EUROPEAN COMMISSION

HUMANITARIAN AID OFFICE (ECHO)

EVALUATION of ECHO INTERVENTIONS in the FEDERAL REPUBLIC of YUGOSLAVIA (SERBIA)

HEALTH REPORT

PROLOG Consult – Belgium June 2003

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A. EXECUTIVE SUMMARY

A.1. THE EVALUATION

Evaluated action: Serbia (Federal Republic of Yugoslavia)
Date of the evaluation: 31/03 to 18/04/2003 (field mission)
Consultant's name: Dr Markus Michael (health)

Introduction:
The sudden appearance of democracy in Serbia, in 2000, did not *ipso facto* lead to the solution of humanitarian problems, due to the near point of collapse of the national economy. A social gap appeared, threatening the most vulnerable parts of the population. Social-related sectors, such as health, had been neglected since the late 1980s. This compounded the ailments of the former centralised and over-specialised Yugoslav health system, suffering from a run-down capital stock, supply difficulties and human resource management problems. Health expenditure per capita was one of the lowest in the region. The health system was therefore unable to cope with an increase of health needs through a demographic shift, caused by the influx of refugees and IDPs and a rapidly ageing population. Out-of-pocket expenses increased for patients; access for the poor to health care become more and more difficult. The poor were many: 2 people out of 3 were living on less than the equivalent of 2 US $ per day. The health system reform, urgently needed, was slow in coming. Owing to persistent weaknesses at ministerial level, the process is being launched in 2003 only.

The main thrust of ECHO's intervention was the support to the Primary Health Care (PHC) sector; starting in areas where a large number of IDPs were concentrated, it was gradually extended to the whole of Serbia. NGO partners supported at first outreach services, which also benefitted from a training program for patronage nurses. They then undertook basic rehabilitation of infrastructure and donated medical equipment, accompanied by a small training component. Other partners focused on people with disabilities, through support to individuals and institutions, including managerial capacity building. A third line of ECHO-funded work was the support to the Institute of Public Health in the field of detection of communicable diseases. The total amount of expenditures in the health sector was 20,250,000 Euro between 2000-2003.

Evaluation: Purpose & Methodology:
The overall objective of the evaluation was to assess the appropriateness of ECHO's intervention in Serbia, and to what extent its goals had been achieved on the eve of its final disengagement from the country. To that effect, the global plans of the last three years (i.e. as from 2000) had to be reviewed. The evaluation had also to analyse a number of current issues: phasing out strategy of ECHO, sustainability of interventions, and decision to fund a few selected last actions in 2003.
In that framework, the evaluation had to focus on two sectors: *Health*, which is the subject of the present report, and Durable Solutions (shelter and return). Among other health-related activities, ECHO had indeed invested up to 30 million Euro since 1999 to improve access to PHC by upgrading equipment and structures throughout the country, which made the issue highly relevant for an assessment of results achieved and co-ordination/LRRD[1] efforts.

The methodology reflects the above objectives. Desired results[2] were translated into a frame containing corresponding evaluation questions, judgement criteria and indicators (Annex J). This frame was systematically used by the evaluation team, throughout the three standard phases of the evaluation. It was also designed to be readily transposed into the main body of the report below.

[1] Linking Relief to Rehabilitation and Development.
[2] Nine desired results were outlined in TOR, chapter 2.3

A.2. MAIN CONCLUSIONS

A.2.1. Overall Intervention Logic

With one exception[3] confirming the rule, ECHO's health operations were extremely relevant. ECHO was the only donor of importance to assist persons with disabilities and their institutions in the whole of Serbia. The same holds true for the Primary Health Care operation, for which it was more difficult to discern 'vulnerable groups'. ECHO did the right thing, however, in assisting PHC services that would serve the whole population.

A.2.2. Results and Means Compared to Objectives

In a post-conflict situation, short planning cycles can limit effectiveness, either directly, because certain development objectives cannot be reached in a short time, or indirectly, by hampering the learning process that should take place over the duration of a couple of years. Too short a time horizon can also prevent the pursuit of appropriate, more development-oriented objectives.
Some shortcomings of the PHC operation with regard to efficiency (e.g. tendering process and poor/inconsistent monitoring indicators) can be attributed to a disparity observed between the blueprint approach at the level of planning and *laissez-faire* approach with regard to implementation and monitoring. The operation, however, was effective within its scope. The training program for patronage nurses is a good point in case that this scope may have been broadened, including, for instance, a larger training component.

A.2.3. Phase Out Strategy and LRRD

Acting in a post-conflict setting, ECHO was challenged at the 'development end' of the LRRD spectrum, which was particularly relevant in cases where ECHO actually designed operations, thereby retaining the function of a duty-bearer. Complex local and regional political settings, which were reflected in a protracted vacuum at the Ministry of Health, did not help.

The lack of a health policy framework was admittedly an external cause for partners to continue acting in humanitarian 'relief mode' (i.e. mainly providing goods). A post-conflict situation requires, however, more of development orientation.
Apart from the objective to cover all districts with the PHC operation, there was no 'phase out strategy' as such, with precise benchmarks and pre-defined criteria. ECHO's communication strategy, however, with regard to the calendar of the phase-out, was successful: it was clearly understood by beneficiary institutions, implementing partners and other actors.

As regards LRRD, direct co-operation/complementarity with the European Agency for Reconstruction (EAR), the main CARDS[4] implementation instrument in Serbia, was minimal: the EAR took over pharmaceutical supplies, and later focused on policy reforms. However, the CARDS Country Strategy Paper 2002-2006 also pointed at LRRD health linkages with other donors[5]: although such activities have been much delayed by the latter's own institutional constraints, these information did not seem to have been appropriately reflected in ECHO Global Plans or at field level.

A.2.4. Reduction of Aid Dependency

The ECHO operations consisted mainly in capital investment and training; aid dependency was in this instance nearly a non-issue. Strong local counterparts with a high sense of ownership were the key for the general success with regard to sustainability.

[3] Early warning system for communicable diseases and support to IPH Laboratories
[4] Community Assistance for Reconstruction, Development and Stabilisation programme
[5] The World Bank would take the lead in Health Insurance Fund, viability of PHC model and social safety net, while EU Member States (Finland) would contribute to funding continuous training activities.

A.2.5. Recommendations for Future Phase Out Strategies

The fact that there was no clear phase out strategy with benchmarks and pre-set criteria can in certain instances be attributed to weaknesses of the initial engagement process: shortfalls of needs assessments, incomplete baseline data and, lack of clarity for intervention criteria.

A.2.6. Continuation of Activities in 2003

The decision to complete the intended nation-wide coverage with the PHC operation was justified, reflecting an objective clearly spelled out in the 2002 global plan (GP).

A.2.7. Recommendations from Previous Evaluations

Only one recommendation of the ones that were very relevant for the health sector was taken into account: ECHO tried very strongly to promote LRRD, with limited success only. Other recommendations were not relevant, or only partly so.

A.2.8. Cross-Cutting Issues

Relevant cross-cutting issues were duly taken into account within in the framework of ECHO's health operations, with the exception of a shortfall with regard to accountability to beneficiaries.

A.3. MAIN RECOMMENDATIONS

A.3.1. Overall intervention logic

- In a context of lack of health policy framework (which implies, in a post-conflict situation, less of a greater licence to act than a greater responsibility for decisions taken), to make sure that every single development program with long-term implication is relevant.

A.3.2. Results and means compared to objectives

- To allow, in a context of post-conflict rehabilitation not only longer project cycle times (one year), but to expand the time horizon in general. A mid-term review, for instance, of the PHC operation at the end of 2000, could have enabled it to profit from some of the findings of this evaluation.
- To take a more holistic view of a PHC service; the assumption that in a post-conflict situation investment in infrastructure and equipment is the most effective way to improve the provision of care is legitimate to a certain degree only.
- In case of a blueprint approach implemented by a variety of partners, to better streamline certain processes, like tendering and monitoring/evaluation, and strengthen them through training.
- In case of a blueprint approach, to limit the number of partners to those with well-defined, appropriate mandates and/or development-adapted capacities. This would improve efficiency and effectiveness and may have an effect on LRRD by increasing chances of continued donor support.

A.3.3. Phase-out and LRRD

- To follow the recommendation of an assistant Minister of Health, to 'pay more attention to what will be, an not what is'. This could at least mean to include change management in an operation that covers a country's entire PHC system, which is known to change soon -and dramatically- from comparable experiences in neighbouring countries.
- To strengthen ECHO own technical capacities in key sectors, especially at field level. The overall lack of training for ECHO field staff is a major constraint for optimum effectiveness of the Office. Similarly, in post-conflict/transition periods, the importance of the training component as multiplier factor for effectiveness of projects and as LRRD tool needs to be stressed. Continuous training is a strong asset of long term technical assistance programmes. The few shortcomings observed with regard to intervention criteria, policy-making, implementation and accountability may have been

avoided – and can be avoided for future, similar actions. (see also A.3.5: Recommendations for other phase-out)

A.3.4. Reduction of aid dependency

- To be extremely careful with the donation of equipment that imposes (admittedly, an exceptional case) a high running cost on an institution that is known to be weak.

A.3.5. Recommendations for other phase-out

- To increase quality of initial needs assessments, gathering more complete baseline data and linking them to clear intervention criteria. Mirroring these, to establish, a phase-out strategy with benchmarks and pre-set criteria.
- To increase efforts to seek LRRD operational complementarity with Commission Services at field level (co-ordination, transfer of staff), and with other donors involved in CSP, at HQ/ field levels.

A.3.6.Decision to continue in 2003

- Instead of applying just one single broad benchmark, to seek better coherence between criteria for phasing out and baseline data linked to intervention criteria, as mentioned in A.3.5.

A.3.8. Cross-cutting issues

- To increase downward accountability by consulting the affected population as primary stakeholders.

A.4. MAIN LESSONS LEARNED

A.4.2. Results and means compared to objectives.

- If ECHO provides, at planning level, an operational blueprint to 10 or so implementing partners, it retains, beyond its natural function as a donor (and therefore duty-holder) also the function as a duty-bearer at implementing level: for policy changes, efficiency and cross-cutting monitoring/evaluation.
- For the extremely complex problems posed by the situation of the *Roma* population, even limited to the issue of health, there are no quick fixes. Including this issue into a specific, broader EU programme with regional/horizontal approach and longer time horizon might be more appropriate.

A.4.3. Phase-out and LRRD.

- In the own words of the ECHO director, Mrs. Adinolfi:: 'LRRD is still a weak link, in spite of all efforts made[6]. At HQ level, LRRD tools may be in place, though co-ordination shortomings can persist in the field. Furthermore, LRRD needs also to be envisaged with external donors, requiring additional efforts in co-ordination and knowledge of agenda, mandates and institutional constraints.

A.4.5. Recommendations for other phase-out.

- Benchmarking and exit criteria for a phase-out strategy depend on the quality of initial needs assessments and clarity of intervention criteria. Shortcomings at this stage will diminish the potential to adopt a convincing phase-out strategy.

A.4.8. Cross-cutting issues: accountability.

- It was admittedly difficult to discern - and impossible to target - 'vulnerable groups', as maintained in the objectives. ECHO did the right thing in supporting PHC services that would serve the whole population. The assumption made that support to PHC services would benefit the whole population and the often quoted 'vulnerable groups' within it, is legitimate to a certain degree. But it does not dispense from the responsibility to consult the affected population initially intended to reach by the operation, about its effects on them.

[6] Report of the mission of Mrs Adinolfi, ECHO Director to Serbia (07-11 October 2002)