Evaluation of the DFID Ebola Emergency Response Fund (DEERF) in Sierra Leone

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Acronyms

CCC	Community Care Centre
CESO	Community Empowerment Support Organisation
DEERF	DFID Emergency Ebola Response Fund
DEOC	District Emergency Operations Centre
DERC	District Ebola Response Centre
DEST	District Ebola Support Team
DFID	Department for International Development
DHMT	District Health Management Team
DMO	District Medical Officer
EOC	Emergency Operations Centre
ERC	Ebola Response Consortium
ETC	Ebola Treatment Centre
EVD	Ebola Virus Disease
FM	Fund Manager
FWC	Freetown WASH Consortium
HCW	Health Care Worker
HKI	Helen Keller International
HMIS	Health Management Information System
HPA	Health Poverty Action
INGO	International Non-Governmental Organisation
IPC	Infection Prevention and Control
IRC	International Rescue Committee
MSF	Médecins Sans Frontières/Doctors Without Borders
MoHS	Ministry of Health and Sanitation
NERC	National Ebola Response Centre
NNGO	National Non-Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Cooperation and Development
OICC	Observation Interim Care Centre
QIP	Quick Impact Project
SMAC	Social Mobilisation Action Consortium
SMART	Social Mobilisation and Respectful Burials Through faith-based alliance
SOP	Standard Operating Procedure
UNDP	United Nations Development Programme
UNMEER	United Nations Mission for Ebola Emergency Response
WASH	Water, Sanitation and Hygiene
WHH	Welt Hunger Hilfe
WHO	World Health Organization

Executive summary

Background

Ebola Virus Disease (EVD) was not officially declared a crisis by the World Health Organization (WHO) until 8 August 2014, by which time the disease was declared 'out of control' by Médecins Sans Frontières/Doctors Without Borders (MSF)[1] and had spread to the already weakened health systems of Guinea, Liberia and Sierra Leone. By the time Sierra Leone was first officially declared Ebola-free on 7 November 2015, 14,089 people had contracted the disease, and 3,955 had died from it, although it is likely that the actual figures are much higher.[2] A further flare-up in January 2016 resulted in a swift response by stakeholders and on 17 March 2016 Sierra Leone was again confirmed free of Ebola transmissions.[3]

The UK is the biggest bilateral donor in Sierra Leone and before the EVD outbreak, DFID had significant involvement with the transitioning of Sierra Leone towards development. To tackle the EVD crisis the UK government allocated an initial amount of £427m. The overarching aim of the UK's Ebola strategy was to 'control the spread of Ebola in Sierra Leone and the region, leaving a legacy of stronger health systems'[4].

The Urgent Needs project, which started in July 2014, was allocated £79.4m. Output 7 of the Urgent Needs project was to establish the DFID Emergency Ebola Response Fund (DEERF). The DEERF was designed to 'respond quickly to emerging operational gaps in the Ebola response in districts' and its main activity was to provide 'rapid funding to meet urgent gaps in the Ebola response'.[5] The DEERF (set up in September 2014) was initially provided with £5m in October 2014. Phase I of the DEERF covered a four-month period from October 2014 to January 2015, with the expectation that the essential gaps would be filled within this timeframe, and that there would be no further requirement for the funding. Ultimately, two further phases were required (Phase II: February to June 2015; Phase III: July 2015 to March 2016), with funding increasing to a final total of £13m.[6] The fund finally ceased operating as of 31 March 2016. GOAL, an international non-governmental organisation (INGO) was appointed fund manager (FM) in September 2014.

In October 2014, a Presidential directive saw the creation of the National Ebola Response Centre (NERC), mandated to manage and coordinate the emergency response. The NERC took over these functions from the Emergency Operations Centre (EOC) and the District Emergency Operations Centres (DEOCs). The NERC oversaw 15 District Ebola Response Centres (DERCs), which were supported by DFID Humanitarian Advisors, and which worked closely with the United Nations Mission for Ebola Emergency Response (UNMEER). From February 2015, DEERF approved proposals with the help of the District Ebola Support Teams (DESTs) based in the individual DERCs, to ensure relevance and coordination with the district-level operational plans.

Objectives of the evaluation

The objective of the evaluation was to assess the DEERF's implementation and fund management process, specifically focusing on the approach and design, implementation effectiveness, fund management efficiency, sustainability and overall impact.

GOAL commissioned Aid Works to conduct the evaluation using quantitative and qualitative methods. A country visit focused predominantly on obtaining qualitative data through semi-structured interviews and a focus group discussion with implementing partners. The evaluation was conducted between April and May 2016.

The questions were based on the five evaluation criteria – relevance, effectiveness, efficiency, sustainability and impact - as defined by the Organisation for Economic Cooperation and Development (OECD). The

[1] Moon, S. *et al*., *Will Ebola change the game? Lancet 2015; 386:2204-21*.
[2] http://kslp.org.uk/about-kings-sierra-leone-partnership/ebola
[3] www.who.int/mediacentre/news/statements/2016/end-flare-ebola-sierra-leone/en/
[4] DFID (2014), *Business Case*
[5] DFID (2015), *Annual Review*
[6] www.goalglobal.org/DEERF_Sierra_Leone_applications

questions covered implementing activities (services) and the fund management process (operations and process).

Overview of evaluation results

Quality and relevance

Overall, the DEERF met its objectives and responded quickly to emerging operational gaps in the Ebola response across districts, by providing rapid funding to meet urgent needs. The DEERF worked towards the overall direction of DFID's Ebola Strategy. As the crisis developed, so did the objectives and priorities of the fund. The DEERF had a simple application process with a quick response time. The fund created equity and brought more actors into the response because it was available to small and large INGOs, irrespective of their eligibility for other funding streams, such as the large consortia.

In Phase I, the objective was to process applications within 24 hours. In Phase II, this objective was loosened and subsequently over the remainder of the DEERF, the response extended to an average of five days. This reflected the need for a more extensive coordination process to ascertain the quality and relevance of applications.

In total, 133 proposals were submitted, with 65 approved (28 in Phase I, and 37 thereafter). 24 INGOs were contracted to deliver the projects, of which 13 utilised subcontractors, including some National Non-Governmental Organisations (NNGOs). Projects were typically funded for a period of 3-4 months at a time corresponding to the DEERF grant end date, with cost and no-cost extensions granted in line with the extension of the DEERF mechanism. Several projects required regular, large cost extensions as they constituted an essential component of the response and there was no alternative funding mechanism available.

GOAL has multisector emergency experience, which was critical for communication, understanding and support. The in-country experience of the fund management team was a contributing factor to quick implementation and successfully covering needs, particularly in Phase I. The implementing partner application and decision-making processes were largely clear, supplemented by a set of straightforward tools developed by the FM to process and monitor grants. Grants were monitored with site visits, and compliance and due diligence checks. In total, 94% of the 34 grants over £100,000 were monitored with a site visit by the FM, whilst 72% of all grants received a monitoring visit. All partners received a compliance visit.

Effectiveness

The DEERF addressed essential gaps, particularly in Phase I, with the aim of helping to prevent EVD escalating further. The funding succeeded in providing quick-release funds to fill these gaps. Partners implemented a wide range of projects that were in line with the DEERF's objectives in each phase. The fund results met expectations and supported critical activities for the overall EVD response, by:

- Supporting 854 beds and 4,813 patients in facilities,
- Providing 4,441 households and 23,676 people with quarantine food and non-food items,
- Training 1,931 community members,
- Training 3,546 health care workers in infection prevention and control (IPC),
- Training 30 quarantine officers,
- Supporting 30 ambulances at the peak of the outbreak.

The number of applications increased in line with the number of EVD cases; as cases fell, so did the approval of projects. As the cases fell, the project approval process focused on cost extensions and managing current projects.

The majority of weaknesses noted were process focused, linked with the need for greater fund transparency:

- Stakeholders did not always understand the difference in roles between GOAL as fund manager and DFID as donor,

- Although the implementing partner application decision making processes were largely clear, the rationale for awards to GOAL, which had the largest number of grants, was not transparent to implementing partners,
- The fund management unit was a small team, so while due diligence and compliance checks were conducted, implementation monitoring was considered light touch with limited detailed checks of activities and finances,
- There was limited involvement of the District Health Management Teams (DHMTs) in the decision making process.

Efficiency

The evaluation compared financial spend against plans. A total of £12,264,239 was approved for implementation across 65 projects, with a management fee of approximately 4% of total spend. This overhead was modest considering the range and number of projects implemented, indicating an efficient fund management process. No economic indicators were monitored (such as direct or indirect costs per output or beneficiary), which could be an area of improvement for future funds.

Due to the inability to predict the duration of the response, several projects were characterised by regular cost/no-cost extensions as their relevance persisted in line with the continued response. This resulted in 23 projects requiring cost extensions and therefore extended project implementation timeframes.

Coordination with stakeholders by the FM was well regarded, particularly in Phase I. From Phase II onwards coordination of projects was, in the main, directed by DERCs at district level.

Sustainability and replicability

The DEERF was created for a rapid emergency response and therefore did not have an explicit focus on sustainability of skills and knowledge, systems or resources. Gains were made in these areas, but they were unplanned and project specific. These included:

- Strengthened local relationships between DHMTs and INGOs;
- Improved people and project management skills amongst local staff from implementing partners;
- Improved knowledge of communities;
- Improved skills of hospital staff;
- Strengthened systems and increased IT resources for Health Management Information Systems (HMIS) and surveillance;

A number of critical success factors can be taken into consideration should a similar funding mechanism be replicated. The DEERF succeeded because it was rapid, simple and flexible. The FM had multi-sector and emergency experience, and was therefore able to provide a broad degree of support to the implementing partners. The DEERF was not constrained by tight programme design and was therefore able to change in response to the crisis.

Impact

Funding was needs driven. The majority of the funding was awarded to four districts (Bombali, Port Loko, Western Rural and Western Urban), correlating to where the number of confirmed Ebola cases was highest. There was widespread agreement from the stakeholders interviewed that DEERF worked, with implementing partners describing the DEERF as ‘live-saving’ and ‘a game changer’.

Potential improvements for replication

The processes and tools established by the DEERF FM could be made into a standard package for use by other emergency funds. Section 4 outlines the potential improvements for replication including greater transparency and information sharing, increasing emphasis on capacity development in the later stages of the emergency, improving monitoring and learning, establishing separate procedures for recipients of larger allocations, and increasing access to funding for NNGOs.

1. Background

Ebola Virus Disease (EVD) was not officially declared a crisis by the World Health Organization (WHO) until 8 August 2014, by which time the disease was declared 'out of control' by Médecins Sans Frontières/Doctors Without Border (MSF)[7] and had spread to the already weakened health systems of Guinea, Liberia and Sierra Leone. By the time Sierra Leone was first officially declared free of Ebola on 7 November 2015, 14,089 people had contracted the disease, and 3,955 had died from it, although it is likely that the actual figures are much higher.[8] A further flare-up in January 2016 resulted in a swift response and on 17 March 2016 Sierra Leone was again confirmed free of Ebola transmissions.[9]

In September 2014, the Office for the Coordination of Humanitarian Affairs (OCHA) estimated that US$1bn would be needed to mount an effective response against the disease; a year later, an unprecedented US$3.75bn had been pledged, although payments were late and in some cases did not arrive at all.[10]

The UK is the biggest bilateral donor in Sierra Leone and before the EVD outbreak, DFID had significant involvement with the transitioning of Sierra Leone towards development after the end of the civil war.[11] The overarching aim of the UK's Ebola strategy was to 'control the spread of Ebola in Sierra Leone and the region, leaving a legacy of stronger health systems'[12]. This was to be supported through four strategic aims:

1. To reduce transmission rate of Ebola to less than 1 in Sierra Leone initially, then zero;
2. To prevent spread to the wider region;
3. To stimulate global public goods to tackle this and future epidemics; and
4. To tackle wider consequences of Ebola in Sierra Leone.

The response was complex and multifaceted. An initial amount of £427m was committed by the UK government to more than 10 projects, delivered through 13 partners consisting of two large non-governmental organisation (NGO) consortia, international NGOs and one multilateral, UNICEF.[13] Some 83 downstream delivery partners received DFID funding, the majority of which were international NGOs (INGOs). District Ebola Response Centres (DERCs) also received logistical support. A breakdown of DFID-funded EVD projects can be found in Appendix 5.1.

The Urgent Needs project, which started in July 2014, was the first DFID response; it had eight outputs and was allocated £79.4m. Output 7 of the Urgent Needs project was to establish the DFID Emergency Ebola Response Fund (DEERF). The DEERF was designed to 'respond quickly to emerging operational gaps in the Ebola response in districts' and its main activity was to provide 'rapid funding to meet urgent gaps in the Ebola response'.[14] The DEERF, set up in September 2014 and managed by GOAL, was initially awarded £5m in October 2014, increasing over the course of several subsequent allocations to £13m.[15]

The fund manager (FM), GOAL, has been in Sierra Leone since 1999, delivering services in the health (including water, sanitation and hygiene (WASH) and health systems strengthening), child protection and empowerment sectors. It implements in six provincial districts in addition to Western Area urban and rural. Globally GOAL has core competencies in four sectors: emergency response, health (including WASH), child protection and livelihoods.

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[7] Moon, S. *et al*., *Will Ebola change the game? Lancet 2015; 386:2204-21*.
[8] http://kslp.org.uk/about-kings-sierra-leone-partnership/ebola
[9] www.who.int/mediacentre/news/statements/2016/end-flare-ebola-sierra-leone/en/
[10] www.odi.org/publications/9956-ebola-response-west-africa-exposing-politics-culture-international-aid
[11] www.gov.uk/government/world/organisations/DFID-sierra-leone
[12] DFID (2014), *Business Case*
[13] DFID (2015), *Annual Review*.
[14] *Ibid*.
[15] www.goalglobal.org/DEERF_Sierra_Leone_applications

DFID also allocated Urgent Needs funding for specific sectors coordinated by various consortia, including the Ebola Response Consortium (ERC) and Social Mobilisation and Respectful Burials Through faith-based alliance (SMART). The activities of the ERC included: Infection Prevention and Control (IPC) at non-Ebola Health facilities; support to community event-based surveillance and district surveillance; provision of a '117' alert function (an EVD emergency telephone number); provision of safe and dignified burials; and operational support to Ebola isolation facilities in hospitals in the Western Area. The activities of SMART included: provision of safe and dignified burials in 12 districts; and Ebola fleet management. The ERC, led by International Rescue Committee (IRC), was funded with £13.7m and SMART, led by World Vision, was allocated £12.7m.[16] A breakdown of Urgent Needs activities and funding is included in Appendix 5.2.

The Social Mobilisation Action Consortium (SMAC) - funded by DFID and the Bill & Melinda Gates Foundation - focused on mass media campaigns, outbreak control, social mobilisation, community engagement and behaviour change.[17] Social mobilisation to change behaviours was perceived as one of the most effective ways of preventing transmission.[18] In addition, the Freetown WASH Consortium (FWC), which existed prior to the outbreak, engaged in the response to improve access to WASH facilities for use in IPC in health facilities, schools and quarantine.

The United Nations Mission for Ebola Emergency Response (UNMEER) established the Quick Impact Project (QIP) Fund. QIPs were administered at district level through DERCs in 13 districts, and were managed by the Ministry of Health and Sanitation (MoHS) District Health Management Teams (DHMTs), led by the District Medical Officer (DMO). The QIP Fund supported a range of activities that contributed to filling essential gaps in the overall Ebola response. The maximum grant total was US$50,000, funding projects of up to three months' duration from registered INGOs and NNGOs. Up until June 2015, 46 QIP projects were approved, totalling $878,034 in funding. In July 2015 UNMEER handed over administration of the QIP Fund to the United Nations Development Programme (UNDP).[19] Implementing partners' views on the effectiveness of QIPs was mixed, and an UNMEER report agreed that there had been funding delays.[20]

To manage and coordinate the emergency response the government of Sierra Leone created the National Ebola Response Centre (NERC) and established 9 pillars[21] to direct sector activities. The NERC took over functions from the Emergency Operations Centre (EOC) and the District Emergency Operations Centres (DEOCs). The NERC served as a command and control structure, overseeing 15 DERCs and reporting directly to the President.[22] The DERCs had a number of implementing partners, including the DHMTs and NGOs. DFID District Ebola Support Teams (DESTs) were based in individual DERCs. The NERC and DERCs conducted daily briefings, which helped the continuous flow of information across actors engaged in the response, both at district level and between district and national levels.

[16] www.gov.uk/international-development-funding/DFID-emergency-ebola-response-fund
[17] http://smacsl.org/about/
[18] DFID (2014) 'UK Response to the Ebola Crisis in Sierra Leone and the Region', *DFID Business Case*.
[19] UNDP (2015) *Quick Impact Project Guidelines*.
[20] UNMEER (2015) *Quick Impact Project Guidelines*, June.
[21] The 9 pillars were: Child Protection and Psychosocial Support; Case Management; Communications; Logistics; Safe Burials; Social Mobilisation; Surveillance; Coordination; and Food Security.
[22] http://sbccimplementationkits.org/ebola/chapter-3-central-ebola-response-mechanism/

2. Introduction to the evaluation

2.1 Objective of evaluation

The objective of the evaluation was to assess the DEERF's implementation and fund management process, specifically focusing on the approach and design, implementation effectiveness, fund management efficiency, sustainability and overall impact.

The main audience for this report is development partners (donors), the government of Sierra Leone, implementers and the FM. Additional deliverables include the debrief presentation provided to GOAL and a public podcast summarising the results of the evaluation.

2.2 Assessment questions

The main assessment questions drew out findings from across the development partners and at all health system levels: national, district and service provision. With reference to the Request for Offer, Aid Works developed the table below to summarise and provide a more detailed description of our understanding of the questions, based on the five evaluation criteria defined by the Organisation for Economic Cooperation and Development (OECD).[23] The questions covered implementing activities (services) and the fund management process (operations and process).

Table 1: Main assessment questions

Evaluation area	Question (Q)	Our understanding
Quality and relevance of design	1. To what extent did the DEERF's adopted approach help respond to EVD control?	Investigate whether the DEERF interventions were critical components of the overall response. The question will focus on: – The DEERF's objectives and alignment with the overall EVD control objectives; – The main contributions of the fund and types of activities undertaken; and – Types of activities most critical to the overall EVD response.
	2. How appropriate were the strategies used?	Investigate the attributes and different stages of the DEERF mechanism: – Fund management selection process; – Funding cycle; – Roles of the FM; – Gap identification process across all phases; – Application and decision-making process; and – Monitoring.
Effectiveness[24]	3. To what extent where the DEERF's objectives met?	This question will draw out findings on activities. It will: – Compare implementing partners' successes with the DEERF's objectives and intended results (related to Q1); – Identify exceptional experiences; and – Describe NNGO experiences.
	4. What were the DEERF's weaknesses?	From qualitative data gathered, we will explain the gaps and failures of the intervention including possible reasons. This will cover: – Weaknesses in implementation; – Challenges of the fund management process; and – Areas of duplication/overlap.

[23] http://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm
[24] No questions were posed in the Request for Offer, therefore Aid Works proposed questions for discussion during the inception meeting.

Efficiency of planning and implementation	5. Was the financial spending in line with developed work plans?	Focusing on quantitative analysis of intervention expenditure. Example analysis area if data is available: – Analysis of expenditure against planned work
	6. How well did the DEERF work with partners, government stakeholders and donors?	This question complements Q2. It focuses on the strengths and weaknesses of the DEERF's coordination with development partners and other funding streams. Topics will include: – Involvement of the government; – Duplication avoidance with other funding (e.g. UNDP); – Coordination and input from the DERCs/UNMEER; – Coordination with other consortia (ERC, FWC, START, SMAC, etc.); and – Coordination and communication with implementing partners.
Sustainability and replication	7. To what extent did the DEERF help build the capacity of EVD response stakeholders?	Through qualitative data collection, the evaluation will outline findings for individuals (e.g. health workers) and groups/organisations (e.g. DHMTs). Findings will cover skills, systems and resources improvements. Furthermore, findings will cover how the fund could be replicated or continued.
Impact	8. To what extent did the DEERF contribute to positive/negative impacts on emergency response?	No specific questions will be explicitly asked for this section because it will be covered as part of Q1.
	9. To what extent did the DEERF contribute to a solid and coordinated EVD response?	After the inception meeting with GOAL, it was agreed to remove this question to merge this question with question 1.

2.3 Approach and methodology

Before arriving in Sierra Leone, the team undertook a systematic desk review of available documentation about the DEERF and EVD interventions, as well as any other evaluations or reviews. The insight gained was essential in identifying gaps in information which needed filling during the visit to Sierra Leone. Quantitative data was used for specific question areas, which GOAL made available before arrival.

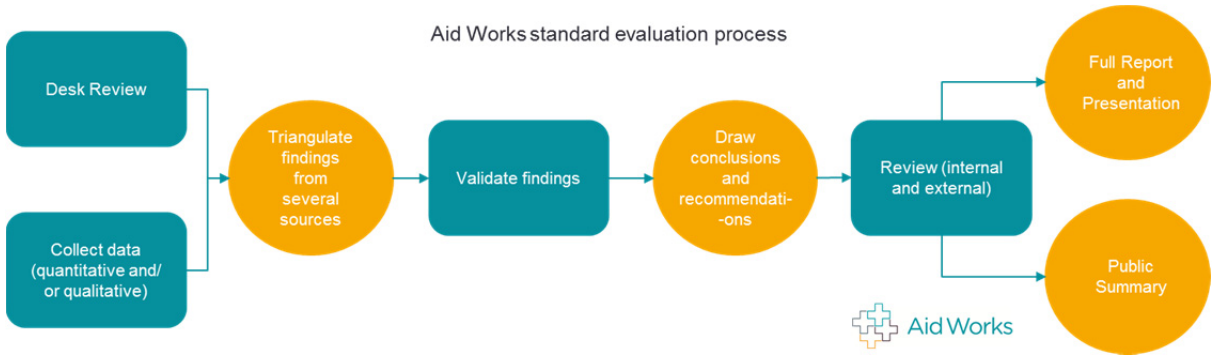
The country visit therefore focused predominantly on obtaining qualitative data through semi-structured interviews and a focus group discussion with implementing partners. A summary of methods and data-collection tools is listed in Table 2, below.

Table 2: Summary of methods and data-collection tools

Activity	Completed	Data collection tools
Document review	– All relevant project documents – Donor programme documents – GOAL/Fund Manager documents – Quantitative data analysis of outputs and finances	Key findings template
Key informant interviews	25 interviews covered:[25] – implementing partners – other funding mechanisms – DFID – DHMT	Semi-structured interview guidelines (see Appendix 5.6)
Focus group discussion	6 implementing partners	Focus group guideline (see Appendix 5.5)
Site visits	Makeni, Bombali District	Semi-structured interview guidelines (see Appendix 5.6)

2.4 Analysis and reporting

Figure 1: Aid Works standard evaluation process



The team developed standardised interview, focus group and workshop tools to capture data in a systematic manner. An overall analysis framework was populated for each question to support triangulation of data from different sources. Findings were presented to and validated with the GOAL team during a debrief presentation at the end of the visit.

2.5 Limitations

The evaluation was primarily qualitative in nature, collecting subjective information on the efficiency, effectiveness, strengths and weaknesses of DEERF. Some of the limitations of the evaluation included:

- Heavy reliance on qualitative data and memory of past experiences (potentially leading to recall bias, particularly with the fast moving and changing nature of the emergency);
- Changes in staff across all sectors, meaning that many of those involved at the start of the emergency have now left, therefore reducing institutional knowledge within DFID, GOAL, implementing partners and others;
- Limited interactions with DHMTs; and

[25] See Appendix 5.4 for list of key informants

- That DERCs were no longer functioning and therefore former staff members were unavailable for interview.

However, the team collected a large evidence base, using a systematic approach to record and analyse information across sources. Where possible, information was triangulated against secondary sources to reduce bias and cover gaps where they existed. The validation process was essential to confirm that field-observation generalisations were correct, and the final debrief offered a chance for GOAL to comment on the preliminary findings, conclusions and future recommendations.

3. Research findings

The questions were based on the five evaluation criteria: relevance, effectiveness, efficiency, sustainability and impact, as defined by the OECD. The questions covered implementing activities (services) and the fund management process (operations and process). The findings cover the following:

- A review the DEERF objectives, types of projects and fund management processes;
- A description of the outputs, strengths and weaknesses of the approach;
- Analysis of financial data available;
- Findings on the DEERF's coordination with other stakeholders;
- A description of the capacity developed due to the fund;
- Overall impact of the fund.

3.1 Quality and relevance of design

DEERF objectives

The initial funding of the DEERF was to cover a four-month period from October 2014 to January 2015, with the expectation that the essential gaps would be filled within this timeframe, and that there would be no further requirement for the funding. However, by January 2015 it was evident that there were still essential gaps and a need for the DEERF to continue.[26] The FM director identified that the majority of partners were applying for funding under the third objective –'Improve the efficiency of the Ebola response system'. The needs of the emergency were evolving, such that the provision of beds was no longer the top priority[27] and DFID and FM agreed that a fourth objective should be added: 'DEERF responds quickly and efficiently to the emerging operational gaps in the Ebola response at district level and in line with district plans'. Table 3 outlines the objectives for Phases I, II and III.

Table 3: Objectives in Phases I, II and III

Phase I (6 October 2014–January 2015)	Phase II (February–June 2015) Phase III (July 2015–March 2016)
1. Increase beds through quick and small-scale interventions across the country. 2. Decrease the need for beds. 3. Improve the efficiency of the Ebola response system.	1. DEERF responds quickly and efficiently to the emerging operational gaps in the Ebola response at the district level and in line with district plans. 2. Increase Ebola treatment or isolation unit beds through quick and small-scale interventions across the country. 3. Decrease the need for beds. 4. Improve the effectiveness of the Ebola response system.

The majority of implementing partners and other FMs understood the broad objectives of the DEERF. However, some implementing partners said that there was a 'little ambiguity' or 'lack of clarity' about what could actually be funded.[28] DFID said that the objectives were deliberately kept vague to allow for flexibility to respond to changing needs.[29]

[26] Interview with FM Director.
[27] DFID (2015), *DFID Rapid Review*.
[28] Workshop with implementing partners.
[29] Interview with DFID staff.

Types of projects

In total, 133 proposals were submitted, with 65 approved (28 in Phase I, and 37 thereafter). 24 INGOs were contracted to deliver the projects, of which 13 utilised subcontractors, including some National Non-Governmental Organisations (NNGOs). Projects were typically funded for a period of 3-4 months at a time in line with the duration of the DEERF mechanism. Further detail on the funded projects is included in Appendix 5.7.

A range of projects were implemented through DEERF:

- Establishing EVD treatment centres and temporary isolation centres;
- Surveillance (e.g. training, logistics support, payments, transport, etc.);
- WASH for IPC (e.g. maintenance/rehabilitation of boreholes and pumps, building safe soakaways, renovating or building latrines and showers, etc.);
- Social mobilisation;
- Provision of EVD ambulance services; and
- Supporting safe and appropriate isolation for children affected by EVD.

The variety of activities funded filled essential gaps and was therefore considered critical to the success of the response. However, in the DFID Rapid Review there was a mixed response from implementing partners about how helpful the focus on beds in Phase I was.

Other consortia also covered activities such as WASH, IPC and social mobilisation. However, stakeholders agreed that delays in funding through other mechanisms prevented implementation of essential projects, and the DEERF enabled partners not included in those consortia to access funding for specific and critical gaps.[30] To ensure activities were not being duplicated, the FM director consulted with appropriate consortia representatives as well as with DFID.[31]

Due to the nature of the funding, the DEERF could support small, innovative projects which would not have been funded through other donors, including the distribution of food and non-food items. One such example was Trócaire, which worked with an NNGO to respond to the livelihoods needs of quarantined households.[32] After consultation with the community a package was devised to provide: a) caretakers and/or labour gangs to manage farms; or b) business support in the form of cash transfers. More examples of good practice and case studies are included in Appendix 5.8.

The funding of the DEERF projects does not appear to have had a negative impact on other projects being delivered by implementing partners,[33] although some implementing partners said that there was an impact on administration due to monthly reporting and resubmission of extension requests.

Selecting a fund manager

As a funding mechanism, the DEERF was designed to release funds as quickly as possible and 'provide support to fill urgent gaps in the Ebola response'.[34] Consequently a suitable fund disbursement method needed to be identified. A DFID representative said that the DFID Sierra Leone office did not have capacity to manage the funds and the historical procurement methods for selecting a fund manager would not only be time consuming, but potential applicants may not have had the necessary experience and understanding of the emergency and context.[35] Therefore, DFID decided to use an INGO based in Sierra Leone as the fund manager. DFID saw this as a potential risk, because an INGO may not have had previous fund management

[30] Interviews with implementing partners, focus group discussion and DFID representatives.
[31] Interviews with FM director, DFID and other fund mechanism representatives.
[32] Solis, M. and Grogan, R. (2016), article submission for World Humanitarian Summit
[33] Interview with implementing partners.
[34] www.gov.uk/international-development-funding/DFID-emergency-ebola-response-fund
[35] Interview with DFID, Sierra Leone.

experience; however, the benefits were that an INGO would have an understanding of the context, experience with different sectors, various actors and partners and more importantly was on ground and ready to implement the programme immediately. DFID talked to a number of INGOs and asked them to submit their proposals. IRC and GOAL were shortlisted and asked to submit proposals to be assessed under a mini-competition.[36] In September 2014 GOAL was selected to act as FM because it had several years' experience working in Sierra Leone and had run a similar emergency fund in Ethiopia. In addition, the DFID Humanitarian Advisor was already working with GOAL to address key operational gaps in the response and they had already displayed the ability to mobilise rapidly with appropriate interventions.[37] The DFID Rapid Review highlighted that some INGOs were unclear about how the fund manager was selected.[38]

The Fund Management unit consisted of two GOAL employees, the FM director and a finance and compliance manager. They acted independently of the GOAL Sierra Leone Country Office and were housed in a separate building. However the resources of GOAL Sierra Leone, including support functions, were made available to support as required.

Mitigating financial risk

Potential implementing partners applied through one of two processes, depending on their award history. To mitigate potential financial risks (and to expedite contractual agreements), grant recipients that had already received DFID funding or were in receipt of large-scale grants from international donors, were eligible for the fast-track application process. Applicants unable to fulfil these criteria underwent a rapid appraisal process. NNGOs could not be the prime recipient of the DEERF but could be a subcontractor, with an INGO as the grant holder (see Appendix 5.3 for the DEERF Terms of Reference). In addition the FM could only approve funding for grants of £100,000 and below; DFID had to sign off anything above that amount. From the end of January 2015, preapproval was required by the DERCs for projects of £100,000 or less. The FM held no accountability for financial or intervention risk.[39]

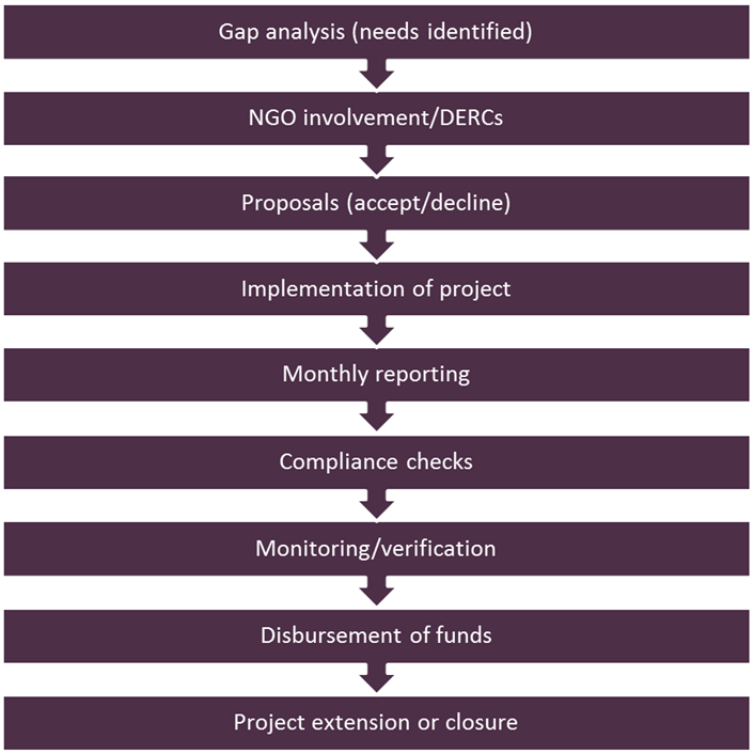
Application and decision-making process

Application forms were accessed through the GOAL website and there was a general consensus from implementing partners that the forms were easy to complete, and that there was a quick response rate from the FM. In Phase I, applications received a response within the 24-hour target.[40] One interviewee said that the quick turnaround was 'amazing… there was a 24 hour approval and in another 24 hours partners could be implementing'.[41] The DFID Rapid Review found that this was a 'significant achievement'.[42] In Phase I the FM director, sometimes accompanied by DFID representatives, would meet with partners to review their proposals, which improved the quality of the projects while allowing a quick approval. However, the majority of these meetings ceased in Phase II when all projects had to have agreement and sign-off from the DERCs, slowing the speed of response.[43] However, stakeholders said that this process improved the quality of projects and helped reduce the potential of activities being duplicated.[44] The average response time over the life of the DEERF was 2.7 days, with the longest response time for an application being 34 days.[45]

The DEERF project funding cycle is illustrated in Figure 2, below.

[36] Interview with DFID, Sierra Leone.
[37] Feedback from GOAL Country Director.
[38] DFID (2015), *Rapid Review*.
[39] Ibid
[40] Also confirmed in the *Rapid Review*, May 2015.
[41] Interview with ERC coordinator.
[42] DFID (2015), *Rapid Review*.
[43] Interview with FM director.
[44] Interviews with implementing partners, FM director and DFID representatives.
[45] GOAL (2016), *Mid-term report*, February.

Figure 2: DEERF project funding cycle[46]



Gaps identification process

There was no specific work plan for the allocation of the DEERF, as it was needs driven and had to respond to specific gaps identified at district level.[47] In Phase I, DFID and the FM director identified gaps in the response through coordination and networking. To fill some gaps, the FM director had to actively find partners to implement specific tasks. From Phase II onwards, coordination shifted to the DERCs, which slowed down the approval process. However, implementing partners described the shift as having increased the 'quality and relevance of the projects… as they were in line with needs on the ground'.[48]

NGO involvement

Smaller INGOs expressed how helpful DEERF funding had been, especially if they were not in a consortium, which effectively excluded them from the main funding streams. The Community Empowerment Support Organisation (CESO), a very small INGO with limited funds, said that the community that it supported would not have received any other funding had it not been for the DEERF: 'we were very grateful … it [the funding] was a huge deal for us, the community would have been much worse off without it'.[49]

Monthly reporting and monitoring visits

The funding was short term and therefore DEERF required partners to complete a monthly one-page narrative on project activities, along with a financial report. All partners agreed that the monthly narrative was easy to complete, but responses about financial reporting were mixed. Some found the spreadsheet used relatively easy to complete and it provided a ready-made way for them to monitor their spending - especially useful when proposals had been developed so quickly. Others described the financial reporting as

[46] Process chart developed and verified with implementing partners at the focus group discussion. The monitoring of the project did not always come before fund disbursement. A few projects were pre-financed.
[47] Interview with FM director.
[48] Focus group discussion with implementing partners.
[49] Interview with implementing partner.

'onerous'[50] and an 'administrative burden'[51] that required GOAL to make a number of checks, thereby delaying payments. All implementing partners interviewed agreed that the two-week deadline for the financial report was difficult to meet, because they could not report all actual spend against budget within the timeframe, which delayed further payments.

The FM had to monitor all projects over £100,000, which was the majority of projects. The FM also monitored projects below this threshold, although this was not a requirement. The same method was used to monitor all projects. The FM director made site visits, sometimes with DFID's participation. The timing of these visits varied and some occurred after the funds had been disbursed. The FM director described monitoring visits as 'light touch' only, to verify that projects had been implemented. A more in-depth monitoring and evaluation process was not part of the contractual agreement. Projects implemented by GOAL with DEERF funding received joint visits from the FM and DFID.

The FM developed and managed a DEERF Grant Award Tracker, a useful tool that kept a track of all proposed projects, including those that had been rejected, and the time taken to process applications. It meant that the FM could monitor itself and make sure that it was meeting its objectives. The tracker sheet recorded the start and end dates of projects, and specific elements of projects such as the number of beds, boreholes, Ebola treatment Centres (ETCs), Observation Interim Care Centres (OICCs), district projects implemented, number of people trained and so on. The tracker monitored total funds allocated to each implementing partner. It did not, however, identify projects by specific DEERF objectives nor provide a breakdown of which districts were supported; this was complicated, because many projects were implemented in two or more districts. [52]

Due diligence and compliance checks

Due diligence and compliance checks were conducted by the FM with partners with projects of £100,000 and over. The FM developed a financial checklist to guide the compliance checks. The majority of partners said that visits had been undertaken after the implementation of projects, although the timing of these varied.

Role of the fund manager

The role of the FM was to support INGOs in applying for grants, coordinate with other consortia and networks to ensure essential gaps were being filled and activities not duplicated, liaise with those coordinating at district level and inform implementing partners of any changes or extension to the DEERF mechanism. In addition, the FM would undertake monitoring visits, compliance and due diligence checks. The FM was also responsible for monitoring expenditure and then making appropriate financial disbursements. Although the FM managed and monitored risks, it held no accountability for IPC nor financial issues.

During the lifetime of the grant the FM employed 2 FM directors; the first from November 2014 to June 2015 and the second from June to December 2015. The majority of those interviewed said that both FM directors were very helpful. Having staff in post with knowledge of the geography and the various stakeholders was important. The first FM director was described as a 'lynch pin' who could 'put the jigsaw together' because she knew the gaps, partners and geography, and could also be 'very persuasive'.[53] The FM directors were also described as being particularly helpful 'in difficult political situations'.[54]

[50] Focus group discussion with implementing partners.
[51] Interview with implementing partner.
[52] DEERF Grant Award Tracker
[53] Focus group discussion with implementing partners.
[54] Focus group discussion with partners and individual interviews.

3.2 Effectiveness

DEERF achievements were measured against four outputs with various indicators, as shown in Table 5. Overall, the outputs were met by the FM against measured performance. In Phase I, 98% of applications were processed within 24 hours. From Phase II onwards this increased to 4.2 days because of the requirement to work through the DERCs, giving an average application response time of 2.7 days for all phases.[55] In total, 94% of grant recipients over £100,000 received a site visit as required. In total, 47 out of the 65 projects (72%) were monitored. There was an indicator for the average response rate for cost-extensions, but data was not recorded.

Table 4 shows the total number of beds and patients by facility type supported by the DEERF. In total, 854 beds and 4,813 patients were supported through ETCs, OICCs, Community Care Centres (CCCs), quarantine beds, holding centres and isolation units in hospitals. However, data was not available for patients utilising CCC beds.

Table 4: Beds and patients by facility type supported by the DEERF[56]

Type of facility	Total number of beds in Phase I	Total number of beds Phases I–III	Total number of patients
ETCs	50	50	84
OICCs	175	175	315
Holding centres	58	118	4,012
CCCs	18	18	-
Quarantine beds	60	380	172
Isolation Units in Hospitals		113	230
Total	**361**	**854**	**4,813**

Overall 4,441 households were supported with quarantine food and non-food items reaching 23,676 people in eight districts: Port Loko, Bombali, Tonkolili, Western Area Rural, Moyamba, Bonthe, Kono and Kambia.

1,931 community members were trained in social mobilisation skills and 3,546 health care workers (HCWs) were trained in IPC. Crucially none of the HCWs trained with DEERF funding tested positive for EVD. The DEERF established a much-needed fleet of ambulances, and a decontamination and fleet management programme in time for a major surge in operations in the Western Area.[57]

[55] Source: DEERF Grant Award Tracker May 2016
[56] GOAL (2016) Final Report, and GOAL Award Tracker
[57] DFID (2015), *Annual Review*.

Table 5: DEERF achievements against outputs and indicators[58]

Output	Indicator	Achievement
Output 1: The DEERF responds quickly and efficiently to the emerging operational gaps in the Ebola response at district level and in line with district plans	Indicator 1.1: Average daily response rate	Phase I = ≤24 hours Phase II onwards = 4.2 days[59] Overall = 2.7 days[60] Longest response time = 34 days
	Indicator 1.2: To monitor all projects over £100,000	27 out of 30 projects (94%) over £100,000 were monitored Overall, 47 out the 65 projects (72%) were monitored
	Indicator 1.3: DEERF applications endorsed by DERCs (starting Feb. 2015)	Occurred 100% of the time.[61]
	Indicator 1.4: Average response rate for DEERF cost extensions[62]	No target
Output 2: Increase Ebola treatment or isolation unit beds through quick and small-scale interventions across the country	Indicator 2.1: Number of beds in ETCs, holding centres, CCCs and OICCs supported by DEERF	A total of 854 beds supported
	Indicator 2.2: Number of people receiving care at DEERF-supported ETCs, holding centres, CCCs and OICCs	A total of 4,813 people received care
Output 3: Decrease the need for beds	Indicator 3.1: Number of quarantined households that received their supply of food and non-food items for the entire quarantine period	Overall, 4,441 households were supported with quarantine food and non-food items for the entire quarantine period. This intervention reached 23,676 people in Port Loko, Bombali, Tonkolili, Western Area Rural, Moyamba, Bonthe, Kono and Kambia districts
	Indicator 3.2: Number of chieftaincy task force members, contact tracers and community stakeholders trained to safely identify and isolate suspected EVD cases	In total, 1,931 community members were trained either to socially mobilise their communities to take action against high-risk practices that could spread EVD within the community, or they were trained to work within their community to trace contacts
	Indicator 3.3: Number of HCWs trained in IPC	A total of 3,546 HCWs were trained in IPC. NB None of the HCWs working on DEERF-funded projects have tested EVD-positive.
Output 4: Improve the efficiency of the Ebola response	Indicator 4.1: Improve the efficiency of the quarantine management system in the Western Area rural and urban districts	A total of 30 quarantine officers were trained in the Western Area.
	Indicator 4.2: Number of ambulances supported to transport patients to and from ETCs, holding centres, CCCs and OICCs in 'hotspot' districts	A total of 30 ambulances were supported at the peak of the outbreak. The fleet decreased in line with the decline in EVD cases.
	Indicator 4.3: Flare-ups or new cases responded to by DEERF-funded emergency teams	Responded to flare up in Kambia and Bombali Districts in Aug/Sept. 2015 and in Tonkolili in Jan. 2016

[58] GOAL (2016), *Final Report*.
[59] Source: DEERF Grant Award Tracker May 2016
[60] Ibid
[61] From mid-May 2015 there was limited number of DERCs with DFID representation. Where there was no DFID representation, projects were reviewed by DFID Sierra Leone Head Offic, endorsement letters were requested from the District Coordinator or District Medical Officer.
[62] There is no target evidenced for Indicator 1.4. It is unclear if this target was subsequently removed.

Strengths

Achieving objectives

The majority of interviewees said that the DEERF objectives were met throughout the duration of the funding, particularly in the initial stages when the priorities were: increasing bed capacity, decreasing need for beds, filling essential gaps, increasing surveillance and supporting transport for patients. The provision of beds was described by the DFID Annual Review as being a 'particular achievement providing much needed bed capacity before the scale up in capacity occurred'.[63]

One interviewee described EVD as 'a unique disaster in that it was not possible to anticipate what would happen next, therefore tight programme design was impossible',[64] but the DEERF was not constrained and could 'develop with the epidemic'.[65]

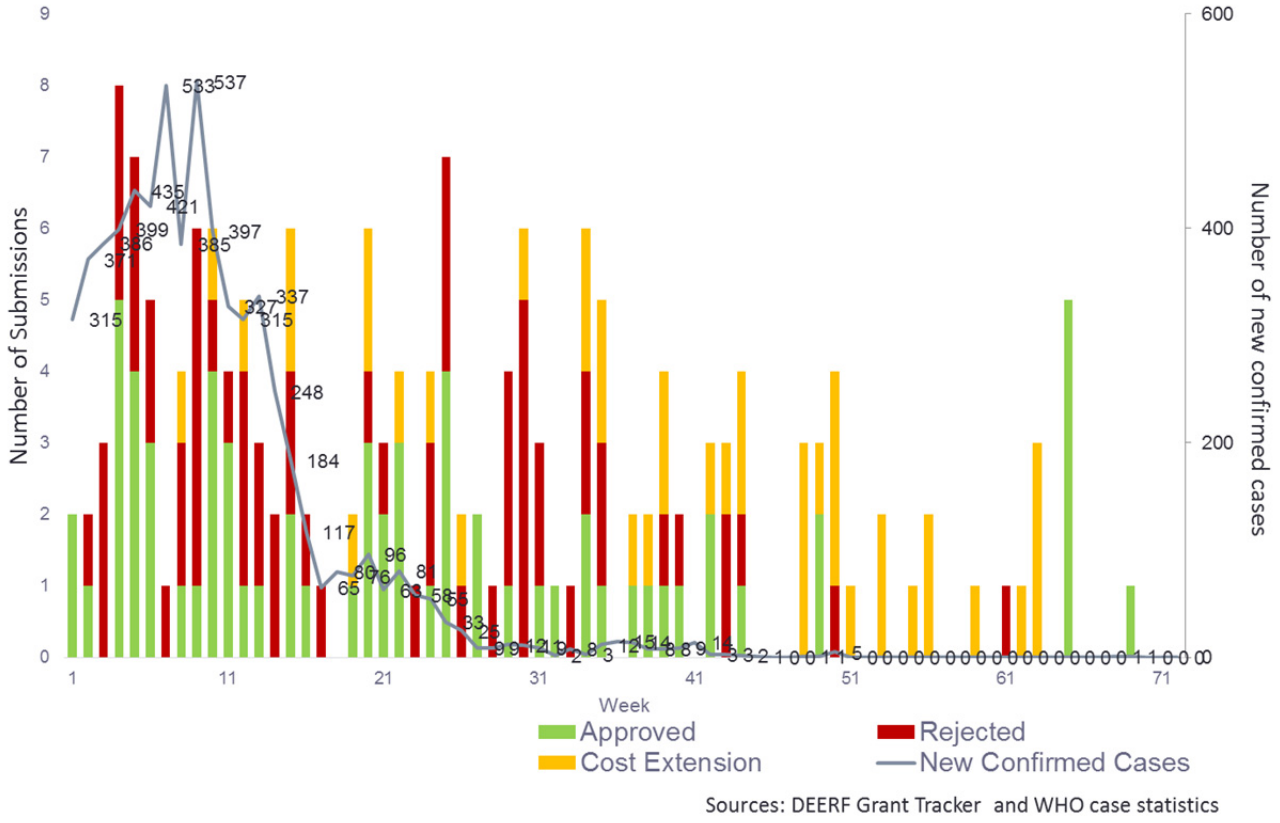
A number of interviewees said that without the DEERF the emergency would have continued for much longer. Various terms were used to describe the funding, including 'life-saving' and 'a game changer'. One implementing partner said that the funding helped to 'restore community confidence in returning to health facilities'.[66] Another interviewee said that the intervention helped to manage the outbreak of EVD: 'By December 2014 everything was in place and by February 2015 cases declined significantly… [it] did peak [and was] much easier to control'. Table 4, above, shows the different facilities that the DEERF supported and the total number of patients who used them.

After an initially slow start in applications, submissions from implementing partners increased around the end of November and beginning of December 2014. Figure 3 shows the project application rates compared to the number of new confirmed EVD cases throughout the funding period. There was an increase in applications in November 2014 (week 4) that correlated with the appointment of the FM director. The graph shows a trend, with applications increasing as the cases increased and declining as cases declined. When there were spikes in cases this resulted in an increase in applications, presumably to respond to the gaps in services. In mid-2015 (week 34 onwards), a decline in cases can be observed, which also shows a reduction in new projects being funded. From 21 August 2015 (week 41) the DEERF stopped accepting unsolicited proposals and there was a deliberate shift from filling essential gaps to an emphasis on right-sizing, which largely focused on cost and no-cost extensions. More recently the DEERF accepted proposals on response readiness and was still able to respond to new confirmed cases in October 2015 and January 2016.

[63] DFID (2015), *Annual Review*.
[64] Interview with ERC coordinator.
[65] Interview with FM director.

[66] Interview with implementing partner.

Figure 3: Application rates compared to number of new confirmed cases



Funded projects included innovations that became essential components of the overall EVD response. For example, Welt Hunger Hilfe (WHH) was one of the first organisations to target quarantined households and provide basic care packages with food and non-food items. It helped develop and influence the standard operating procedures (SOPs) for the composition of the quarantine support packages, which guided all other organisations nationally.[67] Handicap International developed an SOP for putting on and taking off IPC equipment during the rainy season.[68]

Duplication/Overlap

The majority of partners and both FM directors said that duplication of projects was kept to a minimum. Both FM directors said communication and coordination with other consortia was good and it was 'therefore easy to pick up the phone and speak to someone'.[69] The requirement for implementing partners to work through the DERCs and the pillar system further reduced duplication of projects.[70] From Phase II there was more opportunity for INGOS to apply for other funding streams. But, because implementing partners had to go through DERCs for project approval, duplication was minimised. However, the first FM director said that if duplication occurred it was likely to be in the activities of social mobilisation, because at times it 'got very muddled'[71] who was funding these particular projects.

[67] DFID (2015), *Annual Review*.
[68] Interview with implementing partner.
[69] Interview with FM director.
[70] DFID (2015), *Rapid Review*, May.
[71] Interview, FM director.

Some partners said that rather than duplication of projects, there had been overlap of activities; for example, in Makeni Hospital, World Hope International and GOAL both had funding for WASH activities, but they focused on different areas of the hospital. One partner said that the DEERF funded a 'duplication of a SMAC model, but not in the same geographical area'. As a result the model had greater geographical coverage and helped to 'deeply engage on a one-to-one [level]'[72] with those in the communities which SMAC had not reached.

Table 6: Summary of strengths and weaknesses of the DEERF

Strengths	Weaknesses
– Easy reporting – Filled essential gaps – Experience and understanding of GOAL in Sierra Leone – Increased community confidence to return to health facilities – FM very helpful and supportive, both with applications and political situations – Limited duplication of projects – Funded wide range of projects (small and large) – NNGOs supported and strengthened by implementing partners – Rapid release of funding – Needs driven – Level playing field and funding accessible by all INGOs	– Number of DEERF extensions, with no clear end date to funding – Regular changes in DFID staff, loss of institutional knowledge particularly at district level – Lack of transparency of GOAL as a FM and implementing partner – 'Onerous' financial reporting – Slow financial disbursements – Lines of responsibility 'blurred' between DFID and FM – NNGOs not able to apply directly to DEERF – Limited involvement of DHMT – Reliance on goodwill of partners

Weaknesses

Number of extensions to DEERF funding and no specific end date

Given the nature of the ongoing emergency, the end date of the DEERF was repeatedly extended before it finally closed to applications on 31 December 2015. Interviews with implementing partners highlighted that this created an administrative burden, as they had to apply for cost extensions, resubmit project proposals and extend contracts for employees. The lack of a clear end date also created uncertainty around whether to continue to employ staff or give them notice of the end of their contracts.[73] Table 7 shows DFID's contributions to the DEERF.

Table 7: Total funding allocated by DFID to the DEERF[74]

Period	Amount (£m)
October - December 2014	5
January- May 2015	2.5
May - August 2015	1.75
August – October 2015	1.5
October – December 2015	1.25
December 2015 – February 2016	1
Total	**13**

[72] Interview with partner.
[73] Interview with implementing partner and FM director.
[74] DFID (2015), *Rapid Review*, May.

Staffing

Stakeholders said that frequent changes to DFID staff, particularly at district level made communications difficult.[75] The DFID Annual Review acknowledged that the Ebola crisis needed a high volume of staff who were on a three-month rotation, which in turn led to a rapid turnover of staff at all levels and sometimes 'led to confusion over the responsibility for approving adjusted programme activities.'[76] The first FM director and ERC coordinator both said that they regularly had to brief and update new DFID arrivals, which posed a challenge because 'things developed quickly and organically'.[77]

Transparency

Many implementing partners stated, both in this evaluation and the DFID Mid-term Review, that an INGO being both a fund manager and implementing partner was a 'conflict of interest'. It was unclear to partners why and how GOAL, as an implementing partner, was awarded grants. A few partners said that ERC 'was more transparent,'[78] with regular communication and meetings with implementing partners giving a greater awareness of decision making. The FM directors also took on other GOAL roles and, during short periods of absence (such as leave of the FM director), the GOAL country director would temporarily cover the position. Both of these could be viewed as a conflict of interest.

Lines of responsibility

During interviews, implementing partners said that they were unsure of the difference in roles between GOAL as fund manager and DFID as donor and felt that there was a 'blurring' of lines.[79] This was especially so towards the end of the funding period and resulted in protracted decisions over awarding grants, with one project in particular taking over one month to agree.

Management of grants

The maximum grant an INGO could apply for was £500,000. There were several exceptions when projects were not covered by other funds. This included eHealth Africa's surveillance project, and Handicap International's project on ambulance provision.

eHealth Africa was awarded £1,089,853 for six projects, receiving £767,123 for a single surveillance project. This project supported the Western Area Response Centre and the DHMT for 11 months. This support consisted of data manager salaries and allowance payments to district surveillance officers, community monitors, surveillance supervisors and administrative staff. In addition the funding also enabled the provision of mobile phone credit, supplies and vehicle and motorbike rental.

Handicap International received a total of just over £2m over four grants. In the initial stages of the DEERF, it was identified that an EVD ambulance service needed to be managed and the fleet increased. However, no specific funding or donors were identified to support this project.[80] Handicap International took on the ambulance service for the Western Area (rural and urban) and scaled it up from a poorly functioning team of 14 ambulances to a fully functioning team of 30 with decontamination services. While this service was not a main objective of the DEERF, DFID agreed to fund the project. Ordinarily a project of this size would have been covered through a bi-lateral agreement, but because nobody knew how long the emergency would continue, the project remained in the DEERF.

[75] Interviews with FM Director, implementing partners and other fund mechanisms.
[76] DFID (2015), *Annual Review*.
[77] Interview with FM director.
[78] Interview with implementing partner.
[79] *Ibid*.
[80] Interview with DFID representative.

HKI also received two awards just under the £500,000 threshold (£499,174 and £499,997). The first was for quarantine management and support to WFP food distribution in the Western Area, The second award allowed surveillance activities to be added to the project.[81]

Limited involvement of DHMTs and councils

The establishment of DERCs at the district level meant that all stakeholders, including the DEERF, had to coordinate through this system. The DERCs 'gave focus to traditional chieftaincy structures as they had influence with community and the DHMT and Council Chairmen were not recognised'.[82] During an interview with a district medical officer (DMO) it was said that the offices of the DMO and the DHMT 'were not involved in any of the funding decisions per se, but more involved with technical support.'[83] During the focus group discussion, implementing partners specifically mentioned the limited involvement of the DHMT. There was general agreement that in retrospect this had been a mistake, because the DHMTs lacked experience and capacity when control was handed back to them in December 2015.[84] While the DEERF was not responsible for creating this coordination system, implementing partners said that it contributed to weakening the DHMTs, as they were not involved in the decision-making process.

However, some implementing partners said that working through the DERCs had actually improved their working relationships with the DMO and DHMT.[85]

NNGOs unable to be a direct implementing partner

Working at a community level to change behaviours was perceived to be one of the most effective ways of preventing transmission of EVD. NNGOs often have a deeper understanding of and acceptance within the communities than INGOs. In addition local capacity is crucial to the prevention of and response to future EVD outbreaks. However, NNGOs could not apply to be an implementing partner, although they could be a subcontractor. One implementing partner said that not working with NNGOs was 'a missed opportunity … [as] there are reputable NNGOs'.[86] NNGOs were seen as a fiduciary risk, as they typically had limitations with regards to compliance, in particular reporting and management of funds.[87] It should be noted that other mechanisms, such as QIPs, were able to provide funds to NNGOs[88]. One implementing partner who worked directly with NNGOs said that at first it was 'worrying' that they could not receive funds from DEERF.[89] However they were able to work and implement projects with NNGOs and reported that there was a steep learning curve for them and their partners.[90]

Reliance on goodwill

Many implementing partners noted how well the FM directors had worked with them. Good relationships were key to the successful management of the fund. However, there was a reliance on goodwill from implementing partners, DFID and the FM. Once implementing partners knew that their project would be funded, they implemented immediately with the expectation that the DEERF would reimburse the activity costs. There was also an expectation that the implementing partners would deliver what they had promised. Given that checks were limited, there was potential for fraud and poor quality; however, one FM Director said 'we were very lucky… there was no fraud, people did what they said they would do'.[91]

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[81] DEERF Grant Award Tracker May 2016.
[82] Interview with implementing partner.
[83] Interview with DHMT representative.
[84] Workshop with implementing partners.
[85] Interview with implementing partners and focus group discusion.
[86] Interview with implementing partner.
[87] Interview with DFID representative and FM Director.
[88] Interview with UNDP representative.
[89] Interview with implementing partner.
[90] *Ibid*.
[91] Interview with FM director.

3.3 Efficiency of planning and implementation

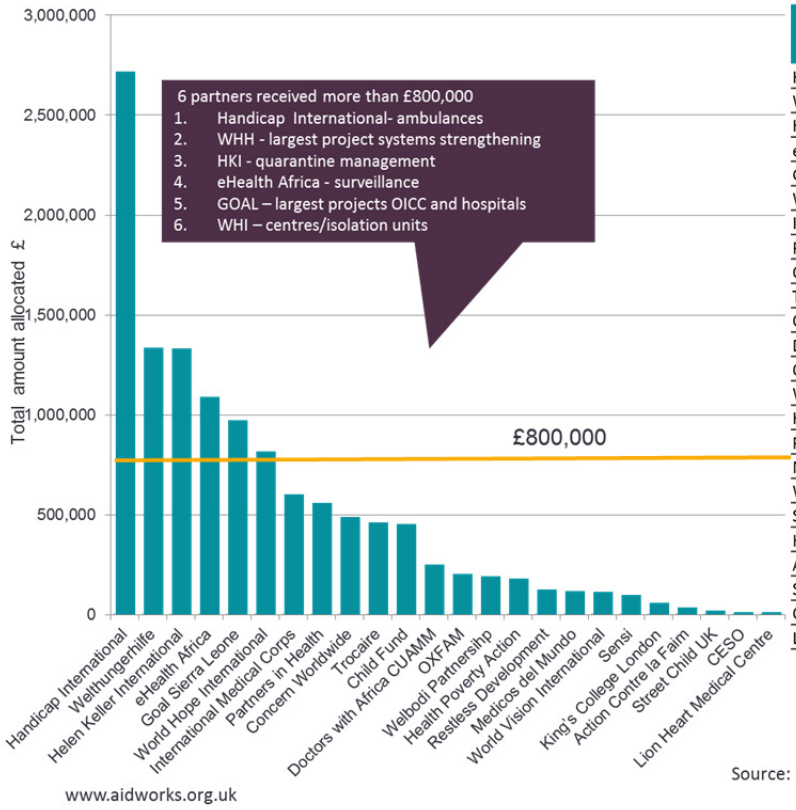
Spend and work plans[92]

Analysis of expenditure against planned

As has been described, the nature of the emergency made it difficult to plan and forecast financial spend, as the priorities changed according to the needs of the EVD response. Projects, such as those provided by Handicap International, had not been the original intention of the fund and contributed to the fund being increased from an initial envelope of £5m to £13m. The grant award tracker shows that the total amount applied for was £25,389,392 and total £12,264,239 was approved for projects.[93] The final disbursement ratio (expenditure against allocation) was 94%.[94]

Grant recipients

Figure 4: Total grants awarded to implementing partners for duration of the DEERF



Implementing Partner	Amount awarded (GBP)	Number of grants
Handicap International	2,716,840	4
Welthungerhilfe	1,334,920	5
Helen Keller International	1,333,186	3
eHealth Africa	1,089,853	6
Goal Sierra Leone	974,537	10
World Hope International	816,961	9
International Medical Corps	604,220	2
Partners in Health	560,401	2
Concern Worldwide	489,292	3
Trocaire	462,304	3
Child Fund	455,321	1
Doctors with Africa CUAMM	252,956	3
OXFAM	203,341	1
Welbodi Partnersihp	192,220	2
Health Poverty Action	181,368	2
Restless Development	124,971	1
Medicos del Mundo	117,115	1
World Vision International	113,568	1
Sensi	98,334	1
King's College London	58,506	1
Action Contre la Faim	38,000	1
Street Child UK	20,584	1
CESO	13,670	1
Lion Heart Medical Centre	11,771	1

Source: DEERF Final Financial Report May 2016

Over the duration of the funding, six of the 24 partners received more than £800,000 (illustrated in Figure 4): Handicap International, WHH, HKI, eHealth Africa, World Hope International and GOAL. Figure 4 also shows that Handicap International, HKI and WHH were awarded the funds through a small number of grants, whereas eHealth Africa, World Hope International and GOAL had six, nine and ten grants respectively.

The types of projects funded varied, including ambulance provision and fleet maintenance, quarantine management, surveillance activities and WASH activities. Partners such as Doctors with Africa CUAMM,

[92] As part of the evaluation it was originally intended to disaggregate data against an agreed set of factors (e.g. comparison by major budget line); however, it became evident that the available data cannot be used in this way.
[93] DEERF Grant Award Tracker Version 06 January 2016
[94] DEERF Final Financial Report May 2016

Trócaire and CESO had a small in-country presence and were therefore very reliant on funding provided by the DEERF.

The majority of projects required no cost extensions but were eventually fully spent.[95] However, if any funds remained unspent, they were simply recouped and made available to another implementing partner.[96]

No-cost and cost extensions

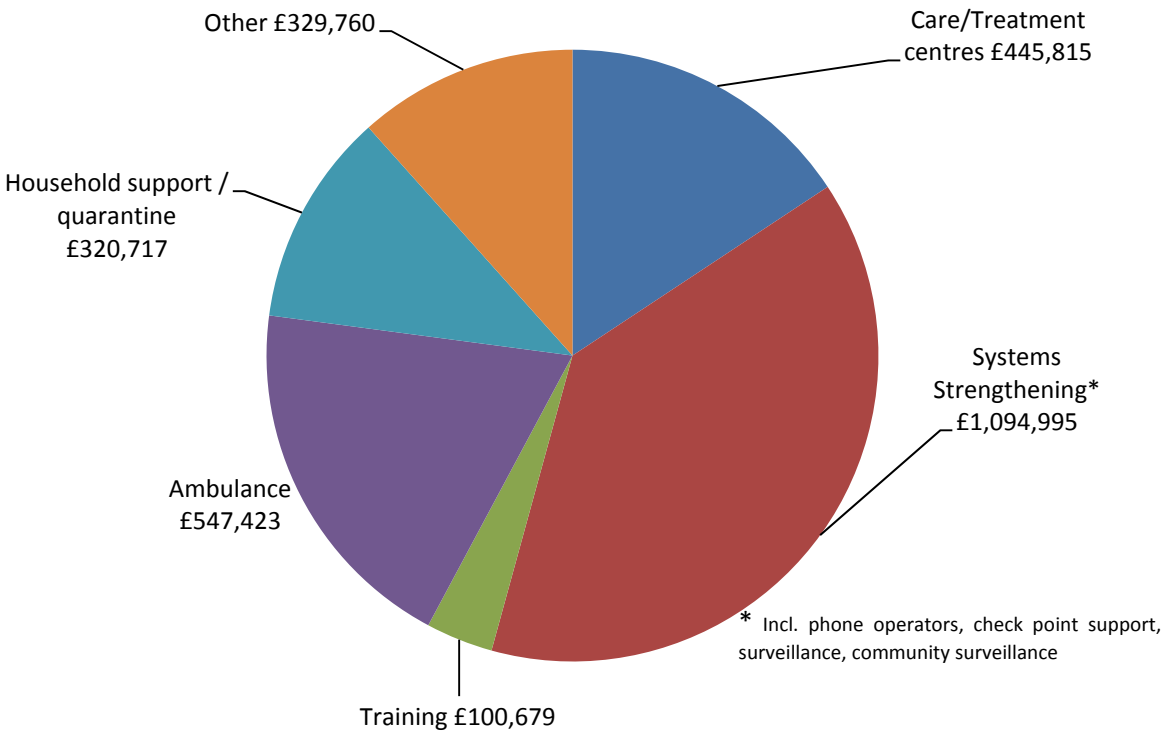
Initially, project applications were to be accepted until 31 December 2014, with projects closing by 28 February 2015. However the crisis persisted, as did the need for continued projects and funding. Partners could apply for extensions to existing projects, as well as for new projects. In total, 24 out of the 65 approved projects had cost extensions. At first, this was done by verbal agreement and emailing a justification, but as the demand increased, forms were developed to help track the necessary changes.[97]

[95] Interview with GOAL representative and implementing partners.
[96] Interview with GOAL representative.
[97] Interview with FM Director.

Figure 3 on page 13 shows how application approvals correlated with the number of confirmed EVD cases. From the middle of 2015, when cases had declined significantly, the focus of the funding was largely on cost and no-cost extensions.

As Figure 5 shows, the majority of cost extensions can be divided into six categories: care and treatment centres, household support and quarantine, training, ambulance and systems strengthening. The largest proportion of cost-extension was for systems strengthening, which was allocated over £1m. This included payments for phone operators with the 117 phone line operated by eHealth Africa, training and support of surveillance officers by Helen Keller International.

Figure 5: Analysis of cost extensions



Financial disbursements

Implementing partners could choose to be paid in arrears or to be pre-financed. The preferred method in the Terms of Reference was payment in arrears (see Appendix 5.3), although partners could be pre-financed in exceptional circumstances. GOAL's Head Office in Dublin administered financial disbursements. The majority of implementing partners opted for funding in arrears. A small implementing partner, which chose to be paid in arrears, reported that this modality put it in a very vulnerable position because it had limited funds and resulted in the trustees of the organisation pre-financing the project.

Management fee

The FM's management fee was approved at £529,434, with actual spend of £470,153, equivalent to approximately 4% of the total DEERF spend. The proportion was considered an appropriate amount by the GOAL country director,[98] as overheads were largely covered by other funding sources and the direct costs of programme oversight were low.[99]

Coordination

The DEERF provided a district-level response, while consortia such as ERC and SMAC provided a national-level response. From the end of January/beginning of February 2015, DESTs that had DFID representatives based in the DERCs gave the initial approval for all project grants. Some DERCs were more active than others in using the DEERF.[100] The available data shows that the majority of funding went to the four districts of Bombali, Port Loko, Western Rural and Western Urban.[101] These districts also had the highest numbers of confirmed cases of EVD, as can be seen in Figure 6, on page 22.

Overall, stakeholders agreed that both FM directors were good at communicating and coordinating with various consortia, donors and district-level teams.[102] Representatives of ERC said that the FM directors were very engaged in networking and speaking to relevant partners. However, UNDP representatives said that they did not have any involvement with the FM, despite QIPs also operating at the district level. There was little communication with the MoHS because DEERF was delivered through the districts with the DERCs. One of the implementing partners said that 'the FM did a lot of behind the scenes discussion before [our] application… so that when the application went in there was a really quick turnaround… I don't know how they did it'.[103]

Some interviewees said that having a DFID representative at district level was very helpful and resulted in less duplication of projects. Some partners said that working with the different actors at the district level also helped to strengthen working relationships, particularly with the DHMT, although this was not always the case.[104]

However, the implementing partners felt strongly that the creation of DERCs 'sidelined' the DHMT and created a 'parallel system', further weakening an already fragile health system.[105]

[98] Interview with GOAL country director.
[99] Feedback from FM director.
[100] Interviews with partners and DFID (2015), *Mid-term Review*, May.
[101] High numbers were seen later in the outbreak in Kenema and Kailahun.
[102] Interviews with implementing partners, other funding mechanisms, DFID.
[103] Interview with implementing partner.
[104] Interviews with partners and focus group discussion.
[105] Focus group discussion with partners.

3.4 Sustainability

The OECD describes sustainability as measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn.[106] It describes capacity building as the means by which skills, experience, technical and management capacity are developed within an organisational structure, often through the provision of technical assistance, short-/long-term training, and specialist inputs (e.g. computer systems). The process may involve the development of human, material and financial resources.[107]

Given the nature of the emergency, sustainability was not part of the design of the funding and implementing partners did not need to report on it. However, many partners felt that sustainability had been built in a number of areas, although this was an unintended consequence and project specific. The majority said that sustainability had occurred in skills and knowledge, systems and resources, both for individuals as well as groups and organisations, as can be seen in Table 8, which also reflects the OECD definition.

Implementing partners said that skills were built with individuals and organisations through training, negotiation, monitoring and budget management. Health Management Information Systems (HMIS) and surveillance were also identified as weak during the EVD crisis and significant support was provided in these areas, which has continued to be funded through other sources.

Table 8: Sustainability examples identified by partners

	Skills/knowledge	Systems	Resources
Individual	– Skills development (e.g. consensus building, roundtable discussions, negotiation and leadership skills) – Budget management, reporting, monitoring and evaluation – Information Technology – Capacity building of hospital staff (e.g. nurses, hygienists) – Increase in capacity of young people through social mobilisation in rural areas – Increased knowledge of community stakeholders through training and meetings – Young people given the opportunity to work in a structured environment	– Clinical case management – Reporting systems and surveillance	– Boreholes – WASH – IT resources for HMIS – Refurbishment of health facilities – Basic infection control – Permanent isolation
Groups/ Organisations	– Greater coordination and networking – Partnerships a) improved working relationships with DHMT; and b) developed established and/or strengthened relationships with NNGOs – Sierra Leone Association of Ebola Survivors: survivors of EVD have set up a community-based organisation and are driving policy (empowered and capacitated)	– Reporting systems and surveillance – HMIS was inadequate before EVD – many partners are now addressing this through consortia funding	

[106] www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm
[107] https://stats.oecd.org/glossary/detail.asp?ID=5103

3.5 Impact

The DEERF mechanism was able to rapidly agree on deployment of essential funding, which enabled objectives to be met and critical gaps to be filled. One partner said 'we wouldn't have got over [the] emergency without DEERF'. The DEERF as a funding mechanism was pronounced as 'very fit for purpose' and even though there were questions about the transparency of GOAL as FM, partners described it as 'fit for purpose.'[108]

In addition, implementing partners said that there was a high level of accountability, with one partner saying: 'the DEERF team [were] very in touch with needs and very responsive to needs, in 20 years in development I have never seen that level of support… Money was used well with a high level of accountability'[109].

Figure 6: Total confirmed Ebola cases with approximate total grants awarded per district

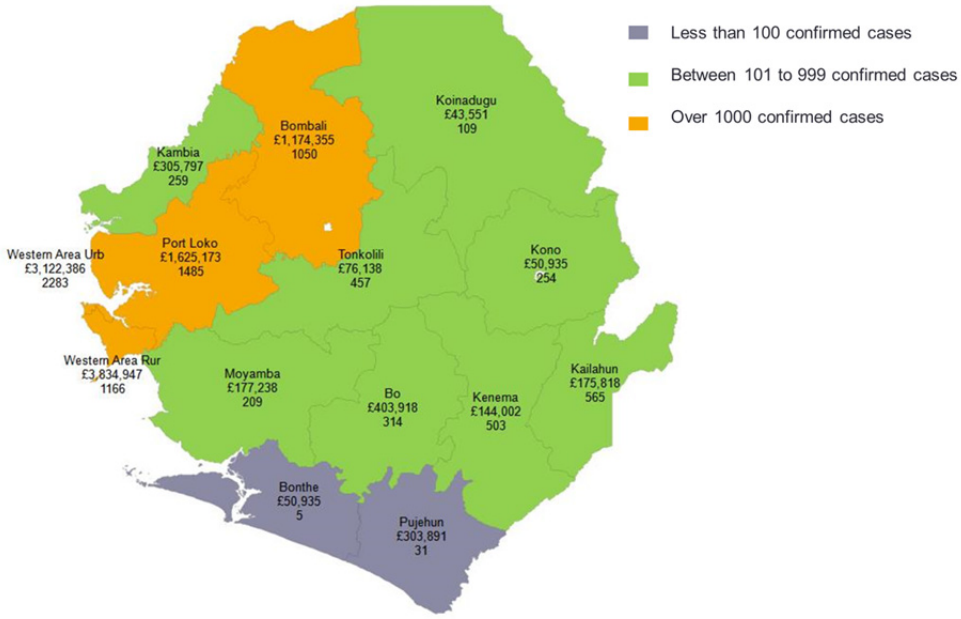


Figure 6 shows approximate figures for how much funding was awarded to each district, as well as the number of confirmed EVD cases for each district. Calculations were based on contract awards and are approximate; where partners had more than one district in a contract, an average was used. The data shows the majority of the funding was awarded to four districts (Bombali, Port Loko, Western Rural and Western Urban). These figures also correlate with the number of confirmed EVD cases (also see Appendix 5.9). The only anomaly was Pujehun where there were a low number of cases, but a substantial amount of funding allocated. Pujehun was the first district to have recorded cases of EVD in July 2014; the local population wouldn't use the health facilities and requested establishment of treatment centres outside of the town, causing the high funding allocation.

The majority of stakeholders interviewed agreed that – as the DEERF was focussed on the emergency - it had done its job and therefore there was no need for it to continue. Further funding has been pledged to continue to support Sierra Leone through transition and recovery.

[108] Focus group discussion with implementing partners.
[109] Interview with implementing partner.

4. Conclusions and recommendations

4.1 Conclusions

Quality and relevance

The DEERF was in line with the overall direction of DFID's Ebola Strategy. It met expectations by filling essential gaps in the EVD response with flexibility to respond to the changing needs. The objectives and priorities of the fund evolved as the emergency developed and continued, updating its priorities between Phases I and II, based on the needs identified by the FM and DFID.

The DEERF filled critical gaps not covered by the existing consortia funding mechanisms, and allowed implementing partners excluded by those consortia to respond. The breadth of the DEERF funded projects covered activities critical to the overall EVD response.

The FM's understanding of the situation, country, and partners, gained from their experience as an implementing agency in Sierra Leone and from their experienced staff, was a critical success factor. The FM directors provided exceptional support to partners to ensure gaps were filled. Competent human resources in the FM team were a contributing factor to quick implementation and covering needs, particularly in Phase I.

The fund provided finances for immediate needs, with a quick turnaround of applications. It enabled partners not included in existing consortia to access funding for specific and crucial gaps. It improved equity between INGOs, with smaller INGOs able to access the funds on equal footing with larger INGOs.

However, there was very little involvement of NNGOs (compared with other funds such as the QIP), with only a few INGOs subcontracting to them. NNGOs often have a deeper understanding of and acceptance within the communities than INGOs. In addition, local capacity could be crucial to the prevention of and response to future EVD outbreaks.

The fund manager selection process was conducted via a mini-competition between INGOs, through which GOAL was selected. The implementing partner application and decision-making processes were largely clear, supplemented by a set of straightforward tools developed by the FM to process and monitor grants. The simplicity of the application procedure and tools meant that they could be used for all types of projects and contributed to the rapid application response time. The FM developed and maintained a grant checker tool that made it easy to record data and produced a lot of relevant and useful information. Monitoring of both large and small programmes was light touch, focusing mainly on verification of project implementation.

Effectiveness

The DEERF addressed essential needs, particularly in Phase I, helping to prevent EVD escalating further. It succeeded in providing quick-release funds to fill gaps, while other funding could be distributed through larger scale bilateral mechanisms. Partners implemented a wide range of projects that were in line with the DEERF's objectives in each phase, achieving the planned outcomes.

The fund results met expectations and provided critical activities for the overall EVD response, by:

- Supporting 854 beds and 4,813 patients in facilities,
- Providing 4,441 households and 23,676 people with quarantine food and non-food items,
- Training 1,931 community members,
- Training 3,546 health care workers in IPC,
- Training 30 quarantine officers,
- Supporting 30 ambulances at the peak of the outbreak.

The number of applications increased in line with the number of EVD cases; as cases fell, so did the approval of projects. As the cases fell, the project approval process focused on cost extensions and managing current projects.

The majority of weaknesses noted were process focused, linked with the need for greater fund transparency:

- Stakeholders did not always understand the difference in roles between GOAL as fund manager and DFID as donor,
- Although the implementing partner application decision making processes were largely clear, the rationale for awards to GOAL, which had the largest number of grants, was not transparent to implementing partners,
- The fund management unit was a small team, so while due diligence and compliance checks were conducted, implementation monitoring was considered light touch with limited detailed checks of activities and finances,
- There was limited involvement of the District Health Management Teams (DHMTs) in the decision making process.

Efficiency

The evaluation compared financial spend against plans. A total of £12,264,239 was approved for implementation across 65 projects, with a management fee of approximately 4% of total spend. This overhead was modest considering the range and number of projects implemented, indicating an efficient fund management process. No economic indicators were monitored (such as direct or indirect costs associated per output or beneficiary), which could be an area of improvement for future funds.

Due to the inability to predict the duration of the response, several projects were characterised by regular cost/no-cost extensions as their relevance persisted in line with the continued response. This resulted in 23 projects requiring cost extensions and therefore extended project implementation timeframes.

In Phase I, there was good coordination and communication between stakeholders and the FM. From Phase II onwards coordination of projects was, in the main, directed by DERCs at district level, minimising duplication with other funding streams. The involvement of DERCs slowed down the communication and information flow. Furthermore, because the DEERF used the DERCs, there was little involvement with the DHMTs in the decision-making process. Overall, stakeholders agreed that due to the FM directors there was generally good coordination and communication with various consortia, donors and the DERCs.

Sustainability and replicability

The DEERF was created for a rapid emergency response and therefore did not have an explicit focus on sustainability of skills and knowledge, systems or resources. Gains were made in these areas, but they were unplanned and project specific. These included:

- Strengthened local relationships between DHMTs and INGOs;
- Improved people and project management skills amongst local staff from implementing partners;
- Improved knowledge of communities;
- Improved skills of hospital staff;
- Strengthened systems and increased IT resources for HMIS and surveillance;

A number of critical success factors can be taken into consideration should a similar funding mechanism be replicated. The DEERF succeeded because it was rapid, simple and flexible. The FM had multisector and emergency experience, and was therefore able to provide a broad degree of support to the implementing partners. The DEERF was not constrained by tight programme design and was therefore able to change in response to the crisis.

Impact

The DEERF met its objectives and provided rapid funding to meet emerging and urgent gaps in the Ebola response. There is agreement by stakeholders that the DEERF worked very well and was essential in helping to contain EVD. Implementing partners described it as 'essential' and 'lifesaving'. The implemented projects did not appear to have had a negative impact on other EVD response activities. The fund worked with partners and DERCs at district level to provide funding that was needs driven. According to the analysis conducted in this evaluation, the majority of the funding was awarded to four districts (Bombali, Port Loko, Western Rural and Western Urban), which correlates to where the number of confirmed Ebola cases was the highest.

The majority of stakeholders interviewed agreed that – as the DEERF was focussed on the emergency - it had done its job and therefore there was no need for it to continue. Further funding has been pledged to continue to support Sierra Leone through transition and recovery.

4.2 Recommendations

Potential improvements for replication in a similar funding mechanism

Transparency

1. There should be greater transparency surrounding the role of the FM, with improved communication with stakeholders, especially if an INGO takes on this role. This includes ensuring that:
   - The process for appointing the FM is transparent and publically available;
   - The role of the FM is defined and understood by all stakeholders, and there is a clear distinction between the role of the FM and the role of the donor;
   - The process for allocating funds to implementing partners is transparent, with clear guidelines for allocating funds to the FM as a project implementer;
   - Regularly updated lists of funded projects, with locations and results, are publically available. This will decrease reliance on the FM directors for information;

Capacity development

2. While the focus in such an emergency response is on life-saving activities, capacity development and sustainability should be brought into the fund's objectives as soon as is feasible. The following options could be considered:
   - The FM takes on an additional role supporting capacity development and sustainability, allowing implementing partners to focus on delivery of services;[110]
   - Implementing partners identify and address capacity development and sustainability needs within their respective project proposals;
   - The FM sub-contracts a specialist firm at the appropriate time to provide standardised capacity development and sustainability support to all grant recipients.[111]

Monitoring and learning

3. Projects receiving large amounts of funding should be managed differently to smaller ones, with more rigorous/robust monitoring and evaluation.

4. There should be an increased emphasis on monitoring results of projects and a system of more rigorous financial checks should be established by:

   - Increasing the size of the fund management unit, which would require a larger management fee (just 4% for the DEERF FM); or
   - Contracting a third party to monitor all projects, which could also review needs on a regular basis.

5. A mini-review should be conducted at the end of each funding phase, when objectives may change. The review would:

   - Document successes, challenges and design changes;
   - Enable the introduction of relevant changes to fund management processes and implementing activities.

Examples of changes include the introduction of: benchmarks for efficiency (cost per beneficiary); plans for capacity development; and changes in how the project will be monitored.

[110] In South Sudan, Jhpiego was an FM for USAID funding. As well as carrying out the usual FM role, they also created IPC standards for use by all their implementing partners.

[111] In South Sudan, the fund manager of DFID's Health Pooled Fund (Crown Agents) sub-contracts a specialist firm to provide standardised health systems strengthening training to implementing partners and district-level government workers.

Project size

6. An upper financial threshold should be enforced for implementing partners, or a separate, more detailed management process should be followed for projects above a certain value. The threshold should be for a single grant or the cumulative amount of multiple grants for the same partner.

National NGOs

7. A mechanism should be identified to involve and fund NNGOs, particularly for activities that require significant community involvement.
8. Additional FM staff should be appointed to carry out appropriately rigorous vetting procedures and to support NNGOs with grant management, including compliance, monitoring and financial systems/reporting. This could also be achieved by appointing an INGO with a specific remit to work with national partners.

Tools

9. The processes and tools established by the DEERF FM should be made into a standard package for use by other emergency funds. Such a toolkit could be developed by GOAL's Humanitarian Unit. This includes the application tools, budget template and project tracker.

5. Appendices

5.1 DFID Ebola funded projects by budget allocation[112]

Project title	Budget allocation (£m)	Start date
Emergency Support to Respond to the Ebola Virus Disease in 2014 (Urgent Needs)	79.41	Jul-14
Sierra Leone Kerry Town Ebola Treatment Facility	89.10	Sep-14
Ebola Treatment Centres in Sierra Leone	45.90	Oct-14
Reducing Transmission of Ebola in Sierra Leone Through Changing Behaviours and Practices	12.55	Oct-14
Ebola Care Units in Sierra Leone	43.40	Oct-14
UK Response to Ebola Crisis Through Support for UNMEER and the Wider UN System	22.13	Oct-14
UK Support to Ebola Crisis Through Support for the Joint Inter Agency Task Force (JIATF)	33.44	Oct-14
UK Response to Ebola Crisis Through Establishing Laboratories	12.15	Nov-14
Ebola Central Health Care Supply Chain Platform	7.20	Nov-14
Match Funding for Ebola Response	6.20	Dec-14
Regional Preparedness	19.20	Jan-15
Transition from Ebola Response to Early Recovery	54.0	
Ebola Vaccines Insurance	1.10	
Total	**425.78**	

[112] DFID (2015) *Annual Review*. Please note the amounts are not final.

5.2 Breakdown of funding for DFID-funded Urgent Needs project[113]

Intervention	Main activities	Implementing partner	Outputs	Total budget (£m)	Expected Duration
Ebola Response Consortium (ERC)	i) Community event-based surveillance ii) Support to district surveillance iii) '117' alert function iv) Safe and dignified burials in the Western Area v) Ebola isolation facilities in the Western Area	Consortium of INGOs led by IRC	Output 8 Output 3	13.70	September 2014–September 2015
DFID Emergency Ebola Response Fund (DEERF)	i) Provision of rapid funding to meet urgent gaps in the Ebola response	GOAL (fund management agency)	Output 7	9.25	October 2014–September 2015
SMART consortium	i) Safe and dignified burials in 12 districts ii) Ebola fleet management	SMART consortium, (World Vision lead with CRS and CAFOD)	Output 6	12.67	October 2014–September 2015
Quarantine support and household decontamination	i) Provision of essential care packages to quarantined households ii) household decontamination	Plan International	Output 5	7.95	November 2014–September 2015
Protection of vulnerable individuals in the Ebola crisis	i) Protection desks in DERCs ii) OICCs	UNICEF	Output 2	2.55	December 2014–September 2015
UN Standby Partnership	i) Emergency human resources for the UN system	UN agencies	Does not contribute to logframe	1.00	Ongoing
Ebola response in Sierra Leone and Liberia	i) Managing ETCs	IFRC and Sierra Leone Red Cross	Output 8	5.10	July 2015–April 2015
Support to emergency Ebola medical treatment in Sierra Leone and Liberia	i) Managing ETCs	MSF	Output 3	0.75	June 2014–December 2014
Ebola response in Sierra Leone and Liberia	i) Provision of emergency Ebola medical supplies	UNICEF	Output 4	7.10	September 2014–April 2015
Lakka Ebola treatment centre	i) Management of Lakka Ebola treatment centre in Freetown	Emergency (NGO)	Output 3	0.95	September 2014–February 2015
Bo District Hospital Isolation Centre	i) Management of Bo District Isolation Centre	IRC	Output 3	0.74	October 2014–February 2015
Scoping study for labs transport	i) Scoping study for labs transport	Riders for Health	Does not contribute to logframe	0.05	October 2014–December 2014
GIS and mapping Support to Ebola Epidemic Control	i) Mapping and GIS support to NERC	MapAction	Does not contribute to logframe	0.05	October 2014 - June 2015
ACAPS Ebola Needs Assessments	i) Ebola Needs Assessments	ACAPS	Does not contribute to logframe	0.55	May 2015 - November 2015

[113] *Ibid*. Please note the amounts are not final.

5.3 DFID Ebola Emergency Response Fund application guidelines

DFID Ebola Emergency Response Fund Terms of Reference

3rd October 2014

1. **Introduction and overview**

In response to the ongoing Ebola crisis in Sierra Leone, DFID have established a £5m Ebola Emergency Ebola Response Fund (DEERF). The fund, managed by GOAL will commence on 3rd October, and will provide support over the next four months. In particular, it will seek to fill urgent gaps in response over the next weeks whilst additional Ebola treatment capacity comes on line. The Fund is designed to low value interventions which donors would otherwise find difficult to support.

2. **Objectives**

The fund will support immediate actions to respond to the Ebola crisis:

- Increase Ebola treatment or isolation unit beds through quick and small scale interventions across the country
- Decrease the need for beds e.g. through reducing convalescent times, more efficient laboratory testing
- Improve the efficiency of the Ebola response system

This will be achieved by identifying actions with partners where quick funding could support immediate operational needs. The DEERF will compliment other DFID support funding mechanisms to the Ebola response.

3. **Eligible Agencies**

Agencies who meet the following criteria will be eligible for fast-track funding application (Form A1)

- Partners who currently have DFID funding, either directly or through a consortium in Sierra Leone or other countries
- International NGOs who have large-scale grants from other international donor agencies e.g. UNICEF, EU, ECHO, OFDA[114]

Other organisations not fulfilling the above criteria are invited to apply and will undergo rapid pre-approval via application using form A2

Additional information:

- All International NGOs (INGO) must be registered with the Government of Sierra Leone
- Direct funding to Government systems is not permitted.

[114] GOAL will use a pre-authorised list from DFID of large-scale donors to assess this criteria.

- Indirect support to Government is permitted in partnership with an INGO. In this case donation in kind of goods is the preferred mechanism.
- National NGOs may apply for funding only in partnership with an International NGO.
- National NGOs must be registered with SLANGO
- Private sector companies may only apply for funding in partnership with an International NGO

4. Funding Criteria

Proposed activities must meet the needs based criteria for use of the Fund i.e. does it increase bed capacity, reduce the need for beds, or improve the efficiency of the Ebola response system.

Applications are invited for a project duration of up to 4 months, to a maximum level of £500,000

Ineligible expenditure includes (but may be amended):

- Purchasing ambulances or specialist medical vehicles (other essential vehicles are permitted where justified)
- International training not permitted
- No direct funding to Government systems
- No funding or subsidising government salaries or incentive schemes directly to GoSL payroll

No funding which duplicates other DFID funding streams

- No funding which duplicates other donor funding streams
- Medical supplies may be purchased if these are not readily available from CMS.

If GOAL wish to add/amend these criteria it must be cleared in advance in writing by DFID

5. Application procedure

Step 1: Applications should be made via submission to DEERF@sl.goal.ie. The submission must include completion of full relevant application form (A1 or A2) and a budget. Templates are available at http://www.goal.ie/DEERF_Sierra_Leone_applications/836

Step 2: It is anticipated that formal agreement of the amount of funding authorised from DEERF will be provided via written notification, and signing of an MOU with GOAL
It is recognised that in this dynamic environment, needs may change. Therefore clear, timely written communication is vital between the partner agencies and GOAL DEERF representative if a proposal needs to be altered significantly.

Final applications from grantees will be accepted up to 31st December 2014. All grants must close by 28th February 2015

6. Appraisal of DEERF applications

Applications will be assessed using the needs based criteria set-out for the fund.

Funds <£100k will have a planned turnaround of 24 hours
Funds > £100k will require additional review including approval from DFID
Any funds to be distributed to GOAL must be approved by DFID regardless of value

7. Disbursement of Funds

The following funding modalities will be available under this programme:

1) Funding in arrears (preferred): The organisation has the cash available to commence work and invoice the Fund for work done in arrears.
2) Pre-financing (in exceptional circumstances where justified): advance payment of 100%
3) Direct procurement and donations in kind: GOAL purchases goods and transfers them to the grantee

8. Partner Reporting Requirements

Partners are requested to submit reporting to GOAL using the formats provided.

a) <£10,000– a one page narrative report, and financial report within 45 days of grant closure
b) >£10,000–Monthly project update (1 page on progress), monthly financial report, final narrative and financial report within 45 days of grant closure.

All final reports will be sent to DFID for their records

9. Grant Management Reporting Requirements

GOAL will submitted a weekly disbursement and progress report to DFID. Additional reporting is outlined in the accountability grant agreement.

10. Publicity

Participating partners are required to show the amount of assistance received from DFID in their annual reports. DFID should also be given appropriate acknowledgement in all publicity issued by implementing partners.

11. Monitoring and Expense verification

Monitoring for this grant will primarily be via the reporting mechanism set out in section 8. In addition for grants>£100,000 GOAL will conduct additional verification of the grantees' report including site visits and external expense verification.

12. Double Funding:

DFID to provide mapping to GOAL on a regular basis of what other funding is being provided to agencies to reduce the risks of -double funding.

5.4 List of key informant interviews

Organisation	Title	Name
CESO	Finance Manager/Trustee	Pauline Jones
DFID	Programme Manager	Ross Hilton
DFID	Humanitarian Advisor	Jane Mogeni
DHMT, Makeni, Bombali District	District Medical Officer	Dr Brima Osaio Kamara
Doctors with Africa CUAMM	Country Manager	Matteo Bottecchia
eHealth Africa	Country Director	Michelle Rose
eHealth Africa	Project Manager	Bryan Gastonguay
ERC	ERC Coordinator	Laura Miller
ERC/Concern Worldwide	Surveillance Coordinator	Joe Jasperse
GOAL	Deputy Country Director - Programs	Anna Fraenzel
GOAL	Interim DEERF Director	Jean Shaw Smith
GOAL	Partnership and DEERF Finance Manager	Sonia Zahi
GOAL	Country Director	Else Kirk
GOAL	FM Director	Charlotte Walker
GOAL	FM Director	Erin Polich
GOAL	Deputy Health Advisor	James Riak
Handicap International	Emergency Response/Recovery Coordinator	Maud Boutonné
Health Poverty Action	Country Manager	Melissa Whitney-Long
Helen Keller International	Country Director	Dr Mary Hodges
King's College London	Grants and Reporting Manager	Philippa Tetlow
King's College London	Operations Manager	Stephen Hindle
King's College London	Volunteer Doctor	Patrick Howlett
Médicos del Mundo	Country Manager	Silvia
Médicos del Mundo	Country Administrator	Alessandro Cerri
OXFAM	Country Funding Coordinator	John Rutaro
OXFAM	Senior Programme Manager	Nyan P Zikeh
Partners in Health	Programme Manager	Lauren Ropp
Makeni Hospital	Probation officer/Ebola survivor/ Chairman of Ebola Survivors Association	-
Restless Development	Director	James Fofanah
Restless development	Field Officer	Jarai Konteh
UNDP/QIP	Country Director	Sudipto Mukerjee
UNDP	Payment Programme Manager	Ghulam Sherani
World Hope International	Health Programme Specialist	Carrie Jo Cain
World Hope International	Health Programme Officer	Brimah Samura
World Vision	Food Assistance Manager	Musa Gamanga

5.5 Focus group guideline

DEERF Workshop Guidelines - Evaluating the experience of Implementing Partners

Thursday 21st April, 2016 10:00am – 1:00pm

Objectives of Workshop

1. Establish how efficient and effective DEERF was during implementation
2. Establish longer term impact and sustainability of DEERF

Agenda Item	Activity
Introductions	**Introductions** i.e. experience in Sierra Leone, experience on DEERF, experience on emergencies Activity – participants write, brief project description and date of project, NGO name, on a **card/post-it**, state (and hand to facilitator)
Reflection of the DEERF (Q3 & Q4) Activity (pairs)	**Show DEERF Objectives** Questions • Quality and relevance: To what extent did the DEERF's adopted approach help respond to EVD control? • Effectiveness: To what extent were the DEERF's objectives met? • Effectiveness: What were the weaknesses of DEERF?
Processes (Q2) Look at the process step, ask them if they agree with the steps?	Identify different stages of DEERF (process map) How were gaps identified? Were identified gaps appropriate? Was the approach agile? How easy was it to access fund? How helpful was GOAL as a FM? How were projects monitored? Was there any other overlap with other funding?
Efficiency (Q6) Split into groups	**Co-ordination** How well did DEERF work with other partners, government, stakeholders and donors?
Efficiency (Q5)	**Financial questions** Was the financial spend in line with developed work plans? E.g. were funds dispersed on time? Were funds paid in advance or in arrears? Did the timing of fund distribution have any impact or delay the project?
Sustainability (Q7)	Use table. Working in pairs identify if any capacity has been built
Session closure: Would you do anything differently?	Plenary (prompt them, by asking should the funding continue) On a rating from 1 to 10, how would rate the DEERF (whole thing)/GOAL as Fund Manager. 10 being excellent.

	Skills/ Knowledge	Systems	Resources
Individual			
Groups/ Organisations			

5.6 Key informant interview template

Introduction	IPs	DFID	Other FM	Gov.	DERC	GOAL
- Introduce the evaluation and provide the 1-page summary (mobile phone silent)	X	X	X	X	X	X
- Confidentiality – specific names will not be mentioned, only stakeholder groups	x	X	x	X	x	x
- What is your experience (role) with the DEERF?	x	X	x	x	x	x
Q2. Quality and relevance: How appropriate were the strategies used? PROCESS	**IPs**	**DFID**	**Other FM**	**Gov.**	**DERC**	**GOAL**
- What was the process of selecting GOAL as a FM?		X			X	X
- DERCS part of phase 2 – why were they not part of phase 1? What was their role? (identifying needs, implementation planning, decision making, monitoring)?		X			X	X
- How did the funding process work? (from call for proposal to project completion)?						X
- How did the roles change for GOAL when DERCs become part of process – if at all (list activities for each, different phases)?	X				X	
- How were gaps identified and analysed at different phases of the fund (start-up , phase 1, phase 2, phase 3, ongoing)? *(E.g gap analysis, epidemiology, hunch?)*	x	x	x		x	
- Were "identified gaps" appropriate for the response?	x	x		x	x	x
- Was the approach agile and able to respond to a dynamic situation? If yes, how agile, can you give any examples? How were NGOs involved in the process (phase 1, phase 2 onwards, pre-selection, open tenders, eligibility criteria)?	x	x		x	x	x
- To what extent was the fund easy to access? Why were applications rejected and who made the decision?	x				x	x
- How helpful was GOAL as a fund manager (examples)?	X				X	
- How were projects monitored?	X	x			X	
- What other similar funds were available? (Overlap, did they change, others come online during the project)?	x	x				X
Q1. Quality and relevance: To what extent did the DEERF's adopted approach help respond to EVD control? ACTIVITIES	**IPs**	**DFID**	**Other FM**	**Gov.**	**DERC**	**GOAL**
- What was your understanding of DEERF's objectives? How well did the DEERF's objectives align with the overall EVD control objectives?	X	X	x	X	X	X
- What were the main contributions? What types of projects were undertaken? What were most critical for the overall EVD response?	x	x	x			x

- What (if any) impact did the separate funds have on how you managed your projects (implementation, monitoring, staffing)?	x					
- How were projects verified? Have they been audited?	x	x			x	x
Q3 Effectiveness: To what extent were the DEERF's objectives met?	**IPs**	**DFID**	**Other FM**	**Gov.**	**DERC**	**GOAL**
- To what extent were objectives met in each phase (1-3)? Were there any other projects outside of the objective funded in each phase? (**prompt** – provide list of objectives per phase)	x	x			x	X
- What worked very well (list objectives per phase)? Why? (didn't work well)?	x				x	x
- How were local/national NGOs able to get involved? How successful were direct contracts, or subcontracts?	x				x	X
- Ask for examples of good practice/case studies etc.	X				X	x
Q4 Effectiveness: What were the DEERF's weaknesses?	**IPs**	**DFID**	**Other FM**	**Gov.**	**DERC**	**GOAL**
- Were there any weaknesses in implementation (expenditure/people management/project management)?		X	x		X	X
- How effective was the fund management process (selection/ transparency/ disbursement/ communication/ feedback/ monitoring activities)?	x	x				
- How well were projects aligned to epidemiology and/or other evidence?	X	X		x	x	x
- To what extent, if any, was there duplication with other funding streams? Advantages/disadvantages of the DEERF compared with others (e.g. QIP)?	x	x	x		x	x
- What projects should not have been part of DEERF (e.g. ambulance)? What projects were missed?		X				X
Q5 Efficiency: Was the financial spend in line with developed work plans?	**IPs**	**DFID**	**Other FM**	**Gov.**	**DERC**	**GOAL**
- Were funds disbursed on time? What tasks couldn't be funded?	x					x
- To what extent did funding in arrears affect programme implementation (did all NGOs who needed advances get it)?	x				x	x
- Were there budgetary limits for projects (types) or implementers (international direct, local direct, subcontract)? What reasons were given for revisions in finances/plans? What was the revision process?					X	x
Q6 Efficiency: How well did the DEERF work with other partners, government stakeholders and donors?	**IPs**	**DFID**	**Other FM**	**Gov.**	**DERC**	**GOAL**
- Referring back to your role in the introduction – **what worked well**? What could have been done better? Did DEERF have any knock-on effects with your other projects (e.g. core projects & implementation)?	X	X			X	X

- What was the involvement of the national/district government? Was it any better at national or district level?		x	x	x	x	x
- What procedures were put in place to prevent duplication of QIP & DEERF projects (or other funding mechanisms)?			x			x
- How did QIP/DEERF/other fund mechanisms complement each other?		x	x			X
- Why did the application response rate change between the phases? How could the efficiency have been improved in Phase 2? What slowed applications?		x				x
- How did the FM coordinate with other consortia esp. QIPs at District level? DERCs and NERCs? Phase changes? (regularity, topics)	x		x		x	x
- What (and how) did the DEERF communicate with IPs? With other consortia? Other DFID outputs leads?		X	x			X
- How were new phases decided? How were new phases communicated?		x				X
Q7 Sustainability: To what extent did the DEERF help build the capacity of EVD response stakeholders?	IPs	DFID	Other FM	Gov.	DERC	GOAL
- To what extent was capacity built? (capacity is improved functions of individuals, groups, organisations, systems and physical resources e.g. hospitals, maintenance, etc.)	x		X	X	X	X
o Individual	x		x	x	x	x
o Group/organisational	x		x	x	x	x
o Skills (for above)	x		x	x	x	x
o Systems (for above)	x		x	x	x	x
o Resources (for above)	x		x	x	x	x
- How has DEERF helped develop relationships between different stakeholders (NNGOs INGOs? Govt? Districts)	X	X	x	X	X	X
Closing	IPs	DFID	Other FM	Gov.	DERC	GOAL
- What would you do differently (focusing on the DEERF) (was FM process the right approach, NGO fund management, design, implementation, stakeholder involvement)?	X	X		X	X	X
- Should the fund continue? If so, how? If no why?	X	X	X	X	X	X

5.7 Projects funded/NGO/amounts/date

Partner	Award amount (£)	Award start date	Award end date	Activity summary	Area/district
ACF	20,641	12-Nov-14	11-Jan-15	Support for infection prevention and control training	Moyamba
CESO	13,670	22-Feb-15	31-May-15	Establishing hand-washing points in Western Area	Western Area
Childfund	455,321	01-Nov-14	30-Jun-15	Support to children affected by EVD	Makeni, Port Loko, Bo
Concern Worldwide	40,393	07-Nov-14	20-Dec-14	Water and sanitation facilities for Hastings Treatment Centre and Waterloo Holding Centre	Western Area Rural – Hastings and Waterloo
Concern Worldwide	58,317	12-Nov-14	07-Feb-15	Improved isolation capacity at holding centres in Tonkolili District	Magburaka, Mile 91, Yele – Tonkolili
Concern Worldwide	390,582	01-Jun-15	31-Dec-15	Support to WAERC	Western Area
Doctors with Africa CUAMM	57,574	27-Jul-15	31-Dec-15	Keep Ebola Surveillance in Pujehun	Pujehun
Doctors with Africa CUAMM	95,478	07-Nov-14	30-Apr-15	Set-up of Kpanga Ebola Holding Centre to improve the Emergency Response in Pujehun District, Sierra Leone.	Kpanga, Pujehun
Doctors with Africa CUAMM	99,905	24-Dec-14	23-Apr-15	Support to CCCs in Pujehun	Pujehun
eHealth Africa	22,356	28-May-15	28-Jun-15	Hastings Volunteer Quarantine Facility	Western Area
eHealth Africa	169,738	14-Dec-14	31-Mar-15	Increase the number of phone operators for the WAS	Western Area
eHealth Africa	82,113	06-Jan-15	30-Apr-15	Training of contact tracers in Bo	Bo
eHealth Africa	40,058	15-Feb-15	30-Jun-15	mHealth for PHU reporting nationally	National
eHealth Africa	767,124	01-Apr-15	29-Feb-16	Surveillance in Western Area	Western Area
eHealth Africa	8,464	01-Mar-15	30-Apr-15	Surveillance in Bo	Bo
GOAL Sierra Leone	137,952	01-Nov-14	31-May-15	Observational Interim Care Centre	Kenema
GOAL Sierra Leone	45,835	14-Feb-15	30-Jun-15	Waste Management at Makeni GH	Bombali
GOAL Sierra Leone	22,471	01-Apr-15	31-May-15	OICC training team	National
GOAL Sierra Leone	78,097	01-Nov-14	28-Feb-15	Logistics support for training	Bombali, Port Loko
GOAL Sierra Leone	23,312	01-Oct-14	28-Feb-14	Improving the Ebola Response at PCMH by reinforcing infection prevention and control measures through establishment of an isolation unit	PCMH, Freetown
GOAL Sierra Leone	279,154	23-Nov-14	31-Mar-15	OICC	Hastings, Western Area Rural
GOAL Sierra Leone	63,172	15-May-15	30-Sep-15	IPC supplies to 5 hospitals in Port Loko, WA and Kambia	Port Loko, WA, Kambia
GOAL Sierra Leone	162,509	16-Jul-15	31-Dec-15	Mobile health teams for QHHs in WA	Western Area
GOAL Sierra Leone	170,352	01-Jan-16	31-Mar-16	Support to Isolation Units in Hospitals	Western Area, Bo, Kenema, Port Loko, Kambia
GOAL Sierra Leone	28,810	15-Jan-16	29-Feb-16	Support for VQF (including mobile health team), Contact Tracing and decontamination. 4 district response	Tonkolili, Kambia

Partner	Award amount	Award start date	Award end date	Activity summary	Area/district
Handicap International	500,000	10-Dec-14	09-Mar-15	Improving the management of ambulance fleet to support the Ebola response in Western Area	Western Area
Handicap International	500,000	01-Mar-15	15-May-15	Ambulance and decontamination in Western Area	Western Area
Handicap International	500,000	21-Apr-15	31-Jul-15	Ambulance support in Western Area	Western Area
Handicap International	1,137,423	21-Jun-15	29-Feb-16	Ambulance support in Western Area (Phase IV)	Western Area
Health Poverty Action	88,125	01-Dec-14	31-May-15	Support to Kamakwie hospital, contact tracing, chieftaincy taskforces	Bombali
Health Poverty Action	99,975	01-Mar-15	30-Sep-15	Training and mobilising secret societies and traditional leaders in Bombali	Bombali
Helen Keller International	499,175	08-Dec-14	13-Sep-15	Quarantine management in Western Area and support to WFP food distribution	Western Area
Helen Keller International	499,998	09-Feb-15	06-Sep-15	Expansion of current DEERF project to include surveillance in WA	Western Rural and Urban
Helen Keller International	334,014	13-Sep-15	31-Dec-15	Support for WA Surveillance	Western Area
IMC	500,000	10-Oct-14	31-Dec-14	Construction of 50-bed ETC	Lunsar, Port Loko
IMC	104,220	01-Aug-15	31-Dec-15	Ebola-Affected Family Support Programme – Kambia	Kambia
Lion Heart Medical Centre	11,771	15-Sep-15	31-Dec-15	Water Supply for Lion Heart Medical Center	Tonkolili
Partners in Health	439,320	01-Feb-15	30-Aug-15	Renovations to the Port Loko government hospital and training of staff to increase infection prevention measures	Port Loko
Restless Development	124,971	01-Mar-15	30-Apr-15	Continuation of SMAC activities in Port Loko, Bo and Bombali	Port Loko, Bo and Bombali
SENSI	98,334	27-Mar-15	31-Aug-15	SMS-based information dissemination in Western Area to enable communities to access information during the 'Stay-at-Home'	Western Area
Street Child UK	20,584	27-Mar-15	29-Mar-15	Feeding street children during the 3-day 'Stay-at-Home'	All districts except Kambia and parts of WA

Partner	Award amount (£)	Award start Date	Award end date	Activity summary	Area/district
Trócaire	99,667	30-Oct-14	28-Feb-15	Support to Quarantine Communities and Households in Port Loko	Port Loko
Trócaire	190,019	20-Dec-14	30-Apr-15	Support to quarantined households in Port Loko and Kambia	Port Loko, Kambia
Trócaire	172,616	22-Jun-15	31-Oct-15	Support for Operation Northern Push	Port Loko, Kambia
Welbodi Partnership	162,597	10-Nov-14	31-Dec-15	Improving the Ebola Response at the Children's Hospital: supporting the holding unit, assisting the surveillance and lab teams and reinforcing infection prevention and control measures	ODCH, Freetown
Welt Hunger Hilfe	113,861	07-Apr-15	15-Oct-15	Chieftaincy taskforces in Bo	Bo
WHH	317,362	10-Oct-14	31-Jan-15	Contact management Emergency supplies/food for quarantined households	WA Rural – Peninsular, Bombali, Port Loko, Moyamba
WHH	499,583	01-Nov-14	31-May-15	EOC Ebola Response System Strengthening along Western Area Peninsula Coastline	44 towns/villages in WA Rural peninsular
WHH	169,768	17-Apr-15	31-Oct-15	Chieftaincy task forces, Kailahun border areas	Kailahun
WHH	234,346	11-Jul-15	31-Dec-15	VQF Support Hastings	Western Area
World Hope	213,619	15-Oct-14	30-Jun-15	Water for Ebola centres (20 boreholes)	Port Loko, Moyamba, Bombali
World Hope International	48,369	11-Dec-14	24-Jan-15	Retrofitting paramedical holding centre	Bombali
World Hope International	51,485	19-Dec-14	18-May-15	Ambulance support to holding centres and hospitals in Bombali	Bombali
World Hope International	116,868	15-Jan-15	30-Aug-15	Support to the maternity ward at Makeni Hospital to increase infection prevention	Bombali
World Hope International	37,501	02-Mar-15	17-May-15	Cross-border training in Koinadugu	Koinadugu
World Hope International	60,667	26-Feb-15	25-Apr-15	80-bed isolation unit support in Bombali	Bombali
World Hope International	15,948	18-May-15	07-Jul-15	Support to check points in Bombali	Bombali
World Hope International	158,714	19-Jun-15	28-Feb-16	Survivor clinic in Bombali	Bombali
World Hope International	99,293	30-Jun-15	30-Sep-15	Support to Kamakwie Hospital, Bombali	Bombali
World Vision International	134,656	01-Dec-14	30-Apr-15	Support to quarantined households in Bonthe, Pujehun and Kono	Bonthe, Pujehun, Kono

5.8 Examples of best practice and case studies

Implementing partner	Best practice/case study
Doctors with Africa CUAMM	Doctors with Africa CUAMM built an isolation unit outside of the hospital and away from the centre of town. This helped to restore community confidence in returning to use the health facilities in the centre of town.
eHealth Africa	eHealth Africa took over and helped refine the 117 help line. When an individual made a call to 117, their mobile number would be automatically registered and geographically mapped. The handler would ask for description of symptoms (e.g. wet/dry symptoms). The individual would then be reported and a team dispatched if necessary. The system would identify if there were clusters and this would then be followed up and a taskforce sent to do contact tracing. The 117 phone line is still active and there are now discussions as to how it can continue to be used.
Handicap International	Handicap International developed a safe environment to dress/undress in IPC gear during the rainy season. In the rainy season it is difficult to dress in IPC gear so they adapted inflatable tents in which to dress/undress. A standard operating procedure (SOP) was developed. Working in slum areas was dangerous, as it was easy to scratch protective clothing. Handicap International trained their staff on how to walk safely through difficult terrain.
Health Poverty Action (HPA)	By their nature secret societies are secret and do not generally engage with partners outside their community, especially INGOs. However, in Bombali district a secret society group approached HPA, because they had not been targeted with social mobilisation and had a desire to be involved. This was seen as a real opportunity to engage with part of a community that would normally be closed off to outside support. HPA will try to capitalise on this opportunity now that the country has been declared Ebola free.
Restless Development	At DERC level, 98 young people were helping with coordination (e.g. administration). One young person, who had previously worked with Restless Development, was placed in Bombali and worked as a secretary for the social mobilisation pillar. Due to his effectiveness, he now has a job working with the International Organization for Migration.
Trócaire	Trócaire's role in Sierra Leone is to support local partners. During the EVD outbreak Trócaire continued its partnership with the Kambia District Development and Rehabilitation Organisation and Action for Advocacy and Development—Sierra Leone, to respond to the livelihoods needs of quarantined households. After consultation with the community, a package was devised to provide a) caretakers and/or labour gangs to manage farms or b) business support in form of cash transfers.
Welt Hunger Hilfe (WHH)	WHH was among the first organisations able to respond to the needs of quarantined households, and helped to inform the SOP which outlined what should be included in quarantine supplies. The SOP subsequently guided all other organisations nationally that were involved in the delivery of food and non-food items to quarantined households.

5.9 Approximate funding per district

District	Funding (£)
Bo	£432,310
Bombali	£1,182,210
Bonthe	£43,906
Kailahun	£175,818
Kambia	£348,598
Kenema	£172,394
Koinadugu	£246,892
Kono	£74,176
Moyamba	£311,712
Port Loko	£1,683,836
Pujehun	£296,862
Tonkolili	£90,547
Western Rural	£3,958,814
Western Urban	£3,246,253
Total	£12,264,327

Notes:

- The figures are based on the contract awards and are approximate.
- Where partners have more than one district in their contract, an average was used.
- The data shows the majority of funds (82%) were awarded to projects in four districts (Bombali, Port Loko, Western Rural and Western Urban).