# Process Evaluation of the Irish Aid COVID-19 Funded Response in Sierra Leone

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## Executive Summary

Concern Worldwide (CWW) contracted Institute for Development (IfD) to conduct a process evaluation of the Irish Aid COVID-19 funded response in Sierra Leone. A consortium of three international non-governmental organisations (NGOs), with Concern Worldwide as the lead agency, implemented the project. The project used an adaptive approach, and consortium partners were keen to reflect and learn from the processes used so that they could apply their learning to future projects. The objective of the evaluation, therefore, was to review the project processes, extract and document the best practices of the adaptive approach adopted by the partners, provide recommendations and compile lessons learnt in a document that could be used for future humanitarian and adaptive programming.

At the consortium's request, IfD used a participatory process evaluation approach to understand how the project was implemented and adapted. This report reflects a comprehensive assessment of the adaptive processes implemented and documented by the partners and incorporates the perspectives of the main actors on the adaptive approach. It is worth noting, however, that this report largely reflects the perceptions of staff of the consortium partners that implemented the project and draws heavily from project reports. These views were not independently verified through interviews with local stakeholders or beneficiaries.

**Key findings**

An adaptive and reflective approach was clearly articulated in the project design phase and incorporated in the original proposal as a critical element of project success. Contextual changes and the potential for shifts in priorities were anticipated in the design as risks that would be mitigated by an adaptive approach" [1]. Project adaptations to respond to other shocks besides COVID-19 were anticipated, and the project proposal included a statement of intention to seek approval from the donor for adaptation and budget realignment in the event of other shocks.

There was an emphasis on using data to inform decision-making to ensure vulnerable groups are served, and the project produced the intended results. The consortium partners monitored the external environment in the changing pandemic context and used external and internal data sources to identify the need for change. The original project proposal was revised to articulate the changing context and the changes in assumptions on which the implied project theory of change was built.

Results from M&E data were applied to identify the need for adaptation and to justify the repurposing of funds. The M&E framework was adjusted where appropriate, clearly stating the indicators that were adjusted downward and where the targets remained the same. Adaptation was incorporated into the budgeting process. The original budget was revised to reflect the adaptations. The adaptive budgets of all partners clearly spelt out the areas where changes were made and the reason for the changes.

A high-level project management team was operationalised comprising of country directors, program managers and senior managers of the partner organisations to provide strategic oversight of the project. Monthly senior management meetings were held with the main goal of reviewing project performance and facilitating learning. A project coordinator appointed by Irish Aid provided overall coordination and promoted inter-organisational coordination and shared learning working with Concern's Program Director. Concern Worldwide was appointed as the lead agency for facilitating learning. There was an M&E working group comprised of the M&E and data collection teams of the various partners. The team put in place a consolidated system of data collection, analysis, and reporting; met virtually and worked together under one M&E framework, harmonised tools, and indicator definitions. Monthly and semi-annual reports and periodic survey reports were produced and disseminated to relevant stakeholders. The monthly reports provided updates on COVID-19 and on each partner's activities, risks, challenges learning and recommendations for

adaptations. The existence of structures to facilitate learning, use of data to inform decision-making and adaptations, the involvement of local stakeholders in decision making and the use of feedback from stakeholders to make adaptations and improve performance are indicative of good adaptive programme management practices [2,3].

Project financial and narrative reporting tools were developed and discussed at an initial start-up meeting, including initial changes likely to be made. These templates were made available to implementing partners to guide reporting. Joint monitoring and supportive supervision of project activities with local stakeholders provided an opportunity to observe challenges, identify the need for modifications and communicate the need for adaptation. Partner coordination meetings were conducted to share updates, plans and discuss challenges. Community engagement preceded interventions in most communities. This provided an opportunity to involve community leaders, community contact persons and direct beneficiaries in decisions about practical steps to follow to protect themselves from COVID-19.

Changes in context were monitored through internal M&E data, assessments, national surveys, official reports, and information gathered through active participation in response pillars to inform the adaptive approach. Internal consultative meetings were held to discuss observed changes and feedback from consultations with local stakeholders. COVID-19 transmission rates and project performance were monitored and communicated to all partners and relevant stakeholders through well-structured monthly reports that included a section on each partners activities, challenges, achievements, and recommendations. Monitoring field visits, face to face meetings, phone calls, regular coordination and quarterly project steering committee meetings, Lead Mother monthly meetings; monthly Community Led Action (CLA) meetings and National and District coordinating meetings on food and nutrition security were also used to exchange feedback, track the progress of implementation, lessons learnt, and challenges.
The relevance of the adaptations implemented was ensured through active stakeholder involvement not only in identifying needs but also in targeting and service delivery. The M&E performance data showed mixed results [Appendix 8.4]. This implies that the extent to which the project adaptations promoted or hindered project impact cannot be ascertained from the available data.

Evidence from project reports, focus group discussions, and key informant interviews point to the fact that the adaptive approach promoted humanitarian standards such as targeting and accountability, among other attributes. In terms of targeting, the project used available secondary and primary data sources and needs assessments to identify needs for change. The feedback received from local partners and stakeholders were relied on to make changes.

## Lessons learnt

An adaptive approach to programming can work in an emergency context without budget overruns if deliberately incorporated in the project design and thoughtfully implemented using evidence to inform adaptations and an information system to facilitate a continuous learning cycle.
Working closely with national structures and local stakeholders improves the relevance and potential effectiveness of adaptations. However, the expectations of local stakeholders for participation in project activities and their timelines for the completion of response activities and sharing of critical information on which project interventions depend were not always in sync with project plans. The expectations of these stakeholders should be anticipated and effectively managed, and provisions made to strengthen anticipated weaknesses in local structures to ensure timely service delivery.
The participation of women in project activities was lower than planned. This gender disparity is typical in national and local emergency response structures, with which the project collaborated. A gendered adaptive approach to programming that is not only gender-sensitive but also gender-transformative should go beyond the use of formal tools to assess the level of integration of gender. It would require additional efforts to improve the participation of women in project decision-making.

The operationalisation of a high-level management team to promote learning and facilitate adaptations is not likely to lead to timely delivery of activities if the team is not empowered to authorise budget allocations under pre-specified conditions without recourse to the donor when the evidence supports adaptations.

## Best practices

Some of the good practices from this project that could be replicated in future programming include the following:

i. An adaptive approach was integrated into the project design and implementation to reflect the changing nature of the crises and communicated to all partners. Adaptations were thoughtful and deliberate, based on evidence, consensus with stakeholders and the availability of resources that could be adapted. Changes were within the overall project goal and were done without overspending. They were intended to improve project effectiveness and were informed by the changing needs of beneficiaries.
ii. Learning was built into the project with a clearly defined budget line to support learning, a designated partner (Concern Worldwide) to champion learning, and a senior project coordinator to coordinate learning activities. A senior management team comprising of Country Directors and other Senior Managers of the consortium partner organisations was responsible for reviewing evidence and recommending adaptations for approval by the donor.
iii. The adaptive project was implemented by a consortium of like-minded organisations with complementary experience in humanitarian response. Local partners that formed part of the consortium were experienced in implementing health emergency response interventions in the target communities. The consortium had clear targeting criteria agreed with the relevant National and District Emergency structures, relevant line ministries and local stakeholders to reach the most vulnerable communities.
iv. The consortium utilised a Community Led Action (CLA) approach that uses a systematic five-step process to engage communities and encourage behaviour change.

## Recommendations

Complex adaptive systems convert data into evidence that is used to inform practice and further adaptations in a continuous feedback cycle of learning and improvement. The critical elements of an adaptive approach are management that is committed to promoting a culture of continuous learning, a systematic process of data collection and analysis, the application of evidence to inform adaptations and implementation of activities, stakeholder and beneficiary involvement in decisions and continuous refinement of outcomes to improve project effectiveness [2, 7]. The consortium's COVID-19 response had several elements of an adaptive system. Future programming could build on and strengthen these elements.

The recommended approach to adaptive programming is to systematically document changes in real-time at all stages of implementation, no matter how small. The consortium partners documented changes in the budget and M&E framework as they happened, but partners could improve information about how the adaptive approach affected outcomes by adopting a comprehensive real-time process of documenting who, how, when, and why changes were made and the effect of changes using a simple tool [7] besides the budget or M&E framework.

Adaptive projects are implemented in environments that are characterised by fluidity which implies that decisions about adaptations and budget allocations to support changes must be made promptly. An adaptive project management team should have the authority to approve adaptations and reallocate funding to meet the need without recourse to bureaucratic processes. Future projects could ensure that contracts to implement adaptive projects include the authority to make budgetary allocations to support adaptations based on prespecified criteria, particularly allocations that do not affect overall project objectives or require overspending on the budget. Prespecified criteria could be based on a clearly articulated theory of change that includes causal assumptions that are closely monitored. Adaptations are warranted when these assumptions break down [3].

Future adaptive projects could improve on the good relationship with local stakeholders developed and maintained by the consortium during the implementation of the COVID-19 response project by anticipating and managing stakeholders' expectations and by making provisions to strengthen anticipated weaknesses in local structures to ensure timely service delivery.

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## List of Abbreviations

| | |
|---|---|
| AAD-SL | Action for Advocacy and Development Sierra Leone |
| COVID-19 | Coronavirus Disease (which is caused by SARS-CoV-2) |
| CWW | Concern Worldwide |
| DHMT | District Health Management Team |
| DiCOVERC | District Corona Virus Disease Emergency Response Centre |
| GOAL | GOAL Sierra Leone |
| KADDRO | Kambia District Development and Rehabilitation Organization |
| MOHS | Ministry of Health and Sanitation |
| NaCOVERC | National Corona Virus Disease Emergency Response Centre |
| PHU | Peripheral Health Units |
| SEND-SL | Social Enterprise Development Sierra Leone |
| WHO | World Health Organization |

# 1.0 Introduction and Project Description

## 1.1 Introduction

### Background and project justification

Sierra Leone reported the first case of coronavirus infection in March 2020. Less than three months from the first confirmed case, almost all districts had reported a confirmed case. Despite the social distancing and other measures put in place by the government, the number of cases was rising. Accompanying the increase in positive cases was the growing number of patients in isolation centres and quarantine facilities. Due to the high level of risk and vulnerability of Sierra Leone, the United Nations Global Humanitarian Response Plan to COVID-19 was updated on the 7th of May to include Sierra Leone on its list of priority countries. As of 11th of June 2020, when the Irish Aid COVID-19 response project was conceived, there were 1,085 confirmed COVID-19 cases with 50 deaths reported in 15 out of 16 districts in Sierra Leone. A total of 1,652 people were in quarantine, with 52.8% of these (872 being in self-quarantine) [1]. Infections and deaths were heavily concentrated in the Western Area Urban and Western Area Rural Districts. Health care workers were identified as particularly at-risk groups with a case fatality rate of 12.3% compared to 4.6% in the general population [1]. The increasing number of cases was seen as a threat to Sierra Leone with the potential to overwhelm and collapse the already weak health and social systems. The consortium partners (Concern, GOAL and Trócaire) understand that, as was the case with Ebola, the COVID-19 pandemic would have potential secondary impacts in terms of increased mortality from other diseases, livelihoods, and education with disproportionate effects on the vulnerable populations such as women and children. Without urgent action, the outbreak could have a devastating effect on urban and vulnerable rural and poor populations. There was a potential for a rapid spread of the infection with the associated loss of trust or reduced access to preventative health care such as routine antenatal care and immunisations, as well as multiple secondary effects in other sectors. As during the Ebola outbreak, women face heightened SGBV risks and reduced access to services. Western Area Urban (Freetown), with the largest number of COVID-19 cases, presented unique challenges., and some women may put up with violent partners as long as such men can provide support to them. The population density and large number of informal settlements in Freetown made social distancing and self-isolation extremely difficult, if not impossible. Partners recognised that there was a need to focus not just on those dying from respiratory illnesses and medical complications linked to the virus but also on the excess deaths among people unable to access treatment and care for other diseases. The Irish Aid COVID-19 response project was implemented to prevent and reduce the rapid spread of the virus and to ameliorate the secondary impact of the pandemic.

### Project aims

The COVID-19 response project had the following specific objectives:

1. Contribute to the national effort to increase awareness of the key risks and other information on COVID-19 among both urban and remote rural communities to counter misinformation and help prevent and reduce the spread and impact of the coronavirus pandemic.
2. Strengthen and enable the more effective functioning of government quarantine facilities and the District Emergency Operation Committees (DEOC) and Community Care Centres (CCCs)

3. Implement actions to support quarantined households and vulnerable communities at risk of severe socio-economic instability to mitigate the corollary impact of the virus on the food security, livelihoods, and wellbeing of vulnerable populations.

## 1.2 Project description

The COVID-19 Response project was funded by Irish Aid and implemented by a consortium of three international non-governmental organisations (NGOs); Concern Worldwide (consortia lead), GOAL and Trócaire. The project's overall objective was "to strengthen community's resilience to prevent and reduce the spread and impact of the coronavirus pandemic" in nine districts in Sierra Leone [1]. The project was implemented in selected communities; Bombali, Bonthe, Kambia, Kenema, Koinadugu, Moyamba, Port Loko, Tonkolili and Western Area Urban. Concern Worldwide (CWW) and GOAL explicitly implemented project activities while Trócaire's activities were implemented through its local partners; Action for Advocacy & Development Sierra Leone (AAD-SL), Kambia District Development & Rehabilitation Organization's (KADDRO), and Social Enterprise Development Sierra Leone (SEND-SL). The partners initially planned the project for eight months (1st July 2020 to 28th February 2021) but obtained a no-cost extension to implement activities to 30th April 2021 due to delays in the implementation of some activities.

Project beneficiaries were vulnerable households and individuals in target communities at risk, exposed or affected by the COVID-19 pandemic. It aimed to reach 314,740 beneficiaries (274,390 direct beneficiaries and 40,350 indirect beneficiaries)[1]. As described in the original proposal, the consortium and its local implementing partners had the initial objectives to (i) improve knowledge of infection prevention and control (IPC) and adoption of measures to prevent/reduce transmission of COVID-19 in nine targeted communities (ii) Support the effective operation of quarantine facilities, community care centres, and district structures (iii) Mitigate the secondary impact of COVID-19 and other regular disasters (e.g. higher levels of SGBV and flooding events) on the food, health, and income security of vulnerable populations.

To accomplish its objectives, the consortium put in place a high-level project management team comprising of country directors, program managers and senior managers of the partner organisations to provide strategic oversight of the project. A project coordinator appointed by Irish Aid provided overall coordination, supervised implementation, and promoted inter-organisational coordination and shared learning under the supervision of Concern's Program Director. Project implementation was further enhanced with monthly updates and review meetings between Consortium partners and Irish Aid, during which adaptations were discussed and agreed upon.

Each consortium partner, including the local partners, had a budget to fund delineated activities in target communities and an M&E framework that fed into a consolidated budget and M&E framework managed by CWW. The M&E working group had representation from each of the three consortium partners. The consortium also maintained a consolidated system of data collection, analysis, and reporting. The consortium adopted an adaptive approach to achieve the overall goal of the project.

## 1.3 Evaluation objectives

The overall objective of this evaluation was to conduct a process evaluation of the Irish Aid COVID-19 response in Sierra Leone with a focus on the adaptation and reprioritisation of project activities made by the consortium and local implementing partners. The specific objectives of the evaluation are as follows:

1. Extract and document the lessons learned and best practices of the adaptive approach adopted by the partners and provide recommendations for future adaptive programming.

2. Solicit and incorporate partner feedback to compile lessons learned and best practices in a document that could be used as a learning resource for future humanitarian programming by both the implementing organisations and Irish Aid.

## 1.4 Evaluation questions

The evaluation objectives were addressed through comprehensive answers to the evaluation questions in table 1.

**Table 1: Project evaluation questions**

| No | Evaluation question |
|---|---|
| 1 | Was the “adaptation/an adaptive approach” defined in the context of this project? |
| 2 | How was an adaptive approach facilitated in design and implementation phases? How did this differ from design and implementation of past projects? |
| 3 | How was the “adaptive approach” supported and implemented by M&E, procurement, HR, and Finance teams? |
| 4 | Was a theory of change developed, monitored, and reviewed to track progress? |
| 5 | What adaptations were made to the project, and how did these affect the budget and the allocation of resources to achieve outcomes? |
| 6 | How was the “adaptive approach” supported and implemented by local partners? |
| 7 | How did the adaptations affect the capacity of the local partners? |
| 8 | How did the adaptive approach play out well in working with other stakeholders (district authorities, DHMT, DICOVERC, etc.)? |
| 9 | Was the management structure appropriate for the adaptive approach? |

| | |
|---|---|
| 10 | What data, processes, mechanisms, and tools supported the adaptive approach? |
| 11 | How were changes in context monitored and communicated (internally, to other partners and final beneficiaries)? |
| 12 | What else worked well/what were the success factors in implementing this approach? |
| 13 | How appropriate was the adaptive approach for an emergency response? |
| 14 | What aspects of the adaptive approach could be replicated or scaled-up in an emergency context? |
| 15 | Did the adaptive approach promote or hinder aspects such as the relevance, the coherence and/or the impact of the project? |
| 16 | Did the adaptive approach promote or hinder the implementation of humanitarian standards (in terms of targeting, safeguarding, accountability…)? |

# 2.0 Evaluation Methodology

## 2.1 Data sources

The evaluation team conducted desk reviews of the existing project documents. The following project documents we reviewed: (i) original and adapted proposals, (ii) monthly and semi-annual reports, (iii) initial and revised activity plans, (iii) monitoring plans, (iv) original and adapted budgets, and (v) original and adapted monitoring and evaluation frameworks. The desk reviews were guided by the evaluation questions (Table 1) and were done to extract and document lessons learned from the adaptive approach to project implementation. Project M&E was analysed to compare project targets on key indicators against the end line performance. The original and adapted budgets were analysed to understand the activities that were affected by adaptations made to the project and the magnitude of the changes. Focus group discussions and key informant interviews were conducted with consortium staff to gather firsthand information on the project theory of change and the adaptive approach as implemented by the partners (see appendix 8.4).

## 2.2 Evaluation design

Our overall approach to the evaluation was guided by the implementation science literature on project fidelity and project adaptation [2-6]. A participatory process evaluation approach was used to understand how the project was implemented and adapted; and how it contributed to the planned outcomes. Following desk reviews, we conducted seven key informant interviews with staff from the donor Irish Aid and the consortium partners. The purpose of these interviews was to document their thinking and assumptions at the proposal development stage. This information was triangulated with our preliminary findings from the desk review to reconstruct the project theory of change. We assumed that a useful starting point to evaluate an adaptive project design is a clearly articulated theory of change that defines the mechanisms or pathways of change to achieve the desired impact based on a set of assumptions. When these assumptions do not hold, and new evidence emerges that suggests a need for a change, adaptive designs allow for learning and feedback loops to understand what is working or not working and the flexibility to adapt strategy in response to new information.

The theory of change and the evaluation methodology was presented and discussed at a one-day stakeholder meeting attended by consortium staff responsible for implementing the project. The one-day workshop was conducted in two sessions: plenary and breakout sessions. In the plenary, the evaluator presented the evaluation methodology and the project theory of change, followed by discussions. Suggestions were documented and used to refine project assumptions. In the breakout sessions, focus group discussions were held with workshop participants. Also, during the breakout sessions, key research questions were discussed. The responses were recorded, transcribed, and analysed.

The recommended approach to adaptive programming is to systematically document changes in real-time at all stages of implementation, no matter how small. In the absence of documentation that shows these systematic real-time changes, we used the tool created by Rabin et al. (2018) to retrospectively document the project adaptations [2]. The tool addresses the domains of *Who, How, When, What, and Why* changes were made. Data on project adaptations was obtained from a review of project documents and from key informant interviews with consortium staff. The data

were triangulated with the budget and M&E data to get a comprehensive view of the adaptive approach implemented by the partners.

## 2.3 Ethical considerations

The project evaluation was approved by the management of the Irish Aid COVID-19 response project. Participation in the evaluation was voluntary. Social distancing protocols recommended by the consortium in dealing with human subjects in infectious disease emergency settings were closely followed.

## 2.4 Data analysis

Thematic analysis was used to review project documents. Nineteen documents were critically reviewed using the evaluation questions as a guide (Table 1). Key points that addressed the research questions were identified from each document to serve as codes. Text from the documents supporting these key points was isolated and grouped under each point. The key sentences were reviewed and reorganised to form a coherent response to the research question, and the support text to each point was used to provide additional explanations.

Focus group discussions were transcribed and analysed using thematic analysis aided by Nvivo version 12. Points supporting the response to the research questions were identified and triangulated with findings from the desk review to produce a comprehensive response to the research questions. Microsoft Excel was used to conduct budget and M&E data analysis.

## 2.5 Adaptive approach to project implementation

Adaptive approaches to project management are widely applied in environmental management, business, health, and other sectors. The underlying concept of an adaptive approach is the application of learning to react and respond to changes in an operating environment characterised by uncertainty [4]. Adaptive project management places emphasis on learning, whereby project owners are encouraged to adjust their actions to provide workable solutions to problems that they encounter in real-time [4]. For this evaluation, we conceptualise an adaptive approach as described in the emerging literature on learning health systems. Learning health systems have the "ability to continuously, routinely and efficiently study and improve themselves" [5]. Learning health systems convert data into evidence that is used to inform practice, and further adaptations are made based on evidence in a continuous feedback cycle of learning and improvement. Drawing insights from the literature on adaptive project management, particularly the literature on learning health systems, we applied the following criteria to guide our evaluation of the project's adaptive approach [4-6].

- There is management or leadership that is committed to promoting a culture of continuous learning.
- The project is guided by a clearly defined theory of change with causal assumptions linking activities to outputs, outcomes, and overall impact across the result chain. Intervention strategies are linked to the pathways of change, and there are smart indicators to monitor performance. [In this project, a clearly defined theory was not provided, although one was implied based on a clearly stated vision and M&E framework].

- There is a systematic process of data collection and analysis, the application of evidence to inform adaptations and implementation of activities.
- Evidence is used to continuously appraise assumptions, modify, or adapt activities and allocate resources based on learning.
- There is stakeholder and beneficiary involvement in decisions that directly affect them and continuous refinement of activities or outcomes to improve project effectiveness [2,5, 7].
- Effective communication mechanisms, including the appropriate information technology, are in place to ensure evidence is immediately available to inform practice and practice is evidence-based.

# 3.0 Results

## 3.1 Was an adaptive approach defined in the context of this project?

The consortium clearly stated in project documents that an adaptive and reflective approach would be used to implement project activities but did not expound on what that will entail. Describing the characteristics of what the adaptive approach will entail or articulating the conceptual basis in project documents would have provided a framework for evaluating the project approach. Nevertheless, project designers clearly stated and justified the necessity for an adaptive and reflective approach in several sections within the project proposal. In one statement, they stated, "*Critical to the effective implementation of this project will be flexibility: as agreed with the donor, we will adopt an adaptive and reflective approach to project implementation and monitoring so as to best manage the changing nature of the pandemic, identify new gaps, and respond to emerging needs"*. [1]. The project outcomes and intervention strategies were further regarded in the project proposal as "**initial assessment of expected results and the initial strategies for the intervention".**

Contextual changes and the potential for shifts in priorities based on data were anticipated in the design as risks that would be mitigated by an adaptive approach and participation in "district-level and pillar meetings to coordinate response with government and align with evolving priorities" [1]. Project adaptations to respond to other shocks besides COVID-19 were anticipated, and the project proposal included a statement of intention to seek approval from the donor for adaptation and budget realignment in the event of other shocks. For example, as Freetown is prone to annual flooding, it was proposed that the project would adapt its approach to attend to the need if Freetown experiences flooding during the implementation period [1].

In addition to data from project documents, evidence to support the adaptive approach at the design stage of the project is corroborated by information from key informant interviews with some programme administrators. When asked about whether an adaptive approach was envisioned during the design phase of the project, one respondent replied, "*So, yes, there's a clear vision. …that was right from the beginning, a recognition that it had to be adaptive because you can't predict how it's going to unfold*." In response to the same question, another respondent emphasised that the project had a clear vision and a specified approach and added, "[Yes]*, I think so, because just given the overall context during when the COVID transmission started, the overall project design and the implementation phase had a clear picture, which is linked with the challenges emerging [from] the COVID-19 transmission. So, I think just all the implementing partners … were very clear in terms of what we want to achieve at the end of the day*." Nevertheless, adaptive management goes beyond having a clear vision; the causal assumptions on which the adaptations were based could have been clearly articulated at the project's onset. This could be achieved by articulating a theory of change with clearly defined pathways of change and causal assumptions linking output, outcomes and project impacts across the result chain. If evidence shows that any of the assumptions are invalid, alternative pathways suggested by the evidence should inform the adaptations. The evaluators conclude that an adaptive approach was partially defined. The project clearly articulated its vision to be adaptive and presented a justification for it. However, the pathways of change and causal assumptions were not clearly defined.

## 3.2 How was an adaptive approach facilitated in design and implementation phases, and did this differ from design and implementation of past projects?

The project design recognised the need for fluidity of the pandemic response, so flexibility was emphasised in the original proposal, and the potential for further adaptations was incorporated into the adapted proposal. [8]. This pre-emptive calculation was critical for this project's success as it set the stage for promoting learning, an important characteristic of an adaptive approach.

A senior management team responsible for learning and adaptations comprising of country directors and senior programme managers from partner organisations was incorporated in the project plan. Additionally, a senior project coordinator was identified as the point person for facilitating learning, and monthly senior management meetings were incorporated into the design as the main channels within the consortium for determining project adaptations [1]. There was a clearly designated partner [Concern Worldwide] responsible for supporting knowledge and learning activities of the consortium [9]. A budget line was allocated to support learning activities. Traditional programmes may have a similar structure in place but with limited emphasis on adaptations through learning or specific budget line provided to facilitate learning beyond M&E support.

During the implementation phases, knowledge and learning activities were part of the project targeting strategy. There was an emphasis on using data for continuous learning to ensure vulnerable groups are served and the project produced the intended purpose. All partners contributed to the consortium's consolidated monthly reports that included a summary of their achievements and challenges, district operational areas, and national level COVID-19 trends, risks, and recommendations and reasons for adaptations. Emphasis was placed on using evidence to inform project adaptations, and there was a system in place to communicate evidence to partners and stakeholders, which are hallmarks of an adaptive approach.

The original project proposal was revised to articulate the changing environment and the changes in assumptions on which the project theory of change was built. All the adaptations made, including the evidence to support the changes, were informed by the available data and the need to optimise project impact [9]. This is different from traditional programmes where programme designs are rarely revisited, and learning is applied after the fact. However, directly comparing the partners' adaptive approach with other projects implemented require caution. The evaluation team only focused on evaluating this project and not previous ones, although reference to other projects was sometimes unavoidable.

## 3.3 How was the "adaptive approach" supported and implemented by M&E, procurement, HR, and Finance teams?

### Monitoring and Evaluation

The M&E team supported the adaptive approach in two specific ways:

i. , Learning from M&E data was applied to identify the need for adaptation and to justify the repurposing of funds.

ii. There was a systematic process of data collection, analysis, reporting, and a system in place to communicate information, including the need for change to all stakeholders.

The consortium partners monitored the external environment and the changing pandemic context and used external and internal data sources to identify the need for change. For example, results from a rapid survey conducted by consortium partners were used to identify the decline in the

utilisation of SGBV services between February and July 2020. The decline was associated with the impact of COVID-19 on the capacity of service providers to sustain service delivery and limitations placed on community members to access services. Data from the Sierra Leone Emergency Food Security Monitoring system indicated widespread food insecurity in most project communities, despite the decline in COVID-19 cases in the general population. ]. Other data sources included empirical data such as COVID cases and the number of people in quarantine, as well as statistics provided by staff members of partner organisations who attend DICOVERC meetings. This prompted the partners to request a repurposing of the budget earmarked for the procurement and distribution of cloth facemasks to mitigate the negative impact of COVID-19 on food and nutrition security and to address the increasing concern about SGBV [10]

The close monitoring based on up-to-date data kept the consortium alert. When numbers of SGBV cases visiting service centres were reported to have decreased during a defined period, the warning was apparent, and the consortium adjusted accordingly. Similarly, news about the opening of the border with Guinea when that country was registering high COVID infection rates signalled the need for adjustment of plans and some activities by the consortium. The M&E team developed tools and ensured the harmonisation of data collection and reporting tools across all partners. Similarly, M&E processes also provided the consortium with an opportunity to use a peer review process to enhance the collective work of the group.

An M&E working group was established. The group held coordination meetings to update the M&E framework, discuss and agree on approaches to project monitoring, evaluation and use of results for learning. The consortium established a joint monitoring and evaluation plan to track project indicators and to ensure harmonised monitoring of project impact. The M&E team prepared definitions that spelled out how indicators in the M&E framework could be calculated and interpreted. Adaptations were documented in the M&E framework against the relevant indicators. Joint focus group discussions at the project's end were organised [11]. While the project had an M&E framework with smart output and outcome indicators, it lacked a clearly articulated theory of change. Although the M&E framework was modified to show the indicators that were adjusted and where the targets remained the same, a revised theory of change, including the causal assumptions to reflect the changes, was necessary.

## Finance

The finance team reallocated the budget to ensure there were no budget overruns, but their role in the project is typical of what is normally expected in traditional programming. The original budget was revised to reflect the adaptations, but the flexibility that will allow funds to flow into activities that produce the best outcomes based on data was not built into the budget. Budgetary allocations to support adaptations were subject to the grantees' approval, even though reallocations were within the overall goal of the project. The adaptive budgets of all partners clearly spelt out the areas where changes were made and the reason for the changes. The finance team participated in coordination and monitoring meetings related to the adaptive processes. [20]. Specifically, monitoring of project expenditure was conducted through reviews of monthly partner financial reports and regular visits to partner offices & operations by Trócaire's Programme Accountant and Programme Officer.  These scheduled visits were based on the needs of partner staff.

Adaptive programmes have defined characteristics relating to budget allocations and financial systems. To facilitate flexible and responsive programming, projects must avoid rigid and pre-defined budget allocations; instead, money should flow to activities that produce the best return on the investments, based on evidence. Similarly, projects must allow enough time for budget reallocations to occur [12].

### Procurement

The role of procurement in the project is not well documented; however primary data from the key informant interviews and focus group discussions yielded some insights into how the procurement process affected the choice of implementation strategies, for example, opting for the use of direct cash transfers instead of purchasing diversified food products for distribution to beneficiaries.

#### Human Resources

Responses of key informants indicate that the human resource team played the traditional recruitment role and ensured that new staff vacancies were filled. Data from focus group discussions indicate that even where there were already qualified internal candidates, new positions were filled through a competitive process. However, there were reports of staff leaving in the middle of the project and new staff not properly being oriented to their roles.

## 3.4 Was a theory of change developed, monitored, and reviewed to track progress?

The project had no articulated theory of change beyond the M&E framework. The absence of a clearly defined theory of change has some implications that are worth mentioning. Its inclusion would have provided a clear vision about the pathways of change that the programme is seeking to support and how the different outcomes together contribute to the overall impact. It would also have been useful as a basis on which to reflect on whether assumptions were valid and strategies were working. Programme designers admitted the non-inclusion of this critical component and attributed it to a lack of time. Despite this omission, an implied theory of change can be discerned because the project contained a clear vision and a well-defined M&E framework.

The project had a clear statement of the problem that needed to be addressed and the consortium's initial assessment of expected results. The anticipated impact the project expected to achieve was that "Communities in 9 districts in Sierra Leone have strengthened resilience to prevent and reduce the spread and impact of the coronavirus pandemic". It was estimated that 314,740 people will benefit directly (n=274,390) or indirectly (n=40,350) from the intervention. The preconditions or outcomes that must be accomplished for the project to create the desired impact were (i) Communities have greater knowledge of Infection Prevention and Control (IPC) measures and are implementing measures to prevent/reduce transmission of COVID-19 (ii) Quarantine facilities, community care centres, and district structures are effective and fully operational and (iii) The secondary impact of COVID-19 and other regular disasters (e.g. higher levels of SGBV, flooding events) on the food, health, and income security of vulnerable populations is mitigated. Each outcome had a clearly defined set of activities linked to defined outputs. The project had a consolidated results framework with clearly defined output indicators linked to outcomes and outcome indicators linked to the overall impact. Few assumptions were also included in the result framework against selected outputs and outcomes. Thus, the theory of change that underlies the project intervention can be derived from its result framework. An analysis of the project M&E framework shows three key pathways by which the project will accomplish its overall goal.

**1.0 Community knowledge and action pathway**: The Consortium partners worked to improve community knowledge in IPC measures and ensured targeted communities were implementing measures to prevent and reduce transmission of COVID-19. Activities were implemented to ensure that vulnerable individuals and households in urban communities directly received IPC materials (i.e., soap, facemasks) in the target districts. Approved BCC messages were disseminated in

remote rural and urban communities in public spaces. Water and sanitation infrastructure was strengthened in selected communities to provide clean water and encourage handwashing in target communities/health facilities.

**2.0 Quarantine pathway: Equally important**: Consortium partners sought to strengthen quarantine facilities, community care centres, and those quarantined at home, supporting them to ensure they provided dignified quarantine services. Supported activities were aimed at ensuring that communities knew about and accepted quarantine facilities, staff, patients, and quarantine operations. Partners provided discharge kits (essential food items/ one-off cash) to people living in quarantine and affected households to allow them to recover from the period of unemployment.

**3.0 Secondary impact pathway**: The mitigation of the secondary impact of COVID-19, which is critical to developing the resilience of vulnerable communities, was the third pathway. Interventions were focused on providing the basic needs of quarantine households those severely affected by the COVID-19 pandemic and by the secondary impact of the restrictions in the target districts through the distribution of food, water, cash, and non-food items. Vulnerable households were provided with a safety net to improve their recovery. Caregivers of children under five years were reached with behaviour change interventions on maternal-infant and young child nutrition (MIYCN) practices and COVID-19 prevention to improve the adoption of recommended child health and nutrition behaviours at the household level. Acutely malnourished children 6-59 months were referred to health services to access timely treatment and prevention services. Frontline health workers, Family Support Unit personnel, and social/shelter/protection service providers were trained in SGBV (identification and referral). Sexual and gender-based violence (SGBV) messaging on prevention and response services were disseminated in remote communities.

The extent to which the project would result in the intended impact was based on the assumptions shown in figure 2 [ see appendix 8.2]. When some of these assumptions did not hold, adaptations were warranted to ensure effective alignment of activities to deliver on the project outcomes.

## 3.5 What adaptations were made to the project, and how did these affect the allocation of resources to achieve outcomes?

A hallmark of adaptive programming is using results and learning to make decisions on scaling up, changing tact, or shutting down initiatives (OPM report, 2017). This project met this criterion by shifting priorities from its initial focus of reducing the spread of COVID-19 to addressing its secondary impact on nutrition, SGBV and economic challenges by making cash transfers to individuals and households. This project made adaptations to activities affecting all three outcomes. The shifts in budget arising from the adaptations are shown in Table 2 and the specific changes made are discussed below under each outcome.

Table 2: Project modifications as reflected in project direct cost budgets of the consortium partners

| No | Outcome | Total original project direct cost budget | Total revised project direct cost budget | % Of Total original project direct cost budget | % Of Total revised project direct cost budget | % Within budget line changes due to adaptations |
|---|---|---|---|---|---|---|
| 1 | 1. Communities have greater knowledge of Infection Prevention and Control (IPC) measures and are implementing measures to prevent/reduce transmission of COVID-19. | 319,630.47 | 274,381.52 | 43.6% | 37.4% | -14.2% |
| 2 | 2. Quarantine facilities, community care centres, and district structures are effective and fully operational. | 219,650.34 | 154,267.61 | 30.0% | 21.0% | -29.8% |
| 3 | 3. The secondary impact of COVID-19 and other regular disasters (e.g., higher levels of SGBV, flooding events) on the food, health, and income security of vulnerable populations is mitigated. | 189,646.91 | 302,184.58 | 25.9% | 41.2% | 59.3% |
| | Other direct costs | 3,388.00 | 3,388.00 | 0.5% | 0.5% | 0.0% |
| | Grand Total Direct Project Costs | 732,315.72 | 734,221.71 | - | - | 0.3% |

**Outcome 1: Communities have greater knowledge of Infection Prevention and Control (IPC) measures and are implementing measures to prevent/reduce transmission of COVID-19.**

As indicated in the project log frame, the following outputs must be delivered to accomplish outcome one (i) IPC materials in communities, public spaces, and healthcare centres distributed (ii) MoHS approved behaviour change messaging disseminated in remote rural communities, urban communities, and in public spaces and (iii) Water and sanitation infrastructure at health facilities assessed and strengthened, as necessary.

The total budget allocated to these activities intended to achieve outcome one was reduced from 43.6% of the original direct project costs to 37.6% of the adapted project direct costs. Project adaptations directly affecting outcome one were related to the following:

- Repurposing of Infection Prevention and Control (IPC) budget for food assistance activities and nutrition response.
- Repurposing of budget to increase the repair of non-functional water points and sanitation facilities in the PHUs.
- Repurposing of budget to increase of Community-Led Action (CLA) activity - Mobilisation of local leaders and training mobilisers.
- Distribution of IPC materials to prevent COVID-19 transmission in schools in Kambia Bonthe, Bombali and Port Loko districts. The budget line for fabric face masks distribution implemented by CWW was downsized from 14.3 % of direct project costs to 1.6%, and the projected target beneficiaries were accordingly reduced (See appendix 8.3). The provision of key inputs such as soap, facemask, and other IPC materials in communities and public spaces was scaled down. Funding was reallocated to other activities, particularly for food assistance activities and nutrition response. However, in Bonthe, SEND increased the budget for awareness-raising and COVID-19 prevention campaigns from 3.7% to 4.3% to support IPC intervention in 28 schools. In Kambia, KADDRO added a new activity to raise awareness and prevent transmission of COVID-19 through improved infection prevention and control, targeting 50 schools. The total cost allocated to this activity represents 1.1% of the revised/adapted direct project costs. The activities supported include the provision of face masks and the setting up of handwashing stations. KADDRO, AAD, and SEND supported these activities by reallocating funding from the budget for the activity to support government quarantine facilities and the provision of discharge packages for post-quarantine or post-treatment households respectively.

GOAL's funding to mobilise local leaders and train CLA supervisors was increased from 13.8% to 14.5% of project direct costs. The number of water points and sanitation facilities that needed repairs was increased, and additional funding was allocated to increase the availability of public handwashing stations. GOAL increased funding for water and sanitation facilities from 9.7% to 11.9% of project direct costs by reducing the budget lines for: "provision of meals to patients at CCC", "support quarantine facilities with food package", and "community engagement with chiefdom authorities".

The overall effect of the adaptation on outcome one was that the distribution of face masks led by Concern Worldwide decreased from 14.3% of the original project direct cost budget to 1.9% of the adapted budget, but other activities related to outcome one implemented by other consortium partners increased from 27.2% to 33.3%. This indicates that shifts were partly within outcome reallocations to better align activities.

**Outcome 2: Quarantine facilities, community care centres, and district structures are effective and fully operational.**

Based on indicators in the project log frame, outcome two would be accomplished if: (i) communities near CCCs know about and accept quarantine, CCC facilities, staff, patients, and operations (ii) the functioning of dignified quarantine facilities and/or community care centres (CCC) is enhanced and (iii) discharge kits (essential food items/ one-off cash) provided for people leaving treatment facilities and their affected households to allow them to recover from a period of not being able to earn income. The total direct project cost allocated to deliver outputs under outcome two was reduced from 30.0% of the original budget to 21.0% of the adapted budget. The adaptations were justified because planned activities such as support to quarantine facilities, community care centres (CCC), provision of discharge kits and engagement of Chiefdom authorities on CCCs were no longer necessary in view of the declining COVID-19 cases. Thus all the adaptations made

under this outcome were related to a reduction in activities with no increase or addition of any new activity. Concern reduced funding for CCC discharge kits by 50% from 3.3 % to 1.6% and funding for CCC operational costs by 54% from 3.1% of the original budget to 1.4% of the adapted budget. Target households were reduced by half from 500 households to 250 households. Concern Worldwide applied some of the savings from its budget line adaptations to support the nutrition response, food security and sexual and gender-based violence interventions.

GOAL reallocated all the funding related to community engagement of chiefdom authorities on CCC in Makeni and Moyamba to fund handwashing stations and to cover the budget deficit for repairs of the sanitary systems in PHUs (about 0.8% of the adapted budget). GOAL downsized the budget for the provision of meals for the patients at Community Care centres (CCC) by 50% (from 1.5% to 0.7% of adapted budget) to cover the budget deficit under repair of non-functional water points in PHUs. There was a 63% (from 2.3% to 0.8% of adapted budget) reduction in the budget line for support to quarantine centres with food packages (average of 60 people per district per month), which was repurposed for mobilisation and training of CLA supervisors and repair of non-functional water points in the PHUs.

Additionally, the budget lines allocated to AAD-SL and KADDRO to strengthen quarantine facilities in Port Loko and Kambia, respectively, were downsized. AADSL reduced its budget by 38% (from 4.1% to 2.5% of overall direct project cost) to support awareness-raising and behavioural change promotion in Port Loko and Bombali districts. KADDRO's support to quarantine facilities was downsized by 27% (from 4.1% to 3.0% of overall project direct costs) to support IPC in 50 community schools at the Kambia border with Guinea.

The overall impact of the adaptations on outcome two was a reduction of activities (as measured by budget reductions) of 30% to support other activities, justified by the decline in the number of COVID-19 cases and the mounting evidence that food insecurity and gender-based violence were key issues that needed to be addressed to achieve project overall goal.

**Outcome 3: The secondary impact of COVID-19 and other regular disasters (e.g., higher levels of SGBV, flooding events) on the food, health, and income security of vulnerable populations is mitigated.**

The only output on the project log frame before the adaptations was that the basic needs of quarantined households and other households severely affected by COVID-19 covered in target districts would be met through the distribution of food, water, cash, and non-food items. Following the adaptations, four outputs were added to the log frame as follows: (i) caregivers of children under five are reached with effective behaviour change communications for improved practices on protection, promotion and support of appropriate childcare practices (ii) acutely malnourished children 6-59 months have access to timely treatment and prevention services (iii) capacity of frontline health workers, family support unit personnel, and social/shelter/protection service providers in SGBV (identification, PFA, referral) is strengthened (iv) sexual and gender-based violence (SGBV) messaging on prevention and response services is disseminated in remote communities. Originally, four output indicators were used to track performance under outcome three. The M&E framework was adapted to reflect the reallocation of the budget and adaptation of activities. The M&E team added eight new indicators to monitor performance on the new activities resulting from the adaptations to address the secondary impact of the pandemic. Four indicators were added to monitor and ensure that acutely malnourished children 6-59 months had access to timely treatment and prevention services. Similarly, three indicators were developed to monitor the training of frontline health workers, Family Support Unit personnel, and social service providers in Sexual and Gender-Based Violence (SGBV). Additionally, one output indicator was used to measure the effectiveness of SGBV messaging on prevention and response services disseminated in remote communities. The addition of these indicators helped to demonstrate the responsiveness of the adaptive approach in dealing with both budgetary as well as M&E issues.

The additional activities were related to the nutrition and the SGBV response implemented by Concern Worldwide. These activities accounted for 6.4% and 4.2% of the overall adapted budget, respectively and were intended to address the secondary impact of COVID-19. Nutrition interventions implemented by Concern in Port Loko, Tonkolili and Western Area Urban districts supported the strengthening of district capacity to scale up nutrition promotion, case detection, referral, and treatment of children 6-59 months with acute malnutrition in Tonkolili, Port Loko and Western Area Urban. Activities were heavily focused on training of nutrition focal persons on integrated management of acute malnutrition (IMAM) and maternal-infant and young child feeding (MIYCN), and community health workers (CHW) on mid-upper-arm circumference (MUAC) training to screen children for acute malnutrition and MIYCN. Supported activities also included monthly reviews meeting with the logistics managers (LMs) at PHU, the printing of IEC materials and reporting tools, monitoring and supervision, and replenishment of nutrition supplies from DMS.

The sexual and gender-based violence (SGBV) package implemented in Tonkolili district included (i) training of frontline workers (health workers, social workers, shelter/protection service providers and police/security) on survivor-centred care and approaches, psychological first aid, identification and referral to specialised SGBV facilities, (ii) support outreaches and community engagement and (iii) provision of IEC materials to facilitate awareness-raising and information dissemination on prevention and response services

Funding for the new activities was derived from the repurposing of the budget for face mask distribution and support to quarantine facilities. This was done to address the secondary impact of COVID-19, and after it was determined that the COVID-19 infection rates initially anticipated did not materialise.

CWW also increased support to the food security budget line by 44% (from 12.3% to 17.6% of overall project costs). The only activity related to outcome three downsized was the provision of vulnerable households with access to food and livelihood support in Bonthe implemented by SEND. This activity initially intended to mitigate the socio-economic impact of COVID-19 on quarantine households in Bonthe was no longer relevant in view of the declining COVID-19 cases. The savings were reallocated to strengthen awareness and prevention of COVID-19 activities in the district.

A further adaptation was approved by Irish Aid on 30th March that authorised KADDRO (Trocaire local implementing partner) to reallocate Euro 4,148 to respond to the needs of the fire-affected community in Yealiboya (Kambia district). According to the project proposal, the total budget for response to the fire incident was Euro 22,419, with the additional Euro 18,271 to be funded by reallocating funds from Concern's unspent funds. These reallocations are not shown on the Irish Aid COVID-19 response adapted budget. The activities funded included cash transfers to affected households, provision of handwashing stations, sensitisation meetings on COVID-19, training of community stakeholders on fire prevention and the provision of households with bedding and mosquito nets.

The adaptations made to the Irish Aid COVID-19 response budget were appropriate because some of the key assumptions on which the interventions were originally based did not hold. The IPC intervention assumed that people who received IPC materials would use them correctly (not discard, sell, give away, use incorrectly, etc.). Data showed that the widespread distribution of facemasks was unlikely to result in the intended outcome due to the continued poor adherence to the wearing of facemasks and lack of measures in place to enforce compliance. COVID-19 cases were lower than anticipated, but the secondary impact of COVID-19 on target beneficiaries became more evident. Data from the WASH infrastructure assessment identified more needs than planned. The steady decline in the number of COVID-19 cases meant that there were fewer people in quarantine homes than originally planned. Some districts had gone three months without recorded cases, making it impractical to continue to provide discharge kits or support quarantine facilities

and households. Without new COVID-19 cases, the reopening of new community care centres was unjustified, and there was no need to engage local leaders to open new CCC facilities. Project adaptations to address the fire incident at Yealiboya were in harmony with the overall objectives to prevent and reduce the spread and impact of the coronavirus pandemic.

### 3.6 How was the "adaptive approach" supported and implemented by local partners?

Three local partners entered into a contractual agreement with Trocaire and implemented key components of the project, including the adaptations on behalf of Trocaire. Local partners, in some cases, identified the needs on the ground, worked directly with district authorities and COVID-19 response structures. For example, KADDRO supplied water for handwashing at the Guinea border crossing; AAD-SL provided food supplies to quarantined homes in Port Loko and Bombali districts; SEND supported administrative structures in Bonthe district by providing internet subscription, while quarantine and discharge packages were made available to many families across districts during critical times. IPC materials and awareness-raising were targeted at many communities and schools in Bombali and Port Loko districts.

It needs to be emphasised that pre-existing relationships between Trocaire and its local implementing partners and between the local partners and communities helped to facilitate many of the activities described above. Local partners had ties with the target communities and were not regarded as strangers by community members when the former came to implement the COVID response project. A key informant described this relationship with communities this way. "*[Yes], I think that was a need that had been identified because … like all our partners are already operating in those districts through their development programme. And so, we know, they had also been adapting their development programme and based on what they were learning from the communities themselves. So, it's not like we're just coming into new districts that we're not already operating in the community level*."

### 3.7 How did the adaptive approach affect the capacity of local partners.

The project produced benefits obtained by local partners, although some may appear to be regular benefits that could result from traditional projects. An important attribute of an adaptive programme is empowering its team members [12], which includes sharing a common vision and aiming at achieving the same goals. This project provided a shared vision and promoted the use of evidence among consortium partners, including local partners. The direct involvement of partners in real-time decision-making can be attributed to the adaptative approach manifest in this project. Additionally, the project provided support in human resources training and in data management processes. The monitoring visits and training on quality assessment that Trócaire provided to partners, including AAD SL, KADDRO and SEND, was meant to ensure consistency in report generation by these organisations. Training in Community-Led Action mobilisation (in Kenema and Kambia) by GOAL; and in tool development and data collection (benefiting SEND-SL) provide a few examples of the many training opportunities provided for the staff of local partners organisations. Local partner human resource capacity was strengthened through the recruitment and training of additional staff [13, 15]. Data

harmonisation and consistency in reporting is an important capacity not only in traditional but also in adaptive project management. The focus on the use of data in decision making promoted by the consortium is a foundation for developing a culture of continuous learning, a critical element of adaptive programming. The provision of tangible material support to local partners in the form of mobile phone credit and internet subscriptions enhanced the flow of information to allow decisions to be made more quickly and the project to be adaptive.

Partners benefited from direct material support to strengthen their operational capacity. For example, Trocaire provided assorted items such as laptops, telephones and motorcycles that supported the operational capacity of recipient partners. Bonthe received a boat by having one built in the local area when it was determined that transporting one from elsewhere was costly and posed logistical challenges.

Local partner organisations also directly benefited through the provision of tools and technical support to implement adaptations.

In many cases, the consortium played a complementary and supportive role in support of the work of other local partners. Rather than unnecessarily duplicating work that was already done by other partners, the consortium identified and filled gaps in critical areas where support was lacking, as was the case in complementing the work of the Saving Lives programme, which was providing district-level support in the COVID-19 response.

### 3.8 How did the adaptive approach play out in working with other stakeholders (district authorities, DHMT, DICOVERC, etc.)?

The adaptive implementation approach encouraged and allowed extensive collaboration with other actors and stakeholders. Members of the consortium and implementing partners coordinated activities with local partners at the district and national levels, as well as with other Non-governmental Organisations. Embedded in this approach was the solicitation of local community/stakeholder views, which were integrated into project adjustments. Below are examples of specific instances when the consortium effectively collaborated with other stakeholders in conducting its activities.

1. There was stakeholder engagement at the national level to garner political support for project interventions and at the district and local levels to ensure local stakeholders' involvement. The project was officially launched by the Embassy of Ireland. The ceremony was attended by the Sierra Leone Minister of Planning and Economic Development, Head of Cooperation at the Embassy of Ireland, Deputy Head of EU Delegation and other government and non-government dignitaries. Launching ceremonies were also conducted in some districts with the relevant local partners in attendance [15]. The Consortium partners worked closely with relevant line ministries, government response structures [NaCOVERC/DICOVERC], UN agencies [UNICEF, WFP] and other NGOs at the national and district level to ensure alignment of the interventions with national COVID-19 response efforts.

2. Local stakeholders (district authorities, DHMT, DICOVERC, etc.) were informed or directly involved in decision making and project implementation, as necessary.

3. Local stakeholders received direct material support in the form of mobile phone credit, water refill, internet subscription etc., proving the enabling environment to actively engage them in the project and to share information.

4. Local stakeholders benefited from project organised training [in Community Led Action Approach, SGBV etc.] and were involved in the implementation of awareness-raising and COVID-19 sensitisation activities.

5. The local response structures such as the DHMT, PHUs, FSUs etc., directly benefited through training of staff and provision of materials.

6. Project partners worked closely with the established COVID-19 response structures, directly supported, and actively participated in coordination meetings to monitor and respond to reported a surge in cases. Consortium partners had been active members of relevant government-led coordination mechanisms at national and district levels, including NaCOVERC and relevant line ministries. Consortium partners played leadership roles in national and district COVID-19 response structure, making it possible to learn about the changing context and communicate project adaptations. For example, Concern, GOAL and Trócaire, through their partners, played a role in local coordination structures across their areas of operation as well as participating in national-level discussions through the 'pillar system'. At the national level, they were active members of the INGO Forum (and members of its Steering Committee) and played a role in the establishment of a mechanism of NGO focal points linked to the government's national and district level COVID-19 response structures (EOC 'pillar system', DEOCs).

7. The consortium, through its local implementing partners, responded promptly to the Yealiboya fire incident to minimise COVID-19 spread and provide relief to affected households.

Although working with local stakeholders had many benefits, it also produced some challenges that partners sometimes had to overcome. There were instances of shifting alliances by local stakeholders who had many other partners going after them; some activities were delayed, and the use of different methodologies or approaches in completing some activities all posed challenges in project delivery. Below are a few excerpts from different respondents during key informant interviews on how the adaptive approach played out working with partners:

***Shifting alliances*** -" "There were always … clashes, you know, there's always a lot of fear that you set a date and then they [local stakeholders] because they have a lot of partners working with them, particularly when you've got something like COVID happening."

***Delayed activities***- "You end up with a lot of things being postponed or delayed, and I think originally we were starting this just before Christmas. I mean, that's also never best times trying to do activities."

***Different approaches*** - "So the partners didn't have the exact same methodologies and the exact same interventions."

### 3.9 Was the management structure appropriate for an adaptive approach?

Data available to the evaluation team are insufficient to make definitive assessments and conclusions about the appropriateness of the project management for the adaptive approach. However, when the data available are compared with what is regarded as appropriate leadership for an adaptive approach, we see elements of good management. A management structure appropriate for an adaptive approach is one that is adaptive in the sense that it; incorporates uncertainty or flexibility into project planning and implementation, has the mandate to

act when evidence points to the need and makes a genuine effort to involve stakeholders, including beneficiaries in learning, adaptation, and project improvements. An adaptive management approach is committed to a culture of continuous learning. It systematically gathers and uses real-time data to measure progress and generate evidence that is used for decision makings related to project implementation and adaptations. Additionally, adaptive programming requires the use of appropriate information technology to systematically gather information, continuously assess project outcomes to refine the process, review strategic approaches and assumptions, implement adjustments and measure effects in a continuous feedback cycle of learning and improvement [3, 16]. **Below are some of the attributes of the COVID-19 response management.**

The project was implemented by a consortium of three international NGOs with Concern Worldwide as the lead agency. A high-level project management team was operationalized comprising of country directors, program managers and senior managers of the partner organizations to provide strategic oversight of the project. The team meet monthly with the main goal of facilitating quick learning and response to evolving risks and proposed project adaptations. Project reports show evidence of a keen awareness of the fluidity of the pandemic response and an emphasis on flexibility and learning to improve response effectiveness.

There was a structure created to promote learning with the lead agency (CWW) charged with the responsibility to facilitate learning. A project manager appointed by Concern provided overall coordination, supervised implementation, and facilitated shared learning under the supervision of Concern's Program Director. The Irish Aid appointed focal person promoted inter-organization coordination and served as a link to the donor. The consortium put in place a consolidated system of data collection, analysis, and reporting—the M&E working group comprised of the M&E data collection teams of the various partners. The team met virtually and worked together under one M&E framework, harmonized tools, and indicator definitions. Monthly and semi-annual reports and periodic survey reports were produced and disseminated among consortium partners, local implementing partners and Irish Aid. The monthly reports provided updates on COVID-19 and on each partner's activities, risks, challenges learning and recommendations for adaptations.

There was a hierarchical fund flow structure, with funds flowing from the donor (Irish Aid) through CWW to the other two partners then to the local partners. Delays in approval to implement adaptations were reported.

Consortium partners actively participated in and supported national and district response structures and worked closely with stakeholders to identify and implement adaptations.

The foregoing discussion highlights a commitment to continuous learning, use of data to inform learning, genuine attempt to involve local stakeholders in decision making and to attempt to use feedback from stakeholders to make adaptations and improve performance.

### 3.10 What data, processes, mechanisms, and tools supported the adaptive approach.

Project financial and narrative reporting tools were developed and discussed at an initial startup meeting, including initial changes likely to be made. These templates were made available to implementing partners to guide reporting, including recommendations for adaptations [15]. Detailed work plans were developed, targeting approaches were discussed and agreed upon, and inception workshops were held with local partners to ensure a common understanding of processes and tools to support the adaptive approach [15]. A tangible product of this

effort is an online resource folder to enhance partner learning. Other tangibles include the transfer of funds to partners after sub-grants were offered to them and signed. Joint monitoring and supportive supervision of project activities with local stakeholders provided an opportunity to observe challenges, identify the need for modifications and communicate need for adaptation [11]. These multi-disciplinary supervision teams included nutritionists and other health staff members from PHUs. For example, Concern conducted and used two such meetings between February and March to validate information received from lead mothers. Data collected from the PHUs during the monitoring visits showed the project's impact as thousands of households (3,351) were reached by Lead Mothers during a specified period while almost 1600 children were screened for malnourishment (in Western Area and Tonkolili) and referred for treatment.

Partner coordination meetings were conducted to share updates, plans and discuss challenges [17]. During the critical month of March 2021, when the COVID-19 pandemic started in the country, several NGOs attended meetings organized by consortium partners. Discussions and ideas shared during these meetings were critical in planning the COVID-19 response.

Community engagement using GOAL's community lead action tool preceded interventions in most communities. By involving community leaders, community contact persons and direct beneficiaries in decisions about practical steps to follow to protect themselves from COVID and identifying community champions to facilitate action, community involvement is enhanced [18].

### 3.11 How were changes in context monitored and communicated (internally, to other stakeholders)?

Partners incorporated learning from internal M&E data, assessments, national surveys, official reports, and information gathered through active participation in response pillars to inform the adaptive approach [15]. Partners actively participated in response fora and engaged with local stakeholders to identify areas in the interventions that needed strengthening. [19].

Partners held internal consultations to discuss observed changes based on available data and feedback from consultations with local stakeholders. **[20].** Sometimes this took the form of physical or remotely held meetings. Decisions that were reached were then communicated to the funding organization (Irish Aid). A key informant explained this experience in the following statements: **"***What was happening was [that] we were having monthly meetings. So, any changes we wanted to make, we would be directly communicating to Irish Aid to say, yeah, we want to do this... and then we would submit it. But yeah, what was happening was the monthly [meetings], physical or remote."*

Consortium monitored the prevailing context, COVID-19 transmission rates and project indicators closely and communicated changes, challenges, and successes to all partners through well-structured monthly reports that included a section on each partner's activities [18].

Some changes were informed by feedback from local implementing partners. Local partners observed the need on the ground and communicated the need for adaptations to the Consortium through the established channels. [18].

The main channels used to communicate changes in context internally to other partners and final beneficiaries included monitoring field visits, face to face meetings, phone calls, regular coordination meetings were used to exchange feedback, track the progress of implementation,

lessons learned, and challenges; Other means used to communicate changes included lead mother monthly meetings; monthly community CLA meetings. Additionally, consortia and national partners participated in National and District coordinating meetings, including NaCOVERC, DHMT, DICOVERCs, food and nutrition security monthly meetings. The M&E consortia tried to meet at least monthly to consolidate and review data and to discuss changes [21].

### 3.12 What worked well, and what were the success factors in implementing this approach?

'The use of an adaptive approach ensured flexibility to respond to community needs. Other success factors included a project management team that is committed to learning supported by a moderate budget to support learning activities, harmonization of data collection processes and tools to improve data quality, systematic collection, analysis, reporting and use of data to make adaptations, increased collaboration between partners, greater involvement of stakeholders to identify needs and implement adaptations, and active community engagement using the CLA approach. Successful community engagement resulted in sustainable water trucking /supply to 46 communities at cost recovery costs, which may outlive the project. Although it was a small-scale intervention, it is worthy of mention as an example of successful community engagement to improve uptake of services [11]. CLA enhanced community involvement and continuity of project activities in hard-to-reach areas even in the face of disruptions caused by flooding. The partners had in place trained community mobilizers who continued to provide support when partners cannot access hard to reach areas (e.g., Flash flood in Bonthe – cut off some islands, but the project continued).

Effective collaboration with DHMT on the identification of beneficiaries for nutrition assistant was helpful in the implementation of the adaptation [14]. Where needed, manual labour was provided to quarantine households to work on their farms while in quarantine. This support, while it was only provided to a few households, was an innovative approach to enhance household resilience **[18]. It is also worthy to note that adaptations were made without effect on the overall budget.**

Testimonies of project beneficiaries provide proof that project support made a difference in the life of real households experience social isolation, financial and emotional stress to COVID-19 [see box 1**)**

Example 1: A 37-year-old female mother of three children exposed to COVID-19 and quarantined was stigmatized, rejected by the community, lost her property and employment. On receiving a post-quarantine discharge package from said “I was so happy and gratified to receive this package from Trócaire and AAD-SL. The food package helped me and my children to be stress free for over two weeks.” [17]

Example 2: A farmer in Bonthe living with a disability sustained from a fall while tapping palm wine was living in poverty with his family at the edge of starvation. The household was selected during the assessment process designed by SEND-SL and partners to provide vulnerable households with access to food to mitigate the secondary impacts of COVID-19 on their food security. The household received support that included a 50kg bag of rice, palm oil, onions, maggi, with other assorted food items, as well as facemasks, soap, and jerry cans for tippy taps to promote engagement in positive hygiene practices. As an expression of joy and appreciation, the household head said “I am so happy for this support! It has been so long since we have eaten rice; we survive only on cassava as our staple food. This package will greatly help us, especially my wife who is now our breadwinner. My wife will now have time to embark on other agricultural activities since we now have food to eat. I have constructed my tippy tap to ensure that our family practices safe hygiene practices amidst the COVID-19 pandemic. We are very much grateful for this support from SEND-SL, Trócaire, and Irish Aid.” [22].

**Example 3**: The expressions of a Senior Registered Nurse in Tonkolili district responsible for conducting safe motherhood services demonstrated that the adaptation of activities to place more focus on SGBV was timely and the training of healthcare workers by Concern and partners was helpful. She said “The training has been timely because we have seen a visible increase of GBV cases during the past 6 months, in some of our communities. This training has enabled us to look for forensic evidence and provide treatment and counselling for the victim. I now know even very simple conversation to reassure the victims that their incident would remain confidential, and they are not to blame, makes a difference to their recovery. I am delighted with the knowledge I have acquired and will share it with other staff at my facility."[23]

The project did not have a clearly articulated theory of change with causal assumptions across the result chain. An adaptive approach to project implementation involves a continuous process of learning and adaptation to achieve the overall goal in the face of uncertainty. The adaptations are made because data shows that the initial assumptions no longer hold, and the defined pathways of change and implementation strategies are no longer appropriate. Thus, the theory of change is revised. Although activities were adjusted, and some effort was made to ensure that the intervention strategies were linked to the pathways of change, a more systematic process of adaptation involves a deliberate effort to link adaptations to the project causal assumptions and a revision of the theory of change, including the pathways of change, implementation strategies and

performance indicators. Partners documented changes in the budget and M&E framework, but it would have been more appropriate if a specific tool was used to document changes. This will facilitate learning from the adaptations and an assessment of the effect of the adaptations on project outcomes. Other aspects of the project (not specific to the adaptive nature of the project) that did not work as planned included the following:

1. Participation of women in some project activities was lower than planned, likely due to inherent gender disparity in national and district level emergency response structures . Few women directly participated in the project activities and decision-making process.

2. Payment of community mobilizers through mobile money posed a challenge. Data from focus group discussions revealed that this was a problem, especially in distant locations away from urban centres. At these locations (e.g., in Bonthe), cash withdrawal points were few and far between. At times, the cash withdrawal points did not have enough cash reserves to meet adequate amounts that people wanted to withdraw.

3. The time needed to identify & get approved project adaptions alongside some procurement delays caused delays in budget expenditure. Only 47% of the budget was spent as of December 2020. The project requested and gained approval for a no-cost extension until April 30th because, in March 2021, 29% of the budget was unspent.

4. The selection of vulnerable households was a challenge as almost all households need some form of help. According to focus group data, in Bonthe, for example, many families who were screened and who met the criteria to receive support failed to receive the critical assistance they needed because the project could afford only so much, and community demands often exceeded the project's capacity to adequately respond to meet many of the demands.

5. The expectations of local stakeholders for participation in project activities and their timelines for completion of response activities and sharing of critical information on which project intervention depends were not always in sync with project expectations. For example, delays in accessing information held by DICOVERC Surveillance teams due to data protection concerns – delay identification of vulnerable HH needing quarantine support. Access to line listing information held by DICOVERC Surveillance Teams was usually delayed, which held back project activities that depended on a comprehensive list of quarantined households.

6. The expectations from MoHS and district authorities for support from the project was sometimes beyond the scope of the project (Tonkolili DICOVERC example).

### 3.14 How appropriate was an adaptive approach for an emergency response?

There is support in the extant literature that an adaptive approach to project implementation is appropriate in an emergency setting. Emergencies are subject to uncertainty, and the rapidly changing environment makes initial assumptions and plans outdated. According to Comfort (2002), in "extreme events, public organizations need the ability to adapt quickly and effectively to rapidly changing conditions". The need for collaboration with multiple stakeholders and real-time

exchange of information implies that a hierarchical approach to project implementation is likely to fail [19]. The COVID-19 situation in Sierra Leone was unpredictable. Although the community spread of COVID-19 was delayed until early April 2020, the number of cases rose rapidly. As at the time when this project was being put together, there were 1,085 confirmed COVID-19 cases, with 50 deaths reported in 15 out of 16 districts in Sierra Leone. A total of 1,652 people were in quarantine, with 52.8% of these (872) being in self-quarantine. Experience with the Ebola response makes it plausible to assume that the infection rate will spiral, but these assumptions did not hold. By October and November 2020, when the adaptations were proposed, the number of new infections had declined dramatically, with some project districts such as Kambia going three months without a confirmed case. It was untenable to build or continue to support quarantine facilities when there were no new cases.

It is reasonable to assert that the Irish Aid COVID-19 response project adaptative approach was appropriate because it was proactive. Adaptations were anticipated. In the fluidity of the pandemic, data supported the need for adaptations. The need for food assistance and support to sexual and gender-based violence interventions become more relevant, informed partly by internal and external data and by the Ebola experience. Changes made were mainly realignments of activities to improve effectiveness and were based on consensus with relevant stakeholders and the availability of resources that could be adapted. Because of the flexibility inherent in the consortium COVID-19 response, it was possible to modify the project intervention to respond to the Yealiboya fire incident- a community that was not part of the beneficiary communities.

**3.15 What aspects of the adaptive approach could be replicated or scaled-up in an emergency context?**

i. Aspects of the Irish Aid COVID-19 response adaptive approach that could be replicated include the following.

ii. An adaptive approach was integrated into project design and implementation to reflect the changing nature of the crises and communicated to all partners. This contributes to developing a culture of learning.

iii. Changes to the project activities were thoughtful and deliberate, based on evidence with stakeholder involvement and the availability of resources that could be adapted.

iv. . Changes were intended to improve project effectiveness and were informed by the changing needs of beneficiaries.

v. Learning was built into the project with a budget line to support learning, a designated partner (Concern Worldwide) to champion learning, and a senior project coordinator

to coordinate learning activities. A senior management team comprising of Country Directors and other Senior Managers of the consortium partner organizations was responsible for reviewing evidence and recommending adaptations for approval by the client.

vi. The consortium monitored the internal and external environment, regularly collected data on the pandemic, progress on project implementation, including challenges and achievements and communicated data to relevant stakeholders through monthly and semi-annual progress reports.

vii. Changes were documented in the project M&E framework, budgets, and monthly reports, including the reasons for the changes. These are practices that can be replicated elsewhere in future programming.

viii. The adaptive approach was implemented by a consortium of like-minded organizations with complementary experience in humanitarian and emergency response. Local partners that formed the consortium were experienced in implementing health emergency response interventions in targeted vulnerable communities.

ix. The consortium had clear targeting criteria agreed with the relevant National and District Emergency structures, relevant line ministries and local stakeholders to reach the most vulnerable.

x. The consortium utilized a Community Led Action (CLA) approach that uses a systematic five-step process to engage communities and encourage behaviour change, particularly in border communities.

### 3.16 Did the adaptive approach promote aspects such as the relevance, coherence and or impact of the project?

The adaptations improved the relevance of the project. It was untenable to continue to build community care centres without COVID-19 cases or to continue distributing face masks when it was clear that they were not used by beneficiaries. As evidence pointed to a decline in the COVID transmission rate, it became more relevant to scale down infection prevention (IPC) and support quarantine activities to address the secondary impact of the pandemic, particularly gender-based violence and food insecurity, which became more apparent. Additionally, the relevance of the activities implemented was ensured through active stakeholder involvement not only in identifying needs but also in targeting and service delivery.

The coherence of the project was not effective because adaptations did not affect the overall goal of the project. The consortium's focus consistently remained on the three original outcomes, with activities realigned to reflect the new priorities. It is expected that consortium members would sometimes adopt different methods to implement certain activities, especially in a situation that involved three different implementing partners. Despite this fact, most project activities have remained on course, according to many focus group respondents and other project documents. The consortium partners had established working relationships and were familiar with each other's operational protocols. This made the management of the adaptive approach easier than it would have been otherwise.

The M&E data, including project endline results, showed mixed results. Key project achievements are listed below: (see appendix 8.4 for details)

- Endline results indicate that 45% of the people in target communities observed met both criteria for correct wearing of facemasks and hand washing while 57% were complying with facemasks only and 48% with hand hygiene only.
- 39,507 in target districts. representing 110% of project target directly received IPC materials (i.e., soap, facemasks)
- 74,310 (187% of project target) were estimated to have received direct behaviour change messaging for COVID-19 prevention.
- 873,422 People (29% of target) received indirect behaviour change messaging for COVID-19 prevention/response or related issues.
- Water and sanitation infrastructure was strengthened at 19 health facilities. Proposed repairs on water systems and sanitation infrastructure were completed respectively in WAU and Kambia districts.

- Only two community care centres were constructed because this activity was adapted as the scale of COVID-19 infection was lower than earlier anticipated. CCCs were only established by DICOVERCs in Bombali and Koinadugu districts.
- Discharged kits were provided to 589 people (15% of the target). The number reached was lower than the original target mainly because of the lower number of confirmed COVID-19 cases than anticipated resulting in adaptation of this activity.
- 2,616 Households (147% of the target) were supported with distributions of food, water, other essential items, or limited cash disbursements to alleviate the secondary impact of COVID-19 and other disasters.
- 4,217 (37% of the target) caregivers of under-five children were reached with behaviour change interventions to improve Maternal Infant and Young Child Nutrition (MIYCN) practices and COVID-19 prevention.
- 693 Lead Mothers (91% of the target.) were trained on disseminating MIYCN messages, and the same number of Mother Support Group members were trained on conducting mother led MUAC screening.
- 5,740 (50% of the target) children 6 – 59 months were screened for malnutrition by mother led MUAC screening
- 1,080 (190% of the target) children 6-59 months were screened and referred by Lead Mothers to the PHUs
- 61 health workers (78% of target) healthcare workers were trained on IMAM/MIYCN.
- 153 health workers, FSU and protection service providers (96% of target), were trained in GBV, including referral pathways. 60% (91 out of 151) of people trained scored 80% or upon their post-test, which indicate they demonstrated appropriate knowledge on GBV cases identification and referral pathways.
- 116,182 (522% of the target) were reached with messaging on SGBV

The extent to which the project adaptations promoted or hindered project impact cannot be ascertained from the mixed results shown above (Appendix 8.4).

### 3.17 Did the adaptive approach promote or hinder the implementation of humanitarian standards (in terms of targeting, safeguarding, accountability …)?

An assessment of the extent to which the adaptive approach promoted or hindered the implementation of humanitarian standards would require determining the extent to which it met the internationally recognized nine commitments on quality and accountability. These nine commitments are: (I) Humanitarian assistance is appropriate and relevant to the specific needs and circumstances of beneficiaries (ii) timely, and relevant (iii) strengthens local capacities and avoid negative effects (iv) is based on communication and participation and feedback from affected people and communities (v) complaints are encouraged and promptly addressed (vi) response is coordinated and complementary (vii) humanitarian actors continuously learn and improve (viii) assistance is provided by competent and well-managed staff and volunteers and (ix) resources are managed and used responsibly for the intended purpose [https://www.concernusa.org/about/codes-policies/core-humanitarian-standard/], While we didn't have data to provide a comprehensive assessment and make a definitive judgement on the extent to which the adaptive approach adhered to these standards, we did not see evidence based on the documents reviewed that point to any violations of these standards.

Concern Worldwide and other consortium partners subscribe and conform to the core humanitarian standards, which implies that accountability is at the core of what they do [21]. The

consortium's commitment to these core standards is evident in its reports, targeting strategies, commitment to working with local partners and stakeholders, realignment of resources to better meet the needs of the target communities and a focus on vulnerable communities. Information provided in previous sections of this report supports the claim that some of these standards were adhered to in the implementation of the adaptive approach. Evidence from focus group discussions and key informant interviews also point to the fact that this project promoted humanitarian standards such as targeting, safeguarding and financial accountability, among other attributes.

**Targeting:** Vulnerable communities were the main target for the intervention, and this is reflected in the project overall goals, outcomes, and activities. Information in the proposal, as well as other data collected during project implementation, show that the targeted communities have some of the worst socio-economic indicators in the country. The vulnerability of these communities is discernible in their poverty risk levels, high illiteracy rates, gender-based violence and other risk factors. Adaptations were made to support the needs of vulnerable communities and were made in consultation with local partners and stakeholders. Project documents show that real people in need of assistance received help [Box 1]. However, there was no data to show the specific vulnerable groups [e.g., people with disabilities, homeless persons, poor households etc.] that were targeted. We did not also get feedback from communities affected by the crises to get their feedback on how helpful the assistance was to them. Key informant interviews show that the identification of vulnerable households was problematic as most households in target communities needed assistance.

**Safeguarding**: Safeguarding includes measures to protect the health, well-being and human rights of individuals so that people — particularly at-risk individuals such as children, young people and vulnerable adults are protected from abuse, harm and neglect.

This project's focus on disadvantaged individuals in many impoverished communities and seeking to address secondary impacts of an ongoing pandemic demonstrates clear intention at safeguarding. Without some of the support (logistical and material support) provided by the project, many women, the elderly and children were likely to suffer more devastating consequences of the COVID-19 pandemic. For example, providing material support to individuals quarantined in homes as well as those affected by the Yealiboya fire disaster helped to ameliorate the suffering of beneficiaries from harm and neglect.

To our knowledge, there was no report of inappropriate behaviour, abuse of power, sexual exploitation or misconduct on the part of project actors that could undermine the duty to safeguard. The primary reason for the adaptations was to protect female beneficiaries from sexual exploitation arising from the power imbalances created by the impact of COVID-19

**Financial accountability:** Financial accountability is part of the nine commitments, requiring humanitarian actors to manage and use resources responsibly. While we did not have access to project expenditure data to determine how funds were used, project reports provide some indications or attempts to manage or use resources responsibly. Accountancy teams visited consortium partners on a need basis to provide oversight. Budget reallocations showed that the changes were made without budget overruns. Concern Worldwide reduced its capital expenditure to reallocate funds to support interventions aimed at reducing the secondary impact of the pandemic. At the programme implementation level, accountability was also addressed. One key informant described the extent to which the project strove to enforce accountability, "We had an agreement with the district partners that they give us one representative, one from the DHMT, one from the council, and one from agriculture to actually form part of the payment team, which was with our finance and program staff of Concern, who actually went facility by facility to actually do the cash disbursements to the beneficiaries.

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# 4.0 Discussion

## 4.1 Study limitations

This report largely reflects the perceptions of staff of the consortium partners that implemented the project and draws heavily from project reports. These views were not independently verified through interviews with local stakeholders or beneficiaries. This context must be taken into consideration in drawing conclusions regarding the overall quality of the consortium's adaptive approach to the COVID-19 response.

The key findings of the evaluation are detailed in the ensuing sections.

## 4.2 Evaluators' interpretation of results

The COVID-19 response project had three overarching goals: to improve knowledge of community members of Infection Prevention, and Control (IPC) measures to prevent/reduce transmission of COVID-19; secondly, it sought to ensure that quarantine facilities, community care centres, and district structures were effective and fully operational, and thirdly, to reduce the secondary impact of COVID-19 and other regular disasters (e.g. higher levels of SGBV, flooding events) on the food, health, and income security of vulnerable populations is mitigated. The project was largely successful in addressing the secondary impacts of COVID-19. This is partly due to the fact that infection rates ended up being lower than initially anticipated, and as a result, the project was able to divert funds originally meant for COVID-19 prevention to instead address its secondary impact among communities.

The more critical question is whether this project used an adaptive approach during its implementation. To answer that question, it is important to revisit the main attributes of adaptive programming. Among the key characteristics are of an adaptive programme are a flexible budgeting process that allows repurposing of funds when necessary, effective communication mechanisms that facilitate learning and reflection, a robust M&E, HR and financing teams that collectively develop and utilise appropriate tools for data collection and finance distribution at different project levels, a funder approach that allows project adjustments, maintaining a team with a shared vision, and having a structured and flexible leadership style.

Based on the above criteria, the overall COVID-19 response had good features of an adaptive programme. The adaptive approach enabled its management structure to place emphasis on learning. The M&E system was in place to facilitate continuous monitoring of the external environment, data collection, analysis, reporting and use of data to inform adaptations.

Health emergency situations (such as the current COVID-19 outbreak and the 2014-16 Ebola epidemic) require quick and flexible decision-making processes, as resources may need to be redirected, service delivery systems revised, or entire interventions scaled up or down. This COVID-19 response project acquiesced to that type of flexibility. Little wonder that in a short period of time, project functionaries were able to complete necessary things (repurpose budgets, scaled-up or down some services etc.) to address both emerging and secondary impacts of the COVID

pandemic in the target districts within the country. Adaptations were made without budget over-runs while keeping the focus on the overall impact of the project.

The project's adaptive approach enabled greater stakeholder involvement, drawing largely on the experience of the consortium partners' experience in interacting with local structures during emergencies. The project disseminated information among partners through (meetings – remote and in-person etc.) and communities through mobilisation to facilitate adaptations and other COVID response mechanisms. The ability to hold virtual meetings when it was unsafe to conduct face-to-face meetings demonstrated the project's ability to adjust to new situations during project implementation.

The funder's flexibility allowed for necessary changes to occur during project implementation. As one interviewee asserted, 'So any changes we wanted to make, we would be directly communicating to Irish Aid to say, yeah, we want to do this, you want to put this, and then we would submit it." This statement is also evidence that the project maintained a communication channel that allowed information dissemination across project levels.

Mechanisms to assure project accountability were embedded within project structures. As mentioned elsewhere in the report, on-site visits were planned and conducted based on need. In an interview, a project official explained another effort to assure accountability as follows, "We had an agreement with the district partners that they give us one representative, one from the DHMT, one from the council and one from agriculture to actually form part of the payment team, …finance and programme staff who actually went facility by facility to actually do the cash disbursements to the beneficiaries."

Team empowerment is crucially important in adaptive programming. This may include anything from members having a shared vision to encouraging a facilitative leadership style and allowing a decentralized management structure for delegating decision-making arrangements. Forgoing discussions in the report show that the COVID-19 response had many of these features, even if some can be improved upon.

In sum, although the project lacked a clearly defined theory of change at the outset, it was adaptable to changes, was relevant at the individual and community level worked with existing data that were routinely updated due to its M&E structures, involved many partners and stakeholders, flexible to meet diverse needs during uncertain conditions, and maintained a management structure across levels. As such, it is reasonable to conclude that the project was adaptive in nature.

## 5.0 Conclusion

The Irish Aid -funded COVID-19 response adopted an adaptive approach to implement project activities. It is reasonable to assert that the Irish-Aid funded COVID-19 response project has the critical elements of an adaptive approach to project implementation. The unpredictable nature of the pandemic was incorporated into the design, and adaptations were anticipated. Furthermore, its ability to facilitate learning through a defined administrative structure that included an effective M&E system for data collection and information dissemination helped capacitate many project partners and stakeholders while addressing the urgent secondary impacts of the COVID-19 pandemic for thousands of households. Adaptations were informed by evidence made with the consensus of local stakeholders. The need for food assistance and support to sexual and gender-based violence interventions become more relevant, informed partly by internal and external data and by the Ebola experience. Changes made were mainly realignments of activities to improve effectiveness and were based on consensus with relevant stakeholders and the availability of resources that could be adapted. Because of the flexibility inherent in the consortium COVID-19 response, it was possible to modify the project intervention to respond to the Yealiboya fire incident- a community that was not part of the beneficiary communities. The consortium was also able to promptly respond to the secondary impact of the pandemic when it became obvious that an intervention was imperative.

Nevertheless, like in many organizations, bureaucratic processes in budget approvals and other procedures delayed the implementation of some urgently needed interventions. Although there was a management structure to promote learning and advise on adaptation, it did not have the budgetary authority to relocate resources to meet the urgent needs without recourse to the donor. There was no well-articulated theory of change with causal assumptions to inform adaptations. Some bottlenecks were encountered in working with stakeholders because the expectations of the stakeholders were not always in sync with those of the consortium. A gendered approach was built into the project, but it did not lead to improvement in the number of women that participated in reaching decisions relating to the response due in part to the gender imbalances in the government local response structures.

## 6.1. Recommendations

Best practices of the adaptive approach that could be replicated in future projects include the following:

v. Integration of an adaptive approach in project design and implementation to reflect the changing nature of the crises or project environment.

vi. Thoughtful and deliberate process of adaptation, based on evidence, consensus with stakeholders and the availability of resources that could be adapted.

vii. Changes were within the overall project goal, informed by the changing needs of beneficiaries and were intended to improve project effectiveness.

viii. Learning was built into the project with a clearly defined budget line to support learning, a designated partner (Concern Worldwide) to champion learning, and a senior project coordinator to coordinate learning activities. Future projects could ensure an enhanced learning budget.

ix. The adaptive approach was implemented by a consortium of like-minded organizations with complementary experience in humanitarian and emergency response. Local partners that form the consortium were experienced in implementing health emergency response intervention in target vulnerable communities.

x. The consortium had clear targeting criteria agreed with the relevant National and District Emergency structures, relevant line ministries and local stakeholders to reach the most vulnerable communities.

xi. The consortium utilized a Community Led Action (CLA) approach that uses a systematic five-step process to engage communities and encourage behaviour change, particularly in border communities.

Other components of the adaptive approach that could be improved to strengthen future adaptive projects include the following.

i. At inception, the project did not have a clearly specified theory of change to guide project implementation. Although the proposal had a clearly stated vision and was backed by an M&E framework, it is good practice to include theories of change in project proposals that serve as “skeletons” on which programme implementation can be based. Adaptations should be informed by causal assumptions, and when these change, adaptive programming requires a careful examination of the theory of change, pathways of change, indicators, and implementation strategies to better align them to changes.

ii. Delegation of authority and decentralized, collaborative decision-making are inevitable requirements for adaptive programmes that are implemented in unstable circumstances. An adaptive project management team should have the authority to approve adaptations and reallocate funding to meet the needs without recourse to bureaucratic processes. Future adaptive projects could ensure that contracts with grantees to implement activities include a clear framework for feedback and procedures for managing change, including the authority to make budget allocations and implement changes promptly. This could be facilitated by defining at the onset the causal assumptions for achieving the project outcomes and overall goal based on the current knowledge and the conditions that warrant adaptation, including supporting evidence. The new information that will compel

adjustment, the decision-makers of when and how to adjust, including budgetary authority, should be defined [2].

The recommended approach to adaptive programming is to systematically document changes in real-time at all stages of implementation, no matter how small. Consortium partners documented changes in the budget and M&E framework as they happened, but partners could improve information about how the adaptive approach affected outcomes by adopting a comprehensive real-time process of documenting who, how, when, and why changes were made and the effect of changes on outcomes using a simple tool [2] besides the budget or M&E framework

iii. Adaptive project implementation depends on the capacity to convert data into evidence and to use evidence to make real-time decisions (2, 5). This requires investment in information technology and M&E processes to ensure prompt application of learning. The IT and M&E system should be strengthened not only to provide quality data but also to ensure real-time collection, processing, analysis, and communication of evidence to facilitate real-time decision making.

iv. Staff turnover is a normal occurrence in NGO operations and humanitarian operations. However, carefully managing these changes will ensure project knowledge transfer for replication and other purposes. During the life of the COVID response project, many staff changes occurred, and although there is yet no conclusive evidence to suggest that such changes affected project delivery, it is documented that a few staff members had some knowledge gaps about some of the operations of the project.

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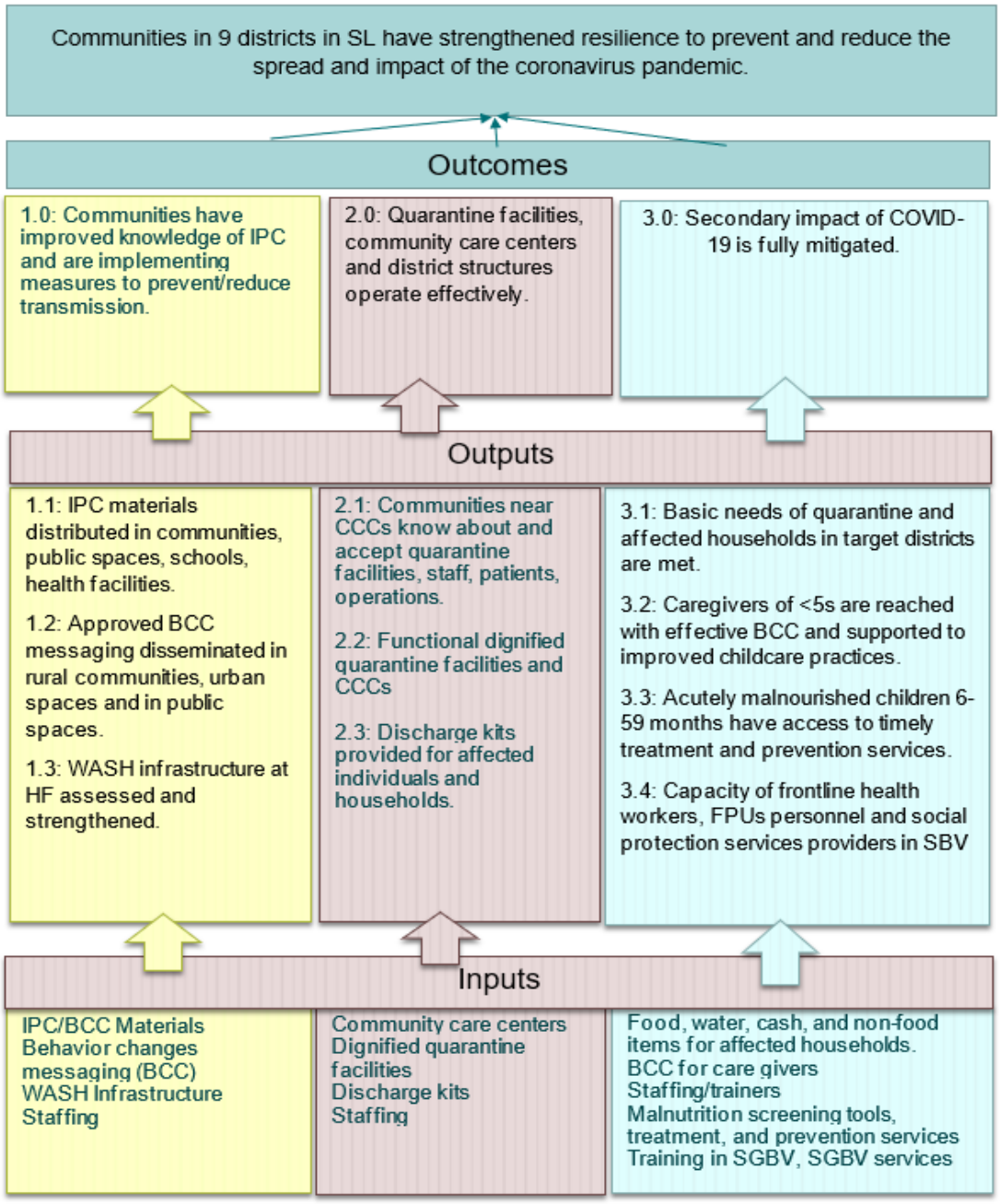
# Appendix 8

## 8.1 Theory of Change



## Appendix 8.2 : Assumptions of the Irish Aid COVID-19 Response Project in Sierra Leone.

### 1.0: Community pathway

- Increased knowledge about COVID-19 will result in the adoption and practice of appropriate safe behaviours
- Dissemination of behaviour change messaging is effective approach to increased knowledge and attitude change.
- Availability of clean water will increase the adoption of hand-washing and other sanitation measures to protect against COVID-19 transmission.
- Project provided IPC materials if used properly are effective at reducing the chain of transmission.
- Communities/individuals that receive IPC materials (e.g. Face masks, soap etc.) will use them properly to protect themselves

### Quarantine pathway

- The spread of COVID-19 would be as large as Ebola.
- Dignified quarantine facilities will increase the number of people exposed or infected persons willing to be quarantined or isolated.
- Providing discharge kits (essential food items/ once off cash) is effective in increasing the number of people that will respect and adhere to quarantine and isolation procedures.
- Adhering to quarantine procedures will result in a breakdown in the transmission cycle, reduction in infection.
- People are willing to be quarantine or isolated when exposed, infected or have symptoms and will compile with quarantine procedures.
- Discharge kits will promote individual and household economic recovery and resilience

### Secondary impact pathway

- Safety nets (food, water, cash, and non-food items) packages provided are adequate to meet the basic needs of quarantined households and other households severely affected by COVID-19 in target districts.
- Increasing access to timely treatment and prevention services for acutely malnourished children 6-59 months will reduce malnutrition, child morbidity and mortality and mitigate the secondary impact of COVID-19 on vulnerable groups.
- Building the capacity of frontline health workers, Family Support Unit personnel, and social/shelter/protection service providers are built in SGBV (identification, PFA, referral), it will improve quality of SGBV services, increase quality of service utilization and reduction in SGBV.
- Caregivers of under five children reached with BCC messages will adopt improved behaviours, and practice appropriate childcare and child nutrition practices.
- Sexual and Gender Based Violence (SGBV) messaging on prevention and response services disseminated in remote communities, it will lead to improved knowledge, awareness of its harmful effect, change in attitudes toward SGBV and reduction in SGBV.
- Safety nets improve household recovery, and resilience.

## Appendix 8.3

Project modifications as reflected in project direct cost budgets of the consortium partners

| No | **Project Outcomes and Activities** | Partner | **Original project direct cost budget** | **Revised project direct cost budget** | **% of Original project direct cost budget** | **% of Revised project direct cost budget** | % Change in budget line due to adaptation |
|---|---|---|---|---|---|---|---|
| 1 | 1. Communities have greater knowledge of Infection Prevention and Control (IPC) measures and are implementing measures to prevent/reduce transmission of COVID-19. | | **319,630.47** | **274,381.52** | **43.6%** | **37.4%** | -14% |
| 1.11 | Fabric face masks distribution | CONCERN | 104,583.00 | 13,944.00 | 14.3% | 1.9% | -87% |
| 1.12 | Support to Social Mobilisation Pillar such as Radio Jingle airing | CONCERN | 2,400.00<br>2,400.00 | 2,400.00 | 0.3% | 0.3% | 0% |
| 1.13 | water trucking to hand washing stations | CONCERN | 4,762.00 | 4,762.00 | 0.7% | 0.6% | 0% |
| 1.14 | Mobilise local leaders and train CLA supervisors | GOAL | 101,182.85 | 106,182.85 | 13.8% | 14.5% | 5% |
| 1.15 | Hand washing Stations | GOAL | 3,428.57 | 4,928.57 | 0.5% | 0.7% | 44% |
| 1.16 | Assess non-functioning water and sanitation facilities in healthcare facilities and non-functioning water points in communities | GOAL | 3,447.61 | 3,447.61 | 0.5% | 0.5% | 0% |
| 1.17 | Repairs to non-functional water points at healthcare facilities | GOAL | 38,962.64 | 49,840.27 | 5.3% | 6.8% | 28% |
| 1.18 | Replacing existing non- functional reticulation system at Health Facilities with Hand pump | GOAL | 3,809.52 | 3,809.52 | 0.5% | 0.5% | 0% |
| 1.19 | Repairs of the sanitary systems in healthcare facilities | GOAL | 28,571.43 | 32,785.76 | 3.9% | 4.5% | 15% |
| 1.20 | Raise Awareness and Prevent Transmission of COVID-19 through Improved Infection Prevention and Control in Port Loko District and Bombali | AADSL | 0.00 | 11,404.76 | 0.0% | 1.6% | 100% |
| 1.21 | Raise Awareness and Prevent Transmission of COVID-19 through Improved Infection Prevention and Control in Bonthe District | SEND | 27,080.95 | 31,374.28 | 3.7% | 4.3% | 16% |
| 1.22 | Support to DEOCs (Improve Operational and Essential Services in District Structures in Bonthe) | SEND | 1,401.90 | 1,401.90 | 0.2% | 0.2% | 0% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1.23 | Raise Awareness and Prevent Transmission of COVID-19 through Improved Infection Prevention and Control in Kambia District | KADDRO | 0.00 | 8,100.00 | 0.0% | 1.1% | 100% |
| 2.0 | **Quarantine facilities, community care centres, and district structures are effective and fully operational.** | | **219,650.34** | **154,267.61** | **30.0%** | **21.0%** | **-30%** |
| 2.10 | CCC discharge kit | CONCERN | 23,810.00 | 11,905.00 | 3.3% | 1.6% | -50% |
| 2.11 | CCC operational cost (support) | CONCERN | 22,857.00 | 10,476.00 | 3.1% | 1.4% | -54% |
| 2.12 | Mass-media awareness raising | GOAL | 17,285.71 | 17,285.71 | 2.4% | 2.4% | 0% |
| 2.13 | Community Engagement of Chiefdom authorities on CCC | GOAL | 5,714.29 | 0.00 | 0.8% | 0.0% | -100% |
| 2.14 | Provision of meals for the patients as Community Care centres | GOAL | 10,877.63 | 5,438.81 | 1.5% | 0.7% | -50% |
| 2.15 | Support quarantine centers with food packages: average of 60 people per district per month | GOAL | 16,619.05 | 6,180.19 | 2.3% | 0.8% | -63% |
| 2.16 | Support Quarantining Households in Bombali and Port Loko | AADSL | 29,404.76 | 29,404.76 | 4.0% | 4.0% | 0% |
| 2.17 | Strengthen Quarantine Facilities in Port Loko | AADSL | 29,840.00 | 18,435.24 | 4.1% | 2.5% | -38% |
| 2.18 | Support to Screening Checkpoints (Improve Operational and Essential Services in District Structures in Bombali and Port Loko) | AADSL | 21,333.33 | 21,333.33 | 2.9% | 2.9% | 0% |
| 2.19 | Strengthen Quarantine Facilities | KADDRO | 29,840.00 | 21,740.00 | 4.1% | 3.0% | -27% |
| 2.20 | Support to DEOC (Improve Operational and Essential Services in District Structures in Kambia) | KADDRO | 1,401.90 | 1,401.90 | 0.2% | 0.2% | 0% |
| 2.21 | Support to Screening Checkpoint (Improve Operational and Essential Services in District Structures in Kambia) | KADDRO | 10,666.67 | 10,666.67 | 1.5% | 1.5% | 0% |
| 3 | **3. The secondary impact of COVID-19 and other regular disasters (e.g. higher levels of SGBV, flooding events) on the food, health, and income security of vulnerable populations is mitigated.** | | **189,646.91** | **302,184.58** | **25.9%** | **41.2%** | 59% |
| 3.10 | Nutrition Response | CONCERN | 0.00 | 46,818.00 | 0.0% | 6.4% | 100% |
| 3.11 | SGBV Response | CONCERN | 0.00 | 30,549.00 | 0.0% | 4.2% | 100% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3.12 | Safeguarding training for FSU and security forces | CONCERN | 1,905.00 | 1,905.00 | 0.3% | 0.3% | 0% |
| 3.13 | Support to food security as a result of secondary impacts | CONCERN | 90,000.00 | 129,464.00 | 12.3% | 17.6% | 44% |
| 3.14 | 5 days training for 30 health care workers for 5 on Psychosocial support | GOAL | 2,142.86 | 2,142.86 | 0.3% | 0.3% | 0% |
| 3.15 | Support to DEOCs (Improve Operational and Essential Services in District Structures in Bombali and Port Loko) | AADSL | 2,803.81 | 2,803.81 | 0.4% | 0.4% | 0% |
| 3.16 | Provide vulnerable households with access to food and livelihoods support which mitigate the socio-economic impact of COVID-19 on target communities - discharge packages in Bombali and Port Loko | AADSL | 13,980.95 | 13,980.95 | 1.9% | 1.9% | 0% |
| 3.17 | Provide vulnerable households with access to food and livelihoods support which mitigate the socio-economic impact of COVID-19 on target communities - Agricultural Labour Support in Bombali and Port Loko | AADSL | 4,977.78 | 4,977.78 | 0.7% | 0.7% | 0% |
| 3.18 | Support Quarantining Households in Kambia | KADDRO | 14,702.38 | 14,702.38 | 2.0% | 2.0% | 0% |
| 3.19 | Provide vulnerable households with access to food and livelihoods support which mitigate the socio-economic impact of COVID-19 on target communities - discharge packages in Kambia | KADDRO | 6,990.48 | 6,990.48 | 1.0% | 1.0% | 0% |
| 3.20 | Provide vulnerable households with access to food and livelihoods support which mitigate the socio-economic impact of COVID-19 on target communities - Agricultural Labour Support in Kambia | KADDRO | 2,488.89 | 2,488.89 | 0.3% | 0.3% | 0% |
| 3.21 | Support Quarantining Households in Bonthe | SEND | 14,702.38 | 14,702.38 | 2.0% | 2.0% | 0% |
| 3.22 | Provide vulnerable households with access to food and livelihoods support which mitigate the socio-economic impact of COVID-19 on target communities - discharge packages in Bonthe | SEND | 6,990.48 | 2,697.15 | 1.0% | 0.4% | -61% |
| 3.23 | Provide vulnerable households with access to food and livelihoods support which mitigate the socio-economic impact of COVID-19 on target communities - food distribution to vulnerable HHs in Bonthe | SEND | 27,961.90 | 27,961.90 | 3.8% | 3.8% | 0% |
| 4 | Other direct costs | | 3,388.00 | 3,388.00 | 0.5% | 0.5% | 0% |
| 4.10 | Knowledge and Learning activities (adaptation) | CONCERN | 1,452.00 | 1,452.00 | 0.2% | 0.2% | 0% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 4.11 | CRM costs | CONCERN | 976.00 | 976.00 | 0.1% | 0.1% | 0% |
| 4.12 | Staff Per diem | GOAL | 960.00 | 960.00 | 0.1% | 0.1% | 0% |
| | **Grand Total Direct Project Costs** | | **732,315.72** | **734,221.71** | | | 0.3% |

Appendix 8.4: Arish Aid COVID-19 Response in Sierra Leone, July 2020 to April, 2021, Project Performance against Targets

| **Overall Impact of Project/Programme:** Communities in 9 districts in Sierra Leone have strengthened resilience to prevent and reduce the spread and impact of the coronavirus pandemic. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outcomes and Outputs** | **Key Indicators** | **Baseline (Qualitative & Quantitative)** | | | | **Target** | **Endline** | | | | **Comments and updates.** |
| **Outcome 1: Communities have greater knowledge of Infection Prevention and Control (IPC) measures and are implementing measures to prevent/reduce transmission of COVID-19.** | Nos. of people observed among specific targeted groups/communities wearing non-medical face masks in public (disaggregate by sex, type of location) | Hand hygiene and face mask | | | | 50% of 250,000 people derived from statistically robust random sampling by district. | Hand hygiene and face mask | | | | Endline was conducted in April 2021 in communities that benefitted from IPC distributions and direct behaviour change messaging. |
| | | Sex | Child | Adult | Total | | Sex | Child | Adult | Total | |
| | No's people observed among specific targeted groups/communities washing hands with soap at key locations (i.e. entrance to health facility, market area, etc.). (Disaggregate by sex, type of location) | Female | 23% | 29% | 27% | | Female | 28% | 47% | 41% | Endline results indicate that 45% of the people observed met both criteria, wearing facemasks and hand washing while 57% were complying with facemasks only and 48% with hand hygiene only. |
| | | Male | 21% | 27% | 26% | | Male | 33% | 53% | 49% | |
| | | | | | | | | | | | |
| | | Facemasks only | | | | | Facemasks only | | | | |
| | | Sex | Child | Adult | Total | | Sex | Child | Adult | Total | |
| | | Female | 32% | 42% | 39% | | Female | 36% | 58% | 51% | |
| | | Male | 32% | 41% | 38% | | Male | 44% | 66% | 61% | |
| | | | | | | | | | | | |
| | | Hand hygiene only | | | | | Hand hygiene only | | | | |
| | | Sex | Child | Adult | Total | | Sex | Child | Adult | Total | |

| **Overall Impact of Project/Programme:** Communities in 9 districts in Sierra Leone have strengthened resilience to prevent and reduce the spread and impact of the coronavirus pandemic. | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outcomes and Outputs** | **Key Indicators** | **Baseline (Qualitative & Quantitative)** | | | | **Target** | **Endline** | | | | **Comments and updates.** |
| | | Female | 35% | 36% | 36% | | Female | 32% | 49% | 44% | |
| | | Male | 34% | 35% | 34% | | Male | 39% | 56% | 52% | |
| **Output 1.1:** IPC materials in communities, public spaces, schools and healthcare centres distributed. | Nos. people who directly received IPC materials (i.e. soap, facemasks) (disaggregated by district). | | | | | | **39,507 (110% of target)** | | | | |
| | | 0 | | | | 36,000 People | Bonthe: 12,625 | | | | |
| | | | | | | | Kambia: 8,336 | | | | |
| | | | | | | | Kenema: 1,080 | | | | |
| | | | | | | | Tonkolili: 587 | | | | |
| | | | | | | | WAU: 285 | | | | |
| | | | | | | | Bomballi : 5,590 | | | | |
| | | | | | | | Moyamba : 3,400 | | | | |
| | | | | | | | Port Loko : 7,604 | | | | |
| | | | | | | | | | | | |
| **Output 1.2:** MoHS approved behaviour change messaging disseminated in remote rural communities, urban communities, and in public spaces | Estimated nos. people who received direct behaviour change messaging for COVID-19 prevention/response or related issues (disaggregated by sex, district). | 0 | | | | 39,700 People | **74,310 (187% of target)** | | | | |
| | | | | | | | Bomballi : 5,590 ( 1,828 M; 3,762F) | | | | |
| | | | | | | Bonthe 4,500 | Bonthe: 12,625 (6,629 M; 5,996 F) | | | | |
| | | | | | | Kambia 15,000 | Kambia: 24,231 (12,952 M; 11,279 F) | | | | |
| | | | | | | Kenema 15,000 | Kenema : 15,513 (7,929 M ; 7,584 F) | | | | |
| | | | | | | Bombali 2,800 | Port Loko : 7,354 (3,260 M ; 4,094 F) | | | | |
| | | | | | | Port Loko 2,400 | Tonkolili : 397 (5M ; F) | | | | |

| **Overall Impact of Project/Programme:** Communities in 9 districts in Sierra Leone have strengthened resilience to prevent and reduce the spread and impact of the coronavirus pandemic. | | | | | |
|---|---|---|---|---|---|
| **Outcomes and Outputs** | **Key Indicators** | **Baseline (Qualitative & Quantitative)** | **Target** | **Endline** | **Comments and updates.** |
| | | | | WAU : 8,600 (3,579 M; (5,021 F) | |
| | Estimated nos. people who received indirect behaviour change messaging for COVID-19 prevention/response or related issues (disaggregated by district, communication medium). | 0 | Plan to use media in each district that achieves 75% coverage. | **873,422 People (29% of target)** | **Underachieved mainly due to the fact that targets initially set for the activity was too ambitious in terms of district coverage. Media used for the indirect behaviour change messaging usually had a smaller coverage.** |
| | | | | Bombali: 22.500 | |
| | | | 3,009,681 People | Bonthe: 28.715 | |
| | | | | Kambia : 102.953 | |
| | | | | Kenema : 678.454 | |
| | | | | Port Loko : 25.900 | |
| | | | | Tonkolili: 2.400 | |
| | | | | WAU : 12.500 | |
| **Output 1.3:** Water and sanitation infrastructure at health facilities assessed and strengthened as necessary. | Nos. of Public Health Units (PHUs) in need of strengthened WASH facilities have properly functioning water & sanitation facilities. | 0 | 20 | **19 PHUs** | **The total number of 19 health care facilities were supported with main repairs on the water systems and sanitation infrastructure. 100% of the 19 health facilities were completion respectively in WAU and Kambia districts.** |
| | | | | WAU: 8 | |
| | | | | Kambia: 11 | |
| | | | | | |
| **Outcome 2: Quarantine facilities, community care centres, and district structures are effective and fully operational.** | | | | | |
| **Output 2.1:** Communities near CCCs know about and accept | No. proposed CCCs with approval from | 0 | 2 | **2 CCCs operational** | **Adapted: As the scale of COVID-19 infection was lower than earlier** |
| | | | | (Bombali and Koinadugu) | |

| Overall Impact of Project/Programme: Communities in 9 districts in Sierra Leone have strengthened resilience to prevent and reduce the spread and impact of the coronavirus pandemic. | | | | | |
|---|---|---|---|---|---|
| **Outcomes and Outputs** | **Key Indicators** | **Baseline (Qualitative & Quantitative)** | **Target** | **Endline** | **Comments and updates.** |
| quarantine, CCC facilities, staff, patients, and operations. | community leaders prior to establishment & opening. | | | | **anticipated, CCCs were only established by DICOVERCs in Bombali and Koinadugu districts. These the project have supported.** |
| | Proportion monthly community sharing sessions completed for each active CCC. | 0 | 95% | N/A | **N/A as the activities related to this indicator were not carried out following the project adaptations.** |
| **Output 2.2:** The functioning of dignified quarantine facilities and/or community care centres (CCC) is enhanced. | Proportion of patients/and or staff satisfied with facility (disaggregate by gender, type of facility) | TBD for existing facilities / 0 for non-existing facilities | 75% | N/A | **N/A as the activities related to this indicator were not carried out following the project adaptations.** |
| **Output 2.3:** Discharge kits (essential food items/ once off cash) provided for people leaving treatment facilities and their affected households to allow them to recover from period of not being able to earn income. | Nos. discharge kits provided. | | 3,900 People | **589 people (15% of the target)** | **The number reached is lower than the original target mainly as a result of lower number of confirmed COVID-19 cases than anticipated. The target was based on an average household size of 6 people. The reported figures are actual number of people reached in each household.** |
| | | | Bombali: 600 | Bombali: 188 (77 M & 111 F) | |
| | | | Bonthe: 600 | Port Loko : 276 (137 M & 139 F) | |
| | | | Kambia: 600 | Kambia : 79 (43 M & 36 F) | |
| | | | Port Loko: 600 | Bonthe: 46 (20 M & 26 F) | |
| | | | WAU: 3,000 | | |
| **Outcome 3: The secondary impact of COVID-19 and other regular disasters (e.g., higher levels of SGBV, flooding events) on the food, health, and income security of vulnerable populations is mitigated.** | | | | | |
| **Output 3.1:** Basic needs of quarantined households and other households severely affected | Nos. of households supported with distributions of food, water, other essential items or specific & | 0 | 1,775 HHs | **Total = 2616 Households (147% of the target)** | |
| | | | Bonthe: 400 HHs | Bonthe: 400 HHs (200 MHH & 200 FHH) | |

| **Overall Impact of Project/Programme:** Communities in 9 districts in Sierra Leone have strengthened resilience to prevent and reduce the spread and impact of the coronavirus pandemic. | | | | | |
|---|---|---|---|---|---|
| **Outcomes and Outputs** | **Key Indicators** | **Baseline (Qualitative & Quantitative)** | **Target** | **Endline** | **Comments and updates.** |
| by COVID-19 covered in target districts through distribution of food, water, cash, and non-food items. | limited cash disbursements (disaggregate by sex of household head, district). | | Bombali: 125 HHs | Bombali: 337 HHs (192 MHH & 145 FHH) | |
| | | | Kambia: 125 HHs | Kambia :516 HHs (194 MHH & 322 FHH) | |
| | | | Port Loko: 125 HHs | Port Loko:1250 HHs (73 MHH & 1,117 FHH) | |
| | | | 1,000 HHs targeted for food assistance in Tonkolili and Port Loko | WAU : 113 HHs | |
| | | | | | |
| **3.2:** Caregivers of children under five are reached with effective behaviour change communications for improved practices on protection, promotion and support of appropriate childcare practices. | # of caregivers and PLW reached with behaviour change interventions to improve Maternal Infant and Young Child Nutrition (MIYCN) practices and COVID-19 prevention. | | Total = 11,380 | **Total = 4,217 (37% of the target)** | |
| | | 0 | Tonkolili = 8,550 | Tonkolili = 1,451 | |
| | | | Port Loko = 1,485 | Port Loko = 1,242 | |
| | | | WAU = 1,350 | WAU = 1,524 | |
| | | | | | |
| | # of Lead Mothers trained and disseminating MIYCN messages | 0 | Total = 759 | **693 Lead Mothers trained (91% of the target.)** | |
| | | | Tonkolili = 570 | Tonkolili: 362 | |
| | | | Port Loko = 99 | WAU: 88 | |
| | | | WAU = 90 | Port Loko: 243 | |
| **Output 3.3:** Acutely malnourished children 6-59 months have | # of Mother Support Group members trained | | Total = 759 | **693 Lead Mothers trained (91% of the target.)** | |
| | | 0 | Tonkolili = 570 | Tonkolili: 362 | |

| **Overall Impact of Project/Programme:** Communities in 9 districts in Sierra Leone have strengthened resilience to prevent and reduce the spread and impact of the coronavirus pandemic. | | | | | |
|---|---|---|---|---|---|
| **Outcomes and Outputs** | **Key Indicators** | **Baseline (Qualitative & Quantitative)** | **Target** | **Endline** | **Comments and updates.** |
| access to timely treatment and prevention services. | and conducting mother led MUAC screening | | Port Loko = 99 | WAU: 88 | |
| | | | WAU = 90 | Port Loko: 243 | |
| | # of children 6 – 59 months screened for malnutrition by mother led MUAC screening | 0 | Total = 11,380 | **Total = 5,740 (50% of the target)** | |
| | | | Tonkolili = 8,550 | Tonkolili = 1,141 (537 M & 604 F) | |
| | | | Port Loko = 1,485 | Port Loko = 1,232 (660 M & 572 F) | |
| | | | WAU = 1,350 | WAU = 3,367 (1,776 M & 1,591 F) | |
| | | | | | |
| | | | | | |
| | # of children 6-59 months screened and referred by Lead Mothers to the PHUs | 0 | Total = 569 | **Total = 1,080 (190% of the target)** | |
| | | | Tonkolili = 427 | Tonkolili = 188 (87 M & 101 F) | |
| | | | Port Loko = 70 | Port Loko = 371 (199 M & 172 F) | |
| | | | WAU = 68 | WAU = 521 (284 M & 237 F) | |
| | # of healthcare workers trained on IMAM/MIYCN | 0 | Total = 78 | **61 health workers (78% of target)** | |
| | | | Tonkolili = 52 | Tonkolili: 35 (5 M, 30 F) | |
| | | | Port Loko = 26 | Port Loko : 26 (18 M, 8 F) | |
| **Output 3.4**: Capacity of frontline health workers, Family Support Unit personnel, and social/shelter/protection service | Number of healthcare workers, FSU and protection service providers trained. | 0 | Total = 160 | **153 health workers (96% of target):** | . |
| | | | 80 HCWs | Tonkolili: 123 (70m, 53f) | |
| | | | 50 FSU personnel 30 protection | WAU: 30 (15m, 15f) | |

| **Overall Impact of Project/Programme:** Communities in 9 districts in Sierra Leone have strengthened resilience to prevent and reduce the spread and impact of the coronavirus pandemic. | | | | | |
|---|---|---|---|---|---|
| **Outcomes and Outputs** | **Key Indicators** | **Baseline (Qualitative & Quantitative)** | **Target** | **Endline** | **Comments and updates.** |
| providers in SGBV (identification, PFA, referral) | | | service providers) | | |
| | | | | | |
| | % of people trained who demonstrate appropriate knowledge on GBV cases identification | 0 | 60% | 60% (91 out of 151) people trained scored 80% or up on their post-test | |
| | | | | | Same test for both indicators |
| | % of people trained who demonstrate appropriate knowledge of GBV referral pathways. | 0 | 60% | 60% (91 out of 151) people trained scored 80% or up on their post-test | |
| | | | | | |
| **Out Put 3.5:** Sexual and Gender Based Violence (SGBV) messaging on prevention and response services disseminated in remote communities | Estimated number of people reached with messaging on SGBV | 0 | 22,760 Direct beneficiaries | **116,182 (522% of the target)** | For GOAL: Through CLA approach so the same people as recorded for covid-19 awareness |
| | | | | | |
| | | | | Kenema: 6,820 | |
| | | | | Kambia: 10,475 | |
| | | | | Tonkolili: 35,562 | |
| | | | | WAU: 48,132 | |

Source: Irish Aid COVID-19 Response M&E Framework

Appendix 8.5

**List of key informants**

| Participant | Name | Surname | Organisation | Job role |
|---|---|---|---|---|
| Interview 2 | Rachel | Newbery | Concern Worldwide | Program Manager |
| Interview 3 | Daniel | Gebremedhin Ashaw | TROCAIRE | Organisational Development Officer and project focal point |
| Interview 4 | Hellen | Donelly | TROCAIRE | Program Manager |
| Interview 5A | Charles | Momoh | SEND | Project Manager for the COVID-19 project implemented in Bonthe district |
| Interview 5B | Mustafa | Kallon | GOAL | Health Coordinator |
| Interview 6 | Yusufu | Conteh | Concern Worldwide | |
| Interview 7 | Josephus/Leslie | Ellie /NiBhrain | Irish Embassy | Senior Governance Advisor/ Ambassador of Ireland to Sierra Leone |

**Key Informant Interview Questions**

**Study Title: Process Evaluation of Irish Aid funded COVID-19 Response in Sierra Leone, July 2020-April 2021**

Thank you for taking the time to take part in this Key Informant Interview. Before you begin, please read through the information below and indicate your willingness to participate by singing the consent form that has been provided.

**Purpose of Evaluation Study**: As you may already be aware, this interview is part of an evaluation of the Irish Aid COVID-19 Response in Sierra Leone, that was implemented from July 2020-April 2021. The specific purpose of the Key Informant Interview is to explore the use of a real or perceived theory of change that guided the implementation of the Irish funded COVID-19 response in Sierra Leone. The interview seeks to capture some of the assumptions on which the project was based or developed during the design phase.

**Selection of Key Informants**: You have been selected because of your knowledge of the project. Persons selected as Key Informants, at minimum have met the following criteria:

- Represent one of the implementing partners of the project.

- Have knowledge of, or played an active role in designing and implementing the project
- Have time to provide an interview (in person or other platform) to data collectors

**Key Informant Questions and Consent Form**
We are really appreciative of your efforts in helping us. This is a straightforward process. My name is _____, and I represent the Institute for Development, which has been contracted to conduct the evaluation study. I will ask you the questions below and hope that you will answer them to the best of your ability.
**Length of Interview**: This Key Informant interview is expected to take one hour. There are no potential risks anticipated to study participants. Every effort will be made by the evaluators to protect confidentiality. All data collected for this study will be aggregated with no individual identifiers like names etc.
**Request to Record the Interview**: We ask your permission to record the interview so that we can capture all the important information that you will provide during the interview. Again, you are assured of information confidentiality.
**Right to Withdraw**: Although we will like you to participate, you are free to withdraw your consent at any time and there are no negative consequences for doing so. If you decide to withdraw, your responses will be excluded from the study. If you have any concerns related to this study, you can contact the Ms. Regina Bash-Taqi, Executive Director of Institute for Development at rbashtaqi@fdsl.gov.
Consent to Participate: If you agree to participate in this study, please sign the consent form.

*Key Informant Questions*

1. What was planned to be achieved at the start of the COVID-19 Response project? [Probe: Was there a clear vision of what would be achieved?]
2. How was change expected to happen in the context of this project?
3. What were the key assumptions that were necessary for the outcomes to be achieved? [Probe: How did these assumptions hold over time?
4. What did we learn during implementation that warranted adaptation /modification to project implementation?
5. What role(s) were played by project beneficiaries in the change or project modification process? [probe: were changes made brought back to the larger team to assess feasibility, value and achievement of project objectives?]
6. At the design phase, what challenges were anticipated to affect project implementation and what strategies were used to achieve the desired outcomes?
7. What factors mostly aided or supported project implementation?