FINAL REPORT

Sierra Leone, ECHO Global Plan 2000 / Intervention Plan 2001

Health, Nutrition, Water and Sanitation - 2001

15 September - 17 October 2001

QUEST-Consult
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The Sierra Leonean people have managed to retain their warmth and friendliness in the midst of conflict. The mission would like to express here its most sincere regards to all of them.

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DESCRIPTION OF THE EVALUATION

This report describes the evaluation of ECHO's assistance to the health, nutrition, water and sanitation sectors. The review covers the actions implemented during the 2000-2001 period and analyses the key strategic elements as developed in the following documents: (i) the Global Plan which has run from May 2000 to February 2001 related to "a Proposal for community financing of humanitarian assistance to Sierra Leonan populations" and; (ii) the Intervention Plan 2001 concerned with delivering Humanitarian Assistance to Sierra Leone from March 2001 to November 2001.

DATE OF EVALUATION: 15 September – 17 October 2001

CONSULTANT'S NAME: Christine Bousquet

PURPOSE & METHODOLOGY

The evaluation's purpose was to provide ECHO with informative and analytical elements so as to assess the suitability of operations for the above-mentioned sectors as well as to enable ECHO, on the basis of lessons learned, to elaborate the strategy and programming for 2002.

This sectoral evaluation was part of a global evaluation performed by a team of three consultants. The team benefited greatly from the contribution of written material. Fieldwork primarily involved interviews with a wide range of stakeholders, including European Commission and ECHO officials, ministries representatives, international agencies, implementing partners, national staff and beneficiaries. The structure of each interview was developed according to the source of information and the different types of contacts. Eleven projects were visited which yielded insights into the difficulties and successes of the work carried out. In addition, informal discussions took place with different individuals involved in project implementation.

During the fieldwork, three interim reports were submitted. Two debriefing sessions were held at the EC Delegation in Freetown with (i) the first draft of recommendations presented to the Head of Delegation and to ECHO's Technical Assistant and; (ii) general observations presented to and discussed with implementing partners.

MAIN CONCLUSIONS

Relevance: Many respondents have expressed their appreciation of ECHO assistance, be they beneficiaries, implementing partners or Commission personnel. Alongside promoting the concentration of resources in various geographical areas, ECHO encouraged a more integrated approach to project identification and planning. The projects were relevant to the acute problems caused by displacement and efforts were made to minimise the burden placed upon the infrastructures by the displaced and returnees and to include resident populations within the scope of assistance. The aid programming for 2001 has also reflected the efforts to meet the basic health needs of people through first and secondary level care.

With large volumes of resources dedicated to health interventions that seek to fill temporary shortages in vital resources such as staff and medical supplies, there has been, however, a general tendency for projects to focus on specific aspects of implementation and not enough on strategy. In some instances, the short project cycle was not adapted to the financing of projects operating at institutional level.

Effectiveness: There are significant constraints on the projects - volatile contexts, institutional weaknesses and difficulties of gaining access to project sites. Effectiveness is also related to the individual characteristics of each project.

Despite an increased caseload and the hungry season periods that were likely to push up levels of malnutrition significantly, ECHO's support has been effective in reducing malnutrition rates. For water and sanitation, the projects have gone beyond building wells, latrines and installation of hardware. A combination of approaches including safer disposal, hand washing and maintaining drinking water free of contamination has been successfully adopted.

The strategy targeting first and secondary level of health care has been effective in meeting basic

health needs and in increasing access and coverage. However, health system-wide issues were not actively considered. For a few health projects, ECHO, using funding mechanisms designed explicitly to respond to short-term emergency needs, has undertaken long-term projects characterised by a high recurrent element cost. This is unlikely to lead to optimal use of resources.

Efficiency: The efficiency of actions has been preserved through competent organisations with good local knowledge and understanding of security implications. No incident in relation to project personnel has been reported and no major looses in equipment, drugs and food supplies incurred.

The implementing partners have not, generally, being systematic in collecting information for monitoring and evaluation purposes. Interim and financial reports have been behind schedule consistently. Reporting mainly concentrates on a description of activities with little analysis taken.

The ECHO office in Freetown has been instrumental in creating a favourable operational environment that allowed partners to keep coherence and to plan for more substantive projects. In view of the large portfolio of projects and limited manpower at ECHO, the gap left by the absence of the Regional Health Coordinator appears to have been mitigated by the high calibre of those staff that are present.

Impact: The impact of relief efforts in preventing the prevalence of malnutrition from increasing beyond regional norms is worth noting. In camp situations, the improved conditions and behaviours are reflected by a lower incidence of disease. In particular, morbidity and mortality due to bloody diarrhoea were controlled and no increase was reported during the period under review.

The impact of immunisation coverage is not yet properly documented. Despite the investment, the programme might not result in the expected reduction of morbidity and mortality due to institutional constraints and weaknesses in supplying the correct items and vaccines.

The contribution that projects have made to restore basic health services has created better conditions for health staff. However, the overall issue of the long-term capacity of public services to sustain a certain level of delivery remains a very significant constraint.

Sustainability: The transition from delivery of goods and services to sustainability continues to present formidable challenges. The sustainability of the projects varies and is often jeopardised by weak public services which should take over from the agencies executing the projects. Where communities have contributed towards project costs, this has created a feeling of ownership. Some impressive examples of community contributions toward building wells and latrines can be cited.

The delays experienced up to date have seriously hampered the Commission's responsiveness to linking relief, rehabilitation and development. In addition, the mechanisms for integrating the current ECHO-funded projects within the long-term perspective of development aid have not yet been established.

RECOMMENDATIONS

• In relation to project management, ECHO and partners should pay attention to the following aspects:
- appraisal should include more effective targeting (especially women and children under five);
- planning should be adequate and realistic, using a Log Frame as a tool;
- monitoring should be improved and focused on process and outcome indicators;
- external evaluation of individual projects commissioned by partners and ECHO within the Framework Partnership Agreement should be more systematic.

• The scope for health activities should be based on a comprehensive plan, developed in accordance with local capacities and actors (e.g. quality versus quantity, strategy versus implementation) and should prioritise quality improvement initiatives such as improved management, supervision and training. As ECHO's efforts to support the problem of immunisation service delivery met with partial success, it is recommended that the scope for EPI assistance be re-appraised and scaled down concentrating either on frontline areas or on a more specific area of support such as vaccine procurement.

• The problem of malnutrition should be approached from a different angle. The current nutritional support should be gradually phased out. Improvement of child care practices should be integrated as much as possible at primary and secondary health care levels and with the water and sanitation

activities.

• Water and sanitation activities at camp level should be scaled down by strengthening the transfer of activities to the beneficiaries. Partners should be able to assist in a strategic manner with resettlement by preparing the conditions for return and by maintaining and reinforcing a proactive community approach as developed adequately during the period under review.

• In the light of the delays that have seriously hampered the Commission's responsiveness to linking Relief, Rehabilitation and Development, ECHO assistance for 2002 should be preserved as an essential mechanism in the range of instruments available to the Commission. If ECHO truly wishes to foster a proactive LRRD strategy, it should, together with the Delegation, continue lobbying for a long-term EC commitment. In addition, the Regional Health Co-ordinator role is seen as critical in planning for health projects orientation and future and in assisting partners to access other Budget Lines eligible to NGOs.

LESSONS LEARNED

The freedom accorded to implementing agencies has to a certain extent benefited health system development because ECHO partners have pioneered some important activities which the Ministry of Health (MoHS) might not have attempted on its own, such as early experiments with cost recovery.

From a project perspective, it may be argued that financial sustainability can be assured through the mobilisation of extra resources through cost recovery. From a sectoral perspective, however, the scale of the problem becomes apparent. The volume of recurrent support being provided by ECHO partners cannot be absorbed by the MoHS or addressed through user charges within the foreseeable future. Thus the viability of the "start-up-and-hand-over' paradigm is called into question.

Since 1995, ECHO intervention remained a major source of funding for NGOs with the availability of funding a major concern for partners. The partners who set up large and ambitious interventions will soon be facing the challenge of phasing out supporting projects which no longer fit within the scope of assistance. The partners should learn the lessons by enhanced priority-setting and strategic planning and by expending a great deal more effort on handing over to the government some of the health facilities they run on behalf of the MoHS. By the same token, partners must be more realistic about their technical, logistical and financial capabilities and use ECHO assistance in a more rational manner.

Currently, the MoHS is severely constrained in its ability to absorb and utilise external resources to consistently deliver quality health services to the population. Such an environment requires an adaptation of donor strategy. Apart from diverting assistance to first level of care and to communities, the options for ECHO are fairly limited. This highlights the importance of different forms of aid.
Rehabilitation of health facilities is one although the long-term benefits are likely to be low where capacity is under-utilised and where increased recurrent costs cannot be met. Health sector support is another and seems the most likely pattern for the future in Sierra Leone.

1 PURPOSE OF EVALUATION AND METHODOLOGY

The purpose of the field mission was twofold: (i) to assess the suitability of the 2000-2001 ECHO's operations for the health, nutrition, water and sanitation sectors; (ii) to make specific recommendations on the basis of the lessons learned. The recommendations are intended to assist ECHO in elaborating the strategy and programming for 2002. The key issues to be evaluated were relevance, efficiency, effectiveness, impact and sustainability. Terms of Reference are included as Annex 1.

The approach was based on a three-phase process. An overview of ECHO's operations in Sierra Leone was obtained from documentation in the Brussels main office and from discussions with ECHO's Desk Officer and Technical Assistant (TA). This revealed a well-developed framework of documents on the status of projects, such as planning and project papers, correspondence between the primary stakeholders and project appraisal worksheets. The second phase of the evaluation included visits to the head offices of ECHO's partners in Sierra Leone and interviews with personnel from the Commission, health officials and international agencies. As part of the third phase, the fieldwork yielded insights into the difficulties and successes of the work carried out. A work plan was drawn up and methods defined, including key informants interviews, physical inspection, visual observation and individual and community meetings. Interviews were also held with health representatives, project staff and individuals as opportunities arose. The structure of interview was developed according to the source of information and the different types of contacts.

During the fieldwork, each member of the evaluation team presented three interim reports. The interim reports were discussed between the team members to clarify data, to check alternative interpretations, and to review recommendations. Two debriefing sessions were held at the EC Delegation in Freetown with (i) the first draft of recommendations presented to the Head of Delegation and to ECHO's TA, and (ii) general observations presented and discussed with implementing partners.

For the period 2000-01, eleven executing agencies were visited and field visits were made to a total of eleven projects currently operational[1]. The list of partners and projects is attached as Annex 2. In order to crosscheck some of the findings, some partners were met with on several occasions. The list of persons interviewed and the detailed programme of activities are presented in Annex 3 and Annex 4 respectively. Whenever relevant or illustrative, specific projects or organisations have been referred to accordingly.

The evaluation was principally limited by the following:
- Figures are really problematic. Reliable population data are not readily available and much of the data records are not accurate;
- It proved difficult to construct a narrative and baseline due to the high turnover of humanitarian agency personnel;
- Weaknesses in project monitoring and reporting made the assessment of quantitative data difficult.

2 GENERAL CONTEXT

Sierra Leone is situated on the West Coast of Africa and bordered by the Atlantic Ocean, Guinea and Liberia. The total area of the country covers approximately 71,740 square kilometres. Based on projections from the 1985 census, the total population in 1997 was estimated at 5.0 million. The country comprises several ethnic groups, of which the Temnes and Mendes constitute the largest groups. About 40% of the population is Muslim and the remainder are Christians or devoted to indigenous beliefs. Sierra Leone is divided into 4 provinces, 13 districts and 150 chiefdoms[2] (Annex 5). Each chiefdom is governed by a paramount chief and a council of elders.

English is the official language for government and Krio is used extensively throughout the country. In addition, there are a dozen tribal languages, including Mende and Temne.

[1] Due to time constraints, the field visits to OXFAM and Tear Fund projects were carried out by the Team Leader.
[2] Source: OCHA Humanitarian Information Centre and the Sierra Leone Information System, 20 April 2001.

The country gained independence from British rule in 1961. In 1978, a single party system was adopted. Over the years the failure of the state to prevent ethnic rivalries, the lack of good governance combined with an unequal distribution of income and wealth created the conditions which led to the civil war. The conflict erupted in 1991 between the Government (GoSL) and the Revolutionary United Front (RUF) forces and violence has torn the country apart claiming the lives of an unknown number of people. Warring parties had massacred and abused civilians, using child soldiers in contravention of the Convention of the Rights of the Child. Furthermore the prolonged fighting and political instability have given rise to population displacements and have deprived the country of much of its basic infrastructure, including water, sanitation and housing. Rebel areas have become completely isolated and the accessibility within the country has been restricted due to insecurity.

In February 1998, a Nigerian-led West African peacekeeping force (ECOMOG) took control of the capital and many up-country areas but was unable to inflict a military defeat on the RUF. To replace departing ECOMOG forces, the UN launched one of its most important peace-keeping operations known as UNAMSIL. Over the past year, the extent of fighting has diminished and the peace process is moving slowly forward through the Disarmament, Demobilisation and Reintegration (DDR) Programme targeted at 45,000 ex-combatants by the end of 2001.

An estimated 82% of the population is living below the poverty line of 1US$ per day. Although Sierra Leone has a high potential for natural resources, mainly agriculture and mining, the UNDP Human Development Index ranks it as the poorest country in the world. The diamond boom of the 1960s led to widespread neglect of the agricultural and fishing sectors. Evidence suggests that the trade in diamonds is continuing regardless of the current instability in the country.

The events of May 2000 have shown that the situation remains complex, volatile and highly dependant on regional outcomes. For most observers of Sierra Leone, a peace settlement remains the *sine qua non* for improved social and economic development. The operational and policy environment for humanitarian aid in the coming months is therefore likely to be characterised by continued uncertainty.

3 THE SECTORS' SITUATION[3]

3.1 HEALTH

In 2000, a national and multi-sectoral survey covering 92% of the country was completed and provided the most recent estimates of key health indicators[4]. The infant and child mortality rates of 170/1,000 and 286/1,000 respectively are among the highest in the world. A similar picture exists for maternal health care statistics with an estimated Maternal Mortality Rate (MMR) of 1,800 per 100,000 live births. Even though the number of maternal deaths about which information was collected is too small to draw conclusions, the study found that induced abortions, the distance to district hospitals at the time of obstetrical emergencies and low income are negatively affecting maternal outcomes.

The most prevalent health problems among the under-five group include malaria, acute respiratory infections (ARI) and diarrhoeal diseases. Data from the national survey suggest that the approach to malaria control is curative rather than preventative. While 61% of children under five received Chloroquine or Fansidar for a fever episode, only 2% of surveyed children were using impregnated bednets. The diarrhoea season is from May to September, with dehydration being a leading cause of mortality among children.
The survey showed that, during diarrhoea episodes, correct home management through increased fluids was almost non-existent. The full immunisation coverage among children 12-23 months old has been estimated at 39%; tetanus toxoid (TT) coverage for protecting women is not known with precision.

[3] The health, nutrition, water and sanitation sectors fall within the responsibility of the Ministry of Health and Sanitation (MoHS).
[4] Source (all statistics for the sectors): Survey Report on the Status of Women and Children in Sierra Leone at the end of the Decade, November 2000, Government of Sierra Leone.

Among the health facilities visited, many were recording high levels of Sexually Transmitted Diseases (STDs) among adults. The presence of HIV has been documented in major urban cities, borderlands and mining areas. An unpublished study indicates a 6% HIV prevalence in adults and demonstrates an increasing trend over time[5]. The situation is further aggravated by population displacements inside and outside the country.

Prior to 1991, the public sector health services encompassed a network of 730 Primary Health Units (PHUs) and 21 GoSL District Hospitals[6]. The PHU network comprised three categories: the highest level known as the Community Health Centre (CHC); the intermediate level or Community Health Post (CHP); and the lowest level of health care or Mother and Child Health post (MCHP)[7]. The traditional sector consisted of an unknown number of Traditional Birth Attendants (TBAs), herbalists, bonesetters and spiritualists. Even before the civil war and despite an elaborate nation-wide network, health care activities did not bring about expected improvements in health status, especially among rural populations.

The breakdown in social services further exacerbated the organisational weaknesses of the health system. The resumption of hostilities in May 2000 once again cut off the Northern Province and parts of the Eastern Province from access to basic health services. To date, Sierra Leone is still characterised by important regional differences in operational conditions (Annex 6). There is no accurate record of the conditions of the health infrastructures across the country. It is estimated that only 34% of the population have access to health facilities, mostly in the Western area. Over the past year, the MoHS initiated the registration of health personnel, estimated at about 4,000 from the 2001 payroll.

The World Health Organisation (WHO) is providing technical support for a number of programmes[8]. To date, implementation of these programmes has met with partial success and is seen as a top-down approach, isolated from the field reality. Within a situation of chronic instability and little scope for institutional development, services have proliferated in response to the health needs and the lack of resources. Internationalisation of health provision is obvious in many ways with a plethora of NGOs operating in various districts (Annex 7).

3.2 NUTRITIONAL STATUS

Access to adequate, nutritious food is a prerequisite for good nutrition. A major contributing factor to under-five mortality for Sierra Leone has been childhood malnutrition. The present levels of moderate and severe malnutrition rates are comparable to the figures reported for Sierra Leone in the period 1990-97[9]. Similar norms are also found for other countries in West Africa suggesting the regional dimension of child malnutrition.

The last nutritional surveys carried out by ECHO's partners in Bo and Kenema Districts found a global malnutrition rate of 3.8% and 5.3% respectively. A recent survey carried out in pre-harvest times showed no significant difference to the data collected in the post-harvest period, indicating that the causes of malnutrition relate more to poor hygiene and child care practices than food insecurity[10]. The fact that safe drinking water is in short supply raised the issue of inadequate food preparation and greater food contamination.

Food security depends on the household's access to food. Agricultural assistance, in the form of seeds and tools has been provided by NGOs. In rural areas of Kenema, where the average household size is at 8.5[11], families continue subsistence farming activities and access food through markets. Among the many and

[5] Source: WHO Office, Freetown.
[6] Source: National Operational Handbook for Primary Health Care, Revised Edition 1997, Ministry of Health and Sanitation.
[7] The main services provided at PHU level are treatment of minor ailments, antenatal care, growth monitoring and immunisation.
[8] including Reproductive Health/Maternal Mortality Reduction, Malaria Control, Control of other Epidemic Diseases and Surveillance, Control of HIV/AIDS[8], Eradication of Polio and Health Information System.
[9] UNICEF. 1998. The State of the World's Children. New York: Oxford University Press.
[10] Source: ACF: Nutrition Baseline Survey, November 2000; GOAL: Nutrition Baseline Survey, February 2001.
[11] Source: GOAL: Nutrition Baseline Survey, February 2001.

complex causes of food insecurity, reduced agricultural production; unemployment, low income and a high ratio of household dependants to earners have been reported[12]. Opportunities for diamond mining also continue to divert labour from agriculture. In certain RUF-controlled areas of the northern province, food has been taxed by the rebels, thus threatening family food supplies.

The long-lasting conflict has also had serious implications for care behaviours and practices. The breakdown of family and community structures placed extra stress on caregivers. Maintaining a stable food supply suggests that caregivers spend more time searching for income, water and food, resulting in less support for childcare. How families in Sierra Leone react by managing declining resources is not well understood. No in-depth study has been undertaken on coping strategies related to food. In discussions with key informants and implementing agencies, a reduction of dietary intake, cooking cheaper and less nutritious food and reduction of the number and size of meals eaten have been mechanisms reportedly mentioned. There is also a tradition among families to allocate food first to men, contributing to inadequate access for vulnerable groups, especially young children.

The benefits of exclusive breastfeeding during the first few years of life have been well documented[13]. Nonetheless the rate of Sierra Leonean children aged 0-4 months exclusively breastfed is 2%, well below the regional average of 31%. Weaning foods are usually introduced before 6 months and are reported nutritionally inadequate, as they tend to be high in carbohydrate with low concentrations of protein and fat.

3.3 WATER SUPPLY AND SANITATION

Conflict and subsequent collapse of government and social structures have caused major damages to the water and sanitation infrastructure. According to the 2000 survey report[14], 54% of the population nation-wide has access to safe drinking water. The situation in the north is worse than in other regions: only 30% get their drinking water from a safe source. The sanitation provision is also very poor across the country. The survey revealed that only 53% of the rural population have access to a safe means of excreta disposal compared to 88% in urban areas. However, the accuracy of data is to some extent subject to caution as the sample frame is based on population estimates by local informants.

Access to clean 'safe' water sources and safe excreta disposal methods remain a major challenge in a country where diarrhoeal diseases account for the third cause of morbidity and mortality in children under 5. National standards for water supply and sanitation in the country are not yet defined. The current general policy climate is in favour of privatisation for the Water Supply Division of the Ministry of Energy and Power which acts as the co-ordinating body for public water supply, especially in rural areas. The broad strategy is to improve access and quality in partnership with the MoHS department that is in charge of health education and community awareness. This process has been seriously hampered by lack of resources, poor planning and management capacity.

While the responsibility for procuring water falls on women and children, most water is taken from streams, rivers or shallow wells. The quality of the water source has also been questioned because, the rebels have been accused on several occasions of polluting the water. As observed on project sites, the wells installed with hand pumps had fallen into disrepair due to lack of maintenance. The importance of environmental hygiene is also crucial. Findings show that 9% of households washed their hands before cooking[15]. The current practices around water handling as well as food handling and storage, wastewater from cooking and washing are main areas of concern.

4 EC CONTRIBUTION TO THE SECTORS

[12] For instance, Kenema town is densely populated with an average of 25 people per household. Source: MERLIN, Nutrition Survey, January 2001.
[13] Giving only breast-milk without additional food or water for about 6 months[13] reduces in particular the incidence and severity of diarrhoeal diseases and as such increases the chances of survival for most infants.
[14] Source (all statistics for the sectors): Survey Report on the Status of Women and Children in Sierra Leone at the end of the Decade, November 2000, Government of Sierra Leone.
[15] Source: GOAL: Water, Sanitation and Health Promotion Baseline Survey, July 2001.

4.1 HUMANITARIAN AID

Since 1995, the European Commission Humanitarian Aid Office (ECHO) has been an important player in the Region. The charts presented in Annex 8 provide a summary of ECHO commitments by sector and by partner. For the period under review, a major emphasis is put on the provision of health care with a gradual increase in individual project budgets for 2001. As shown in Annex 2, an estimated 37% of the total budget for 2001 has been spent on purely health projects.

Most of the projects have been programmed for a duration of up to 9 months. The indicated duration of projects is not a real expression of the duration of the interventions at field level, since many projects are a continuation of previous projects. The ECHO-financed projects were confined initially to the eastern half, western and southern parts of Sierra Leone which offered conditions of relative security, but have been gradually extended. To date the operations are mainly implemented: (i) in areas controlled by the GoSL with large IDPs concentration; (ii) in GoSL "enclaves" in RUF controlled areas and; (iii) in rebel controlled areas.

4.2 REHABILITATION AND DEVELOPMENT

The EC-Sierra Leone Resettlement and Rehabilitation Programme (EC-SLRRP) was designed in 1996 as part of the 7th European Development Fund (EDF). Geographical areas of interventions include the Northern, Eastern and Southern Regions targeting a total of 5 districts. Assistance to the health sector provided funds for the rehabilitation of PHUs, District Hospitals and training of community members. The Water and Sanitation sector also received funding for the rehabilitation and construction of wells and latrines. Annex 9 summarises the achievements of the programme in health and water and sanitation for the period 1999-2001. Nonetheless, the implementation of the programme was disrupted and delayed on a number of occasions by the conflict. To date, due to delays in launching the tender for a new Technical Assistance, a gap in the management of the programme is unavoidable.

The Health Support Sector Programme (HSSP), complementary to the SLRRP, is a 28 MEURO allocated under the 8th EDF[16] and covers a 5-year period. According to the last HSSP appraisal[17], the programme is aimed at improving access and quality of health care at primary and secondary level. The strategy is based on institutional strengthening with a central pharmacy, human resources and District Management Board Fund as key priorities.

The recruitment of a National Health Co-ordinator to link ECHO funded interventions to HSSP is crucial. However, this bridging arrangement, subject to tender and procedural constraints, may not become operational before the end of 2002. Two consultants are currently preparing a Memorandum of Understanding with the MoHS for the paramedical school in Bo and the District Health Fund. In addition, they will write the terms of reference for the whole TA team, expected to arrive in the field in five months time[18].

[16] The HSSP has been approved by the EDF committee in December 2000.
[17] "Finalisation of the Health Sector Proposal for Sierra Leone", Interim Report, Alter SARL, Freetown, 10/8/00.
[18] Personal communication: Mrs Suzanne Kodsi (AIDCO)

5 MAJOR FINDINGS WITH RESPECT TO EVALUATION CRITERIA

5.1 RELEVANCE

5.1.1 Identification of needs

Alongside promoting the concentration of resources in various geographical areas, ECHO encouraged a more integrated approach to project identification and planning. Given the continuing uncertainty about the direction of the peace process, political factors have, however, constrained the objectives and conditioned the possibilities of assistance. In particular they have strongly influenced the geographical assignments of funds, with the humanitarian space being restricted to GoSL-controlled areas. The overwhelming need remains in rebel-controlled areas, access to which was severely restricted. However, ECHO's support has shown its ability to expand into new areas and to restore essential services in health. This is particularly relevant for the Northern province where most donors have been virtually absent.

Large volumes of resources are being dedicated to health interventions that seek to fill temporary shortages in vital resources such as staff and medical supplies. Within a context of instability, ECHO funding aid has increasingly been used as a substitute for services and resources which, in secured areas, have been rendered accessible. In that sense, partners have taken an overly short-term approach to what became largely structural problems. To date, assistance is going beyond the emergency-relief mode, covering gaps left by the absence of a relevant post-conflict instrument.

ECHO's budgetary support through the provision of supplies and equipment[19] nationwide is a critical resource for UNICEF, representing 39% of the total budget allocated to the Expanded Programme for Immunisation (EPI). Although immunisation is recognised as one of the best investments in health, ECHO programming has underestimated the structural and contextual constraints that are affecting the prospects for immunisation delivery, in particular, the poor MoHS capacity at field level and the lack of adequate monitoring and follow-up systems for EPI. In addition, the type of ECHO aid, based on a short project cycle and using funding mechanisms designed explicitly to respond to short-term emergency needs, does not seem the appropriate instrument to address institutional weaknesses in the area of EPI management.

Focus on high-risk areas and groups has been the objective of water and sanitation programmes. Building latrines and bathhouses and providing health education are the traditional functions of this component. Most projects have community maintenance systems and introduced community participation during implementation. Indeed, thanks to the efforts of ECHO partners, the camps in Kenema and Port Loko are well supplied with water of an acceptable quality. The water and sanitation intervention is, however, constrained by the limited number of partners and their operational capacity.

Over the year 2001, there has been a reorientation because of the fact that returnee and displacement problems are not restricted just to those groups, but are rooted in, and affect, the lives of host and resident communities. An approach designed to help the displaced achieve self-sufficiency is gradually emerging and emphasis is now put on the provision of water and sanitation to rural communities. The ECHO programming has reflected the efforts to reduce the gaps in coverage between various categories of population and the disparities arising from preferential treatment to the displaced alone.

5.1.2 Target population

The catchment population is often fluid and unknown. Due to the uncertainty surrounding the issue of beneficiary numbers, including the fluctuating data on IDPs and returnees, the exact nature of the population being assisted remains unclear. Although this may be considered as a weakness from the point of view of reporting, it reflects the flexibility of the aid instrument.

The choice of beneficiaries for health projects remains broad and relates mainly to the general population. With large gaps in the use of health facilities, it is apparent that full coverage is not feasible. This implies the need to identify which segments of the population have the highest risks and need to be approached on a priority basis. Given the high infant and maternal mortality rates that prevail in Sierra Leone, a more precise

[19] Including measles and TT vaccines, auto destruct syringes and needles, and cold chain equipment.

definition of target groups such as women and children under five is worth considering.

Most of the nutrition and water and sanitation interventions benefited populations which have been displaced, thus reducing the prospects of malnutrition and water-borne diseases. Interventions aimed at improving nutritional status are targeting vulnerable groups including children less than five years, pregnant and lactating women. There are two main treatment options for severely malnourished children. These, together with the admission criteria for both Therapeutic Feeding Centre (TFC) and Supplementary Feeding Centre (SFC), are presented in Annex 10.

5.1.3 Strategy

The strategy of targeting the first and secondary levels of health care has been appropriate in meeting the basic health needs of people. However, the projects executed during the reference period had a standard duration of nine months, a time constraint clearly incompatible with the objectives of most health interventions which aim to cover as many health facilities as possible. In most districts, the majority of the population lives in remote villages, with very poor road access, which gets worse during the rainy season. Since many health facilities require time-consuming journeys, proper follow-up and monitoring are difficult, resulting in short visits whose purpose is to provide drug supplies. The rationale for the selection of PHUs is not always clear and too often falls beyond the partner's capacity especially for IRC and MERLIN projects. The current situation at PHU level produces strong arguments for strengthening quality instead of quantity and for enhanced planning based on a set of criteria for prioritisation of support[20].

The management of the project cycle in a fast-changing and evolving context and for projects targeting a "population on the move", requires high-quality planning. Some partners such as ACF were able to apply for funds in a repetitive manner over an extended period of time but, due to their relief-oriented mandate, did not take the opportunity for better planning and enhanced consistency in project strategy.

5.1.4 Co-ordination, coherence and complementarity

At Central and District levels, mechanisms for sectoral co-ordination take the form of monthly meetings and include 'information" co-ordination, providing a forum for the exchange of information between the different actors. The capacity of ECHO partners to move beyond this type of co-ordination is limited by differences in the style, mandates and personalities associated with agencies.

In the case of the health sector, efforts by health professionals to establish effective mechanisms for co-ordination are undermined to a considerable extent by structural features of the health system, in particular the problems of acute under-financing and very low public sector pay. In most instances, input from MoHS counterparts at district level remains minimal and respondents felt the MoHS was poorly equipped to take leadership. What the NGO co-ordination mechanisms cannot achieve is a coherent analysis of the primary problems facing the health sector, nor do they have the power to influence the MoHS allocation of resources to that need. The latter is illustrated at Kenema hospital where, despite the critical need and lobbying for national doctors to be posted at the paediatric ward, a MERLIN expatriate doctor is still filling the vacuum.

The expansion in NGO activities heightened the challenge for operational co-ordination of ECHO-funded projects, especially as it relates to needs assessment, planning and implementation. In this respect, the establishment of a database containing the distribution of NGOs resources and activities has been extremely beneficial. Assessment contents are usually shared at district-level meetings. Anthropometric surveys using the 2-stage 30 by 30 cluster sampling technique is the methodology widely used by partners to assess the nutritional status of children aged 6-59 months. In Kenema District, duplication has been avoided through the selection of different chiefdoms. The current approach in bringing together ECHO partners has shown that they can collaborate and be involved in complementary health-related activities.

5.2 EFFECTIVENESS

Collecting data on effectiveness has been problematic. The heavy demands upon field staff and organisational structures preclude adequate and reliable data collection. In addition some activities are far more amenable to performance measurement than others. The provision of health services, for instance,

[20] e.g. building, reasonable level of staff, suitable population catchment, distance to a referral centre.

represents intangible benefits and in retrospect it was difficult to track down the consultations carried out and the vaccinations given.

5.2.1 Health

The health sector represents the most important sector in terms of expenditure. However the sector costs may not be truly representative due to the presence of a few very "expensive" health projects (e.g. the District Hospitals in Bo and Kenema). The health projects[21] are well spread geographically, although there is a concentration in Kenema district. The total number of beneficiaries is very difficult to assess and their interpretation is subject to caution as implementing partners have included a large number of potential users. Based on those population estimates, health projects would benefit an estimated 2,300,000 million people, showing how distorted the figures are. The problem of multiplication of beneficiaries is that there is an unknown degree of overlap between the beneficiaries of the different sectors.

Activities in the sector include support to four District hospitals and to an estimated number of 55 PHUs. The objectives were often ambitious and the results much lower than originally anticipated. On a few occasions, inconsistencies were found in the number of PHUs currently supported and those listed in the interim reports. The discrepancy could be partly explained by poor record keeping and monitoring. For instance, while MERLIN reported support to 15 PHUs, the field visit showed that in fact a total of eight health facilities were currently operational.

The strategy targeting first and secondary level of health care has been effective in meeting the basic health needs of people and in increasing access and coverage. Nonetheless the partners, while committed, have focused too much on specific aspects of implementation and not enough on strategic planning. For instance, the current approach to the paediatric ward of Kenema hospital and to Kabala hospital -replacing rather than supporting- tends to normalise institutional weaknesses and to perpetuate the counterpart role of MoHS as a passive one. As a result there is a danger that project outputs will not be sustainable such as ACF's TFC in Bo and Children's Aid Direct (CAD)-supported health facilities in Port Loko. In addition, there appears to have been insufficient consideration of the use of on-going training and supervision, including a lack of mechanisms for follow-up. This is particularly evident in the area of diagnosis and drug prescription at PHU level.

EPI in Sierra Leone is implemented at static clinics and during National Immunisation Days (NIDs). Immunisation services rely upon the availability and quality of resources such as cold chain equipment, vaccines, injection equipment, as well as the correct use of these supplies and equipment. While UNICEF's interim report does not provide detailed information of what has been achieved, the field visits indicate that, in most instances, routine immunisation is virtually non-existent and poorly conducted. Obviously the NIDs campaigns are diverting significant resources from the strengthening of routine systems but poor planning and irregular transport from the MoHS are also negatively affecting the supply of the correct items and vaccines at district level.

The lack of supplies, including auto-destruct syringes and needles, has been reportedly pointed out in all projects. This situation has forced partners to use their own syringe supplies, paid for by ECHO, resulting in double funding to administer vaccines. Furthermore, the absence of equipment maintenance has had serious implications for the reliability of the cold chain as shown in Lungi where the newly established District cold room is no longer functional due to the breakdown of the refrigerator. Additionally, cultural factors seem to affect the acceptance of TT immunisation. Overall progress toward development of effective immunisation depends to a large extent on the DMO capacity and varies by region, being better in areas where NGOs operate. The crisis of the public health system has created a delivery gap that is being filled by NGOs.

Prevention of outbreaks was addressed similarly by dealing with specific activities. The preventive mass vaccination campaign against yellow fever[22] has been effective in vaccinating 26,850 persons.

5.2.2 Nutrition

[21] Implementing partners: CAD, GOAL, IRC, MSF-B, MSF-H, MERLIN and UNICEF.
[22] Period: 13/09/2000-12/11/2000; partner: MSF-B.

The 3 main projects[23] are spread over Eastern, Southern and Western provinces and are concentrated in areas with high numbers of IDPs and returnees. The targeted population for TFCs and SFCs includes children under five, pregnant and lactating women. Differences in data availability for dry food distribution are compounded by the fact that there are a number of organisations involved in delivering food supplies[24]. The results so far can be summarised as 3 functional TFCs and an estimated number of 38 SFCs. In Bo and Kenema, twenty-two health centres and three screening teams are undertaking nutritional surveillance.

No reliable data was available on the CAD project due to lack of reports but a significant defaulter rate was observed in 2001 due to the highly fluid population movements in the Western Province. Due to the returnee and displaced caseload, there has been considerable variation in the Lungi and Port Loko area and it has been impossible to determine any trends in nutritional status over the past year. In addition the field visit showed the limitations of the SFCs in nutritional education. High attendance and demanding growth-monitoring activities are undermining effective education on nutritional issues.

5.2.3 Water and Sanitation

This is a small sector with only four approved projects[25]. The number of expected beneficiaries is estimated at 86,000. Available data from ACF has shown quantitatively that the project has led to an increased number of physical structures. In 2001, a total of 60 showers and 24 latrines have been constructed. In addition, 60,000 soap bars have been distributed and 40 Community Health Promoters (CHPs) trained. In the IDP camps, there was a growing realisation that a demand-driven approach through increasing people's participation contributed to coverage and use more than a supply-driven approach. The projects in rural communities have involved village members in implementation (e.g. digging wells and pits and constructing structures), health education and monitoring. Flexibility in the choice of technical options that suit different groups within a given area has been ensured, as reflected in the latrine design for school children in the GOAL-funded project.

Experience elsewhere has demonstrated that a comprehensive approach can influence the health status of a community and be more effective than establishing the infrastructure only. Over the past year ECHO-funded projects have gone beyond building wells, latrines and installation of hardware. A combination of approaches including hygiene promotion, safer disposal, hand washing and maintaining drinking water free of contamination has been adopted by ACF, GOAL and OXFAM.

5.2.4 Assumptions and Risks

Again political factors have been crucial in constraining aid approaches. Interruption has been particularly problematic in 2000 and partners have had to deal with the consequences of evacuation. Whilst affecting certain projects more than others, it has limited their effectiveness. Operations have been hampered by the rainy season, especially for digging wells and accessing remote PHUs.

There has also been insufficient attention given to the issue of local capacity. Some projects have been established without considering the capacity of the MoHS to support their intervention over the long term. In Bo, the dependence on ACF for nutritional aspects has resulted in a system that has grown up unplanned and without the involvement of the district health authorities, which are now asked to take responsibility for recurrent costs for the TFC and SFC structures.

5.3 EFFICIENCY

5.3.1 Partner's Operational Capacities

Under difficult circumstances, it can be said that ECHO has been very efficient in dealing with a portfolio of diverse projects. While technical aspects of the projects seem satisfactory, most partners have gained experience in working in Sierra Leone where the terrain is difficult and the logical infrastructure poor.

It is worth noting the excessively long hours of work which expatriate staff are doing in order to meet the activity time-frames. Some are visiting health facilities seven days a week. This reflects the fact, that within

[23] ACF, CAD, GOAL, and to a certain extent MERLIN (TFC in Kenema) and MSF-B (TFC in Kabala).
[24] World Food Programme and Catholic Relief Services.
[25] Implementing partners: ACF, Oxfam, Goal (in the process of establishing a baseline survey) and Tear Fund.

a context of medium-term planning, projects are still implemented in emergency mode. On the other hand, the operational capacity of ECHO partners is relatively limited. While most projects have lacked realistic objectives in relation to their time-frame, ongoing projects with ever-growing budgets have created extra burdens and have made some partners fairly impermeable to change. In certain cases, their ability to operate in areas of greater needs has been undermined.

5.3.2 Personnel

In practice, most expatriates are not only responsible for major decision-making but also for day-to-day decisions in all areas of implementation. The fact that some of them have little experience in developing countries reduces the benefits of adequately planning for a medium-term strategy. Because of their over-reliance on expatriate staff, projects have suffered from a high level of staff turnover. As a result, it is difficult to develop in-depth knowledge of the local context and to pass it on to new staff.

There is an overall tendency to employ large numbers of national staff. However their particular role and key functions are not always clear and organogrammes, when available, are far too complex. National staff salaries are fairly comparable with those of most international NGOs in Sierra Leone. Incentives, also known as emergency allowances, were first introduced in order to support the MoHS staff and gradually became part of normal salary payment. Following budgetary support to the civil servant payroll from the international community, paying allowances was discontinued as from June 2001. This has created major problems, especially for MERLIN who relied on extremely high incentive rates.

5.3.3 Management of the operations in the field

Overall, the partners have a good understanding of the context and are well aware of security implications. In the Northern province, MSF-H operates in the absence of national accountability mechanisms. This has LED to a cautious approach as a way of structuring their relationships with rebel groups. No incident in relation to project personnel has been reported. Both security and evacuation procedures are available and each project has a well-established security routine based on daily radio checks and security meeting updates. The partners are also well equipped with cars, computers and communication systems, including radio handsets.

Although it is possible to purchase drugs and other materials in the country, the costs are relatively expensive and most procurement is performed abroad, mainly through European firms. Minimum stock levels were observed with drugs being ordered on a 6-monthly basis. Only a few partners had experienced a shortage of drugs, especially antibiotics. The methods for estimating drugs requirements are either service- or consumption-based. With a few exceptions, the main tools for stock management are in place, including stock cards and stocks reports. For the projects visited, food aid has been largely administered by the World Food Programme (WFP) and Catholic Relief Services (CRS). Dry rations are being supplied to ECHO partners on a regular basis and stored adequately. Due to the high degree of humidity, all the warehouses have a proper ventilation system. They are also guarded and no major losses were incurred.

Budget management remains a headquarter-led process and the task of financial departments in Freetown. Field staff are not always well informed on budget issues and overall, knew little about the budget status of on-going projects. This disconnection could partly explain the discrepancies in budget spending. While under-spending was commonly reported, weaknesses in the planning process do not facilitate the link between objectives and expenditures. As indicated earlier, the project proposals were deemed too ambitious in the context of the implementation environment.

5.3.4 Monitoring, Evaluation and Reporting

Baseline surveys have been regularly carried out by ACF, GOAL and MERLIN in order to monitor the nutritional situation. Most partners argued that the SPHERE standards were too high regarding water quantity[26] and quality and water use facilities. The standards are, however, used as a baseline for assessment and monitoring of water and sanitation projects. A consensus for health and nutrition key indicators has not been reached so implementing agencies use their own monitoring system.

Monitoring of ongoing project performance remains the responsibility of head offices in Freetown but there is insufficient time to develop monitoring and management processes. The partner reports on field missions

[26] 15 litres/person/day.

on file are very descriptive. Moreover there is limited evidence that analysis of the many activities is done so that potential corrective action can be made. This would be improved if field staff had sufficient time and a clear vision of the projects' aims. GOAL and MSF-B in Bo have excelled in developing thinking on this, as reflected in their intervention logic and phasing-out plan. The quality of monitoring has also depended on the availability of individuals with a good understanding of indicators. Logical frameworks tend to be loosely constructed with indicators too often ill-defined, lacking quantification and time limits.

Partners had observed a trend in ECHO towards increasing control and detail in monitoring. ECHO has recently streamlined their monitoring indicators for measuring progress but partners are questioning their suitability. In particular there is some debate in the areas of EPI and Out-Patient Departments (OPD). In addition, the introduction of indicator tables was perceived as an extra burden and partners expressed concern in this respect, arguing that the new requirements had a negative effect upon their efficiency. However, and as highlighted above, it is critical for implementing agencies to improve their monitoring systems and use data collection systems that facilitate ECHO assessment of project performance. Addressing these problems will require concerted action to ensure that agreement is reached on key indicators.

Too often interim and financial reports have been behind schedule. Reporting mainly concentrates on a description of activities with little analysis. Although field staff complained that they lack adequate time to do this, the importance of key documents that allow judgements to be made about the overall project appropriateness and performance are not well recognised by partners. Despite the fact that some projects, of a temporary nature, have either been transformed into lasting projects or expanded in size, no partners had made an external evaluation of their programmes. They have more usually had backstopping from headquarters as an evaluation. This fact is regrettable in that no analysis of the intensive work done has been carried out, and little gained experience has been shared.

5.3.5 Quality of ECHO Monitoring

The ECHO office in Freetown has acted as an interface between partners and Brussels, enhancing responsiveness and flexibility in project management. It has been instrumental in creating a favourable operational environment that has allowed partners to keep coherence and to plan for more substantive projects. As pointed out by the majority of co-operating partners, the nature of personal interactions has had a critical influence. Successive TAs have differed in their relationships with partners but their support have been described as extremely valuable and positive.

In view of the large portfolio of projects and limited manpower at ECHO in Freetown, the projects have been visited and monitored as regularly as possible by the TAs. The fact that the Regional Health Co-ordinator position has remained vacant over the past months may have limited technical monitoring, especially for large and complex projects such as EPI and MERLIN. While this position is complementary to the TA work, conflicting personalities have, in the past, undermined the potential for improving project monitoring.

The influence of the Regional Health Coordinator in determining when and how to implement cannot be underestimated. However, an analysis of the reports suggests that the criteria applied were not always consistent and subject to a certain bias, as was the case for introducing EPI even though the rationale for providing large budgetary support to a long-term programme within ECHO's short project cycle is open to discussion. In addition and as noted in the project appraisal worksheets, some of the criticisms of certain projects may not be well-justified, especially when compared with the relative freedom accorded to others that, as demonstrated, performed well below standard.

5.4 IMPACT

5.4.1 General Impact

The difficulty of measuring impact has been acknowledged for some time, especially when there remains a lack of consensus about the rationale for and scope of humanitarian assistance. On a whole, and on the basis of field evidence, ECHO-funded projects have mitigated the impact of conflict by financing operations of a stabilising nature and by improving the capacities of local communities to integrate IDPs and returnees. The situation of assisted populations has clearly been improved in areas where water and sanitation projects have taken place. Improved conditions and behaviours are reflected in a lower incidence of disease. According to

camp morbidity and mortality rates[27], morbidity and mortality due to bloody diarrhoea were controlled and no increases were seen during the period under review.

The impact of relief efforts in preventing the prevalence of malnutrition from increasing beyond regional norms is worth noting. Over the past two years, nutritional surveys have shown an observable and declining trend in global malnutrition rates. Across Sierra Leone, the available health statistics are of questionable quality and relate mainly to the patients attending the health facilities. It is difficult to assess the health status of the population and due to the lack of baseline, the projects do not allow for a conclusion on morbidity and mortality patterns. The theatre room as operated by MSF-B in Kabala allows referrals from MSF-H in Makeni and is likely to reduce the negative outcomes of obstetrical emergencies.

The contribution that projects have made to restore basic health services has created better conditions for health staff but the overall issue of long-term capacity of public services to sustain a certain level of delivery remains a very significant constraint. As a proper surveillance mechanism is lacking, the impact of immunisation coverage is not yet properly documented. Despite the investment, the programme might not result in the expected reduction of morbidity and mortality. While sporadic cases of measles and tetanus have been reported by medical NGOs, the achievements in tetanus immunisation coverage and child immunisation remain to be seen[28].

5.4.2 Shortcomings

Apart from a general positive impact, there can be unintended consequences of ECHO assistance, including:

- The effect on the government budget: as shown in Bo, where financial support from MSF-B will leave the MoHS with long-term expenditures that it cannot afford;
- For operational reasons, to deliver aid in rebel areas involves negotiating with rebel leaders, thus conferring them a certain legitimacy that may reinforce existing power structures;
- A "dependency" syndrome is visible in many ways. The NGOs are dominating the direction of health development and many activities are expatriate field-driven. The MoHS counterparts at district level tend to accept and use assistance with a limited involvement in priority-setting and planning.

5.4.3 Cost-Effectiveness

In relation to health, a number of strategies have been identified by ECHO to achieve increased coverage and effective delivery at lower cost. It is well recognised that health facilities properly managed may be providing the same health benefits as a district hospital but at less cost. This highlights the needs for supporting first-level health facilities and for strengthening secondary care.

In most projects, partners reported on the implementation of fees for service with patients paying for consultation[29], with the exception of the displaced and returnees. While no decline in rates of visits has been observed so far, the fee revenue is divided among staff and used as an incentive, with community management mechanisms ensuring accountability to the community. However, it is too premature to evaluate the impact of cost-recovery. The public financing of PHUs is so dismantled that individual projects are unlikely to design models which could be easily replicated throughout districts.

The structure of the budgets makes it difficult to identify budgets allocated to primary health facilities, as hospital budgets are often included under the same heading. Another limitation is the fact that some partners are undertaking a wide range of activities that involve the contribution of other donors. For health facilities co-funded between ECHO and OFDA, the budget is difficult to assess properly as there is no global overview of E.G. MERLIN's costs and funding. As a result, the particular effects of ECHO interventions are impossible to isolate. In addition, most partners involved in the provision of health services do not record their expenditure by activity or beneficiary group.

[27] Nyandeyema camp, Morbidity trend for all diseases observed, Africare Kenema, May 2000 - February 2001.
Lebanese camp, Morbidity trend for all diseases observed, MCSL Kenema, May 2000 - February 2001

[28] The forthcoming results of the EPI survey carried out in September should provide an indication of the coverage in accessible areas.

[29] At PHU level, between 500 and 1000 per visit for adults and between 200 and 500 Leones for children
(1 US$=2,000 Leones)

5.5 SUSTAINABILITY AND COHERENCE IN RELATION TO OTHER INSTRUMENTS

5.5.1 The transition from delivery of goods and services to sustainability

Over the last year, ECHO has developed considerably its capacity to address a post-conflict situation and has moved rapidly into post-emergency programme areas under a June 1996 Council Regulation which defines humanitarian aid as covering "…. the full duration of crisis and its aftermath". Important changes have been introduced to minimise the dependency created by international aid. In that respect, a major shift has been the drastic reduction of incentives and the introduction of cost-recovery at health facilities. However, cost-recovery has tended to be seen as an end in itself rather than as a means to improve utilisation and quality, preceding in many instances the establishment of services of a minimally acceptable standard. There are also problems in the area of equity with user fees. The clause providing exemption for the destitute and IDPs and treatment of emergencies is not always used and people are sometimes denied the care they need. The cost-recovery initiative at Bo hospital is, however, promising despite the limitations to financial sustainability[30].

In the context of camps, the only realistic form of sustainability is skills transfer for the delivery of basic health services and for the promotion of environmental sanitation. This means that, part at least of the responsibilities can be ensured by the beneficiaries themselves and that they accumulate skills for use after their return home.

Where communities have contributed towards project costs, this has created a feeling of ownership. Some impressive examples of community contributions toward building wells and latrines can be cited from ACF and GOAL. Nonetheless a collective system of payment-for-service ensuring that maintenance costs are met have not been established as yet. The importance of creating a supporting environment which will allow for the lasting return of the displaced has also been underlined. In this sense ECHO should be regarded as a form of aid that can create the conditions that will bring people back to their areas of origin.

In the current context, it is evident that full-scale rehabilitation and development assistance is premature before a political settlement. In addition, the operational environment will continue to present formidable challenges. The challenge for field operators will be to try to promote self-sufficiency as opposed to the simple delivery of services and maintenance of an assistance culture.

5.5.2 The health system today

Currently, the health system in Sierra Leone is operating under hostile conditions and develops sporadically, according to the availability of external support. The establishment of internationally-NGO-run services suffers from different constraints and may be detrimental to the principles of building local capacity. The extreme decentralisation of health services which emerged as numerous NGOs established different services in different areas, may become a primary threat to the MoHS's capacity to design and implement a coherent and sustainable national health programme. Even very well-designed projects may be difficult to sustain in the long run and the NGOs will soon face the challenge of phasing out supporting projects which no longer fit within the donors global mandate and/or the GoSL health system

In health projects where the operational practices of most ECHO partners are rooted in emergency approaches, with their emphasis on service delivery as opposed to capacity building, the creation of individual and collective capacities has been challenging and will remain so.

5.5.3 Defining new modes of assistance

Despite the rhetoric surrounding the relief, rehabilitation and development continuum (LRRD), there is a significant difference between perception and reality. Although theoretically, different financial instruments (Rehabilitation, AIDCO) deal with different phases of the LRRD continuum, the field mission showed that in practice, it is difficult to speak of a link between different funding instruments. Although ECHO and the EC-SLRRP have taken active measures to co-ordinate their activities, evidence indicates that the delays experienced up to now have seriously hampered the Commission's responsiveness. The lengthy procedures for the establishment of technical assistance, including launching a tender, makes it unlikely that a replacement operation under a new contract can be put in place rapidly.

[30] MSF-B contribution represents 63% of the total hospital costs.

Understandably the HSSP will operate in a number of targeted districts, where ECHO partners are primarily implementing activities[31]. However, it is unclear how the current projects can fit within the HSSP objectives and work towards a common goal. This process has been neglected and entails a careful and practical analysis on ways to link the assistance in order to optimise the benefits of ECHO interventions.

5.5.4 ECHO contribution in the future

For the period under review, ECHO has demonstrated the capacity to work in different geographical areas, across different sectors and with different target groups. The fact that partner capacity had become overstretched and under-resourced is one of the key elements to consider for future support.

Based on the evaluation findings, it will be for ECHO to determine which aspects of this flexible approach should be reduced and which should be strengthened. However, there is evidence that current nutrition and water and sanitation interventions need to be oriented toward community-level actions, ensuring a phasing out in the short- or medium-term. In RUF-controlled areas such as Kailahun and Kono districts, nutritional aspects will have to be considered and targeted accordingly.

For health interventions, the large volume of assistance should be reduced in secured areas, such as Freetown, Port Loko and Bo Districts. In Kenema, where large movements of population have added TO the pressure on the health services, it is critical to review and refocus the strategy of MERLIN and IRC projects if quality of performance is to be ensured. In the North, and based on the lessons learned in Bo, there is a need for maintaining support to the MSF-B project which, rather than expanding, should place emphasis on strengthening MoH capacity at hospital and PHU levels. In newly accessible districts, future interventions should remained realistic and targeted at specific groups such as women and children under five. As opposed to providing EPI support nationwide, a strategy concentrating either on frontline areas or on a more specific area of support such as vaccines procurement, should be elaborated with UNICEF.

Ultimately, the implementing agencies, rather than placing heavy reliance on the availability of ECHO funding, should be able, through enhanced project planning and appraisal, to identify elements for phasing out and to search for additional sources of funding.

6 CONCLUSIONS AND RECOMMENDATIONS

6.1 MODALITIES OF PROJECT MANAGEMENT

- Over the past two years, the modalities of project management have ensured responsiveness and effectiveness of the interventions but could be further enhanced in order to improve ECHO and partners' capacity to deal with strategic issues.

In particular it is recommended that attention be paid to the following aspects:
-appraisal should include more effective targeting (especially to women and children under five);
-planning should be adequate and realistic, using a Log Frame as a tool;
-monitoring should be improved and focused on process and outcome indicators;
-external evaluation of individual projects commissioned by partners and ECHO within the Framework Partnership Agreement should be more systematic.

6.2 HEALTH

- The current strategy seeks to fill temporary shortages in vital resources such as staff and medical supplies. However, complex health projects are difficult to implement in the current environment.

It is recommended that the scope of activities be based on a comprehensive plan, developed in accordance with local capacities and actors (e.g. quality versus quantity, strategy versus implementation) and more emphasis be put on quality improvement initiatives including improved management, supervision and training.

[31] Personal communication: Mrs Susanne Kotzi (AIDCO).

• The quality of EPI delivery is dependent upon technical and human resources and requires a long-term investment based on a health reform process, including decentralisation and institutional strengthening at district level. In this context, using the ECHO funding mechanism designed explicitly to respond to short-term emergency needs is not seen as an appropriate instrument.

While the ECHO position is to maintain a delicate and subtle equilibrium with UNICEF, this strategic consideration must be taken into account and highlights the need for ECHO to re-appraise the situation. Given the parallel funding for auto-destruct syringes and needles and the limited achievements in cold chain maintenance, it is recommended that the scope for EPI assistance be scaled down, concentrating either on frontline areas or on a more specific area of support such as vaccine procurement.

6.3 NUTRITION

• In ECHO-funded projects, the current levels of malnutrition would not support the continuation of TFCs and SFCs.

The problem of malnutrition should be approached from a different angle. Based on nutritional assessments and in collaboration with MoHS, the current activities undertaken at TFC and SFC levels should be gradually phased out. Improvement of childcare practices should be integrated as much as possible into primary and secondary health care level services and with the water and sanitation activities.

• As access to populations affected by the conflict in Kailahun and Kono districts increases, a coherent framework defining strategy and prioritising activities is crucial.

It is recommended that ECHO and the partners with expertise in nutrition co-ordinate and are able to respond rapidly to acute nutritional situations. The partners should urgently define strategies and prioritise activities.

6.4 WATER AND SANITATION

• Given the big population movements, ECHO support enabled partners to ensure that the general sanitary conditions could be maintained and improved. To date, there is a need to expand activities within the rural communities.

It is recommended that activities at camp level be scaled down by strengthening the transfer of activities to the beneficiaries. Partners should be able to assist in a strategic manner with resettlement by preparing the conditions for return and by maintaining and reinforcing a proactive community approach as developed adequately during the period under review.

6.5 LINKS WITH REHABILITATION AND DEVELOPMENT

• The situation of Sierra Leone remains uncertain and subject to regional geo-strategic decisions. The EC financial instruments designed for the long term do not guarantee the integration of ECHO-funded projects into the portfolio.

This stresses the need for ECHO assistance to be maintained 2002. If ECHO truly wishes to foster a proactive LRRD strategy, it should, together with the Delegation, continue lobbying for a long-term EC commitment.

A Regional Health Co-ordinator who deals with the question of linking emergency, rehabilitation and development could be enabled to be more pro-active in this matter. The Regional Health Co-ordinator role is seen as critical in planning for health project orientation and in assisting partners to access other Budget Lines eligible to NGOs such as co-financing.