# AN EVALUATION OF DG ECHO FINANCED ACTIVITIES

# IN THE HEALTH SECTOR

**DG ECHO/ADM/BUD/2007/01209**

**MAY – AUGUST 2007**

**COST OF THE EVALUATION € 122,366**

## Final report excluding Annexes

This evaluation report has been financed by and produced at the request of the European Commission.
The comments contained herein reflect the opinion of the evaluators only.

Leusden, 26 November 2007
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Reference 074325 Final Report DG ECHO Financed Activities in the Health Sector excluding annexes 26.11.07
This report contains 63 pages, including the summary (6 pages) and the main report (51 pages).

The ETC team was composed of Dr. Wilma Meeus, team leader and Dr. Joanne Harnmeijer. The peer review was conducted by Dr. Pim de Graaf.

**Acknowledgements**

The consultants would like to thank DG ECHO staff members – in Brussels, Nairobi, the Democratic Republic of the Congo, Thailand and Lebanon – and representatives of other Commission Services, UN and donor agencies, and partner organisations for sharing their information and advice, and their support in making relevant documentation and precious time available in completing this evaluation. Special thanks go to the DG ECHO country teams for their support in the preparation of and during the field visits and to Walter van Hattum, Policy Coordinator, DG ECHO 0/1, who provided consistent and thorough guidance and support during the assignment.

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## SUMMARY


### Background to the evaluation

This external and independent evaluation was commissioned by DG ECHO to meet the commitment made in the Operational Strategy 2007, which emphasises sectoral rather than partner and country evaluations. The health sector which receives a significant proportion of DG ECHO funding was the first sector to be evaluated.[1]

The Terms of Reference (ToR – annex 9) provided the overarching framework for this evaluation. The ToR was clarified and translated in conceptual and operational terms during briefings in Brussels and Nairobi (Inception Report, annex 12). The master document records[2] and Regional Medical Experts' (RMEs) mission and end-of-term reports were agreed on as entry points for the evaluation. The evaluation team made use of primary data sources (questionnaires and key informant interviews) and a multitude of secondary data sources. In addition the team visited three countries, one in each of DG ECHO's operational units (A/1 – the Democratic Republic of the Congo, A/2 - Lebanon and A/3 - Thailand).[3]

The main evaluation questions were formulated as **"In humanitarian health sector interventions, what is it that DG ECHO does well and should continue doing, and as importantly, what is it that DG ECHO does less well and therefore should improve on, or discontinue doing",** and **"What are the boundaries for DG ECHO's involvement in humanitarian health interventions?"**

Two consultants and a peer reviewer of ETC UK / ETC Crystal carried out this assignment. Annex 1 – Evaluation Methodology - contains the consultants' biographies.

### Summary of the evaluation team's conclusions and recommendations

### Conclusions

**Overall conclusion**
**The evaluation team concludes that DG ECHO is an important donor in the health sector. DG ECHO's particular advantages in comparison to other donors lie in its in-country presence, its proximity to affected populations, its diverse partnerships, its focus on forgotten crises and its funding flexibility. However, these comparative advantages could be more fully exploited.**

1. **Coverage:** The analysis of DG ECHO funded health interventions in 2006 shows clearly that the humanitarian needs in A/1 were far greater than those in other regions. Africa received the largest share of humanitarian aid, both from DG ECHO and from other donors, which in the opinion of the


[1] The 2005 Water and Sanitation Review had a different purpose where it generated a Concept Paper and Model Guidelines.
[2] The three DG ECHO Units have made their master document records available to the team on condition of strict confidentiality. These records are the desks' working documents for each contract and as such provide a history for each and every DG ECHO funded contract.
[3] A/1: Africa, Caribbean and Pacific countries; A/2: Central & Eastern European countries, Newly Independent States, Mediterranean countries and the Middle East; A/3: Asia, Central & South America.

evaluation team was justified. In A/1 and A/3 basic health service provision was the most frequently DG ECHO funded activity, while psycho-social care was the main activity funded in A/2.

2. **Relevance**: The evaluation team concludes that health interventions have been relevant given the specific regional contexts and in-country circumstances.
3. **Effectiveness**: The evaluation team concludes that DG ECHO funded health sector activities have contributed to a reduction in excess mortality and improvements in health status.
4. **Efficiency**: The provision of basic health services, generally considered cost efficient, was the most frequently funded activity. Due to the difficulty in accessing detailed humanitarian health funding data of other donors, it is not possible to conclude that DG ECHO was more efficient than other donors. The evaluation team found that the application of unit costs has been inconsistent in DG ECHO's decision making processes. The lack of an agreed set of appropriate indicators and benchmarks to monitor impact of humanitarian assistance was identified as a major obstacle facing both DG ECHO and the humanitarian donor community as a whole.
5. **Sustainability**: The evaluation team concludes that significant efforts are being made to ensure that achievements resulting from DG ECHO funded humanitarian health interventions are sustained. These efforts are being realised either by active engagement of DG ECHO with other Commission's Services or with other development assistance donors.

**Regional convergence and divergence**

6. There is considerable divergence between the operational units in terms of health activities funded as well as applied unit costs in projects. However, there is also convergence between the operational units: the most striking one is the routine of repeat projects. In 2006, 122 (85%) of 144 funded health sector interventions were continuations of previously started projects, the majority of which had been funded for several years.
7. The differences in health status in and between regions are significant and imply different health needs. In the absence of durable solutions (e.g. efficient national government structures, funding and commitment and/or long term development assistance), DG ECHO's continued support to vulnerable groups, especially care & maintenance programmes for refugees, is appropriate as withdrawal would lead to a reversal of gains made by humanitarian interventions. DG ECHO's acceptance of divergence is fully justified.

**Positioning of DG ECHO on boundary issues**

8. The evidence gathered in this evaluation is that DG ECHO has not been entirely consistent on what it has been prepared to fund, not only across units, but also within regions, and sometimes even within countries. Urgent requests from partners for increased clarity on 'boundary issues' such as the delivery of 2$^{nd}$ level hospital care thus appear reasonable. At the same time DG ECHO's flexibility in considering such projects has been much appreciated, especially where field evidence was provided to justify a partner's request. The following sections elaborate DG ECHO's positioning on two specific boundary issues.

*Linking Relief, Rehabilitation and Development (LRRD)*

9. DG ECHO has the well-deserved reputation of being a donor that responds to humanitarian needs and vulnerability. It is however clear that DG ECHO makes choices in terms of what resources it is prepared to spend in which countries and for which purposes. In order to avoid gaps in health service provision, LRRD is given significant attention within DG ECHO. Evidence however shows that efforts to achieve a smooth transition mostly related to projects and that these have been very labour intensive.

*Disaster Preparedness and Disaster Risk Reduction (DP/DRR)*

10. The evaluation team applauds the recent steps taken to address DP/DRR in the health sector. The Sahel Decision on early detection and response to malnutrition is an example, developed in close cooperation with other Services of the Commission and resulting in the inclusion of food security in the CSPs of countries included in this regional programme. DG ECHO's current monitoring routine is likely to be a obstacle in measuring impact of such programmes as it focuses on confirmed cases treated rather than likely cases prevented.

**DG ECHO and its position in the humanitarian community**

11. DG ECHO's size and significance as a major donor was consistently highlighted when discussing the issue of its position within the humanitarian community. However, many key informants commented on DG ECHO's low profile given the significant contributions it makes. DG ECHO's vast experience at country level is not optimally utilised as its participation in humanitarian platforms is perceived as inadequate. This limited participation in meetings consequently results in DG ECHO having insufficient knowledge of and influence on developments that are presented in such fora. In other words, DG ECHO is neither seen nor acts as a reference donor, and loses opportunities to influence developments in the humanitarian community and to increase its visibility.
12. DG ECHO's ambition of being a reference donor requires it to reconsider the balance between administrative issues and project content.

**DG ECHO as a learning organisation**

13. The findings of the evaluation indicate that there is a disconnect between the considerable field experience and expertise and what is commonly referred to as "Brussels", which has implications for DG ECHO's international profile.
14. The evaluation team has found evidence that available health expertise is not utilised in a systematic and appropriate manner. Non-medical DG ECHO field staff were positive about the advice they received from Regional Medical Experts (RMEs) when such was requested. However, many of them indicated that they did not feel the need for specialist advice. This was confirmed by RMEs who also indicated that they are not optimally utilised. Heads of Regional Support Offices (RSOs) expressed their regret at what they described as missed opportunities in using such expertise, particularly for more strategic and conceptual planning, and deplored the so-called project approach of field staff.
15. The evaluation team concludes that the involvement of RMEs in country strategy development and conceptualisation of DG ECHO's decisions is inadequate.

**DG ECHO and health policy development**

16. The terms 'policy' and 'guideline' are being used rather indiscriminately. The evaluation team has not seen any health-related policy or guideline that has been officially endorsed by DG ECHO management, even though some have been published on the DG ECHO website. The evaluation team concurs with respondents to the questionnaire, who were almost unanimous that DG ECHO should not duplicate existing international health policies as ample guidance is provided by normative organisations such as WHO and UNICEF, and more specifically for humanitarian operations, by the SPHERE standards.

**Recommendations**[4]

**General**

1. **DG ECHO should provide more clarity on what it is able and willing to fund.**
2. **Depending on specific circumstances and contexts, DG ECHO should remain flexible to ensure that negotiating space is maintained for funding of activities that straddle the boundaries of humanitarian assistance.**
3. Submitted proposals that are not funded should be properly documented with reasons for their rejection. This will facilitate regular analysis and improve the understanding of coherence in decision making processes between and within units.
4. Similarly, proposals that are approved should be regularly analysed to determine coherence and/or divergence in decision making processes between and within units. The analysis done by this evaluation team could serve as a starting point.
5. **DG ECHO should strengthen the collection of evidence on efficiency and impact of its interventions by promoting and actively participating in defining appropriate indicator sets and standardised inputs per type of intervention and beneficiary.**

**DG ECHO position in the humanitarian community**

6. **DG ECHO should become a more prominent participant in health fora to match its considerable contributions to the health sector and maximise opportunities to influence humanitarian health sector debates.**
7. DG ECHO should create more time for its own staff at all levels and partner organisations to interact and learn from past experiences for future use. This would include the notion of circular learning processes.

**DG ECHO as a learning organisation**

8. **In order to maintain institutional memory and strengthen its corporate identity DG ECHO should encourage sharing of experiences at all levels and should in particular encourage**

[4] Recommendations in bold represent the recommendations that were prioritised by participants of the 27 September and 10 October debriefing meetings (refer to annex 10).

**documentation of best practices. Internal networks such as the Anopheles group can provide the required technical input in such processes.**

9. **In order to strengthen the development of appropriate health sector strategies in Country or Global Plans, DG ECHO should systematically utilise its available health expertise.**
10. **DG ECHO should specifically demand that experts and desks are alert on both new and obsolete practices and the funding implications of such practices. Relevant information emerging from implemented projects and programmes should be communicated to all staff.**
11. DG ECHO should better recognise and use opportunities that lead to improved communication between field experts and Brussels-based staff to ensure that important (emerging) topics requiring DG ECHO's attention are timely identified, explored and addressed by staff at all levels.
12. Differences in RMEs' health expertise resulting from region-specific health priorities should be utilised to provide advice on relevant health topics.
13. **DG ECHO should create opportunities for peer-to-peer learning and comparison between NGOs that implement similar projects in the same area. DG ECHO should further consider carrying out a comparative evaluation of cost-efficiency and cost-effectiveness of health activities funded by other donor agencies of similar size and with a similar mandate.**

**DG ECHO's policy environment**

14. **DG ECHO should encourage and facilitate the development and consistent use of technical guidelines, which the evaluation team proposes to categorise as:**
    - **Technical Issue Papers (TIP)[5]: Papers that provide technical details on a specific health issue, mainly for internal use to allow non-medical staff to grasp the essential elements in question. TIPs require limited consultation, have limited authority and could include indicative rather than binding funding recommendations, notably on reasonable unit costs. TIPs may be annotated publications of norm-setting agencies such as WHO and UNICEF.**
    - **Guidelines: These provide more comprehensive operational guidance on how to deal with specific health service delivery issues. Guidelines should include DG ECHO's recommendations on complex issues such as HIV/AIDS, for which there should be consultation with all operational units. Guidelines will require endorsement from DG ECHO management as they generally have funding implications.**
    - **Position papers: These official papers, issued by the Director General to all DG ECHO staff, would be fully authoritative and would have a binding effect. Broad consultation within DG ECHO but also inter-service consultation in the Commission and with partners is required.**
15. **Considerations of cost-effectiveness and speed in introducing new approaches should be given more emphasis. DG ECHO should therefore re-engage in the discussion and consistent application of unit costs both to improve efficiency and efficiency in relation to impact of funded health projects. This would enhance DG ECHO's understanding of justified differences between regions in the costs of inputs to achieve intended results.**

*Linking Relief, Rehabilitation and Development*

16. In addressing LRRD, DG ECHO should make use of its own institution-specific strengths. Notably these are: its field expertise; proximity to affected populations; connections with and influence on a vast network of partners; neutrality and impartiality; its funding flexibility. To surmount DG ECHO's limitation in funding duration close collaboration with relevant Commission Services is required.
17. **Develop a framework for analysing the issues and funding implications of long-term crises.**
18. **In close collaboration with other Commission's Services, develop a programming tool to: identify the specific needs of the post-emergency pre-development phase; assess the comparative advantages of DG ECHO vis-à-vis other Services of the Commission in given circumstances; building on experience in selected countries, use the development of the programming tool as a learning and capacity building exercise, utilising both the appropriate coordination mechanisms and DG ECHO's own strengths as listed above; in keeping with the concept of circularity, design this project as an exercise in incremental learning, without seeking 'one for all' solutions.**

*Disaster Preparedness and Disaster Risk Reduction*

19. **DG ECHO should recognise innovations that have the potential to cross institutional boundaries, such as the Sahel and Epidemics Decisions, and which merit specific attention. Such regional programmes should be monitored as pilots and documented as case studies, explicitly aimed at organisation-wide learning and at enhancing DG ECHO's profile in thematic areas. Such experiences could result in new guidelines.**
20. DG ECHO should ensure that senior staff members are involved from the start to better anticipate and address potential implementation obstacles of innovative programmes.
21. DG ECHO should seek cooperation with key institutional partners such as UNICEF and WHO to develop monitoring formats for thematic issues addressed with a DP/DRR lens.

[5] The TIP has meanwhile been formalised as a modality by the DG, in July 2007.

## ABBREVIATIONS

| | |
|---|---|
| ACP | Africa, Caribbean and Pacific nations |
| ACT | Artemisinin-based Combination Therapy (for malaria) |
| AIDCO | Aid Cooperation |
| ALNAP | Active Learning Network for Accountability and Performance in Humanitarian Action |
| AMI | Aide Médicale Internationale |
| ARC | American Refugee Committee |
| ART | Antiretroviral Therapy |
| ARV | Antiretrovirals |
| AUP | Aid to Uprooted People |
| BDOM | Bureau Diocésain des Oeuvres Médicales |
| CCSDPT | Committee for Coordination of Services to Displaced Persons in Thailand |
| CDR | Centre de Distribution Régionale |
| CERF | Central Emergency Response Fund |
| CHAD | Conflict and Humanitarian Affairs Department |
| CIDA | Canadian International Development Agency |
| CRS | Catholic Relief Services |
| CSP | Country Strategic Paper |
| CTC | Community-based Therapeutic Care |
| DART | Disaster Assistance Response Team |
| DfID | Department for International Development |
| DG | Directorate General |
| DGIS | Directorate General Internationale Samenwerking (International Cooperation) |
| DP | Disaster Preparedness |
| DRC | Democratic Republic of the Congo |
| DRR | Disaster Risk Reduction |
| EC | European Commission |
| ECHO | European Commission's Humanitarian Office |
| ED | Essential Drugs |
| EIDHR | European Initiative for Democracy and Human Rights |
| EMDH | Enfants du Monde – Droits de l'Homme |
| ERC | Emergency Response Coordinator |
| EU | European Union |
| GBV | Gender Based Violence |
| GHD | Good Humanitarian Donorship |
| HAC | Health Action in Crises (WHO) |
| HCC | The Higher Council for Childhood, Ministry of Social Affairs, Lebanon |
| HI | Handicap International |
| IASC | Inter-Agency Standing Committee |
| ICRC | International Committee of the Red Cross |
| ICU | Instituto per la Cooperazione Universitaria, Italy |
| IDP | Internally Displaced Person |
| IOM | International Organisation for Migration |
| IRC | International Rescue Committee |
| LRRD | Linking Relief, Rehabilitation and Development |
| Map UK | Medical Aid for Palestinians |
| MFA | Ministry of Foreign Affairs |
| MI | Malteser International |
| MPDL | Movimiento por la Paz |
| MSF | Médecins sans Frontières |
| NRC | Netherlands Red Cross Society |
| OECD | Organisation for Economic Cooperation and Development |
| OFDA | Office of the U.S Foreign Disaster Assistance |
| oPT | Occupied Palestinian Territories |
| PA | Palestinian Authority |
| PF | Pooled Funding |
| PHC | Primary Health Care |
| PLO | Palestine Liberation Organisation |

| | |
|---|---|
| PMTCT | Prevention of Mother to Child Transmission (of the HIVirus) |
| PMU Interlife | Relief and development department of Swedish Pentecostal Mission |
| PPAT | Planned Parenthood Association of Thailand |
| PRCS | Palestinian Red Crescent Society |
| RME | Regional Medical Expert |
| RRM | Rapid Response Mechanism |
| RTG | Royal Thai Government |
| RVF | Recto-vaginal fistula |
| SC Sweden | Save the Children Sweden |
| SGBV | Sexual & Gender Based Violence |
| SIDA | Swedish International Development Aid |
| SMRU | Shoklo Malaria Research Unit |
| SST | Sectoral Support Team DG ECHO |
| TBBC | Thailand Burma Border Consortium |
| TdH | Terre des Hommes |
| TIP | Technical Issue Paper |
| TYP | Three Year Plan |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNRWA | United Nations Relief and Works Agency for Palestine Refugees in the Near East |
| UXO | Unexploded Devices |
| VVF | Vesico-vaginal fistula |
| WHO | Women's Humanitarian Organization |
| WHO | World Health Organisation |
| WTO | World Trade Organisation |
| ZS | Zone Sanitaire |

# 1. INTRODUCTION

ETC UK was contracted by the European Commission's Humanitarian Office (DG ECHO) to carry out an evaluation of DG ECHO funded health sector activities in the period 2000 – 2007. The evaluation started in May 2007 and is the first evaluation of DG ECHO's involvement in health sector activities since its inception in 1992.

The evaluation is undertaken to meet the requirement as stipulated in Article 18 of Council Regulation (EC) 1257/96 which states that *"the Commission shall regularly assess aid operations financed by the Community in order to establish whether they have achieved its objectives and to produce guidelines for improving the effectiveness of future operations."*[6]

1. The Specific Objectives of the evaluation as described in the Terms of Reference (ToR) are to provide DG ECHO with a multi-regional evaluation of its activities in the health sector, draw conclusions and provide recommendations at strategic and operational level through:
   - The analysis of all stages of the decision making process applied by DG ECHO in deciding upon which partners and which activities to fund, involving each of the operational units of DG ECHO and should cover the entire spectrum of financed health activities in all types of humanitarian crises.
   - The evaluation shall assess the relevance, coverage, effectiveness, efficiency, sustainability (if appropriate) and results achieved as well as the way the results have been achieved.
2. In cognisance of the fact that limited accessibility and availability of documents and resource persons for the entire period 1995-2006 would render the evaluation unreasonably time consuming, the terms of reference cover the period 2000 - 2006.
3. The evaluation team submits its findings, conclusions and recommendations contained in this report, which is divided in three chapters: Chapter 1 provides the general background, the evaluation questions and evaluation methodology, elaborates on the current humanitarian environment and the changes in humanitarian relief mechanisms within which DG ECHO operates, and provides a brief overview of financing mechanisms available for humanitarian aid, including those of other European Commission Services; Chapter 2 covers the main findings. This chapter is organised in sections that capture findings using the OECD DAC criteria of coverage, relevance, effectiveness, efficiency and sustainability, and the three Cs (coherence, complementarity and coordination). Each section ends with a summary of the main findings. Chapter 2 ends with an analysis that assesses and illustrates DG ECHO's strengths and weaknesses in the stages of decision making. This then forms a bridge to chapter 3, which provides the conclusions and recommendations based on the main findings of chapter 2.

[6] European Commission - DG ECHO, Unit 0/1 Evaluation Sector. Terms of Reference for an Evaluation of DG ECHO Financed Activities in the Health Sector.

### 1.1 Evaluation Questions

4. In discussions with senior officials of DG ECHO, the main evaluation questions were formulated as follows:

> **"In humanitarian health sector interventions, what is it that DG ECHO does well and should continue doing, and as importantly, what is it that DG ECHO does less well and therefore should improve on, or discontinue doing".**
>
> **"What are the boundaries for DG ECHO's involvement in humanitarian health interventions?"**

### 1.2 Evaluation Methodology

5. It was the understanding of the evaluation team that the evaluation should elicit views and opinions about DG ECHO's support to humanitarian health interventions, rather than attempting to quantify these, with the exception of available financial data for health interventions. This has informed the choice of data collection methods, which are qualitative in nature with different units of analysis for each of these methods (refer to annex 1 for detailed description of the evaluation methodology).
6. The evaluation team adopted methodologies to suit the setting and time limitations in order to achieve the objectives set in the ToR and aimed to ensure triangulation of data from multiple sources.
7. For all OECD DAC criteria the team adopted what they called 'filters'. For example, the filter for 'effectiveness' was, 'available competence, norms and standards, for optimal effectiveness'. The filters served as an initial 'lens' for data collection, which helped the team to focus, in the absence of defined health sector objectives. The filters were, however, not used restrictively as over time confidence increased as to what should or should not be included under the various OECD DAC criteria.
8. In summary,
    - The master document records were used to provide an overview of 2006 funding decisions related to health, nutrition and psycho-social care interventions to include the different types of health activities supported in the three operational units, and the funding made available by DG ECHO for these activities during the period 2005 - 2006.
    - The RMEs' mission reports and end-of-posting reports were used to identify salient issues, which could subsequently be further explored in personal or telephone interviews – as happened for the Global Plan Sahel 2007, on malnutrition, and also on the Decisions regarding Humanitarian Aid to populations affected by epidemics in West Africa.
    - The questionnaire sent to three groups of respondents (partner organisations involved in health, field experts and desk officers) was deliberately brief and general, with 4-5 open questions. The team received responses from 9 desk officers; 23 field staff (including the six RMEs); and 20 partners. (Refer to Annex 2 for the synopsis of questionnaire responses.)

- Similarly, findings derived from key informant interviews, especially findings of the field visits and available evaluation reports were used to enrich the team's understanding and for comparison and validation.

### 1.3 DG ECHO's Mandate and Identity

9. DG ECHO's mandate, described in Regulation (CE) n° 1257/96 is *"to provide emergency assistance and relief to the victims of natural disasters or armed conflict outside the European Union"*[7]. Health projects funded by DG ECHO mostly contain direct health care provision elements intended to:
   - Save and preserve lives, measured by crude mortality rates in the overall and/or under-five population;
   - Assist people traumatised by the events, by provision of psycho-social support;
   - Rehabilitate health infrastructure aimed at facilitating the return of or to prevent the worsening of the impact of the crisis on people affected by the crisis;
   - Lay the foundation for future recovery and development of the population affected by the crisis (also referred to as Linking Relief, Rehabilitation and Development - LRRD);
   - Include elements of emergency preparedness, aimed at early identification of and response to possible risks, where appropriate.
10. The European Union's (EU) humanitarian aid budget is composed of contributions managed by the European Commission and contributions of individual EU Member States. Collectively, the EU is the biggest donor of humanitarian assistance[8]: in 2006, the total EU contributions amounted to over € 2 billion, equivalent to approximately 40% of the global amount for humanitarian aid.
11. The DG ECHO budget for 2006 was € 671 million, approximately one third of the total EU contribution to humanitarian aid. Other important EC contributions were the Food Aid budget (approximately € 400 million), then still managed by DG Aid Cooperation (AIDCO), in cooperation with DG External Relations (RELEX) and the contributions from the 9$^{th}$ EDF B-envelop, managed by DG Development (DEV). EU Member States contributed an estimated € 205 million to the Central Emergency Response Fund (CERF), established in 2006 (refer to ¶ 19).
12. The 2006 DG ECHO contribution was significantly higher than the contribution of the Office of U.S. Foreign Disaster Assistance (OFDA), the humanitarian office of the United States government which has a similar mandate as DG ECHO. OFDA allocated USD 596 million (approximately € 460 million) in response to disasters.[9,10]
13. DG ECHO's operational capacity is significant with approximately 200 (permanent) staff members at its Headquarters in Brussels and approximately 100 (contracted) international staff in more than 20 Country Offices, the six (6) Regional Support Offices (RSOs) and the Sectoral Support Team

[7] http://ec.europa.eu/echo/presentation/mandate_en.htm
[8] European Commission. 2007. Towards a European Consensus on Humanitarian Aid. Communication from the Commission to the European Parliament and the Council. Brussels.
[9] USAID / OFDA. 2007. Annual Report for Fiscal Year 2006. Washington
[10] Further details of donor contributions to the health sector could not be found, either on individual donor websites or the OECD/DAC website (www.oecd.org/dataoecd).

(SST) in Nairobi. Country Offices and RSOs are managed by the three operational units - A/1, A/2 and A/3.[3] The recently added unit A/4 is responsible for Food Aid and Disaster Preparedness.

14. DG ECHO works within the framework of the European Commission and its policy environment. DG ECHO's identity as a humanitarian donor is determined, among others, by:
    - Its firm commitment to the principles of humanity, impartiality, neutrality and independence;
    - Its attention for 'forgotten' crises;
    - Its reaction speed, especially in allocating primary decisions' funds;
    - Its field presence, i.e. Country Offices and Regional Support Offices, which together constitute an important body for rapid reaction to and monitoring of quality humanitarian assistance;
    - Its partnerships with the UN, the Red Cross movement and European NGOs, framed in the Financial and Administrative Framework Agreement (FAFA) for the UN and the Framework Partnership Agreement (FPA) for NGOs and International Agencies.

### 1.4 DG ECHO and changes in humanitarian relief mechanisms

15. DG ECHO is operating in a rapidly changing environment, having to respond to the reforms in the delivery of development assistance in general and the proposed reforms in humanitarian relief mechanisms in particular, in line with the developed countries' commitments to improve aid effectiveness as pledged in the Paris Declaration (2005). A recently concluded peer review of the aid policies and programmes of the EC by the OECD commended "*the role of the Commission in re-shaping co-operation and the progress made since …2002 …. in delivering Community Assistance*[11]*"* and *"…encourages the Commission's endeavour to further improve the effectiveness of its humanitarian assistance".*
16. DG ECHO is one of 24 donors of humanitarian assistance who have agreed to abide by the (23) principles of the 2003 Good Humanitarian Donorship (GHD) Initiative, the aim of which is to improve the quality of contributions to the humanitarian system.
17. DG ECHO's consultation on EU humanitarian aid policy,[12] which included the EU member states and 220 DG ECHO partner organisations, resulted in the recently (June 2007) published document "Towards a European Consensus on Humanitarian Aid" and provides guidance that could lead to endorsement of the Good Humanitarian Donorship at EU level.[8]
18. DG ECHO has been actively involved in the introduction of the cluster approach as a way to address gaps in humanitarian relief and to strengthen the effectiveness of humanitarian response. DG ECHO has, for 2007, provided € 23 million towards the cluster approach (thematic funding). The cluster approach was one of the recommendations of the Humanitarian Response Review of the global humanitarian system, undertaken at the prompting of the UN Emergency Relief

[11] http://europa.eu/rapid/pressReleases. Reforms deliver results: European Commission welcomes the positive review of its aid by the OECD. Dated: 05/07/2007.
[12] Commission of the European Communities. 2007. Commission Staff Working Document accompanying the Communication from the Commission to the European Parliament and the Council – Towards a European Consensus on Humanitarian Aid – Report on the results of the consultation on a consensus on European Humanitarian Aid Policy. Brussels.

Coordinator, in 2005, *"as a way of addressing gaps and strengthening the effectiveness of humanitarian response*[13]*".*

### 1.5 Financing mechanisms of humanitarian aid

19. The changes in humanitarian relief mechanisms have been accompanied by new funding instruments. Of note is the pilot of the Pooled Fund (PF) that started in 2005 in the Democratic Republic of the Congo (DRC), administered by the Humanitarian Coordinator, and the introduction in 2006 of the Central Emergency Response Fund (CERF), administered by the UN Emergency Relief Coordinator (ERC). Both funds were established to increase humanitarian funding as these funds should be additional to already committed financing as well as improve predictability and flexibility of humanitarian funding.
20. DG ECHO's financing mechanisms consist of four types of funding decisions. Applications for funding require the completion of the 'single form' as described in the FPA and FAFA.
    - The Primary Emergency Decision refers to financial allocations to address immediate humanitarian needs in new, acute onset crises. The decision has to be taken within 72 hours after the onset of the crisis, can be used for a maximum of three months and cannot exceed € 3 million.
    - The Emergency Decision also refers to acute-onset humanitarian needs; it can be used as an alternative to the Primary Emergency Decision if the latter is not feasible and can fund interventions for up to six months.
    - The Non-Emergency / Ad Hoc Decision. This decision is mostly used to meet humanitarian needs as a continuation of emergency decisions or in case of slow-onset crises where humanitarian needs can be established before a funding decision is made. The Ad Hoc decisions include two specific funding modalities, i.e. thematic funding and the grant facility. Thematic funding was introduced in 2002, and refers to funding of UN and International Agencies aimed at strengthening the capacity of this group of partner organisations. The funding duration can exceed the limit of 18 months. The grant facility provides co-funding for small, one off projects not related to a specific crisis or to the health sector, most often used by NGOs and NGO networks to strengthen capacity, conduct research and to develop procedures aimed at improving quality of humanitarian responses.
    - The Global Plan. Commonly used in complex, protracted crises that allow the development of an integrated, multisectoral Country Strategic Plan for humanitarian response with input from partner organisations. Most Global Plans are developed for a period of 18 months, although contracts are generally issued for a 12 months' duration.
21. Prior to the establishment of (DG) ECHO in 1992, a number of EC Services were responsible for the management of humanitarian aid activities. While DG ECHO has, since its inception, been given the formal responsibility for the implementation of humanitarian aid, which since the beginning of 2007 also includes the EC Food Aid contributions, DG AIDCO, DG DEV and DG

[13] Accessed through google: ocha.unog.ch/humanitarianreform/

RELEX continue to manage funding instruments that can be used for humanitarian crises through the EC Delegations:

- The Rapid Response Mechanism, established in DG AIDCO and DG RELEX.
- The Aid to Uprooted People (AUP) instrument, specifically developed to finance programmes aimed at supporting internally displaced people (IDPs), refugees and their host communities in Asia and Latin America, and "*intended to form the crucial bridge between short-term emergency aid, notably from the European Commission's Humanitarian Aid Office (ECHO), and long-term development assistance, such as financial and technical cooperation."*[14] NGOs and UNHCR are important partners in the implementation of AUP projects, which are managed by DG AIDCO in cooperation with DG RELEX.
- The B-envelop of the European Development Fund (EDF) is managed by DG DEV and is available to ACP countries for activities in post-emergency and transition situations, including LRRD programmes.

[14] http://ec.europa.eu/external_relations/upp/intro/index.htm

# 2. MAIN FINDINGS DG ECHO AND HEALTH INTERVENTIONS

## 2.1 Coverage - Overview of DG ECHO funded health intervention in 2006

Coverage is defined as *"the need to reach major population groups facing life-threatening suffering wherever they are"* (ALNAP, 2006). For this evaluation coverage includes the boundary issues, i.e. is DG ECHO, while aiming for coverage in the above conventional sense, seeking to explore and assess what it is that it must do *in addition* in order to address life-threatening suffering.

22. The questionnaires (refer to ¶ 1.2 and annex 2) elicited interesting views with regard to coverage. In general, DG ECHO's focus on life-saving activities was praised by a majority of respondents, in terms of readiness, to:
    - address acute health needs;
    - classify need according to the degree of vulnerability;
    - focus on the most vulnerable people and those who do not benefit from other assistance provided by Government medical services or other NGOs;
    - work from partners' needs assessment, and so promoting relevance, coverage, efficiency, and effectiveness of funded health programmes.
23. Several respondents simply stated that DG ECHO's mandate is its strength, as it allows for choices that are not politically motivated, e.g. *"DG ECHO funds critical interventions in remote areas that other donors are reluctant to fund."* Or, *"DG ECHO intends the aid to go directly to people all over the world in distress, irrespective of race, religion or political convictions."*

The overview of 2006 project documents provided information on:
- Implementing partners: country of origin of partner, number of projects implemented, budget of projects and DG ECHO contribution;
- Geographical coverage: recipient countries;
- Type of activity included in projects divided in PHC, hospital care, disease control activities, outbreak responses, rehabilitation of physically handicapped, psycho-social care including care for victims of sexual and gender-based violence, nutrition rehabilitation and provision of essential drugs;
- Type of funding decision, duration of funding and start of interventions.

24. DG ECHO's contribution to humanitarian interventions in the health sector has been significant and is testimony of the importance the EC attaches to the health of people affected by humanitarian crises, considered an important aspect of its mandate. DG ECHO estimates that between 1995 and December 2006 approximately € 1.9 billion, equivalent to 27.3%, of its overall commitments to humanitarian crises was allocated to health and health related projects (table 1 refers), which include health interventions per se as well as interventions targeting people requiring psycho-social care and the provision of first aid items.

**Table 1: 1995 – 2006 DG ECHO budget allocations health sector interventions**

| | Total 1995-2006 | % of total |
|---|---|---|
| Health/Medical (only) | € 1,137,295,438 | 60% |
| Health/Medical as primary type of aid | € 471,509,846 | 25% |
| Health/Medical as secondary type of aid | € 278,951,630 | 15% |
| **Total, including all activities** | **€ 1,887,756,913** | |
| ***As % of total contracts*** | ***27.3%*** | |

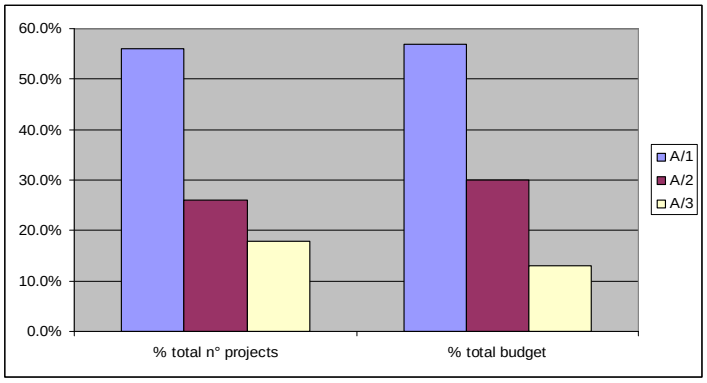
*Source: Health Strategy – DG ECHO's input in Mapping Exercise DG SANCO, 2006*

25. The total DG ECHO budget for 2006 was € 671,000,000 of which at least € 128,339,190 (19.1%) was allocated to health sector interventions[15], which include psycho-social care projects and a number of, but most likely not all, nutrition rehabilitation projects. Table 2 below provides actual figures of DG ECHO assistance to the health sector, while graph 1 shows the proportion of projects and the 2006 budget per operational unit.

**Table 2: Distribution of 2006 projects and budget per operational unit**

| Unit | # projects | # countries | budget | % budget |
|---|---|---|---|---|
| A/1 | 101 | 16 | € 73 million | 57% |
| A/2 | 47 | 5 | € 38.6 million | 30% |
| A/3 | 32 | 11 | € 16.7 million | 13% |
| Total | 180 | 32 | € 128.3 million | 100% |

**Graph 1: Proportion of 2006 projects and budgets per operational unit**



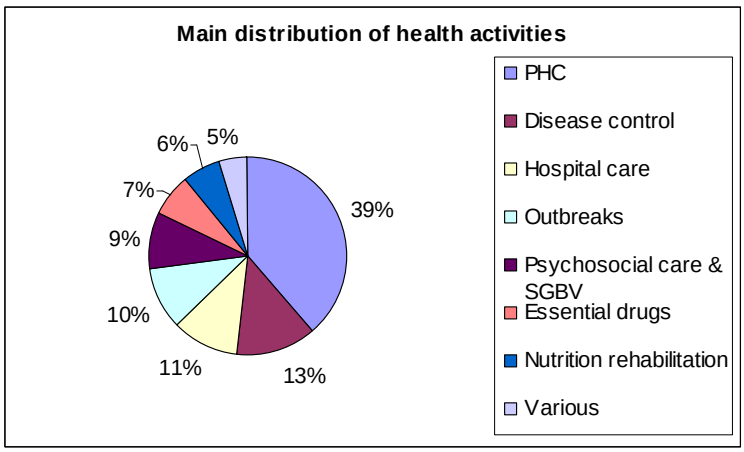

26. Comparison with OFDA data shows that the health sector was also the most funded sector by OFDA, at 20% (USD 100 million - approximately € 77 million) of the overall 2006 budget.[9] Similarly, SIDA reported that approximately 25% of its 2006 humanitarian budget of 2.2 billion SEK (approximately € 60 million) was dedicated to emergency and refugee health.[16]
27. As could be expected given the extent of humanitarian suffering to be covered, A/1 received more than half of the total expenditure on health. Of note is that 95 projects (53%) were implemented in 5 countries only (Sudan - 34, oPT - 18, DRC - 17, Liberia – 13, Lebanon - 13).
28. The analysis of the master document records allowed the breakdown of the 180 projects into 305 specific activities. Graph 2 shows the distribution of the main activities: PHC was the most

[15] Note that the overview and therefore the calculated budget allocation for health interventions only refers to those projects where 'health/med' or 'psycho' was listed as "primary type of aid". The overview excludes projects with nutrition listed as primary aid, with health/med listed as secondary type of aid and, except for the FAO project, thematic funding.

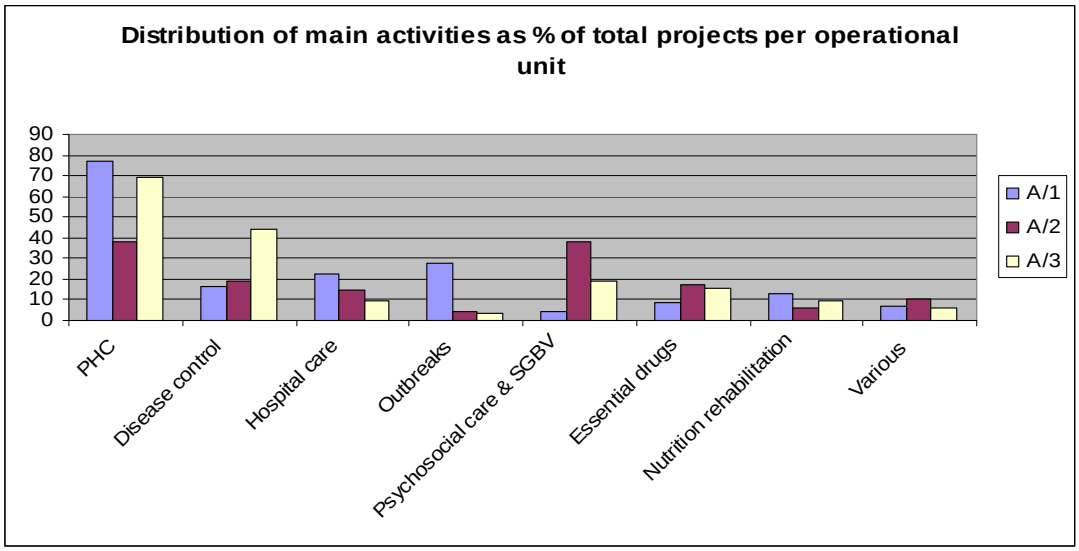
[16] Sida, Health Division. 2007. Progress in health development; Sida's contributions 2006.

frequently funded health activity in 2006 (39%). Disease control, hospital care provision, outbreak responses and provision of psycho-social care (which includes care for victims of Sexual & Gender Based Violence – SGBV) were also important components of health sector projects, representing 13%, 11%, 10% and 9% of activities respectively.

**Graph 2: Distribution of the 305 different health sector activities in 2006**




**Graph 3: Distribution of main activities as % of total projects per operational unit, in 2006**




*Note that in graph 3 'project' is the denominator, hence that the total of percentages per operational unit is higher than 100, as the percentage refers to the separate activities.*

29. Graph 3 shows that PHC is the most important programme activity in A/1, where more than 75% of projects include PHC provision. In A/3 almost 70% of projects include PHC provision, often targeting Internally Displaced People (IDPs) and / or refugees. The main activities in A/1 are, in addition to the provision of PHC, in-patient care and outbreak responses which are often required to cover the most pressing humanitarian needs because of the poorly functioning health systems. In comparison, psychosocial care projects are the most important activity in A/2. Of all psycho-social / SGBV care activities, 64% are implemented in A/2 and 21% in A/3.
30. The provision of PHC features more prominently in DG ECHO funded health interventions than hospital service delivery, in line with the SPHERE standards on health services which state that:

*"In most disaster settings, referral services and hospital-based care, while important, have a smaller public health impact than primary health care interventions"*. Nevertheless, 18.3% of the 2006 health sector projects included hospital service delivery, mostly (70%) in A/1, where such provision often refers to paediatrics, obstetrical care and safe blood transfusion services as was for instance advised in the DRC.[17] This figure excludes the rehabilitation of physically handicapped that are often hospital based activities, and which are more common in A/2 and A/3.

31. With regard to differences in main activities between the three operational units, respondents made the following remarks:
    - *"Standards and levels of development are different between countries, so ECHO's health programs will naturally be different as they have to be adapted: for example, standards for health programs with Lebanon IDPs will be very different from standards for Darfur IDPs."*
    - *"I imagine that each geographical area has its own disease and pathogen distribution and that health projects in different areas will reflect this and the different customs and cultures."*
    - *"Yes, in Africa the majority of needs are more life-threatening than in Asia and with limited funds [DG ECHO must] focus on the most urgent interventions".*
32. At least 40 (22%), but possibly more, of the 180 projects funded by DG ECHO in 2006 cannot be regarded as 'life saving' but rather are projects that prevent further suffering - of which 28 provide psycho-social care & mental health (including to victims of SGBV) - or assist in restoring the dignity and/or the quality of life of people affected by the crisis; the latter include the 9 projects providing rehabilitation services for physically handicapped. These projects account for 9.4% of the 2006 health expenditure and are mostly implemented in A/2 and A/3, where basic health care provision is less pressing and humanitarian partners can respond to assist people traumatised by events.
33. The need for psycho-social interventions in emergencies has been acknowledged: the Inter-Agency Standing Committee (IASC) Mental Health Task Force recently (June 2007) published its guidelines on 'Mental Health and Psychosocial Support in Emergency Settings'. The Anopheles group (refer to section 2.3) developed a grey / technical issue paper to outline the assistance DG ECHO partners can provide.[18] The psycho-social care programmes implemented in countries such as Lebanon, the occupied Palestinian Territories (oPT), Russia, Colombia, Sri Lanka and the DRC are responding to identified needs of the population, especially of children and women subjected and / or exposed to acts of war and violent conflict and were, in the given circumstances, prioritised.
34. Some respondents indicated that *"Health programmes do not differ by region / unit, but by emergency (natural catastrophe like flooding, earthquake, drought or man-made catastrophe like civil wars".* This suggestion is not supported by the analysis of 2006 funded projects.
35. As table 3 demonstrates, DG ECHO's funded health programmes in 2006 mostly relate to conflicts or to IDPs / refugee crises resulting from conflicts, the most important cause of humanitarian crises in all the DG ECHO regions. DG ECHO's health interventions in response to conflicts do not significantly differ from responses to for instance the natural disasters which occurred in A/3

[17] DG ECHO. 2005. ECHO DRC healthcare programme 2005: key concepts and definitions for partners.
[18] DG ECHO. 2006. Psycho-social projects in humanitarian situations (PSP). Technical issue paper – Anopheles group, November 2006.

(Indonesia, Ecuador and Suriname) - PHC, disease control activities and care for people with physical disabilities.

**Table 3: Type of emergency per operational unit - 2006**

| Type emergencies | # Countries | A/1 | A/2 | A/3 |
|---|---|---|---|---|
| Conflict | 15 | 6 | 3 | 6 |
| Refugees / IDPs | 6 | 4 | 1 | 1 |
| Outbreak | 3 | 3 | | |
| Natural disaster | 3 | | | 3 |
| Famine | 1 | 1 | | |
| Ill defined | 4 | 2 | 1 | 1 |
| | 32 | 16 | 5 | 11 |

36. What the above table above does not capture is the forgotten crises, defined by DG ECHO as *"crises that receive little or no media attention and whose victims receive relatively little or no international assistance"*[8] which for instance refer to countries such as the Central African Republic, Ethiopia and Eritrea, but also to countries where the host government is unable or unwilling to meet the humanitarian needs of IDPs and refugees. Examples of the latter are Thailand, Burma/Myanmar, Tanzania, Algeria and Lebanon. DG ECHO's decisions to provide humanitarian assistance in such forgotten crises is considered a main strength:

    *"ECHO's focus on forgotten crisis and gaps is its main strength. ECHO funds programmes that cover needs that are not addressed either by the authorities or the other NGOs. This "added value" is not fully harnessed and ought to be emphasized" and "……. critical interventions in remote areas that other donors are reluctant to fund."*

37. DG ECHO's humanitarian assistance is provided through a wide network of partner organisations. In 2006, humanitarian needs were addressed by 68 partners: 61 FPA partners and 7 UN agencies. The majority of partners, 38, signed a contract for one project, while 11 partners implemented two projects. Only 19 partners were involved in three or more projects. Remarkably, most of the 144 projects implemented by FPA partners in 2006 were continuations of projects: only 15% (22 of 144) NGO projects were started as 'new' projects; moreover in six of these cases the partner organisation already had an established presence in the country and was therefore familiar with the local circumstances. (The projects implemented by the UN are not included in this count as UN agencies have a continued presence in most countries.)
38. The large number of implementing partners in the health sector amounts to a significant and diverse capacity in the coverage of needs as well as in continuous gaps analysis, as most partners remain involved for longer durations. Examples of this were encountered in the three countries visited, i.e. in the DRC, partners start implementing health interventions when access has improved; in the refugee camps in Lebanon and Thailand continuous efforts are made to improve the quality of services.
39. Remarkable is that 10 of the 68 partners – 2 UN and 8 FPA partners - implemented 91 of the 180 projects with a budget of € 75,016,465, equivalent to 58% of the total health expenditure of DG ECHO in 2006. It was not possible to determine whether this skewed distribution is a general trend or mere coincidence, as a comparison with 2005 could not be made because of the incomplete data set.

40. In 2006, most projects were implemented within Global Plans (10) and Ad hoc / non-emergency decisions (16), indicating that the humanitarian crisis existed before 2006 and merited longer term funding. The 2006 decisions further included 6 Emergency decisions and 2 Primary Emergency decisions. The latter refer to the May 2006 earthquake in Yogyakarta, Indonesia and the July 2006 Lebanon crisis. The number of partners that applied for primary emergency funding in the wake of these two crises was limited to five: Lebanon – three partners; Indonesia – two partners. Both primary emergency decisions were followed by emergency decisions to address identified humanitarian needs requiring longer term involvement.
41. 'Optimal' coverage refers to the diversity and capacity of DG ECHO´s partners, but also to funding of activities that aim to continuously improve or innovate humanitarian responses in the given circumstances. The field trips (refer to annexes 6, 7 and 8) provided further evidence of attempts to achieve optimal coverage:
    - In the DRC, Sexual and Gender Based Violence (SGBV) has become a tool of war and is widespread. DG ECHO funded projects addressing the needs of people, especially women, submitted to such violence have increased, either as an integral part of PHC or as separate programmes. In one case, DG ECHO has crossed its own 'boundary' by financing hospital care specifically aimed at women with severe conditions resulting from sexual violence.
    - In the Thai – Burmese border camps, DG ECHO's engagement in discussions with other EC Services has resulted in EC funding for activities that require longer than 12 months' funding, the common duration of DG ECHO funding. In this case, the funding of the 18 months' training component was provided from the AUP budget of DG AIDCO and DG RELEX.
    - In Lebanon, DG ECHO has been actively engaged in improving the Palestinian Red Crescent Society (PRCS) hospital service delivery and has made efforts to streamline a number of psycho-social projects targeting the South Lebanese population. It has done this by its active role in the coordination of all partners, including the appropriate Government authority, to ensure that beneficiaries of the programme who require further assistance and support will be reached through national programmes after DG ECHO ceases its involvement.
42. Two other examples of DG ECHO's attempts to achieve optimal coverage are, firstly, the Sahel Global Plan that, apart from funding relief operations to reduce acute malnutrition, includes a response to deal with underlying causes of high malnutrition rates (refer to section 2.5) and secondly, the 2004 ad hoc Decision aimed at improving the identification of and early responses to epidemics in West Africa.
43. In conclusion, on coverage:
    - DG ECHO's strengths are well recognised and include: (i) assistance in a large number of humanitarian crises with a wide range of health sector interventions that correspond to the specific humanitarian needs of crisis affected populations; (ii) the continued engagement of a large and diverse group of partners with a wide ranging capacity to address humanitarian needs; (iii) flexibility, especially related to a quick response capacity and field presence, which in turn allow both (iv) for rapid decision making when acute crises occur and (v) adaptation of strategies based on needs identified in the field; (vi) support to protracted and forgotten crises,

and (vii) support to new initiatives, notably the Sahel Global Plan and the Epidemics Decisions.

In contrast,

- Weaknesses in DG ECHO's operations relate to (i) the observed lack of overviews / analyses of approved project proposals, per sector and per unit[19]; (ii) the current procedure to discard rejected proposals, which does not allow a comparison of accepted and rejected projects. A potential weakness is (iii) the finding that relatively few partners implement the majority of projects, which reduces the possibility to harness the diversity in partners' wide ranging capacities and could limit opportunities to introduce new or different approaches in addressing humanitarian needs.

### 2.2 Relevance - pursuit and timing of alternative options

*"Relevance is concerned with assessing whether the project is in line with local needs and priorities (as well as donor policy). Appropriateness is the tailoring of humanitarian activities to local needs, increasing ownership, accountability and cost-effectiveness accordingly"* (ALNAP, 2006). As a starting point for the assessment of DG ECHO's relevance in the health sector the team focused on DG ECHO's pursuit and timing of alternative implementation options, in order to be and remain relevant. In the course of the evaluation other aspects pertaining to relevance were added, as appropriate.

44. The new DG ECHO Framework Partnership Agreement (FPA)[20] that came into force in January 2004 commits signatory organisations, "*to implement humanitarian Operations in accordance with best practices in the sector and taking into account the particular operating environment, based on the concept of quality in aid. Quality in humanitarian aid implies a clear focus on the beneficiaries. Priority shall be given to analysis of the beneficiaries' situation given the circumstances and context of intervention, including assessments of the different needs, capacities and roles that might exist for men and women within the given situation and its cultural context.*

*To this end, signatory organisations will:*

- *allocate funds according to the needs and to needs assessment and promote the common objective of responding globally to humanitarian needs;*
- *promote the participation of beneficiaries in the formulation, implementation and evaluation of humanitarian aid Operations;*
- *endeavour to base humanitarian aid Operations on local capacities, respecting the culture, the structure and the customs of the communities and of the countries where the humanitarian aid Operations are carried out, without prejudice to the fundamental rights of the person;*
- *establish the linkage between relief, rehabilitation and development to help the affected population regain a minimum level of self sufficiency, taking long term development objectives into account, whenever possible;*
- *co-operate to the strengthening of capacities of communities affected, in order to prevent, prepare for, reduce and respond to future humanitarian crises."*

The above is in perfect agreement with the principles of Good Humanitarian Donorship and is as such not different from what other donors aspire. It also qualifies DG ECHO's understanding of

[19] An overview as was done by the consultants for this evaluation was started by the Regional Medical Expert based in Dakar, in his end-of-term report, for West Africa, at his own initiative.

[20] European Commission – DG ECHO. 2003. Framework Partnership Agreement with Humanitarian Organisations. Ver. 041221

relevance of projects and provides clear indications as to the importance given to participation of communities / beneficiaries in disaster preparedness and prevention, and to the LRRD process.

45. As related in section 2.1, more than 65% of projects had a PHC component largely implemented by partner NGOs. A review of past country and thematic evaluations reveals that relevance of such projects is generally judged positive.

    - *"ECHO funded health and nutrition interventions were designed as emergency lifesaving interventions, and, in the context of the situation, were relevant and appropriate." (Uganda evaluation, 2005)*[21]
    - *"In general it can be stated that all operations have been found relevant to the prevailing need situation of the target population. This is true for the health sector, the water and sanitation sector and also for projects in support of social marginalized groups." (Yemen evaluation, 2006)* [21]
    - *"ECHO correctly identified needs and showed a good choice of beneficiaries. As a whole a majority of operations showed a sound design of strategies and a fair deal of logic in the way the interventions were planned." (Hurricane Mitch evaluation, 2001)*[21]

46. Generally, evaluations assessed if programmes had been relevant, notably in their choice of target group or in the type of interventions. The answers were largely affirmative as the assessments remained 'in the box' of the programme at hand. This does not suffice for this evaluation which seeks to find factors within DG ECHO's mode of operation that enhance relevance and factors determining optimal relevance.

47. Respondents to the questionnaire did emphasise such underlying factors. In addition to factors already highlighted in the preceding section on coverage respondents singled out DG ECHO's in-country presence, in terms of:

    - *"Generally good field support, with open dialogue and regular field visits*
    - *Knowledge and understanding of contexts and issues; field experience and knowledge of ECHO personnel*
    - *Efficient monitoring mechanism during implementation phases*
    - *ECHO HQ is committed to follow the TA recommendations which allows for the desired level of flexibility."*

    As expressed by a DG ECHO desk officer, DG ECHO's strength lies in, "*Flexible, rapid procedures based on needs assessments with established partners and a strong field presence*". Another partner states, "*The presence of a technical assistance near to the operations is a real help during the different phases of the project*".

48. Although fewer in number, there were also expressions to the contrary, however:

    > "*The DG ECHO desk officers at Brussels HQ often seem to rely solely on their field officers` opinion; nevertheless the communication between HQ and field is often insufficient. Sometimes it seems as if the desk officers do not have a thorough knowledge of the project countries as well as the procedures in general*."

49. Many partner organisations commented on the short funding duration, regarded as a hindrance.

    > "*In our view, project funding cycles ranging from 3 to 12 months for health interventions are too short, particularly within the context of conflict / fragile states*." And, "*The short duration of funding does not take into account the prolonged period of time required for populations to recover from disaster*."

[21] http://ec.europa.eu/echo/evaluation/country_en.htm

50. The review of the 2006 master document records puts the last remark – on the short duration of funding – in perspective. As noted in section 2.1 only 22 of the 144 health sector projects were started as 'new' projects and the large majority of projects funded in 2006 thus were repeat projects a good proportion of which moreover had been running for several years. A frequently encountered remark in the master document records then is "*This project proposal is a continuation of a previous ECHO funded* [name of partner removed] *project in the area of operation*". In the opinion of partners interviewed this has severe implications for the relevance of these projects, such as:
    - Projects risk being stale as a result of cut and paste follow-up proposals.
    - Project staff cannot be offered long-term job-security. In particular experienced staff will quit their job to the projects' disadvantage and at high cost to the partner NGOs.
    - Projects can only guarantee short term results and as such leave out activities with a future perspective (or juggle them in, an example being capacity building of local staff).

    Thus, although many projects in all likelihood will continue for many years and the FPA (refer to ¶ 44 above) explicitly demands a future-oriented design, the short time horizon of DG ECHO contracts hinders this.
51. Some partners, however, are set to avoid the trap of staleness and use the repeat exercises as an opportunity to bring in new elements based on newly acquired lessons. Examples, in Sudan, are of projects that:
    - Continuously strive for improved quality and access, at acceptable or even reduced cost and effort, for example by changing from mobile to fixed clinics as soon as this is feasible.
    - Replicate a service model that proved itself in one area, to a neighbouring one.
    - Add on new components to existing projects.
    - Propose new or better practices as the following example in Box 1 shows.

Box 1: Covering innovations; the example of Community-based Therapeutic Care (CTC)

A 2005 master document record on a PHC & nutrition project in the DRC, then in its 5th cycle, remarks that, *"The results of the current Centre-based nutrition programme have been very disappointing with mothers simply not bringing their children in – due to other priorities. The idea is now to introduce a community based therapeutic feeding approach. This technique involves treating the children early at home with a special dried food mix and using local peers to monitor compliance. I.e. we are taking the mountain to Mohamed! This new technique, CTC, has been successfully pioneered in Sudan but needs certain skills to be learned and applied. [*name of partner organisation removed*] do not have these skills but realise that they might get better results from the new technique. As such they need to bring in a specialised team to assess the situation and help* [name of partner organisation removed] *to introduce CTC if appropriate."*
The first pilot CTC programme was implemented out of necessity during the famine in Ethiopia in 2000. The local government had prohibited Therapeutic Feeding Centres (TFCs) and malnourished people had to be treated as outpatients. The impact of the programme was positive, demonstrating that, for individual children, the clinical effectiveness of the outpatient therapeutic approach was equivalent to, or better than that achieved in TFCs (Collins and Sadler, 2002). A much larger programme followed in Darfur, Sudan, in 2001, which achieved similarly positive clinical outcomes (Grellety, 2001). From then on references to CTC are increasing until, in 2006, a manual appears based on five years of experience.

Noteworthy is that the 2003 DG ECHO evaluation of Zimbabwe already writes, *"Ready to use*

*therapeutic food (RUTF) or a dry food ration should be given to malnourished children who cannot stay in the hospital until full recovery (e.g. defaulters) and who are not covered by a community-based SFP."*

In DG ECHO there are no established guidelines yet on CTC. Some NGO partners will now incorporate CTC as a matter of course while others will not yet do so. This is one example of a continuum of 'best practices' in health and nutrition on which both desks and field staff need to be alerted in a more systematic way.

52. This is where DG ECHO's flexibility (as discussed in 2.1) comes in handy: field experts generally know how to appreciate such innovations and will recommend them to desk officers in Brussels. Also, the opportunity to discuss project amendments with the field expert before handing in the new proposal helps partners to judge what will and will not be acceptable for DG ECHO.
53. A feature of DG ECHO funding that is particularly appreciated is the possibility of designing for multi-sectoral interventions that are tailor-made to situations. The evaluation team saw this in the field, as in the East of the DRC where roads were co-funded by DG ECHO in an effort to open up health zones that had been inaccessible for several years. It was also noted as strength by respondents to the questionnaire, particularly partner organisations.
54. DG ECHO's relevance in terms of projects 'at the basis' is much applauded. Given this strength a missed opportunity for heightened relevance at the country level was signalled by many respondents, partners in particular: the insufficient use of leverage which DG ECHO naturally has, both based on its substantial role as a donor and in terms of extensive and relevant field experience. A selection from the responses on potential, but under-exploited relevance:
    - *"Developing and strengthening of National Health Policies as many developing countries affected by emergencies do not have or are not in a position to implement existing policies in their countries."*
    - *"Strengthening of health systems and their governance at the foundational stage of rehabilitation. A point of crisis can be an opportunity to influence policy change that would not be possible in a stable situation. Thus ECHO can have a longer term view than the immediate crisis."*
55. In addition, there are noticeable differences with regard to in-country situations that determine relevance and are examples of divergence between the operational units. In Lebanon, the United Nations Relief and Works Agency (UNRWA), mandated to provide assistance to Palestine refugees, spends an estimated USD 39 per capita per year, an amount that does not include all health expenditure for Palestine refugees in Lebanon. This amount is far higher than the average per capita health expenditure in most of the countries of A/1 and supports the concerns expressed by DG ECHO partners in the DRC, who deliberated the appropriateness / viability of the reduction in funding by long term development donors at that point in time – from € 4.0-6.0, to USD 1.5–2.0 per capita per year - which could result in financial barriers to access health care in a still precarious situation.
56. The health status of Palestine refugees in Lebanon and of Burmese refugees in Thailand is better than the health status of the host community, a common finding in most refugee situations. In both countries morbidity patterns of the target population have changed and compare to patterns found in the host community (and developed countries). Although one can hardly speak of a humanitarian crisis in these situations, the involvement of DG ECHO in funding health

interventions remains relevant as withdrawal of DG ECHO funding for health interventions would significantly reduce access to health care. The relevance of projects in those countries could be disputed when compared to the many unmet needs in A/1 countries.

57. In 2002 DG ECHO introduced a new funding modality, i.e. thematic funding. For the health sector the thematic funding to the WHO, in a Three Year Program (TYP) to Enhance Performance for Health Action in Crises (HAC), is noteworthy. The TYP started in 2004 and has had four major donors (DG ECHO, the Department for International Development (DfID), Swedish International Development Cooperation Agency (SIDA) and the Canadian International Development Agency (CIDA). DG ECHO's financial support to the HAC has totalled € 10.5M. In addition DG ECHO health experts, both of the SST and of RSOs as well as desk staff have participated in most if not all joint evaluations of HAC pilot countries (the DRC, Ethiopia, Uganda, Sudan, Chad, Liberia, Pakistan, Tajikistan and Indonesia).
58. The objectives of the HAC can be summarised as improved emergency preparedness and response, at all levels, of the WHO, including not only WHO Geneva but also the regional and country offices, and even the offices at sub-national level. Four functional areas are distinguished:
    1) Assessing priority health needs;
    2) Ensuring effective health sector coordination;
    3) Identifying and filling critical gaps in health;
    4) Strengthening local capacities and systems.
59. That WHO – HAC had not yet met its objectives became clear during the field visit to Lebanon, where WHO Lebanon Office indicated that, at the time of the July 2006 crisis, staff had not heard of and were therefore not familiar with the HAC. They certainly had not participated in the capacity strengthening activities.
60. The debates in the context of Good Humanitarian Donorship (GHD) and UN Reform resulted in a wide-reaching innovation, of the cluster approach, implemented through the Inter-Agency Standing Committee (IASC) of the UN system. Not surprisingly, WHO was given to be the health cluster lead (refer to section 2.6), which naturally changed the nature of the HAC programme's implementation, as success was now judged along the lines of both WHO's performance as health cluster lead – that is, primarily in a coordinating capacity, and in the original HAC terms – that is, primarily in translating its core business in terms of emergency preparedness.
61. The HAC TYP has been evaluated in 2006[22]. Key staff interviewed by the evaluation team, particularly of donor agencies, stated that, *"on HAC, the jury is still out"*. For DG ECHO the thematic support to WHO has been something new, and nearly an experiment, in deviation from DG ECHO's traditional projects. At the same time there are concerns that are not unlike those for traditional field-level projects, that is: on WHO's capability to sustain results at project completion, at the end of 2007. (Section 2.6 lists the many tasks of cluster leads.)
62. Another 'experiment' for DG ECHO has been the 2004 funding decision of a regional programme in West Africa (17 countries) enabling these countries to respond more rapidly and therefore more

[22] Gleadle A. 2006. Health Action in Crises. Mid-Term evaluation of the Three Year Programme To Improve the Performance of WHO in Crises. Fauvelife Consultancy Group.

appropriately to the various epidemics that year after year have posed a risk, albeit of differing magnitudes. Well known examples are cholera, meningitis and yellow fever. The former RME has been instrumental in drafting the first Decision, in 2004, and for arguing its validity.

63. Box 2 gives some details and also hints at administrative difficulties for DG ECHO to shift to disasters that are yet to happen, in the health domain.

> Box 2: Increased relevance by increasing preparedness; the example of Epidemic Decisions
>
> DG ECHO's first Decision on Humanitarian aid to populations affected by epidemics in West Africa was taken in 2004, for an amount of € 1M. Part of the argument was, *"In recent years, ECHO has been supporting emergency projects that respond to outbreaks of communicable diseases in West Africa. One lesson learned is that, on most occasions, it is very difficult to determine a specific date that would trigger emergency procedures, such as a Primary Emergency Decision. ECHO's experience in the region shows that every year ECHO spends at least € 1,500,000 reacting to the most important epidemics; thus a yearly level of expenditure can be anticipated justifying the preparation of a humanitarian aid decision to help those affected by epidemics in West Africa. Reaction to epidemics is particularly needed in West Africa due to the high incidence of epidemics there. Initial effective experience with the epidemic decision for West Africa may lead to it being applied to other areas of Africa."*
>
> As the RME for West Africa noted in his end-of-posting report, *"For example, the Touba yellow fever outbreak in Senegal, just before the yearly Muslim peregrination to Touba could have been controlled with insecticide spray worth 25000 Euros; not doing so required afterwards the vaccination for 1.5 million people in Dakar city. In a case like this, ECHO timely support can make a major difference."* Similarly, the current RME says, *"A considerable time is saved because the development of a multitude of small emergency decisions takes considerable working time at all levels: Referring to the year 2005, if the "Epidemics" decision did not exist, ECHO would have developed not less than 8 emergency decisions with its corollary of workload on all levels. Without an Epidemic decision, there would have been not less than 4 emergency decisions in 2006."*
>
> Despite the obvious relevance of preparedness for epidemics that are predictable year after year, the impact in terms of lives saved, or disabilities avoided, is hard to demonstrate as one cannot know for sure what would have happened without the preparedness. This is a problem for an organisation that bases its funding on needs and results. Another hurdle for DG ECHO is the issue of stocks' prepositioning, which is a critical element of preparedness. Ultimately, the 2007 Epidemics Decision was not granted because of legal issues related to the prepositioning of stocks. This rejection appears to be in contrast to the approved decision "Groundbreaking partnership between Commission and WFP on Humanitarian Response Depots (UNHRD)" of 30 July 2007, which also involves prepositioning of stocks.

64. In conclusion, on relevance, DG ECHO's apparent strengths are:

- DG ECHO can avail itself of a significant potential for diversity, which offers opportunities for the introduction of innovative approaches, such as the CTC, the care for victims of SGBV programmes and the Epidemic Decisions.
- DG ECHO's continued support to vulnerable groups in the absence of other solutions can be considered a strength as it avoids a reversal of gains made by humanitarian interventions.
- Taking situation-specific needs the relevance of support to specific vulnerable groups cannot be disputed, despite significant differences between regions. DG ECHO's acceptance of such divergence appears justified.

In contrast,

- The DG ECHO funding limit for projects, 12 months, affects job security of staff and reduces the chances that partners take a longer-term perspective in the implementation of activities. It could therefore limit inputs that focus on health systems' strengthening and influencing policy changes.
- The funding limit and the fact that the majority of NGO projects were continuations of previously started interventions carries the risk of such projects becoming stale and hence less relevant.

### 2.3 Effectiveness - available competence and norms and standards applied

*"Effectiveness measures the extent to which an activity achieves its purpose, or whether this can be expected to happen on the basis of the outputs. Implicit within the criterion of effectiveness is timeliness"* (ALNAP, 2006). The available competence to effectively implement health sector activities, and applied norms and standards were the starting points to assess DG ECHO's effectiveness in the health sector. In the course of the evaluation other aspects pertaining to effectiveness were added, as appropriate.

65. *"It is part of being an effective, accountable donor that decisions are not solely based on need. The other element of the decision focuses on whether a particular response will have an impact on reducing humanitarian need by saving lives or alleviating suffering."*[23]

66. DG ECHO has published three 'standards' that are relevant and applicable to humanitarian health sector interventions, i.e.
    - Review of Quality Assurance (QA) mechanisms for Medicines and Medical Supplies in Humanitarian Aid – Concept paper & Guidelines;
    - A Review of DG ECHO's approach to HIV/AIDS – Concept paper & Guidelines;
    - A Review of Water and Sanitation issues relating to the funding of humanitarian operations under the EC humanitarian regulation – Concept paper & Guidelines;

Box 3: Best practices for predictable effectiveness - the case of Quality Assurance mechanisms for medicines and medical supplies

In 2005 DG ECHO carried out an external review of Quality Assurance (QA) mechanisms for medicines and medical supplies.[24] The review was undertaken as a part of DG ECHO's commitment to promote quality assurance and in particular intended to assist partner NGOs. The theme was chosen because, as the reviewers note: "*The volume of funds accorded to health activities is telling. In most countries receiving DG ECHO's support, health absorbs from 30 to 50% of DG ECHO's funding, depending on the year. Of the amounts devoted to health, from 20 to 30% of the funds go for the purchase and management of medicines and medical supplies (i.e. between 40 and 90 million Euro, again depending on the year).*" The concern prompting the review was the growing risk of counterfeit medicines, with serious implications for emergency situations.

The review and its concurrent guidelines concentrate on Humanitarian Procurement Centres (HPCs) and the advantage of procurement from pre-qualified HPCs that are complying with the WHO Good Manufacturing Practice Guidelines.

[23] Willitts-King B. 2007. Allocating humanitarian funding according to need: towards analytical frameworks for donors. Discussion Paper. 12 March 2007

[24] http://www.ec.europa.eu/echo/pdf_files/evaluation/drugs_quality_concept_paper.pdf

The problem with the above notion is two-fold, as remarked by a partner organisation in its written comments on the consultants' recommendations. Firstly, although HPCs are admittedly a 'better' safeguard for QA of drugs they are by no means a guarantee. According to this partner the majority of (10) HPCs listed in the review cannot offer compliance with WHO norms and standards, for one because they lack proper pharmaceutical expertise. This then, secondly, generates a problem of "*who should control the controllers*" (pharmaco-vigilance), which is hardly a task that partner NGOs can be expected to fulfil themselves.

Another remark, made by an RME, is that rules and regulations differ over the world. Prescriptions on exclusive use of donor-vetted HPCs would, for example, be unacceptable in most of Asia.

This thus typically appears an issue on which gold standards for predictable effectiveness – 'always and everywhere' - would be highly desirable, and yet apparently cannot be had.

67. The documents are presented as consultancy reports, that is, have not been 'translated' into official EC documents, which suggests that the content does not comply with certain EC regulations, which DG ECHO is obliged to respect. The EC regulations are strict and require partner organisations to request 'derogations' from the 'nationality rule' and the 'rule of origin'[20], for instance for purchase of vehicles or for local purchase of drugs and medical supplies. The master document records show that derogations are often requested (and approved by DG ECHO). Another example of regulations is the now again recommended use of DDT for Indoor Residual Spraying in malaria endemic areas, which is considered a cost-effective intervention to reduce malaria transmission. The use of DDT is, however, prohibited by the EC as it is party to the Stockholm Convention that bans the use of chemicals such as DDT.
68. *"The need for DG ECHO to consider existing EC Regulations in any policy document"* (personal communication) continues to be an issue of debate in DG ECHO's attempts to establish standards, which by some are referred to as "policy", but would possibly better be referred to as DG ECHO position papers for humanitarian assistance. The result of a study carried out in 2006 by the Policy Unit of DG ECHO (DG ECHO 0/1) among EU Member States and partner organisations (approximately 220 respondents) did not resolve this debate[12], although DG ECHO was requested to contribute to policy development.
69. The non-endorsement of the review documents as standards for humanitarian operations limits their use. Box 3 above demonstrates some of the difficulties encountered in the use of the Guidelines for Quality Assurance (QA) mechanisms for Medicines and Medical Supplies in Humanitarian Aid. One of the key informants mentioned the scant use made of the Water & Sanitation Review document by TAs in the field even though the process of drafting the review had been both thorough and participatory. Table 4 below, however, which is a guideline on use of Artemisinin Combination Therapy (ACT) for malaria, produced by DG ECHO's Anopheles members (refer to ¶ 76 and 77 below) gives an example of a guideline that is eminently practical, also for future users.

**Table 4: Guidelines for ACT use**

| Scenarios | Anopheles recommendation |
|---|---|
| National Protocol is ACT | • Fund ACT |
| National protocol accepts ACT and resistance is over 15% to other treatments | • Fund ACT |
| National protocol accepts ACT and resistance is unknown or below 15% | • Fund ACT where partners propose it<br>• Fund national protocol treatment if partners propose it in areas where resistance is less than 15%.<br>• In areas where resistance is not known, fund national protocol treatment only if resistance studies are done at the same time |
| National protocol forbids ACT and resistance over 15% | • Support the partner asking for an ACT exception in the case of excess mortality in a particular area and population, e.g. refugee arrival |
| National protocol forbids ACT and resistance is unknown | • Accept national protocol only if coupled with resistance studies. |
| National protocol forbids ACT and resistance is below 15% | • Accept national protocol |
| National protocol just changed to ACT | • Diagnosis by Microscopy or RDT to be included.<br>• Partners should provide training on new protocol to their staff,<br>• Usually introduction of ACT is done one district at a time => ECHO to lobby government to select as priority introduction areas the ones where ECHO is funding/ready to fund partners using ACT.<br>• Importation of ACT should be negotiated as early as possible to avoid delays.<br>• Encourage procurement from quality purchase centers, notably the national medicine supply system, usually via GF.<br>• Once the ACT protocols are available chloroquine should be destroyed unless it is used for a high prevalence of vivax malaria (over 25% of cases). |

Source: Malaria key points for ECHO desks and TAs – version 4/10/2005

70. Respondents voiced clear opinions in answer to the question "*Should DG ECHO, as a donor, actively contribute to international policy development as well as draft its own health policies and guidelines, and if so, which aspects of the health sector should be considered as priorities?"* While few respondents suggest that DG ECHO should develop its own health policies "*to balance positions of organisations such as WHO or to offer different opinions on standards like SPHERE*"[25], most respondents indicate that:

- *"ECHO as a donor should not get involved in technical guidelines for its partner. Partners are supposed to be professional health workers, and there are already many handbooks that are circulating. When one wants to build a home, one doesn't ask his bank how to build a wall."*
- *"We believe that several health policies and guidelines already exist (WHO, UNICEF, SPHERE, local Ministry of Health….)."*
- *"…. ECHO's added value is not on the establishment of its own independent health policy. Guidelines for their application in ECHO's context/operations are always welcomed."*

71. Respondents suggested various subjects for further DG ECHO attention. Field experts listed among others: "*cost-recovery & user fees, LRRD, HIV/AIDS, chronic diseases in emergency*

[25] DG ECHO contributed to the development of the first (1997) and subsequent (2004) edition of the SPHERE Handbook, which contains minimum standards for humanitarian assistance, agreed by 400 organisations. The SPHERE standards are generally used to determine the need for humanitarian assistance by the commonly agreed thresholds, e.g. on levels of acute malnutrition, crude mortality rates, and provide minimum requirements to be met by humanitarian organisations, *"based on the principle that populations affected by disaster have the right to life with dignity."*

*settings, the definition of essential packages of health interventions for specific disaster situations and impact evaluation based on specific health indicators".* Partners listed the same subjects, as well as: *nutrition, mother and child care, sexual and gender based violence",* and referred to issues such as *"cooperation and communication between all stakeholders, and coordination between health structure and authorities"*; while desk officers added "*measures to improve preparedness and rapid response capacity to fight recurrent epidemics, and early warning and disaster preparedness in health sector"*.

72. DG ECHO's country presence is considered important by many. In this, DG ECHO differs from other humanitarian donors, who often deploy teams for short periods at the beginning of a crisis (Disaster Assistance Response Team (DART) – Office for Foreign Disaster Assistance (OFDA), Conflict and Humanitarian Affairs Department (CHAD) – DfID and only if their in-country (Embassy) teams cannot cope with the demand for input in the response to the crisis.

- *"It is common practice that the ECHO funded operations are widely ….. discussed and assessed jointly in the field by the ECHO partners and ECHO's TAs & expert staff, allowing a smoother decision process and finalization at the ECHO's HQ*."
- *"The presence of expert representatives at country level enables DG ECHO to respond quickly to sudden onset disasters and changing contexts. Knowledge of local partners, existing health system constraints and the capacity to offer contextual analysis are beneficial to NGOs such as* (name of organisation removed)*."*

73. DG ECHO's operational capacity was further enhanced by the establishment of six (6) RSOs in 2003 in Nairobi, Dakar, Bangkok, Amman, Delhi and Nicaragua. The RSOs are managed by the respective operational units (A/1, A/2 and A/3). The RSOs can provide health expertise on request of DG ECHO field offices through the RMEs. However, contrasting views were expressed by different respondents with regard to the value of RMEs:

- *"Health experts are not systematically included in the discussions with partners and other institutions concerning health issues ….. Health expertise [is] only considered as a support to TA and for monitoring purposes. Generally not involved in strategic decisions ….considering the volume of health projects a missed opportunity."*
- *"DG ECHO's management should optimise the use of its sectoral expertise in decision making, as RSO staff members are generally more experienced than field experts and desk officers."*
- *"The health experts in the RSOs are a vital source of assistance. However while there are some excellent ECHO field health experts there is a shortage of expertise in HQ."*
- *"There is a fundamental question here: have sectoral experts a function of systematic quality control and therefore adding another layer in between the geographical expert and his/her desk? My opinion: yes. There is a waste of resources here and a problem of credibility because of incoherencies and uneven quality of our programmes*."

74. To respond to the identified lack of technical capacity in Brussels, the Sectoral Support Team (SST) was established in 2005. Although the SST is based in Nairobi, it has a global technical support mandate and manages capacity strengthening projects of UN agencies (thematic funding). The SST is managed by the DG ECHO Policy Unit (0/1), an understandable decision in view of the SST's global support role. It has implications, however, for the effectiveness of the SST in relation to country offices and RSOs as the official lines of communication of the SST are with the Policy Unit, not with the operational units, where decisions are made. As one RSO team member indicated:

*"Considering I am part of a RSO, my answer reflects only on the SST. Little to no contact, guidance or coordination comes from the SST (or ECHO 01). I think so far DG ECHO is not using its capacity to full potential."*

75. Interviews with partner organisations taught the evaluation team that their sectoral staff have all found ways to communicate new approaches amongst each other. The organisations related that, in addition to informal, internal demand, also management teams request state-of-the-art publications on how to deal with complex issues such as HIV/AIDS. One partner has addressed this in a participatory way, starting from country level partner experience. Others have recently decided to start an informal network that encourages case studies of salient field experience, or organise regular meetings on specific (sub) specialties to brainstorm on new developments and how these could be incorporated in existing practice.
76. In a similar vein, and aimed at harnessing the competence of its field staff and improve information sharing on health sector issues, DG ECHO established the Anopheles working group:

"*Specialist networks of experts and working groups have been established … to provide technical advice both to Headquarters and to the field in order to ensure consistency and coherence in DG ECHO's policies and operational guidelines and to establish agreed practices*."

Box 4. The Anopheles Group

The Anopheles working group was established in 2004 as an informal, mostly 'electronic' network. The initial aim of the working group was to map the different health activities implemented with DG ECHO funding and to share technical information between the RMEs. This evolved into the development of technical standards for use by field experts to ensure coherence and consistency in humanitarian health assistance across countries and regions. The group was supported by a focal point in Brussels who organised regular meetings.

The initial exchanges that took place between the various stakeholders of the working group and the many papers produced (see annex 4 – references) were met with enthusiasm. *"Desk officers and field experts have too many contracts to handle, which leaves poor practices unidentified and not corrected"* (personal communication). The RMEs produced guidance and technical 'standards' for operations on issues as varied as disease specific topics (e.g. malaria, cholera, sleeping sickness, HIV/AIDS), malnutrition, vaccinations, and epidemics; topics related to specific target groups such as children or to a specific programme (psycho-social programme), and programme management issues such as the basic health package, monitoring & evaluation, unit costs and user charges. The various topics on which guidance was sought were divided between the (at that time) five RMEs, each RME taking on topics that he or she had most experience and affinity with.

The Anopheles group and especially the health experts have also been called to comment on the results of independent consultancies, such as the review of DG ECHO's approach to HIV/AIDS and the Review of Quality Assurance Mechanisms for Medicines and Medical Supplies in Humanitarian Aid (Prolog Consult Belgium, 2004; Pomatto & Schuftan, 2006).

77. The evidence is that the Anopheles network flourished, particularly when there was a joint purpose to respond to management level requests for clarity on thematic issues, which could in turn serve the entire institution. Desk officers indicated that they found the papers useful, even though on some topics, such as psycho-social support, the discourse was too general to be applicable in specific situations, gender-based violence in the DRC being an example. It was less successful in the mapping of health interventions. As pointed out by one RME: *"Real time mapping of grants in the region is incomplete because we depend on the courtesy of each TA and desk to share their*

*funding allocations."* The Anopheles group came to a virtual standstill after the October 2006 meeting with senior managers of DG ECHO, largely because managers reiterated the support and advisory role of RMEs.

78. In conclusion, on effectiveness,

- DG ECHO funded health sector interventions have resulted in reductions of excess mortality and improvements in the health status of crisis affected populations.
- DG ECHO's strengths are (i) its ability to attract competent and motivated staff, and (ii) its presence at country level. The availability of health expertise at regional level (and sometimes even at country level) has all the potential to turn DG ECHO health operations into exemplary programmes.

In contrast,

(i) the Anopheles group had grounded to a virtual halt which affected opportunities to thoroughly analyse past interventions and maintain close interaction between professionals to ensure that new developments in the health field are, where appropriate and relevant, incorporated in DG ECHO funded interventions; (ii) DG ECHO does not fully harness its available operational capacity as RSO's, and even more so the SST, are under-utilised in the development of country strategies, decision making and (technical) management; (iii) the evaluation team agrees with respondents that DG ECHO should not develop health policies and technical guidelines, and supports a firm DG ECHO endorsement of the existing body of policies developed by normative institutions such as WHO and UNICEF.

### 2.4 Efficiency - use of tools, protocols and available capacity

*"Efficiency measures the outputs – qualitative and quantitative – achieved as a result of inputs. This generally requires comparing alternative approaches to achieving an output, to see whether the most efficient approach has been used"* (ALNAP, 2006). The use of existing tools, protocols and available capacity to efficiently implement health sector activities were the starting points to assess DG ECHO's efficiency in the health sector. In the course of the evaluation other aspects pertaining to efficiency were added, as appropriate.

79. Following the example of other major donors of humanitarian assistance, the 2004 DG ECHO FPA emphasises outcomes rather than focusing on control of inputs. The aim of the output and outcomes-oriented approach is, among others, to better determine efficiency of humanitarian operations by measuring outputs and outcomes against inputs.
80. A review of past country evaluations provides evidence that, prior to the 2004 FPA, determining efficiency of interventions was complicated if not impossible:

- *"Project inputs have been efficiently and appropriately introduced; the quality of those contributions is judged to be good….. ECHO-supported HCs now treat between 300 and 1000 patients a month; the quality of those services has improved." (Cambodia evaluation, 2002)*[21]
- *"Were things done in the best possible way? Considering history and political constraints, this specific refugee population has generally received an appropriate level of humanitarian assistance. If, as an indicator of efficiency for example, one was to look at all the camps funded by ECHO and ask "do you have access to medical facilities at all times", the answer would be* ***yes****. "Are the systems being run in an efficient way" is perhaps more difficult to define. The NGOs operating the systems have funds with which to work, and generally speaking, provide value for money." (Thailand evaluation, 2002)*[21]

- *"In general health and nutrition projects were assessed as highly efficient and effective, both in terms of the inputs used and in overall implementation. ECHO-supported HCs and mobile clinics (which were the subject of this evaluation) treat over 35,000 patients every month, not including those treated through ECHO-supported hospitals." (Uganda evaluation, 2005)*[21]

81. The above difficulty in measuring efficiency remains an issue since the introduction of the results-oriented approach.

    *"An excellent initiative is the systematic introduction of quantified indicators in the agreements signed from 2005 on. This DG ECHO effort to educate and guide partners is very positive but greater care should be taken to adopt expected results that are actually resulting from and therefore can be credited to partner activities: reduction of crude mortality rates or many health indicators are definitely not the result of a single sector or project intervention. Too many indicators are "cut and paste" from the Sphere Handbook."* (Darfur evaluation, 2006)[21]

82. The new FPA contracts require partner organisations to determine benchmarks against which outcomes of humanitarian interventions are measured. To support partners in defining the most appropriate indicator set for their humanitarian operations, the draft "Catalogue of Operational Performance Indicators. For Title 01: Goods and services delivered to the beneficiaries" (March 2004) was developed.
83. The review of the master document records shows that project proposals include indicator sets against which partners' performance is monitored. Not all master document records provided adequate details, while others contained between 30 and 50 (!) separate indicators against which progress is measured. This detailed monitoring of project implementation, however, presupposes:
    - That data on intended beneficiaries are reliable;
    - That standard definitions of indicators are used;
    - That measured changes can be attributed to project implementation;
    - That field and desk staff have adequate capacity to identify the value of measured changes and judge whether data have been collected according to standard.

    And last but not least:

    - That data are useful for measuring efficiency, relevance and effectiveness of projects.
84. That this is not necessarily the case was demonstrated during the field visits (refer annex 6, 7, 8):
    - In the Thai-Burmese refugee camps information on the number of beneficiaries is collected regularly by community workers. However, partner organisations indicated that health services are also used by relatives of registered refugees normally not residing in the camps and by Thai people living close to the camps, but could not provide accurate figures of the latter group of beneficiaries of their / camp services. This will among others affect the reliability of utilisation and coverage data (vaccination coverage, ANC coverage, utilisation rate).
    - Mortality data in the Thai – Burmese border camps are collected using the registration of vital events. There were some suggestions, which could not be verified, that not all deaths are reported to increase the number of food rations per family.
    - International definitions of standard health status indicators were not applied consistently. An example is the definition of the neonatal mortality rate, a rate measured as neonatal deaths per 1,000 live births, which can, but does not have to, include the number of still births. This

indicator can only be reliably measured when registration of vital events is accurate. Another example is the definition of under-five mortality rate, which can be measured per 10,000 under-fives (mostly used in acute crises when crude mortality rates are high), but which generally is expressed as the number of under-five deaths per 1,000 live births.

- In the DRC, partners were requested to conduct mortality surveys to determine crude mortality rates in the general and under-five population. However, to judge the appropriateness of the design and methodology of the survey and the survey results, specific capacity is required.

85. Questionnaire respondents made mention of the often cumbersome and long administrative procedures of DG ECHO, which lead to delays in the start or continuation of projects, despite the large number of staff at Brussels and field level.

- *"ECHO's rules and requirements in terms of administrative and financial procedures are very constricting and heavy."*
- *"The implementation of projects is hindered by complicated rules and regulations that need much time in advance for planning and lots of manpower to adhere, e.g. procurements in compliance with Annex 5 and specific regulations like the "country of origin"-rule."*
- *"Rigid procedural guidelines and formats are an issue sometimes given contextual difficulties and rapid changes."*
- *"Even though we listed as one of ECHO's strengths its capacity to rapidly take decisions, we would still like to draw your attention on the fact that in some cases, the processing of grant applications is too long and bureaucratic."*

An example of how cumbersome it can become is obvious from this example:

> *"The total ECHO contribution request in the narrative is 390,000 EURO, whereas in the budget breakdown it is 389,900.* [Name of partner removed] *needs to clarify this."*

86. A further effort to assist in measuring efficiency was the, not formally endorsed, introduction of 'unit costs' for standard interventions, including the unit costs of different components of health service delivery. DG ECHO staff, both permanent staff and experts (contracted staff) produced three papers on this topic. As the author wrote in the introduction of the 2001 paper, [26, 27, 28]

> *"This document is only a first draft and is most likely still not ready for wider distribution. The data should be field-tested and corrections will be needed. It is a dynamic document and further inputs from the field experts and HQ staff are an absolute requirement to improve the accuracy and relevance of the document. All ECHO staff are encouraged to critically use the document ..."*

This, however, has not happened, at least not in a systematic way or with much encouragement of DG ECHO management. That the interest among staff is still there is apparent from a recent study by the RME, Delhi, at the request of DG ECHO's Pakistan desk, to make a comparative assessment of unit costs for partners engaged to deal with the 2005 earthquake in that country.

87. The overview of 180 DG ECHO funded health interventions in 2006 shows the following trends[29]:

[26] European Commission Humanitarian Aid Office. The Unit Cost Approach of humanitarian activities; document by the Regional Support Office, First draft, March 2001, 55 pages.
[27] European Commission Humanitarian Aid Office. Acute Malnutrition: Costs and Trends; food for thought for updating the ECHO Unit Cost paper.
[28] DG ECHO position on charges made for health services in developing countries in humanitarian crises. Draft 3, November 2006
[29] Note that many organisations implement health programmes with more than one component: DG ECHO field staff members generally calculate the cost per beneficiary using the overall budget of the operation.

**Table 5: Range in unit costs per type of intervention in 2006**

| Intervention | Lowest | Highest |
|---|---|---|
| PHC | € 1 | € 29 |
| Hospital care | € 4 | € 356 |
| Outbreak response | € 0.16 | € 138 |
| Nutrition rehabilitation | € 16 | € 75 |
| Rehabilitation physically handicapped | € 4 | € 200 |
| Psycho-social care / SGBV | € 30 | € 359 |

88. The above details show that comprehensive PHC is generally least expensive, confirming the generally accepted cost-efficiency of the delivery of basic health services. Psycho-social care & mental health programmes are most expensive, closely followed by rehabilitation of physical disabilities.
89. The clear differences in cost per beneficiary in the same country do not appear to trigger DG ECHO staff members in attempting to identify the reasons for and / or addressing such disparities in efficiency. Examples of this were found in a number of project documents relating to programmes in the same country where different partners provide a similar services package and have similar impact, but where the cost per beneficiary is substantially different.
90. The cost per beneficiary is not always calculated, either because it is not possible to distinguish the costs related to specific project components, or because the number of beneficiaries is inadequately established:

    *"The budget is not detailed enough to separate the cost of activities related to psychosocial assistance to IDPs and to coordination. Considering the 1200 direct beneficiaries of psychological support, the unit cost per beneficiary is € 175. Nevertheless, this figure is not relevant as it does reflect only partly the impact of the project. Considering the 70,000 indirect beneficiaries from the coordination, the unit cost is coming down to € 3. This is also not a fully relevant figure as not all the indirect beneficiaries would benefit from psychological support. Nevertheless, the overall budget of this project is reasonable."*

91. The introduction of new disease control protocols has been subject of extensive discussions in DG ECHO, especially in relation to costs and the existing national protocols. An example is the disease control protocol for malaria, in many African countries the most important cause of morbidity. The introduction of ACT as standard treatment for malaria - generally accompanied by an increase in diagnostic capacity and improved prevention methods such as Insecticide Treated Nets (ITNs) and Intermittent Preventive Treatment (IPT) during pregnancy - has resulted in an increase of cost per beneficiary of between € 1.50 and € 3.00, especially in PHC programmes in Africa – A/1. Despite the higher costs, DG ECHO (informally) agreed to support the use of ACT and increased diagnostic capacity[30] which shows that improved outcomes, in this case treatment outcomes, inform decisions of DG ECHO. However, the prevention of transmission by the use of ITNs is still not accepted as standard practice, especially not during emergencies, which is mainly related to strict EU rules and regulations on the insecticide used for impregnation of bednets. Box 5 below sketches 'the case of ACT' as another example of a topic in the health domain for which alertness on new developments is of the essence.

[30] DG ECHO. 2005. Malaria key points for ECHO desks and TAs. Grey paper, version 12/09/2005.

Box 5: Best practice for cost-effective operations: the case of ACT

A significant number of countries where DG ECHO funds humanitarian health interventions have a high malaria burden: between 30% and 40% of curative consultations relate to malaria episodes. The increasing levels of resistance of the malaria parasite against Chloroquine have necessitated malaria endemic countries to adjust their treatment protocols. Based on recommendations of the WHO, ACT was introduced as first line treatment for malaria, replacing Chloroquine. The new malaria treatment protocol combines two anti-malarials to prevent rapid resistance development with artemisinin as the main ingredient.

Because of the dramatic increase in costs many countries are supported by Global Health Initiatives such as the Global Fund for the Fight against Aids, TB and Malaria (GFATM) and Roll Back Malaria (RBM). A number of countries in crisis did not have the financial or technical capacity to adopt a new treatment protocol, despite the need to do so. However, partner organisations of DG ECHO requested funds to provide the new treatment protocol in these situations, in defiance of existing national protocols.

The RME of West Africa was charged by the DG ECHO technical working group on health, Anopheles, to develop guidelines / recommendations on malaria treatment. The grey papers "Malaria: Experience, practice and lessons learned in ECHO-funded medical projects in West Africa" (not dated) and "Malaria key points for ECHO desks and TAs – version 12/09/2005" provide recommendations, which are now applied in malaria endemic countries, despite the increase in costs. The papers are written in a hands-on style and provide clear instructions how to act on the issue of ACT in different contexts.

However, in a number of countries, among others the DRC, ACTs were not available in a fixed dose combination. During interviews in the DRC, mention was made of continued use of inappropriate treatment regimen (monotherapy), because of the (perceived or real) side effects of one of the two components of ACT (presented in separate tablets), Amodiaquine, despite efforts of WHO to ban the use of monotherapies.

MSF International has recently announced that it will introduce *"…. a new user-friendly and cheaper 2-in-1 tablet of artesunate-amodiaquine against malaria called ASAQ….. The current cost of ACTs is one of the key obstacles to making them more widely available. The new fixed-dose combination ASAQ will cost less than US$ 0.50 for children under five, and less than US$ 1 for adolescents and adults, 40-50% less expensive for adults than the separate tablets."* The introduction of this new product will result in cost reduction and increased treatment efficiency.

In the context of this evaluation this is an example of guidelines that supports field operations and of the requirement to remain abreast of new developments in the health domain.

92. In conclusion, on efficiency:

- DG ECHO's strengths are (i) the change from controlling inputs to a result-oriented approach in line with the changes in humanitarian relief mechanisms that focus on effectiveness and accountability; (ii) the willingness to accept higher costs for inputs, such as anti-malarials, when adequate evidence is provided that show better outcomes, and possibly impact.

In contrast,

- The indicator sets used to measure performance and outputs against inputs are too extensive and do not fully appreciate the difficulties in collecting reliable data, the inconsistent use of standard definitions, the attribution problems, and the required capacity to interpret provided data sets; (ii) there is evidence that the use of unit costs is inconsistent and that significant

differences do not necessarily trigger a response that would lead to at least addressing unjustified disparities; (iii) the heavy, complex and bureaucratic procedures of DG ECHO can cause delays in the start and / or continuation of projects, despite the high number of staff at DG ECHO offices; (iv) there is further evidence that partners are micro-managed rather than monitored, which is possibly linked to the lack of a limited number of useful indicators and benchmarks that can be used by field staff to determine efficiency as such and efficiency in relation to impact.

- Within the context of 'optimal' efficiency, DG ECHO's 'no' to funding of anti-retroviral treatment (ART) for people living with AIDS against the 'yes' to psycho-social care is inconsistent: ART is life saving or at least life-prolonging; both interventions improve the quality of life; both are costly and require follow up support through a national system after the crisis abates. (This report will address HIV/AIDS in section 2.5.)

### 2.5 Sustainability – current day emergencies in protracted time frames

Although this section is called 'sustainability', in conformity with the evaluation's ToR, it should be read with ALNAP's definition of 'connectedness' in mind. Connectedness then is a specific lens for sustainability as it "refers to the need to ensure that activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account. Connectedness has been adapted from the concept of sustainability – *"the idea that interventions should support longer-term goals, and eventually be managed without donor input"* (ALNAP, 2006). Use of this filter enables to address in this section not only LRRD, but also issues such as forgotten crises, disaster preparedness and HIV/AIDS – topics that are not normally associated with sustainability.

93. LRRD was the topic most often commented on by questionnaire respondents, both partners and DG ECHO field staff:

- "*ECHO is getting rapidly in difficulty in complex emergencies, where a repetitive program leads inevitably to enter into the secondary level – sometimes third level in particular cases, such as surgery for rape victims in DRC.*"
- "*While it is normal, regarding ECHO's mandate, that its financial support quickly decreases and stops when the countries start to recover from a crisis, the transition is sometimes very quick and not enough is being done to help implementing partners in the reorientation of their programmes*."
- "*The gap between ECHO and EC needs to be addressed. Otherwise some ECHO funded interventions and resources may loose value due to the transitional gap*."

Desk Officers likewise commented:

- "*ECHO sometimes is replacing absent multi-year (development) donors that would be more appropriate to ensure sustainability, as health often is a long-term issue. That is true for many sectors of intervention of ECHO, but is probably even more true in the health sector*."
- *"LRRD is essential in the health sector and therefore requires much more political and operational follow-up with development counterparts to be successful."*

94. The above is of course no surprise to those familiar with humanitarian debates. Donor agencies interviewed by the evaluation team indicated that they have not yet found satisfactory answers to the transition issue. This is supported by comments in evaluations of humanitarian health operations funded by other donor agencies. One example, on Liberia:

"*The result of these developments in the transition period for the health sector has been two-fold. On the one hand, humanitarian agencies managed to gradually reach more people, meeting immediate humanitarian needs and starting rehabilitation of quite a number of health facilities, in particular in areas of foreseen return of IDPs and refugees. On the other hand, one sees an almost complete absence of a coordinated effort to start addressing the short and medium term rehabilitation and reconstruction of the health sector. There has been little attention paid to health sector policy and implementation strategy and the underlying problem of health financing. This policy void is not only detrimental to the health sector, but also causes difficulties for current and potential stakeholders in the health sector, in terms of developing plans or formulating appropriate exit strategies*." (Interagency Health Evaluation[31] Liberia, 2005; on ALNAP website)

95. In addition to inherent DG ECHO constraints discussed in section 2.2, notably the short time horizon of humanitarian funding, other 'fixed' obstacles also play out and hamper structural LRRD solutions. One such obstacle is the dramatic drop in the accepted level of per capita expenditure that is inherent in the transition from a humanitarian modality to a development modality. In the DRC this meant that DG ECHO partners wishing to continue under regular EU funding had to accept a unit cost that was 25% of what they were used to under DG ECHO funding. This at best resulted in protracted negotiations and at worst in withdrawal of the NGO (personal communication).
96. The evaluation team witnessed a variant of the above, also in the DRC, where the NGO partner was clearly grappling with the transition of health zones to less generous USAID funding, which resulted in a decimation of the budget for medicines, and thus increased user fees with predictable implications for utilisation of services.
97. The evidence then is that LRRD is not something that DG ECHO does not consider, or only considers at the very end, when suddenly there is a gap that appears unbridgeable. For example in the DRC there was consistent and intense effort on both the side of the EC Delegation, and of DG ECHO, to secure continuity between the two modalities, and thus to extend DG ECHO contracts until such time that all hurdles were cleared, without a gap in service provision, as in Ituri and Tanganyika.
98. A sizable part of DG ECHO's work indeed takes place in countries where the willingness and/or competence of Ministries of Health has been eroded after many years of conflict, or where there never was a strong tradition of health care management by government.

"*The war caused enormous attrition of trained health staff of all cadres; a stark example is the reduction of doctors from a pre-war level of 237 to less than 20 now. Of staff that remain, the majority is not on the government payroll, being so-called 'volunteers'. Those that are on the payroll receive irregular payment of extremely low salaries, if they receive anything at all. The payroll also contains many 'ghost' workers, listing staff that have long left the service.*"[31]

In these cases, phrases such as transition, LRRD and exit strategy appear euphemisms for what happens in practice, which is that humanitarian organisations leave and with their departure leave another void that no one is prepared to fill. As a medical doctor remarked in the DRC, "*In this country we cannot speak of gap-filling of the health care system. The entire system is a gap*."

[31] http://apps.odi.org.uk/erd/download.aspx?rep=summary&ID=3392). The inter-agency health evaluation (IHE) initiative aims to stimulate evaluations across the health sector in humanitarian crises and the period afterwards.

99. The real problem is that in countries such as the DRC the health system will need rehabilitation that is beyond the scope of the development budgets usually granted. As respondents emphasized (also see above): *"At the very least this post acute emergency transition involves (i) health systems analysis, (ii) health sector financing and (iii) capacity building for human resources."*
100. Some partner organisations interviewed argued, firstly, that the 'gap' between withdrawal of humanitarian aid and start of development on average takes at least three years, and secondly, that the gap in itself warrants specific programming, with dedicated transition funds.
101. As was related in the section on coverage respondents singled out DG ECHO for being the one donor that is prepared to provide support in forgotten crises, which often are the aftermath of complex crises. The main instrument that DG ECHO uses to identify priority needs and in particular forgotten crises has recently been updated, from a global needs assessment (GNA), to a tool that combines vulnerability (VI, for vulnerability index) and the state of crisis (CI for crisis index). The combination of indexes is said to give a more accurate picture of need than was the case with the GNA, which is also apparent from the fact that countries that score high on both VI and CI are indeed prominent in DG ECHO's latest Strategic Plans.
102. The mission reports and end-of-posting reports of DG ECHO health experts suggest that there are in practice also other ways of looking at 'crises' – be they acute, protracted, complex, or forgotten – which is an assessment, with the eyes of an expert, of the potential for preventive or reparative action, at reasonable cost. 'Opportunity', in other words, is in reality always part of the assessment, in addition to assessment of crisis and vulnerability. (The reverse is also true, but less transparent, at least for outsiders: perceived lack of opportunity will make donors refrain. In the words of Willitts-King, quoted earlier, "*There may be a judgement at a wider strategic level that access and security concerns make funding a particular crisis a poor investment.*[23])
103. Experts may identify new or unusual opportunities in dealing with old problems, and may even succeed in making others see the same. Box 6 below on malnutrition in the Sahel sketches such an opportunity in its infancy: of disaster preparedness that may go as far as prevention[32], provided partners succeed in identifying and implementing those interventions that most effectively reduce vulnerability in the given circumstances.

> Box 6: Reducing vulnerability; the case of malnutrition in the Sahel
>
> Early in 2007 a Decision was taken that was out of the ordinary, for DG ECHO, as its aim is disaster preparedness and risk reduction (DP/DRR) in the health domain.[33] This preparedness goes even further than the preparedness for Epidemics (Box 2) since the argument is that it makes sense to address malnutrition at its roots and so prevent children from slipping into severe malnutrition, before it is too late. The Sahel Decision amounts to € 15M and is implemented in five countries (Burkina Faso, Chad, Mali, Mauritania and Niger), for a period of 20 months (this 'long' funding duration is also a novelty). Several Food Aid Decisions, also in the Sahel, are designed to be complementary.

[32] In medicine, prevention is any activity that reduces the burden of mortality or morbidity. This takes place at primary, secondary and tertiary prevention levels. http://en.wikipedia.org/wiki/Prevention_(medical)
[33] http://www.ec.europa.eu/echo/pdf_files/decisions/2007/gp_sahel_en.pdf

For this to be accepted as an idea worth trying, both at the level of government decision makers, and with fellow donor agencies, the RSO Dakar has had to adapt its working routine, and re-allocate tasks among its entire staff, including the Head of Office. The main task may be described as advocacy against fatalism: malnutrition should be avoidable, even in the Sahel (personal communication). A major help was the fact that one country (Niger) had tangible lessons to share from its 2005 nutritional crisis and was prepared to follow through at the highest political levels. One such lesson put in practice was providing free access to basic health care for children under 5 years and lactating and pregnant women, as the cost-effectiveness of this was convincingly demonstrated by DG ECHO partners in Niger.

At the level of DG ECHO a contributing factor was the ex-ante evaluation[34] that gave a coherent discourse on the cumulative effects of a range of 'stressors' - food insecurity, droughts, locusts, epidemics, poor feeding habits, lack of appropriate health services, lack of hygiene and access to clean water, to which may be added illiteracy and the position of women.[35]

The timing, momentum and cooperation with EC Delegations and the Commission Services at HQs was such that eventually all draft 10th EDF Country Strategic Papers (CSPs) articulated their LRRD approach to include measures to improve food and nutritional security, either as a sector of concentration or as a strategic objective. The resulting operational strategy proposed for the Sahel is based on three pillars: (i) preparedness/data analysis, (ii) response and (iii) advocacy.

UNICEF was a partner from the very beginning and has been a driving force all along. This is helpful not least because this is new terrain, with many unknowns, for which nutritional and monitoring competence is required. DG ECHO partner NGOs are also put to the test, as they have been asked to come up with creative proposals, geared to Government actors, preferably in alliances and across different countries, with a longer than usual time perspective.[36]

For DG ECHO the Decision and all that it entails represents a novelty, in terms of RSO staff taking a catalyst role on such a significant issue; working side by side with EC Delegations and multi-lateral agencies; on a regional scale; and demanding innovative approaches. This may be seen as 'visibility' in the truest sense, even if most of the work has been back-stage.

104. Respondents, including desk staff, indeed emphasised the importance of early warning and disaster preparedness in the health sector. Specific reference was made to increased capacity to fight recurrent epidemics, as exemplified in Box 2 in section 2.2, for West Africa. Although there is no explicit sectoral application as yet of DP/DRR principles it appears that the health sector in fact lends itself to such a translation, and that a successful translation would benefit DG ECHO's image as a reference donor. Forgotten crises would then get a thematic and more positive connotation, of crises that deserve to be in the limelight, because something can be done about them in a way that is more than gap filling.
105. If this were to happen – with both the Sahel Decision on malnutrition and the Epidemic Decisions in West Africa as pilot cases - staff used to work with results based monitoring will need to accept a different type of evidence: of likely cases prevented, rather than of affirmed cases treated. In addition the knee-jerk reaction which the 2004 DRC evaluation alluded to will need to be resisted:

[34] http://www.ec.europa.eu/echo/pdf_files/evaluation/2007/west_africa_sahel.pdf
[35] It is noteworthy that in 2002 the evaluators of ECHO's Reaction to Serious Drought Situations wrote, "..The weakness in the African integrated approach as response to drought has been the little attention given to the health, sanitation and hygiene projects. .. The chronic and remaining high global acute malnutrition rate in this region could be due to inappropriate management of health, sanitation and hygiene issues." (Drought evaluation, Global Report, 2002)
[36] http://ec.europa.eu/echo/pdf_files/calls/call_sahel_fr.pdf

"*When indicators improve, an immediate caveat is indicated: indicators have improved because of humanitarian aid; it is a fallacy to conclude that humanitarian aid can then be dispensed of.*"

106. HIV/AIDS has been the centre-piece of intense debates within DG ECHO. Respondents to the questionnaire likewise singled it out as a concern on which clarity is urgently required. In the words of one partner, "*DG ECHO's policies on HIV Voluntary Counselling and Testing and anti-retroviral provision have been overly restrictive. The policies are also unclear – we have yet to see an actual policy statement and have only been referred to a consultancy report that purports to be DG ECHO's policy on the matter*." Box 7 below sketches, in a very minimal way, some of the intricacies.

Box 7: Doing no harm; the example of HIV/AIDS

In the course of 2003 DG ECHO health experts produced HIV/AIDS guidelines for internal use at the request of management. In 2004 a team of external reviewers, in cooperation with the health experts, followed through and produced a Concept Note[37] and Model Guidelines[38]. The Guidelines gave a detailed description of three priority areas, the first priority being, *"to prevent HIV contamination by negligence through ECHO funded programmes"*; this included, as just one element, *"Training of ECHO staff (HQ and field) on essential managerial elements of HIV/AIDS prevention and care programmes."* Both documents were published on the DG ECHO website.

In 2006, DG ECHO management was presented with a follow-up HIV/AIDS guidance/instruction note by one of the RMEs, in which he noted: *"Over two years have passed since ECHO launched its HIV/AIDS concept paper and guidelines. Few ECHO staff and partners have yet familiarized themselves with its contents."*

Even so it appears that at least some of the recommendations in the Guidelines are being followed up. Examples are:

- Blood security measures preventing HIV infection through blood transfusion, which is a matter of course as shown in analysed master document records[39]
- HIV/AIDS testing and Post Exposure Prophylaxis for victims of gender based violence, as for example in projects in South Kivu, the DRC.
- Food distribution to vulnerable groups during the lean season and targeted feeding programmes for children, HIV/AIDS affected and IDPs, in Zimbabwe.[40]

The evaluation team notes that the last example, of food distribution, represents a hidden policy shift, tucked away as it is in the 2007 135M Food Aid Decision, without this being mentioned in the separate Zimbabwe Global Plan.

Noteworthy is that actions that appear to be both feasible and top priorities have not yet been implemented. A good example is that of HIV/AIDS workplace policies for partners (internal mainstreaming). A staff member of a partner organisation interviewed in Kenya expressed surprise that internal and external HIV/AIDS mainstreaming was not demanded by DG ECHO. She narrated how some nurses in the project team were blatantly reluctant to touch malnourished children suspected to be HIV infected, for (mistaken) fear of getting infected themselves.

[37] http://www.ec.europa.eu/echo/pdf_files/evaluation/2005/HIV_conceptpaper.doc
[38] http://www.ec.europa.eu/echo/pdf_files/evaluation/2005/HIV_modelguidelines.doc
[39] There are, however, exceptions. As one RME noted in his end-of-posting report, *"... the standard minimum package is far from being accomplished and we even detected harmful practices such as syringe re-use during monitoring visits."*
[40] http://www.ec.europa.eu/echo/pdf_files/decisions/2007/food_aid_en.pdf

107. With the concept of 'connectedness' (see above) in mind it is clear that funding comprehensive HIV/AIDS services, particularly ART, poses a problem in terms of creating dependency on aid, which a humanitarian donor is understandably uncomfortable about. However, DG ECHO has also been reluctant to fund HIV/AIDS services that do not have long-term repercussions, such as VCT and Prevention of Mother to Child Transmission (PMTCT). Although separate elements are funded at times, silently and without a structured effort to learn from the experience, the judgement must be that the HIV/AIDS Concept Note and Guidelines have not been the starting point for concerted action at management level.
108. In the perception of the evaluation team there is in DG ECHO a reluctance to address HIV/AIDS for fear of doing harm rather than providing relief. This is particularly so for the issue of antiretroviral treatment. The step from guidelines to actual implementation generally appears too large as it takes knowledge of (changes in) local situations in order to avoid harm. Yet DG ECHO, given its field competence of both field and sectoral experts, is in a far better position than other donor agencies to advise local adaptations to standard guidelines. This may or may not include ART, which is the issue that gives most anxiety. The Guidelines are in fact quite clear on this: ART is only to be considered in exceptional circumstances – notably as gap-filling for specific groups of beneficiaries already on ART, whose treatment got interrupted. Here harm is avoided by safeguarding ART continuation.
109. A similar conclusion, however, on lack of concerted action, was drawn in section 2.4 on the unit cost approach, even though in this example there is no fear of doing harm. As discussed in Box 3 in section 2.3 it appears unlikely as well that the externally commissioned review of Quality Assurance for medicines and medical supplies will be followed through in its entirety. This has yet other reasons, but if so, will then be another example of a well-intended effort that does not come to full fruition.
110. In conclusion, on DG ECHO's efforts towards sustainability, here specified as 'connectedness', the evaluation team cannot pass judgements in terms of strengths and weaknesses. It can conclude, however, that major efforts have been made, but that not all efforts have been chosen and pursued in ways that had a chance to succeed at a systemic level.
    - DG ECHO has tried to address LRRD at the project level, by protracting its funding in order to avoid a service gap; there are some case by case successes but these have been very labour-intensive.
    - The evidence is, as also has been suggested by respondents, that LRRD warrants specific programming with dedicated transition funds.
    - There is an urgent need to provide clarity, in the form of a DG ECHO position paper, on HIV/AIDS service delivery, especially on ART provision.
    - In efforts to position itself as a pro-active learning organisation DG ECHO has largely banked on the production of guidelines. Authors of guidelines, including DG ECHO's own experts, have been adamant that guidelines were 'living documents' and required to be used in order to retain their relevance. Endorsement of guidelines has, however, not happened, for a variety

of reasons. One obstacle has been the 'one-for-all' character of guidelines; another one the legal implications.

- Although it is early days it appears that a different modality, as sketched in this report in boxes on epidemic preparedness and malnutrition, stands a better chance of continuity, where DG ECHO has cooperated with institutional partners right from the start and has sought complementarity in the partners' strengths. This applies in particular to DG ECHO's most natural partners, other Services of the Commission, which in the Sahel malnutrition example appear to have taken full (co) ownership. It is noteworthy that the above has proceeded without any guidelines, although guidelines may well result, from practical experience and from cooperation with knowledgeable partners such as UNICEF.

### 2.6 Coherence, Complementarity and Coordination: the 3Cs

Following on text in this report's introductory sections, on the changing contexts in which DG ECHO operates, this section aims to pose findings reported earlier in this chapter in that dynamic context. The evaluators will argue, firstly, that DG ECHO has been hesitant to play out its role of a reference donor to the full, and secondly, that the health sector offers particular scope to exploit this role, given DG ECHO's particular strengths in comparison to other donors.

111. Several DG ECHO evaluation reports relating to the health sector remark that implementing NGO partners do not coordinate between themselves, even if they work in the same geographical areas (also noted by the evaluation team during its field visits):

> *"Although all ECHO partners are confronted, in their respective sectors, with a similar range of problems, they appear to work in relative isolation from each other. All partners taken together have probably found appropriate solutions for all relevant problems within their control, but individual lessons learned are hardly put to use beyond a specific situation and partner. ECHO's technical assistants do make considerable efforts to streamline approaches, but the mechanisms for joint learning and programming need to be strengthened."* [41]

112. One major new development is that of the cluster approach, implemented through the Inter-Agency Standing Committee (IASC) of the UN system and introduced in 2005, shortly after the TYP of the HAC had started (refer to section 2.2). Like the HAC the cluster approach aims for system-wide preparedness and technical capacity to respond to humanitarian emergencies. The focus of the cluster approach, however, is on coordination of efforts and on predictable leadership, in all the main (9) sectors of humanitarian response. What is new is the leadership concept and the formal operational accountability that the lead agencies must assume. Lead agencies are *"accountable for ensuring, to the extent possible, the establishment of adequate coordination mechanisms… as well as adequate strategic planning and operational response."*

113. The cluster approach has brought major changes in humanitarian operations at country level, especially because of the simultaneous introduction of new humanitarian funding modalities that are directed and channelled through the cluster system. Even though DG ECHO does not contribute to these funds it needs to adjust its operations to be complementary and it likewise

[41] DRC evaluation, 2004; on "Joint learning and programming, defining best practices and harmonising approaches"

needs to participate in coordination meetings striving for coherence of the total of donor funded operations. The 2007 DRC Global Plan Decision mentions, for example:

*"In this context, donors including DG ECHO, meet to discuss funding issues such as the Pooled Fund and the CERF and to maintain a perspective of where humanitarian strategy fits into the wider DRC picture. ... In a more general sense the imperative to match needs and responses is what donors expect from the cluster concept. DG ECHO and its partners have a broad outline of the overall needs... but the final mix of ingredients... will be an on-going process that must be defined close to the ground and that takes into consideration priorities, capacities, community participation and, increasingly, government policies."*

114. The literature on clusters – and a lot has recently been written about them – is with few exceptions positive on the concept. (NGO partners qualified their position: they do not oppose the concept, but expressed doubts that independent and untainted leadership can be had from the UN.) As Oxfam writes in its recent Policy Compendium Note on Humanitarian Coordination: [42]

*"The cluster approach suffered in its inception, failing to engage in an inclusive dialogue with NGOs; focusing on the role of UN agencies; lacking clarity on terminology and intent; and failing to make links to field experience and understanding. Although the initial process was flawed, the intent and substance of the approach is sound. The aim in the future is to develop cooperative coordination mechanisms around key sectors and cross cutting themes, recognizing the interdependency of agencies, and managing leadership and responsibility."*

115. It is fair to state that 'coordination' is widely recognised as a necessary ingredient of successful delivery of humanitarian aid, at all levels, and yet that it is hard to programme for, particularly when there are real or perceived conflicts of interest. As argued by Oxfam:[42]

*"Emergencies can be characterized by competition, not collaboration, as agencies vie for scarce donor (public and government) resources. A range of actors, including local and international military forces and business, driven by different motivations to those of humanitarian organisations, are now seeking to engage in the provision of assistance in emergencies. Donors often hinder coordination, emphasizing different, and sometimes contradictory, approaches to humanitarian response. Existing coordination mechanisms often ignore, or contradict the wishes of, beneficiaries, local communities and government response agencies and groups."*

116. As related in section 2.2 WHO became the lead agency of the health cluster. The list of cluster leads' responsibilities is long and includes, at country level[43]: the establishment and maintenance of appropriate humanitarian coordination mechanisms; coordination with national/local authorities, State institutions, local civil society and other relevant actors; needs assessment and analysis; emergency preparedness; planning and strategy development; and provision of assistance or services as a last resort.
117. Remarkably, the above responsibilities are the same regardless of the type of crisis even though the cluster approach is primarily a mechanism to 'super-resource' surge capacity to lead coordination groups, in rapid onset emergencies. The current evaluation of the health cluster may be able to discern a pattern, why clusters are more effective in some crises than in others. The preliminary evidence, albeit casuistic, is that in acute crises actors do coordinate, provided there

[42] http://www.oxfam.org/en/files/oi_hum_policy_coordination.pdf
[43] http://ocha.unog.ch/humanitarianreform/

is leadership. In the Pakistan earthquake this led to what was later recognised to have been a cluster approach (personal communication). Another example of this is coordination role the WHO Lebanon Office assumed in July 2006 despite the fact that WHO staff members had not heard of the cluster approach before these events.

118. In other situations clusters have not worked satisfactorily. The WHO response to recent meningitis outbreaks in Burkina Faso, for example, has been disappointingly slow, despite available (DG ECHO) funding. Health cluster meetings in other West African countries are likewise said to suffer from lack of WHO leadership (mission reports and personal communications).
119. A notable achievement of the cluster approach has been that the distribution of resources between sectors has reputedly become more equitable, and that the health sector has benefited from this (personal communications). The evaluation team has, however, seen no evidence in countries visited, particularly the DRC, that the cluster approach has brought with it a different way of designing and implementing projects, other than avoiding overlap – the risk of which was low in the DRC given the multitude of needs. The apparent aim certainly has been to achieve better coverage at acceptable quality, but the main mechanism has been to seek increased funding, for a larger number of projects. The projects in themselves were, however, no different in terms of, for example, an agreed and systematic LRRD approach. A key indicator of success of the cluster approach was likewise reported in terms of (additional) resources that were generated.
120. Interviewed donor agencies confirmed their principled stand on the UN as the main coordinator of humanitarian aid. Both DfID, the Netherlands Ministry of Foreign Affairs (MFA) - (DGIS) and the SIDA are channelling approximately 75% of their humanitarian aid budget through multi-lateral agencies. The above donors said they were understaffed and using the multilateral channel was also an expedient way of spending money. In order to accommodate the cluster approach DfID has had to make some amendments in its strategic partnerships with UN agencies, including that with WHO, for the HAC programme. SIDA and MFA (DGIS) acknowledged that funding channels such as CERF shifted transaction costs down the line, and were committed to cushion this effect by making timely money transfers. However, late and especially unpredictable arrival of CERF and PF funds has been a major obstacle for implementation of Health Action Plans, as witnessed in the DRC, and has had the effect of undermining the spirit of the joint formulation of plans.
121. The three donors have specific NGO funding channels, albeit in relatively low proportions of their budgets. One donor (MFA/DGIS) has streamlined its procedures in a deliberate attempt to cut down on transaction costs, not only for itself but also for the NGOs. An example is the instruction to only report deviations – either positive or negative – from the expected results of a project.
122. The three donors interviewed themselves had very little or no health expertise in their humanitarian departments and yet did hardly regard this as a constraint: they all had ways to access in-house expertise when needed, and "*only needed to make a couple of phone calls*" for advice. The Head of the Dutch Humanitarian Department clearly saw a lean team of generalists as an advantage. The donors all relied heavily on Embassy staff, including humanitarian advisers.

123. A comparison between DG ECHO and other funding agencies in terms of internal coordination and efficiency of the apparatus seems not entirely fair, in view of the difference in funding modality. If DG ECHO were to increase its UN funding, and decrease the share of the NGO channel, however, one could argue that this would lessen the administrative burden and would also make DG ECHO less different from other donors.

124. In this respect Oxfam, in its 2007 review[44] of CERF funding, expressed that,

> *"In order to take full advantage of ECHO's unique experience and ways of working, Oxfam believes that ECHO's independent funding for emergencies should be upheld and that ECHO should not be pressed to contribute to the CERF under the present circumstances. However, in-country co-ordination between the CERF and ECHO is necessary and will have to improve to prevent duplication and the funding of multiple short-term micro projects."*

125. The evaluation team notes that 'sectoral translation' of coordination has not been a prominent part of the cluster approach: thematic issues and opportunities such as highlighted in this report – on CTC; on ACT; on preparedness and prevention of chronic malnutrition; on epidemic preparedness and other ground-breaking developments – have not been driving forces of cluster activities. (A yet to be published study by the Health Cluster sub-working group on 'identification of gaps' may shed light on this issue.)

126. Yet it appears that the above sectoral or thematic translation is a potential strength of DG ECHO, and particularly so where it has something that other humanitarian donors lack: expertise at both country and regional level, which expertise is exclusively dedicated to humanitarian aid.

127. Opinions on utilisation of this expertise for coherence of health programmes differ, however. One field staff response to this question in the health evaluation[45] summed up what many said:

- *"The setting of RSOs has introduced a new modus operandi in ECHO not yet well absorbed by the institution at all levels as it was intended for different reasons.*
- *The "routine" approach of Sector Experts is slowly taking place but is not yet in place. Different degree of involvement depending on personal/professional relations SE/TA/DO/HoU.*
- *"Routine" approach to "projects" (project management cycle) is NOT sufficient. RSO sector experts, (health included) need to get involved at three levels:*
  - *a) Country/operation strategy development*
  - *b) Financial decision conceptualisation*
  - *c) Project management*
- *Not to mention contribution to technical/policy papers*

*The involvement of sector experts at level c) when the operation strategy is absent / weak / inconsistent lead to the "project approach" which largely undermine the potentialities of the RSO's sector experts and often result in weak sector approach. Similarly, if RSO's sector expert is not involved in the conceptualisation of the financial decision, very often we have projects not well conceptualized and at this point the SE can do very little."*

[44] The UN Central Emergency Response Fund one year on, Oxfam Briefing Paper 100, March 2007

[45] "In what ways have you/your projects benefited from technical advice of Regional Support Offices and/or the Sector Support Team? Do you routinely pass your projects through the above offices or only for specific reasons (which ones)?"

128. Many respondents identified a lack of internal coherence of DG ECHO operations. It appears that such coherence cannot easily be forced by guidelines alone. As noted by one RME:

> *"The group of health and nutrition "Anopheles" came together to exchange views in order to create coherence and consistency in ECHO's actions worldwide. It does not intend to obtain "la pensée unique", a universal response, but to understand if ECHO does things differently in two locations and why this is so. Coherence and strength of ECHO's image to partners stems from the capacity to explain our behaviour and how this behaviour changes in different contexts. .. Policy is not about what is technically possible or technically desirable. .. It is about choosing what should be done in particular cases based on what is technically possible and desirable."*

129. The evidence is that DG ECHO coherence between programmes demands more interaction, and faster learning than currently is the case, particularly where the Anopheles network (refer to section 2.3) has grounded to a virtual halt. "*Lack of institutional memory c.q. reliance on individuals' memory*" was quoted as a weakness by both field staff and desks, together with "*lack of analysis of past interventions."*
130. DG ECHO is bound by its position as a DG in the European Commission. As discussed in section 2.3, the obstacles to official endorsement of guidelines produced by Anopheles members were largely of a legal and institutional nature. Other constraints have come from DG ECHO's own administrative rules and regulations – the main example being DG ECHO's limitation to fund longer contracts, on which many evaluations, including the 2006 DG ECHO evaluation, have commented.
131. There are some good examples of complementarity of DG ECHO and other Services of the Commission, i.e. joint efforts resulting in funding of activities that could not be implemented with DG ECHO funding due to the 12 months' limit. The AUP funding of training activities for medical staff in the Thai-Burmese Border camps and the use of the B-envelop of the 9$^{th}$ EDF in the DRC are cases in point, of complementarity of DG ECHO and other EC Services.
132. It is to be expected that a new initiative on LRRD will need to tackle the above in a more systematic way if DG ECHO is to live up to the promise made in June 2007 by Louis Michel, European Commissioner for Development and Humanitarian Aid:

> *"The Communication the Commission is putting forward will pave the way for the adoption of a Joint Declaration on an EU consensus on humanitarian aid by the three European Institutions namely the Council, the Parliament and the Commission. This Declaration will set out the values, guiding principles and policy scope of EU humanitarian aid. A European consensus is important because it will strengthen our capacity to help people suffering in crisis zones across the globe. I am committed to make it happen*."

133. A study underpinning the above was initiated by DG ECHO's Policy Unit, resulting in a Working Document entitled, "Towards a European Consensus on Humanitarian Aid"[12] with broad agreement of respondents on several topics. Of particular relevance for this evaluation is the consensus of Member States (82%) and partners (99%), that the EU should develop policy guidelines regarding LRRD that recognise the need for a flexible transitional approach.
134. LRRD then appears a priority topic on which a joint EU position would be both feasible and appropriate. Returning to the example sketched in Box 6 in section 2.5 on malnutrition, there are in fact recent precedents of 'joint positions' on health-related issues in what is often called the

grey zone between the humanitarian and the development domain. To quote a June 2007 Press Release:

> *"The European Commission gives particular attention to improving the linkage between relief and development assistance to boost the long-term sustainability of humanitarian aid and to mainstream humanitarian concerns into development aid planning. ECHO therefore coordinates closely with the Commission services responsible for development policies and programmes, notably in the context of the 10th European Development Fund (EDF). All the relevant 10th EDF country strategy papers now include measures to respond to nutritional insecurity in the Sahel."*

135. Respondents to the evaluation's questionnaire had strong reservations on the role DG ECHO plays especially in international fora. The responses sketched both the large potential and the perceived underutilisation of this potential, given the strong field presence of DG ECHO. This was also often highlighted in interviews with donors and partner organisations. As one donor remarked, *"You never see them (DG ECHO) in international fora and when they are there they are mostly silent."* The following box contains a selection of quotes of respondents that qualify their perception of DG ECHO's strengths and weaknesses in relation to the three Cs.

A selection of quotes from responses of field staff, partners and desks, on DG ECHO strengths and weaknesses with regards to the three Cs:

- *"Wide partnerships and influence with International NGOs and UN agencies is DG ECHO's strength"*
- *"Working at the same time with 'implementing partners (mainly NGOs) and 'policy makers/implementing partners' (International and/or specialized Agencies) increases the potential for donor effectiveness."*
- *"With the grass root experience in the field and the information gathered through a wide network of field people, ECHO could certainly contribute to international policy discussions from a technical point of view."*

- *"(A weakness is) lack of global vision of the health sector of a country, including poor coordination with other humanitarian and development actors".*
- *"ECHO should be in the forums where humanitarian policies and guidelines are drafted".*
- *"ECHO is not or poorly involved in coordination with other donors and institutions during transition periods."*
- *"DG ECHO should take a more long term strategic approach to health policy planning, taking into consideration areas where the EU has comparative advantage."*
- *"As a member of the IASC Health Cluster at global level, and our recent experience from the Pakistan earthquake response, we believe that DG ECHO could do more to strengthen its engagement in the cluster approach. The EU should be involved in all key clusters such as Health and Early Recovery, at country and global level, providing technical and financial support."*
- *"ECHO technical advisors are not particularly prominent and at Brussels level it has often been difficult to identify a health person to talk to."*
- *"ECHO is not fulfilling its potential full role as a donor of reference in the health sector. The scale of ECHO's humanitarian aid, its permanency, long track record and the wide numbers of partners call for a more proactive approach to assist policy development and action in the health sector."*

136. In conclusion, DG ECHO's apparent strengths and weaknesses in Coherence, Complementarity and Coordination, are,

- DG ECHO has a strong presence at the field level where other donors are largely absent, but, vice versa, it is virtually absent at the level of international coordination fora.

- DG ECHO does not capitalize on its authority in terms of volume of funds and technical abilities and does not make sufficient strategic use of its own expertise towards other donors and agencies.
- The cluster approach has brought about changes which DG ECHO is in a position to take into its stride and complement, at country level and below, in its position as a donor.
- DG ECHO's international presence and involvement in donor coordination, including global health cluster meetings, should increase.

### 2.7 Making a difference

The preceding sections have followed the OECD DAC criteria for presentation and analysis of findings. This section aims to highlight some recurrent themes that have surfaced, particularly findings corroborated by different sources or findings contradicted by few if any sources. In doing so the evaluators aim to also cover a remaining item in their Terms of Reference, which is, 'to analyse all stages of the decision making process applied by DG ECHO in deciding upon which partners and which medical activities to fund.' The analysis of the completed questionnaires supports the text in this section but is for the sake of brevity presented in Annex 2 (Synopsis of questionnaire responses).

137. The stages of decision making may in general terms be distinguished as follows:
    1. framework setting (guidelines and funding policies and priorities; criteria setting for eligible partners)
    2. targeting (including coordination / clustering with other donors)
    3. decisions on proposals, on Global Plans
    4. monitoring and adjustment (on the basis of ongoing contacts and interim reporting)
    5. evaluation
138. In an ideal world the five points listed above are linked circularly, in which, for example, lessons learned in project monitoring and in evaluations would feed into the decisions and frameworks; and this, preferably, across the institution. Going further, one would also wish that this was both a routine within DG ECHO, but also was fed by exposure to and sharing with other institutions, starting with (but not limited to) the other Services of the Commission.
139. While all donors have routines in the above DG ECHO's routines are decidedly different in one particular way, which is determined by its field presence. This may be illustrated in the way decisions are taken on partner proposals (point 3 above - refer to section 2.1) and even more so in the monitoring and adjustment of projects under implementation (point 4 above). Mission reports of RMEs testify how, time and again, hands-on monitoring has served a purpose, of making projects more relevant, more effective and more efficient. The evaluation team's observations during the field visits, as, for example, the Lebanon visit, also support this (Annex 8 of this report). Interviews with other donors made clear that they do not aim for, nor could they achieve this kind of proximity, given their available manpower.
140. There is no denying that DG ECHO is a large institution, compared to the humanitarian departments of other donors (section 2.6 refers). Those humanitarian departments are moreover

embedded in their parent institution, of which they are an integral part and on which they rely for advice and support in the five points listed above. DG ECHO's sheer size makes such natural institutional linkages with other services of the Commission less spontaneous. In addition, however, the internal linkages within DG ECHO itself – between desks; between desks and field staff; between desks and field staff and RSOs – are not a matter of course, unless project portfolios so demand.

141. The evaluation team has noted the thorough analysis in the Global Plans Decisions – for example for the DRC; Lebanon; the Sahel in 2007 – with evidence of joint strategising by actors based in Brussels and in the field. However, the 2007 DG ECHO Operational Strategy, presumably produced in Brussels, does not appear to have benefited from a diversity of horizontal and vertical inputs and as such does no justice to strategies that do, at times, exist. (And, as pointed out in Box 7 the team has noted examples of policy shifts hidden in Decisions, without further explanations.)
142. DG ECHO has to make choices regarding the lessons it finds important enough to draw and share. A problem identified by the evaluators is that DG ECHO is not set up to identify the issues on which there is leeway to improve. Lessons are there, but they float, in different forms and at different levels, as their potential niche of application is ill-defined or goes unrecognised, or is simply not sought. Examples relate both to framework setting (the QA study in Box 3 is a good example), but also to evaluations, which rarely if at all are designed to draw wider lessons that may serve DG ECHO as an institution rather than (only) the projects in a particular country. Even partnership evaluations of DG ECHO[46] have often focused on changes partners should make to comply with ECHO rules rather than on changes DG ECHO itself could make.
143. The Sahel Decision on malnutrition (Box 6) and possibly also Decisions with which the team is less familiar, such as the 2006 Greater Horn of Africa Decision, confirm that there is the possibility of innovation in DG ECHO. In fact, it is said that the very success of the Greater Horn of Africa Decision has made it possible to also entertain a Sahel Decision (personal communication).
144. Relating the above to partners, the evidence is that partners have found it difficult to get the innovations they propose accepted. More precisely: innovations are accepted, eventually, but this can take huge efforts and time, and often depends on relationships with individual field staff.
145. Somewhere along the line signals need to be made and picked up – be it on content issues such as CTC or ACT or epidemics, or on issues such as unit costs. The evidence is that such signals are made, and even quite persistently, but that the mechanisms that distinguish their merits and ways to channel these are lacking.
146. Organisations that are successfully engaged in making lessons work for them have done so by carefully picking the topics, one by one, and taking them through a circular process, roughly defined by the above five steps, without a defined starting point. The starting point of the process then rarely is a polished guideline; rather the idea is to arrive at a guideline that is as good as it

[46] http://www.ec.europa.eu/echo/evaluation/partners_en.htm

needs to be, for the intended users, within certain, given constraints. What such organisations then find is that *"one thing leads to another"*. The efforts of UNHCR's Health Unit are a good example: having started with a first priority for which there was enthusiasm in the field (definition of a basic health care package, in East Africa), they then proceeded to take on more complex topics, strengthened by positive feedback.

147. In summary,

- DG ECHO has a comparative advantage of being a defined institutional entity, with a defined humanitarian mandate, a significant budget and considerable field presence. However, DG ECHO's size and institutional setting make it difficult to exploit this advantage to the full and in particular to identify and act on lessons that are generated both within and outside the institution.
- More specifically there is insufficient routine in what the evaluation team calls 'circularity': the pathways that are designed to allow incremental learning. These pathways are admittedly challenging, as they concern several directions – both horizontal and vertical, and both within and outside the organisation.
- In the opinion of the team it is, however, not necessary to 'make a difference' in each and every thematic area. The issue is rather to know where to start and on what with realistic expectations, and to arrive at new routines that not only are different from the past, but also are significant enough to be appreciated for their (potential) impact.
- Realistic expectations include an appreciation of the niche of application; making a difference thus also entails knowing how to apply guidelines and policies in given circumstances: "*The response needs a technical base but is not only technical. Different answers may be recommended for the same problems."* It is this type of knowledge which RMEs have, but which is under-exploited.
- In the opinion of the evaluators, DG ECHO could make a significant difference by increasing the speed with which such circular learning processes take place. It appears, for example, that there is no mechanism to speed up identification and acceptance of improved practices such as CTC (Box 1) for DG ECHO as a whole.
- Also lacking, and this is a difficulty that is underestimated, is appreciation for the fact that there is a difference between (technical) guidelines and their translation in (funding) policies – what the team has called position papers. Given that DG ECHO is a donor, it is not surprising that guidelines which include or facilitate this translation – the ACT case in section 2.3 is a good example – stand a better chance of being used.

# 3. CONCLUSIONS AND RECOMMENDATIONS

Conclusions below are derived from the findings. They have, however, been adapted and expanded, in response to comments received from DG ECHO staff. The first section (3.1) summarises the identified strengths and weaknesses, opportunities and threats. At the end of subsequent sections recommendations are formulated that start to operationalise the conclusions.

## 3.1 In summary: strengths, weaknesses, opportunities and threats

DG ECHO's strengths are well recognised and include:

- Assistance in a large number of humanitarian crises with a wide range of health sector interventions that correspond to the specific humanitarian needs of crisis affected populations.
- Support to protracted and forgotten crises
- Continued engagement of a large and diverse group of partners with a wide ranging capacity to address humanitarian needs.
- Flexibility, especially related to a quick response capacity and field presence, which in turn allow rapid decision making when acute crises occur and adaptation of strategies based on needs identified in the field.

Weaknesses relate to the under-exploitation of the above strengths and to strengths turning into weaknesses. Taking as an example 'support to protracted and forgotten crises' it is self-evident that these crises are by nature lengthy and out of the limelight. This carries the risk that projects become repetitive and stale, which could be reinforced by the under-exploitation of the pool of partners (50% of the 180 health projects in 2006 were implemented by only 10 of the 68 partners). There also is evidence that DG ECHO, despite its field presence, has insufficiently managed to encourage peer-review between partner NGOs. The notion of comparison – within DG ECHO, but also with other donors – is generally underdeveloped. For example, lessons documented in country evaluations appear to be utilised insufficiently. Related to this is the erratic use of DG ECHO's considerable health expertise. A main weakness and often commented on by respondents to the health evaluation's questionnaire is DG ECHO's funding duration, which is not in keeping with the LRRD-focused principles expressed in the FPA and which also has an opportunity cost in terms of project relevance, effectiveness and efficiency.

Opportunities lie in better utilisation of available resources and in deliberately seeking diversity and innovation, with documentation of best practices and peer reviews between partners. Opportunities are in fact stated in DG ECHO's FPA, which rightly emphasises best practices and the concept of quality in aid based on the particular operating environment. These typically are qualities for which DG ECHO can harness its comparative strengths, notably its presence at country level and its apparent ability to attract competent and motivated staff in the field. The availability of health expertise at regional level (and sometimes even at country level) has all the potential to turn DG ECHO health operations into exemplary programmes. Furthermore, the evaluation team has identified opportunities

that focus on higher efficiency vis-à-vis impact as these would also deal with notorious threats. Representation in important international platforms offers a major opportunity that could result in higher visibility of DG ECHO in line with its own global role and expertise.

Threats are three-fold: Firstly, in seeking one-for-all solutions where these cannot be had (as appears to have been the case for some reviews cum guidelines earlier produced). A second threat lies in internal processes that are unduly protracted and run out of steam as appears to have happened with the attempts to address unit costs. A third threat is the imbalance between administration and content. An example of this is the often long list of project indicators, which are unlikely to reliably measure the impact of projects, especially when projects have a limited funding duration.

Please refer to annex 13 for the SWOT analysis (in table format) which was drafted by the consultants and enriched by members of the Anopheles group in a participatory session on 27th September 2007 in Brussels (refer to annex 10 for proceedings of this meeting). Additional comments were received during the debriefing meeting with DG ECHO's Senior Management Team on 10th October 2007.

### 3.2 Convergence and divergence between DG ECHO operational units

The provision of PHC is the most common activity funded by DG ECHO. The main activities in A/1 are, in addition to the provision of PHC, hospital care and outbreak responses which are often required to cover the most pressing humanitarian needs because of the poorly functioning health systems. In A/3, the most important activities are the provision of PHC and disease control - often targeting IDPs and / or refugees - and psychosocial care. In comparison, psychosocial care projects are the most important activity in A/2. Of all psycho-social / SGBV care activities, 64% are implemented in A/2 and almost 21% in A/3. The identified differences between the three operational units mostly relate to the weakness of health systems in African countries; in A/2 and A/3, national governments are generally able to adequately cover basic health needs.

As narrated in sections 2.1, 2.2 and 2.4 there is considerable divergence between the units in terms of health activities funded. These differences in funded health interventions relate to where the crisis occurs, not to the type of crisis. The most striking similarity is the routine of repeat cycles. As noted in section 2.1 only 22 of the 144 health sector projects (15%) were started as new projects. The large majority of projects funded in 2006 (85%) were repeat projects, many of which had been running for several years. The possibility to use the repeat exercise as an opportunity to improve has been used by some NGOs and not by others. Likewise the input of RSO specialist advice for the same has been erratic, as will be discussed below. There has been an overall increase, however, in the number of Global Plans, which offered opportunities to better strategise. Use of health expertise to do so, has, however, again been erratic.

The evaluation team has no remarks on the actual choices made in the various regions of the programmes funded, or not. (As expressed earlier, the team has had no insight in proposals that were

rejected.) The evidence is that Africa receives by far the largest share of humanitarian aid, also from other donors, and that this share is increasing. This corresponds with the 2006 findings that show that the health needs in A/1 have been overwhelming in comparison to other regions, which explains that, for example, psycho-social support has not been funded to the same extent as it has been in A/2.

### 3.3 DG ECHO and its position in the humanitarian community

There are different ways to sum up the observations made and opinions gathered by the evaluation team on the issue of DG ECHO's position in the humanitarian community. The most consistent comments referred to DG ECHO's size and significance as a major donor and its low profile in comparison to its significant financial contributions. Here we can speak of a disconnect in the sense that vast country experience does not surface in the fora that could utilise such experience. In other words, DG ECHO insufficiently acts like a reference donor and misses an opportunity of visibility that matters.

Because of its relative under-representation in humanitarian platforms, DG ECHO has insufficient recognisance of developments that are presented in such fora. Partner organisations remarked that the presence of donors in health cluster meetings would be highly appreciated and would bring in a different angle, also on thematic issues.

Several respondents, in particular field staff and partners, reported a characteristic which, in the opinion of the evaluation team, is incompatible with the profile of a reference donor: a tendency to emphasise administrative issues, which at times is related to inadequate understanding and knowledge of (health) content issues. There is of course no firm prescription as to how to become a reference donor in the health domain. Key would be a demonstrated ability to develop a corporate identity that is recognised by staff, partner organisations and the public, based on a deliberate and persistent attempt to exploit comparative advantages, and minimise institutional constraints. The sections below explore this notion.

Recommendations:

- Although it would be unrealistic to demand that DG ECHO sets aside resources to attend each and every meeting, the evaluators recommend that DG ECHO increases its efforts to participate in relevant health sector meetings.
- An ambition to function as a reference donor would include a willingness to contemplate what it is that DG ECHO should change in its own routines. This would almost certainly include a reconsideration of the balance between administration and content. To achieve this, DG ECHO could follow the example of other donors who have cut down on so-called transaction costs. By doing so, DG ECHO creates more time for its own staff (at all levels) and for partner organisations to interact and learn from past experiences for future use. This would include the notion of a circular learning process as set out in section 2.7.

### 3.4 DG ECHO as a learning organisation

DG ECHO has significantly increased its in-house health expertise since the establishment of RSOs and deployment of RMEs. The evidence is that available health expertise is mostly utilised in project monitoring (albeit not consistently). Although field officers who requested technical advice were unanimously positive about the input of RMEs, others indicated that their programmes did not require specialist advice. This was confirmed by RMEs themselves. Senior field staff expressed their regret at what they called 'missed opportunities', particularly of utilisation of available health expertise in strategic and conceptual planning, and deplored the so-called 'project approach'. In agreement with the suggestion of several respondents, the evaluation team concludes that the 'routine' approach to projects (project management cycle) is insufficient if DG ECHO wants to maximise the opportunities to learn from experiences.

The availability of health expertise at regional level has all the potential to turn DG ECHO health operations into exemplary programmes. The evidence gathered in this evaluation, however, points to a rather specific gap in the use of health expertise which is a disconnect between the considerable field experience and expertise, and what is commonly referred to as "Brussels". The example of 'guidelines' may serve to illustrate this.

The implementation of guidelines – be they prepared by external or internal experts, at official request or born out of perceived need – has clearly presented a challenge. Even though numerous documents have been prepared at considerable expense and effort, and some have been published on the DG ECHO website, the evaluation has not seen any officially endorsed health-related guideline or policy document by DG ECHO. (Annex 5, the references of this report presents an incomplete sample.)

Guidelines that tell the reader in what way he or she should act differently have been produced for certain topics, for instance the guideline on use of ACT for malaria, produced by Anopheles members (table 3, section 2.3 refers). The ACT guidance is clear-cut on what to do in a specific context. Because contexts (scenarios) could not be delineated as clearly as in the ACT example, other health-related guidelines have not been able to provide such clarity. The Quality Assurance for Medicines guidelines, for example, are incompatible with certain contexts, as discussed in section 2.3. It follows that guidelines need to be produced with foresight and knowledge of potential implementation obstacles in given contexts. Section 2.4 gave an example of Insecticide Treated Bednets (ITN), which are not accepted as standard practice, as EU rules have prohibited the use of particular insecticides.

The recommendations on the use of technical expertise:

- RSO sector experts should be involved systematically in strategising at different levels (section 2.7 refers), which include involvement in: the development of country/operation strategies such as Global Plans; conceptualisation of financial decisions; and the project management cycle.
- In order to maintain institutional memory and strengthen its corporate identity, DG ECHO should ensure that experts at all levels share experiences and should in particular encourage

documentation of best practices. Internal networks such as the Anopheles group can provide the required technical inputs in such processes.

- It should specifically demand that experts and desk officers are alert on both new and obsolete practices and the funding implications of such practices. Relevant information emerging from implemented projects and programmes should be communicated to all DG ECHO staff through appropriate dissemination channels.
- DG ECHO should better recognise and use opportunities that lead to improved communication between field experts and Brussels-based staff to ensure that important (emerging) topics requiring DG ECHO's attention are timely identified, explored and/or addressed by staff at all levels.
- Differences in RMEs' health expertise resulting from region-specific health priorities should be utilised to provide region-specific advice.
- DG ECHO should create opportunities for peer-to-peer learning and comparison between NGOs that implement similar projects in the same area.
- In the same vein, DG ECHO should consider carrying out a comparative evaluation of cost-efficiency and cost effectiveness of health activities funded by other donor agencies of similar size and with a similar mandate.

### 3.5 DG ECHO and health policy development

The phrases 'policy' and 'guideline' have been used rather indiscriminately. The evaluation team concurs with respondents to the questionnaire, who almost unanimously replied that DG ECHO should not duplicate existing health policies, as ample guidance is provided by norm-setting organisations such as WHO, UNICEF, and more specifically for humanitarian crises, the SPHERE standards.

The team conclude that a distinction can be made in, firstly, guidelines that serve to better understand a certain thematic sub-domain (for example, what field staff should look for in events of a cholera epidemic) and secondly, guidelines that should assist the decision making process (e.g. what reasonable unit costs would be in the event of cholera). There also are, thirdly, guidelines that list and (sometimes) prioritise the actions management should take on certain new or disputed thematic topics, and under which conditions. The HIV/AIDS Guidelines are an example.

DG ECHO's current guidelines tend to be a mix of the above and do not always provide sufficient guidance to the intended users. Once guidelines have been piloted and have positive results, DG ECHO could declare its position on what it is prepared to fund, based on practical experience by a (published) position paper. It is clear that also position papers will need updates, the frequency of which will depend on the topic. DG ECHO will want to limit the number of formal position papers to what in this evaluation have been called 'boundary issues, and more specifically those issues that are of sufficient importance and complexity to warrant a stand on funding.

The recommendations on DG ECHO and health policy development:

- The development of guidelines requires that a flexible annual work plan is established for priority topics, which should be supported by DG ECHO's senior management. Priority should be given to topics that can be addressed successfully.
- DG ECHO should encourage and facilitate the production and use of technical guidelines, which should include a clear commitment to disseminate the developed guidelines internally and to partner organisations.
- Categorisation of outputs which would constitute the 'guidelines and policies' institutional memory for DG ECHO:
    - Technical issue papers (TIP)[5]: Papers that provide technical details on a specific health topic without an outspoken policy dimension e.g. on psycho-social activities. These papers would be internal and especially assist non-medical staff to quickly absorb the essential elements of a specific topic. Papers could include recommendations, notably on reasonable unit costs, which are more indicative than binding. Papers would be easily accessible to all DG ECHO staff. They would require only limited consultation and would have limited authority. TIPs may be (annotated) state-of-the-art publications produced by norm-setting agencies such as WHO and UNICEF.
    - Guidelines: more exhaustive operational guidance on how to deal with specific issues that contain DG ECHO broad recommendations on complex issues such as HIV/AIDS. Guidelines require consultation with all operational units and endorsement from management as they will generally have funding implications.
    - Position papers: These official papers, issued by the Director General to all DG ECHO staff, would be fully authoritative and would have a binding effect. Broad consultation within DG ECHO but also inter-service consultation in the Commission and with partners is required. Broad consultation within DG ECHO but also inter-service consultation in the EC and with partners is required. An example would be DG ECHO's position on user charges for health services in the humanitarian setting.
- DG ECHO should establish clear procedures to guide the policy development process. It is likely that the definition of the roles of Headquarters, field experts, partners and other Services of the Commission will vary, depending on the issues under discussion. Clarity may thus be had over time, rather than be pre-defined. Management may consider the use of task groups, which will include relevant SST and RSO expertise.
- Considerations of cost-effectiveness and speed in introducing new approaches should be given more emphasis. DG ECHO should therefore re-engage in the discussion and consistent application of unit costs to improve efficiency and efficiency in relation to impact of funded health projects and to enhance its understanding of justified differences between regions in the costs of inputs to achieve intended results.

### 3.6 Positioning of DG ECHO on boundary issues

The evidence gathered in this evaluation is that DG ECHO has not been entirely consistent on what it has been prepared to fund not only across units, but also within regions and sometimes within

countries. Urgent requests of partners for increased clarity on 'boundary issues' thus appear reasonable. The evaluation team has found, on the other hand, that DG ECHO's flexibility in such matters, especially where field evidence was solicited to corroborate a partner's case, has been much appreciated.

The recommendations on taking position as a donor:

- DG ECHO should aim to be clearer in what it will fund in which contexts, but maintain negotiating space for boundary issues.
- An inventory should be kept on (parts of) proposals that have been rejected, and for what reasons, for discussions on coherence between and within units.
- For the same purpose, an inventory should be kept on (parts of) approved proposals (the 2006 analysis carried out by the evaluation team could serve as a starting point).

Two boundary issues are selected in which the implications of sections 3.1 - 3.5 are illustrated in more detail: LRRD and Disaster Preparedness.

### *3.6.1 LRRD*

DG ECHO has the well-deserved reputation of being a donor that responds to humanitarian needs and vulnerability. It is however clear that DG ECHO makes choices in terms of what resources it is prepared to spend in which countries and for which purposes. In order to avoid gaps in health service provision, LRRD is given significant attention within DG ECHO especially at project level. Evidence shows that efforts to achieve this have been very labour intensive. As argued in section 2.5 these choices are not only fed by instruments such as the Crisis Index and Vulnerability Index, but also by perceived opportunities or lack thereof.

The trap should be avoided of seeking over-arching solutions for 'the LRRD issue'. The team would thus recommend that DG ECHO, in addressing LRRD, combines a number of its own institution-specific strengths, notably its field expertise; proximity to the field; connections with and influence on a vast network of NGOs, UN partners and the Red Cross; neutrality and impartiality; and of course its funding flexibility. Lacking in this list is a strength that is also needed, which is an ability and willingness to strategise. Many respondents felt that DG ECHO is neglecting this particular competence and saw this as a flaw, particularly in view of DG ECHO's rare combination of strong qualities.

Further recommendations for DG ECHO in addressing health sector specific LRRD issues:

- DG ECHO should engage in the LRRD process in close collaboration with relevant Commission Services to surmount DG ECHO's limitation in funding duration.
- Develop a joint framework for analysis and funding of long-term crises.

- In doing this consider the concept of programming for a post-emergency pre-development phase, with its own specific needs (section 2.5 refers). Similarly, include an assessment of comparative advantages vis-à-vis the other Services of the Commission.
- Building on experience in selected countries, and utilising both the appropriate coordination mechanisms and its own strengths, DG ECHO should develop this framework as a stand-alone project of incremental learning without seeking one-for-all solutions in keeping with the concept of circularity (section 2.7 refers).
- DG ECHO should be open-minded on the desired outcome, i.e. should specifically aim for guidelines and/or policies that have proven their practical use and that thus have stood the test of time. It is conceivable that such processes would ultimately lead to position papers.

### *3.6.2 Disaster Preparedness and Disaster Risk Reduction (malnutrition; epidemics)*

The evaluation team is positive on recent steps taken to address disaster preparedness and disaster risk reduction (DP/DRR) in the health sector. The examples explored are the Epidemic Decisions for West Africa, and the more recent Sahel Decision in a conglomerate of Sahel countries. In particular the latter decision has come about in close cooperation with EC Development services and has included the incorporation of food security in the CSPs of all countries involved.

DG ECHO's current monitoring routine is inadequate for the introduction of a different measure of impact, i.e. the number of cases prevented, rather than of confirmed cases treated. The prepositioning of stocks has proven to be an obstacle for granting the 2007 Epidemics Decision, illustrating DG ECHO's constraints in granting pro-active decisions. These will need to be addressed as disaster preparedness loses part of its meaning without prepositioned stocks.

The evaluation team recommends that:

- DG ECHO recognises innovations that have the potential to cross institutional boundaries, such as the Sahel and Epidemics Decisions. These programmes could be monitored as pilots and documented as case studies explicitly aimed at organisation-wide learning, and at enhancing DG ECHO's profile in thematic areas. Such experiences could result in new guidelines.
- DG ECHO should ensure that senior staff members are involved from the start to better anticipate and address potential implementation obstacles of innovative programmes.
- DG ECHO should seek cooperation with key institutional partners such as UNICEF and WHO to develop monitoring formats for issues such as malnutrition and epidemics addressed with a DP/DRR lens.