kailahun District, January 2018

[42] FGDs Kailahun; KIIs SRC delegates

[43] FGD chief, Belu

[44] FGD CEA For Post-Ebola Recovery, Endline Assessment Report, March 2019; FGDs youth group Gbanyawalu, men's and women's groups, Kpelamu, community leaders, Jalla

[45] CEA for Post-Ebola Recovery in Sierra Leone, Report on Pilot Programme in Kailahun District, January 2018

[46] Ibid.

[47] CEA programme manager

[48] FGDs Kailahun

[49] A total of 18 communities: six communities in Kailahun, 12 of 14 communities in the endline report.

[50] FGDs Kailahun; Endline Assessment Report, March 2019

[51] KII, FGD in Kailahun; CEA for Post-Ebola Recovery, Endline Assessment Report, March 2019

[52] FGD women's group, Kpelamu

[53] FGDs men's group, Foidu, women's group Belu, youth group Gbanyawalu

[54] CEA for Post-Ebola Recovery, Endline Assessment Report, March 2019

[55] Views of and Attitudes towards Ebola, Listening Study Findings, SRC, 2016

[56] Schoolchildren Foidu and Jalla communities

[57] FGDs Kpelamu and Gbanyawalu

[58] KII CHO, Jalla Health Facility

[59] A Red Cross Red Crescent Guide to Community Engagement and Accountability (Pilot Version), ICRC, 2016

[60] FGDs Kailahun; KII SRC delegate

[61] KII CEA officer, Kailahun; FGD women's group, Belu

[62] KII Volunteer, Jalla

[63] KIIs SRC delegate, SRC staff

[64] Delays were caused by 1) the presidential election and 2) a change in SLRCS management.

[65] FGDS and KIIs Kailahun; CEA For Post-Ebola Recovery, Endline Assessment Report, March 2019; Project monthly reports; CEA for Post-Ebola Recovery in Sierra Leone, Report on Pilot Programme in Kailahun District, January 2018

[66] CEA For Post-Ebola Recovery, Endline Assessment Report, March 2019

[67] FGDs in six communities Kailahun; FGD volunteers; KII volunteers; KII CEA officer

[68] CEA for Post-Ebola Recovery in Sierra Leone. Report on Pilot Programme in Kailahun District, January 2018; KII programme manager

[69] CEA For Post-Ebola Recovery, Endline Assessment Report, March 2019

[70] KII SRC delegate

[71] FGD CEA officers and branch managers

[72] This was an issue caused by disbursal of funding between SRC and IFRC.

[73] FGDs Kailahun; CEA for Post-Ebola Recovery, Endline Assessment Report, March 2019

[74] FGD CEA officers and branch managers; CEA programme manager

[75] KII DHMT, Kailahun; KII programme manager

[76] FGD CEA officers and national branch managers; CEA programme manager

[77] KIIs SMT SLRCS; KII programme manager

[78] KII SRC delegate; KII SRC staff

[79] Ibid.