Central America. Hurricane Mitch Global Plans 1998 and 1999. Health sector-2.000

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Juan Luis Domínguez González, MD, MPH
Independent consultant.

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I SUMMARY.

SUBJECT OF THE EVALUATION:

Country of Operation (or region): Central America. El Salvador, Guatemala, Honduras and Nicaragua.
Name of Partners:
Operation contract nº:
First Decision - ECHO/TPS/210/1998/12000
Second Decision - ECHO/TPS/210/1998/15000
Global Plan - ECHO/TPS/210/1999/06000
Fourth Decision* - ECHO/NIC/HND/210/01000
Dates of the operation:
First Decision - November 4th, 1998
Second Decision - December 21st , 1998
Global Plan - September 23rd, 1999
Fourth Decision* - August 11th, 2000
Amount:
First Decision - 6,8 MEURO
Second Decision - 9,5 MEURO
Global Plan - 16 MEURO
Fourth Decision* - 3,34 MEURO
Sectors concerned and description:
First Decision - Emergency relief (shelter, basic health care and drugs, basic water and sanitation, food relief).
Second Decision - Health, basic housing, water and sanitation.
Global Plan - Water and sanitation system rehabilitation, more permanent housing, health.
Fourth Decision* - Water and sanitation system rehabilitation, health.
*Honduras and Nicaragua only.

DESCRIPTION OF THE EVALUATION:

Dates for the evaluation: From 04/12/2000 to 30/04/2001 (extension included)
Report nº: 300
Name of consultant: Juan Luis Domínguez González.
Purpose and methodology:

This evaluation was completed in response to a request by the European Commission Humanitarian Office (ECHO), to assess to what degree humanitarian health-related operations approved after the hurricane Mitch, brought about significant relief to the target population and also contributed, among other things, to strengthen coping capacities to that same population. This report provides the findings on the emergency aid ECHO committed to the four Central American countries (Honduras, Nicaragua, El Salvador and Guatemala). Project sites of 19 operations, out of a total 22 health-related interventions, were visited in order to assess the impact reached.

The health-related evaluation analysed operations focusing mainly on epidemiological surveillance systems' development or reinforcing, vectoral control programmes' support, basic health care services' strengthening, etc. A two-pronged approach was used in order to assess ECHO's performance. One looked at the decision-making process, supervisory visits, follow-up, and control and evaluation sessions carried out by both ECHO HQ's and experts in the field. The other converged on the performance of the ECHO partner INGO's.

This evaluation concentrated mainly on the 1999 Global Plan document. However, the team as a whole tried to sustain some general findings and conclusions which might also apply to those first and second decisions, always with the respect due to those main players who remained absents by the time the evaluation was performed.

The first ECHO response took place on November 4th 1998, amounted to 6.8 MEURO, and was channelled among 17 INGO's through 17 operations. It funded immediate emergency relief interventions on shelter, food, basic health care and basic water and sanitation. The second decision was issued on December 21st 1998 and amounted to 9.5 MEURO. This time 29 INGO's were funded through 29 operations (5 were reconverted) based on temporary housing, water and sanitation, and health care. The Global Plan committed 16 MEURO which were disbursed among 39 INGO's through 50 operations, aimed at more permanent housing and water and sanitation systems, strengthening of health care services and epidemiological surveillance systems.

MAIN CONCLUSIONS:

1. Impact:

ECHO operations meant a significant impact for the well-being of the target populations, both in its contribution to reducing and alleviating human suffering, in its effects on health and nutritional practices, and also on local capacity-building. The operations openly contributed to diminish the risk of epidemiological outbreaks, and substantially improved the health situation of the vulnerable population.

A large amount of the beneficiaries expressed satisfaction by the way the projects had improved their purchasing economies, freeing them from being forced to allocate an important part of their meagre income on medicines, and by their improved knowledge on how to fight infections. They didn't feel that they had grown *dependency on the external aid* provided, as most interventions focused more in helping them to develop their coping capacities than making them only passive recipients of aid.

Effects on the preparation, mitigation and prevention of catastrophes: Most interventions included a disaster preparedness component.

2. Relevance:

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.

The fact that a great share of INGO's not only implemented their activities through the MOH's existing network, but reinforced it, contributed to make their methodological design more consistent and technical.

3. Co-ordination and Coherence:

Co-ordination with other humanitarian players wasn't the strongest point for nearly half of the assessed INGO's. ECHO partners in the field still show an inclination to work in an isolated way. Co-ordination seemed to be tantamount to "overlapping prevention". Some very positive signs, though, were detected in some areas.

Co-ordination to local authorities: INGO's made an excellent job in committing local health authorities to the operations performed.

It seemed that a few INGO's didn't understand what *beneficiary's participation* was about. In some cases, it seemed that the beneficiaries were more an acquiescent receiver of aid than someone actively involved in the project's several implementation stages, from identification to evaluation, from analysis of other options to decision-making, etc. Some operations also seemed to use the beneficiaries as a sort of easily available workforce, sometimes drawing them away from attending their agricultural duties. ECHO in the field didn't seem to play a role in boosting a sound participatory approach.

4. Effectiveness:

It appears that the Global Plan was rather effective in reaching the objectives proposed, although very few operations backed those results with appropriate technical indicators beyond a list of consultations made, or actions performed, or tables showing number of cases registered overtime, with no explanation on whether those data meant either a positive or a negative trend of the disease. However, in a general sense, they showed a fair share of positive effects achieved. Some INGOs have not a capacity to run rehabilitation interventions.

Coverage was found to be reasonably satisfactory, although the extent of the health care delivered wasn't always so clear. Health support never went alone. Generally good training and health education activities accompanied health care in most interventions.

However, some questions remained unanswered: are six months enough time to set up a sound epidemiological surveillance and monitoring system sufficiently viable as to allow local institutions to continue it with a near-similar degree or effectiveness?

5. Cost-effectiveness:

A key was set up by which projects committing up to 20% of their budget to indirect costs (see text in the report for explanation) would be rated as fairly high cost-effective. Between 20% and 30% would be deemed as reasonably cost-effective; from 30% to 40% would be considered low cost-effective, and from 40% upwards, the operation should not simply be financed unless specific humanitarian reason recommended otherwise.

Less than a third of all operations studied had a reasonable ratio of expenditure between budget lines spent directly on improving the population welfare, and those use for keeping the "machinery working". And even one fourth of the whole, had such disparity between institutional costs and expenditure aimed at the beneficiaries, that it raised concerns over whether ECHO should finance them at all.

Furthermore, when the projects considered to be highly cost-effective, according to the aforesaid criteria, were cross-checked with those having scored high in effectiveness, no strict direct relationship between them could be found.

All in all, **nearly 60%** of all health interventions evaluated were low cost-effective in terms of budget allocation.

6. Efficiency:

The Global Plan made manifest a good planning capacity of ECHO partners. Most INGO's were solid and experienced health-related organisations, with long time presence in Central America and with proven and effective strategies in place. Not surprisingly, they were able to set up very good systems of epidemiological surveillance and vectoral control.

Considering that almost all INGO's requested ECHO to amend the length of their operations, nearly half the interventions showed no convincing reasons to request an extension. Logistics used in the operation showed to be well planned as a whole. Changes in the budget allocation were not always found consistent with sound financial explanations, although ECHO eventually accepted them all.

The monitoring skills of the majority of INGO's were missing. Just three operations out of nineteen -all developed in Nicaragua- showed what might be described as an impressive quality of monitoring and measurement mechanisms put in place. This lack of indicators wasn't either remarked in the "*Fiche de suivi d'operations*", when it is so stated in the CCP/FPC. The general quality of the reporting was rather low: less than half of all operations evaluated submitted what was considered by the evaluation team as high-quality documentation, both in the proposals and the reporting.

7. Viability:

It seems that an approach such as that of the Global Plan, with a specific and clearly cut aim of seeking durability, could not fail to attain that. However, no health-related intervention assessed included in the Global Plan was found to have a relevant evidence of viability. No intervention based on epidemiological surveillance system strengthening -80% of all health-related projects- could be expected to achieve a durable result in a six-month period. People interviewed coincided in that almost all health programmes financed by ECHO would collapse shortly after the INGO would stop its support. Although some key players consider this shortcoming mostly related to the poor response local institutions deliver after termination of the operations, in reality it seems to be caused by a lack of funding those same institutions chronically face.

8. Visibility:

Visibility in the Global Plan was expensive -around 1,22% of the total budget, within a range going from 2,03% to 0,17%-, badly planned, and satisfied no one.

9. Horizontal issues:

a) Gender:

According to the Global Plan document, ECHO didn't appear to be seen too concerned about the gender problem in developing countries, as it was not shown as a priority or one of the strongest interests. Hence, a majority of INGOs didn't include gender in their strategies, although at least some of the operations had tackled the problem. Components about gender issues included in the demands were not taken to scrutiny within ECHO "*Fiches de suivi d'operations*".

Gender, however, is an issue which doesn't seem to bear a negative burden as far as health-related interventions are concerned. Even though for many various reasons, maternal-child care tends to be one of the specifically addressed target groups-, just one fourth of the projects deliberately included components specifically aimed at women.

b) LRRD

For a "continuum" to be successful, three principles need to be followed:

1. A hierarchic and time-abiding sequence between emergency, rehabilitation and development.
2. A continuousness in the focus on the same beneficiaries.
3. A concept of "integral approach".

The Global Plan focused on PRRAC[1] as the natural link between ECHO actions and a longer-term approach. Although ECHO had already included PRRAC into its "*Fiches de suivi d'operations*" as a desirable link, there was only one single mention to ECHO found in PRRAC established strategies, wherein INGO's have only access to a small component -"*Local Initiatives Fund*"-, which considerably limits their possibilities to arrive at a durable and comprehensive action.

RECOMMENDATIONS.

1. ECHO experts in the field could sit down with its partner NGO's in the field -both European and local- and set up a comprehensive and agreed upon list of performance indicators to be of common use in those operations with specifically shared patterns (communicable diseases control, improvement of the health care services, etc.). Activities for disaster awareness, preparation and mitigation could also be discussed with partner NGO's, so they could incorporate this component regardless of the time span allowed for the operation.

The issue of what partnership actually means for both ECHO and its partner INGO's should be addressed. Whether or not ECHO can take the leading role in humanitarian emergency response, and whether ECHO can be a truly motivated donor and has a strategy to achieve a goal, and share this goal with its partner organisations. ECHO therefore could make an extra effort in carefully screening which INGO's are actually capable to carry out the kind of humanitarian medical actions ECHO wants to share with them.

2. For many INGO's, co-ordination seemed to be tantamount to not overlapping. ECHO might start thinking of financing pools of INGO's, each with different expertise and skills, to carry out integral relief to the populations in need. ECHO needs partners and not customers.
3. By participation of beneficiaries, INGO's should make explicit not only that beneficiaries were taking an active role in the project implementation, but also that they were involved in the choices made, the study of alternatives, the decision-making process and the way funds were spent. ECHO could request partner INGO's to provide with detailed explanations on how they were going to incorporate the beneficiaries in their operations' different stages, in their strategies and plans of action. ECHO experts in the field could therefore consider this point as one which had to be closely followed and supervised.

ECHO could care more about the way its European partners interact with local ones, and give them more of a say, thus giving ECHO a better insight on how needs were met.

4. Proper monitoring and supervision were affected by the lack of performance indicators, as they seemed to be one of the most prominent shortcomings ECHO should come into terms with. ECHO should work hard with its partner organisations in order to set up an agreed upon collection of process and results' indicators and commit all financed operations to stand by them. Regular workshops between ECHO HQ's and partner INGO's to discuss specific performance indicators and effective ways to collect information needed for them.
5. ECHO could rethink the contents of its CCP/FPC regulations, in order to allow partner INGO's to leave some essential items to their counterparts in the field, once the operation is over. As ECHO becomes the final proprietor of all non-perishable goods purchased with ECHO financing, it could turn into an excellent instrument of assuring a higher degree of project durability.

[1] PRRAC: "*Programa Regional de Reconstrucción de América Central*" (Regional Reconstruction Plan for Central America).

6. That same absence of performance indicators hindered any attempt to make any analysis on costs. ECHO could work with its partner INGO's in order to bring forward a structured design to raise awareness concerning cost-consciousness. To that aim, ECHO could modify the way financial reporting is required now. Nevertheless, the evaluator admits that in terms of contribution to the well-being of the populations in need, too many parameters are to be considered, and some of them are beyond quantification.
7. ECHO has to develop what it is already contained in the revised CCP/FPC, and perhaps make an extra effort to design more training tools to improve ECHO experts' skills in monitoring and evaluation. This, together with giving more empowerment to those experts in the field, would always be the most adequate tools to monitor how far already prevailing and new regulations were being fulfilled.
8. ECHO has to make its choice, either limiting the timeframe for an operation, or showing a flexible "*à la carte*" approach.
9. ECHO should face viability in two ways: duration and methodology:
    a) Duration: a health-related intervention should not accept strict time restrictions and boundaries. A health-related intervention must be lengthy enough to secure that its objectives be clearly achieved, and show beyond any doubt that the results will be sustained within a reasonably timeframe after the intervention is finished.
    b) Methodology: this kind of operations should bear implicit within the proposal: i) a detailed, deep and thorough health needs analysis, ii) a clearly stated intervention strategy, and iii) a monitoring methodology with a set of objectively verifiable indicators, both quantitative and qualitative.
10. Visibility ought to be subject of a shared, multidisciplinary approach rather than a marginal action carried out by the partner INGO's at its own risk. Visibility guidelines should be enclosed in a Global Plan.
11. ECHO needs the backstopping of well trained professionals to address the gender issue. ECHO should take a more energetic action to favour participation of women at every level of the implementation.
12. ECHO could play a paramount role in connecting the partner INGO's to other longer-term financing lines such as DGDEV -both line B7/6.000 and Food Security-, DGRELEX -PRRAC, etc. ECHO seems to ignore the social implications entailed by the support it gives to the populations targeted.
13. DIPECHO should develop a more straightforward impersonation in disaster preparedness, maybe by detaching itself away from a limited ECHO strategy, and taking a leading role. This would mean strengthening of DIPECHO's weight in Brussels, with a consistent increase in budget and staff.

LESSONS LEARNED:

1. Accepting a proposal submitted when ECHO knows that completion of its goals, technically speaking, would reasonably take longer than the maximum period ECHO is prepared to finance, should be careful weighted against the harm it can cause to ECHO if the results end up being of a poor quality.
2. Partnership is a concept ECHO seems to be at odds with. Partnership is about two-way trust and neither ECHO nor the partner agencies show a proactive commitment to each other.
3. ECHO has apparently learned that problem-sharing is something more rewarding and effective than a vertical approach to a difficult question, and ECHO seems to have started the right path towards achieving it with its partner INGOs in the field. ECHO would benefit a great deal if it incorporated this process at a decision-making level.
4. It seems obvious that ECHO could profit from all the knowledge and skills its partner INGO's have developed all around the world. From ways to design, plan and analysis to monitoring tools, strategies set up, effectiveness, and so on, ECHO's partner INGO's could bring an endless source of expertise to ECHO.

II INTRODUCTION.

This evaluation was completed in response to a request by the European Commission Humanitarian Office (ECHO), in order to assess to what degree humanitarian health-related operations approved after the hurricane Mitch devastated vast areas of Central American countries, brought about significant relief to the target population and also contributed, among other things, to strengthen the capacities of that same population to cope with disasters.

This report presents the findings of an independent health sector evaluator on the emergency aid ECHO committed to the four Central American countries (Honduras, Nicaragua, El Salvador and Guatemala). ECHO funded health-related relief and rehabilitation programs in those areas devastated by the hurricane Mitch through three different decisions, the latter being launched under the framework of a Global Plan. A fourth decision launched on August 11th 2000, was focused on both Honduras and Nicaragua, amounted to 3.34 MEURO, and by the time this evaluation was performed, most interventions within that decision had just taken off.

The evaluators were also requested to concentrate their study on the Global Plan mainly, as it was the most structured, comprehensive and strategically planned decision. The evaluation was conducted throughout the four countries where the aid was delivered, although no field visits could be organised in El Salvador due to the severe earthquake having occurred immediately before the visit was scheduled.

Health-related projects focused mainly on epidemiological surveillance systems' development or reinforcing[2], vectoral control programmes' support[3], and basic health care services' strengthening. Project sites of 19 operations, out of a total 22 health-related interventions, were visited in order to assess the impact reached. Direct information was provided both by beneficiaries to whom a questionnaire was introduced, and by the INGO responsible and local counterparts. The information resulting from this wide range of informants and sources was analysed by the team in order to shed light on the way health aid provided by ECHO in Central America after the hurricane Mitch had a consistent impact on the lives and living conditions of the disaster-hit populations, and also whether the aid had strengthened the communities' coping capacity against recurrent natural disasters.

III HEALTH BACKGROUND.

Many of the endemic communicable diseases which are repeated in Central America seemed to show a pattern closely related to the severity of the damages inflicted by the hurricane Mitch to these countries. An early estimate considered to be at least 30% the amount of all health services affected. All factors prone to develop epidemic outbursts were present: heavy flooding, massive destruction of households, contamination of water and food supplies, human and animal migration. Communicable diseases such as cholera, malaria, dengue, leptospiroses, not to mention other water-borne disorders, were bolstered by the increased vulnerability of the population after the Mitch. The disruption -or in many cases the plain destruction- of the health care infrastructure contributed to heighten the risk of spread of epidemics.

[2] An epidemiological surveillance system has to do with setting up a whole framework of different levels of data collection and analisys, based on previous development of in-the-field surveillance teams which encourage the population to adopt measures to fight againts communicable diseases by means of training, health education, etc. These teams monitor the disease behaviour, collect and register new cases, and take them to the upper level.

[3] Vectoral control programmes are aimed at reducing the cases of a vectorally (mosquitoes, flies, rodents...) transmitted diseases such as malaria, dengue, leptospiroses, etc., by means of promoting the use of mosquito nets, building insecticide or rodentcide barriers inside households, fighting breeding sites, etc.

Cholera is endemic in Central America since 1991, becoming widespread during the years 1992 to 1994. During 1998's first ten months -before the Mitch- an increase in cholera cases both in Guatemala and, to a lesser extent in Nicaragua, was reported, especially during the two months prior to the hurricane. This acute rise continued increasing throughout November 1998, and by December 1998 started to quickly decrease. A sudden peak was also reported in El Salvador immediately after the Mitch, which quickly subsided to pre-Mitch levels.

Dengue is also endemic in Central America, and epidemics can occur at random. A severe outbreak in Honduras and Nicaragua, and El Salvador to a lesser degree, was also reported before the Mitch. By the time Mitch hit, a significant decrease was detected. Therefore, a sharp rise in the first months of 2001 should be expected.

A sudden upsurge in Malaria cases was experienced throughout Central American countries immediately after the Mitch. It is expected to further increase during the first months of 2001.

Leptospiroses is transmitted by rodents. Although endemic in Nicaragua, only random cases have been reported in the other countries. Because of the dramatic deterioration of infrastructures and living conditions, a rise is expected during 2001.

IV CONSTRAINTS.

A significant constraint encountered by the evaluation team was that during the briefing meeting on January 9th 2001 in Brussels, ECHO could not facilitate the dossiers related to both the first and second decisions, and the Global Plan's operations. As a result, the team had to rely on the ECHO experts in the field for project visit selection.

Most of the dossiers belonging to the operations subjected to study could be found at the ECHO offices in Tegucigalpa, Honduras, and in Managua, Nicaragua, albeit some of them showed to be fragmented, incomplete and with some files missing. The dossiers and files found to be lacking, could eventually be supplemented with those examined during the stay in ECHO HQ's in Brussels during days March 13th and 14th 2001.

Because of the changes in schedule forced by the devastating earthquake occurring in El Salvador, shortly before the team travelled to Central America, some of the country visits were altered, which forced to tighten even shorter the timetable allowed in the first place. That did affect, although to a minimum degree, the outcome.

V METHODOLOGY.

The evaluation team analysed whether it was more representative to study the findings separately by country, or else pool the findings together, and from those extract general conclusions valid for all humanitarian decisions as a whole in that specific regional environment. Eventually, it was decided to make use of the latter.

A two-pronged approached was used in order to assess ECHO's performance. One looked at the decision-making process, supervisory visits, follow-up, and control and evaluation sessions carried out by both ECHO HQ's and experts in the field. The other focused on the performance of the ECHO partner INGO's.

A crucial factor which facilitated the health sector evaluating process was found. A majority of INGO's working in health interventions within ECHO post-Mitch framework had built a good collaboration and technical co-operation with the ECHO expert in charge, based on the fact that she herself was a medical professional. That relationship helped a great deal in co-ordinating and facilitating the different field-visits and meetings with the INGO responsible for the specific health-related operation.

In those countries where that link wasn't present -Honduras- the ECHO expert in charge overcame his lack of technical expertise in that field with an impressive and exemplary work through frequent and detailed supervisory visits, and his ability to also build an extremely productive interaction with the partner INGO's.

This evaluation focused mainly on the 1999 Global Plan document. However, the team as a whole tried to sustain some general findings and conclusions which might apply to those first and second decisions, always under the respect due to those main players who remained absents by the time the evaluation was performed.

The first ECHO response took place on November 4th 1998, amounted to 6.8 MEURO, and was channelled among 17 INGO's through 17 operations. It funded immediate emergency relief interventions on shelter, food, basic health care, and basic water and sanitation.

The second decision was issued on December 21st 1998 and amounted to 9.5 MEURO. This time 29 INGO's were funded through 29 operations (5 were reconverted), and focused on temporary housing, water and sanitation and health care services.

The Global Plan committed 16 MEURO which were disbursed among 39 INGO's through 50 operations, aimed at providing with more permanent housing, water and sanitation systems, and strengthening of health care services and epidemiological surveillance systems[4].

The fourth decision applied to Nicaragua and Honduras only. It was launched on August 11th, 2000, and involved 3.34 MEURO.

V.1 TERMS OF REFERENCE

- IMPACT: contribution to the reduction of human suffering, creation of dependency on humanitarian aid, effects of humanitarian aid on the local economy, effects on the incomes of the local population, effects on health and nutritional practices, effects on the environment, impact of humanitarian programmes on local capacity-building, effects on the preparation, mitigation and prevention of catastrophes.
- RELEVANCE: of the objective, the choice of the beneficiaries, and the deployed strategy in relation to identified needs.
- CO-ORDINATION and COHERENCE: to other donors and international operators, as well as with local authorities, to other European Commission services that might be operating in the same zone with projects that are similar or related to those of the Global Plan.
- EFFECTIVENESS: in quantitative and qualitative terms.
- COST-EFFECTIVENESS: as establishes on the basis of the quantitative elements identified under the previous issue.
- EFFICIENCY: planning and mobilisation of aid, operational capacities of the partners, the strategies deployed, the systems of control and auto-evaluation set up by the partners.
- VIABILITY: the feasibility of setting up development and/or co-operation policies which could eventually replace humanitarian aid as having been provided.
- VISIBILITY.
- HORIZONTAL ISSUES: GENDER, LRRD,

V.2. SOURCES OF INFORMATION

V.2.A. Primary Data:

a) *ECHO partners in the field*, in their Regional and National offices there where they still were kept operational. Because of the time span already passed between the termination of the projects and the implementation of the evaluation, some offices had closed and the agencies' staff members left the country.
b) *Local partners*. The health sector teammember interviewed where possible the INGO's former local partner organisations.
e) *Relevant health key informants*. MOH officers, VTD[5]'s directors,
c) *Beneficiaries.* Where feasible, the teammember held gatherings with community members and community health workers involved, and tried to address the appropriateness, effectiveness and viability of projects.
d) *Visits to projects*. All together, the health sector teammember visited 19 projects: one in El Salvador (MDME), 6 in Guatemala (MOVIMONDO, COOPI, CISP, PTM, MDME, MSFCH), 6 in Nicaragua (ACSUR Las Segovias, GVC, MDME, CRE, AMI, MOVIMONDO), and 6 in Honduras (ASB, Malteser, MOVIMONDO, COOPI, OIKOS, TROCAIRE). The visits had different degrees of thoroughness, mostly related to the various levels of in-place achievements still remaining.

[4] Data provided by ECHO 3 desk responsible for the Central America operations.
[5] Vectorally Transmitted Diseases.

V.2.B.Secondary data:

a) *Proposals, intermediate and final narrative, and financial reports*: As it is already been outlined in the chapter on constraints above, the team members weren't able to consult the projects' full dossiers during the briefing day in Brussels and, therefore, couldn't design a proper planning and preparation of the visits to be carried out. It has to be remarked that most health sector dossiers could be reviewed at ECHO offices in Tegucigalpa and in Managua. The very few ones found to be incomplete, could be supplemented with those files examined during the stay in ECHO HQ's in Brussels during days March 13th and 14th 2001.
b) *ECHO's "Fiches de suivi d'operation":* A fair source of information was obtained from ECHO's "fiches d'operation" in order to assess to what degree ECHO could closely follow the interventions in the field.

V.3. EVALUATION TECHNIQUES

a) *Interviews*:
Separate questionnaires were used at every interview with: ECHO experts in the filed, key representatives from ECHO's partner INGO's, governmental partner health institutions, local partner organisations, and beneficiaries community members (see annexes) and health counterparts.
b) *Field notes and project matrix*:
A standard non health-specific project matrix developed by IUDC-UCM[6] (see annexes) was applied to every project studied, where both information collected through the interviews and data gathered from project documents were enclosed.
c) *Participatory observation*:
The health sector teammember spoke to many people in informal meetings in order to cross-check information and to broaden background information.

VI. FINDINGS.

The team believed there wasn't enough quality and quantity information on the two first decisions, as to be able to state which one was the most co-ordinated or coherent. And therefore it was decided to separate those two emergency decisions away from the main focus of this paper, and marginally include them in the findings only there where some information could be obtained.

On behalf of a more practical approach, and taking into consideration the constraints above mentioned, this evaluation of the health-related sector focused on the 1999 Global Plan document. Notwithstanding that quite a few interventions shared more than one sector in their approach, twenty-two operations could be labelled as incorporating specifically health-related components. Of those, nineteen (86%) were evaluated. Therefore, it can be fairly assumed that conclusions drawn from the evaluation of those 19 operations are more or less valid to give an overall picture of this sectoral approach.

VI.1. IMPACT

(contribution to the reduction of human suffering, creation of dependency on humanitarian aid, effects of humanitarian aid on the local economy, effects on the incomes of the local population, effects on health and nutritional practices, effects on the environment, impact of humanitarian programmes on local capacity-building, effects on the preparation, mitigation and prevention of catastrophes)**.**

Impact can be basically determined by: a) *fulfilment of the general objectives proposed*, and b) *side-effects produced*, -effects on the local markets' economy and the incomes of the local population, creation of dependency, effects on the environment, adverse effects on population groups not included, unintended increase of corruption, etc.

Even though every impression gathered was that a great majority of the health projects had a very high impact when it came to the degree by which the general objective proposed was attained, both in its contribution to reducing and alleviating human suffering, in its effects on health and

[6] Instituto Universitario de Desarrollo y Cooperación-Universidad Complutense de Madrid (*University Institute for development and co-operation- Madrid Complutense University*).

nutritional practices, and also on local capacity-building, only projects in which some remaining in-place evidence of their impact, both physical and documental, could still be found were evaluated. In those cases where, because of the total absence of proper performance indicators found, no objective trail of an impact could be ascertained, it was highlighted accordingly.

a) Focusing on the *fulfilment of general objectives* as outlined in the proposals, **most operations were found having had a high impact**. The operations contributed openly to diminish the risk of epidemiological outbreaks, and substantially improved the health situation of the vulnerable population.

b) In what refers to *side effects* brought about by the interventions, such as *i) dependency on humanitarian aid, ii) on local economy and population incomes, and iii) on the environment*, a large amount of the beneficiaries clearly expressed their satisfaction by the way the projects had improved their purchasing economies, if only to free them from being forced to allocate an important part of their meagre income on medicines, as water-borne diseases and other communicable diseases had been chased away in many communities to a great extent, because of a better water supply and excreta disposal, and by their improved knowledge on how to fight infections.

The beneficiaries didn't feel that they had grown *dependency on the external aid* provided, as most interventions focused more in helping them to develop their coping capacities by means of training, workshops, etc., than making them only passive recipients of aid.

- *Effects on the preparation, mitigation and prevention of catastrophes:* Most interventions included a disaster preparedness component. Those which didn't, put the blame on the "*short operational timeframe*" for the actions to be of any impact. Different degrees of commitment were found: from one operation which even set up a disaster evacuation drill where the whole population was involved (MDME in El Salvador), to the majority including training workshops on disaster preparation, mitigation and prevention.

VI.2. RELEVANCE

(of the objectives, the choice of the beneficiaries, and the deployed strategy in relation to identified needs).

Most health interventions channelled both their *needs appraisal*, their *choice of beneficiaries*, and the *objectives targeted*, through the local MOH institutions. Thus, their relevance as such should be tested against the assessed relevance given to local MOH priorities.

However, according to the findings, most operations assessed **showed to have made a good problem assessment and sound needs analysis**, and this greatly contributed to heighten the *relevance of objectives* attained.

ECHO partner INGOs also seemed to have carried out a good *identification and choice of beneficiaries*. C*ensuses of beneficiaries* were enclosed into the activities of the majority of the interventions, albeit at very different degrees of complexity which were not reflected here -some agencies relied more than convenient on censuses already made by local counterparts. The same amount of interventions also enclosed a *community diagnosis appraisal*

In what refers to the *deployed strategy in relation to identified needs*, it was assessed by: *i) design strategies framework* and *ii) logic of the interventions*.

The fact that a great share of INGO's not only implemented their activities through the MOH's existing network, but reinforced it, contributed to make their methodological design more consistent and technical. It could also be that in order to reach the maximum amount of population, ECHO might have sometimes devalued the coherence of the aid delivered (i.e., building water systems and not latrines, or constructing a health post and not providing a water supply system or sanitation to that same population).

VI.3. CO-ORDINATION and COHERENCE

(to other donors and international operators, as well as with local authorities, to other European Commission services that might be operating in the same zone with projects that are similar or related to those of the Global Plan, direct link with beneficiaries, etc.).

a) *Co-ordination with other humanitarian* operators. It seemed that ECHO partner INGO's weren't too eager to strengthen co-ordination, if that means something more than simply trying to avoid overlapping actions with other agencies within the same area. However, some signs which could give way to optimism were detected in some areas, for instance in the Valle de Polochic, Guatemala. There, health-related INGO's had built quite an efficient pool of activities by sharing the same technical strategy, working in a rational way with the MOH authorities, using the same training approach, and improving their outreaching capacities by means of merging financial resources.

b) *Co-ordination to local authorities:* it has to be outlined that almost unanimously INGO's made an excellent job in **committing local health authorities** to the operations performed. Not so much at central level, where only INGO's with a long-term presence in the country seemed to have developed links with the MOH authorities. But almost all had been working in close alliance with municipal and regional health authorities. However, some INGO's declared having troubles in building links with national authorities because of what they considered a lacklustre low profile shown by ECHO with those authorities.

c) *Participation of beneficiaries:* most interventions included the beneficiaries in one or more stages of their operations. In some cases, these beneficiaries had a relevant characteristic which made them apt for being incorporated to the intervention (e.g. community health workers, malaria control volunteers, etc.) but, in other cases, it seemed that the beneficiaries were more a acquiescent receiver of aid than someone actively involved in the project's most relevant implementation stages, from identification to evaluation, from analysis of other options to decision-making, etc. Some operations seemed to use the beneficiaries as a sort of easily available workforce, sometimes drawing them away from attending their agricultural duties. It also seemed that ECHO had a leaning to work closely enough with the INGO's and much less -provided there was sometimes any contact- with the local counterparts, neglecting the fact that local partners seemed to have a knowledge of the reality which was miles ahead any INGO's could possibly develop.

No specific details reflecting participation of beneficiaries were found in ECHO "*fiches de suivi d'operation*", in spite of being stated in the CCP/FPC second provision, which says: "*involve beneficiaries of the operation in the management of relief aid*", and also being given an outstanding position in the Global Plan's methodological approach: "*the beneficiaries, **especially women**, should actively participate in the design and in the implementation process...*".

Some local informants approached declared that international foreign organisations "*...arrived in the country with their ideas learnt from the places they belonged, and not always believed what local people told them"*; some others said that "*...they should spend more time in the communities, talking with people, and listening to the several opinions, and in the end, they would be able to tell what the people really need*" (meeting at "*Nueva Concepción*" community. *El Estor, Valle Polochic*. Guatemala).

VI.4. EFFECTIVENESS (in quantitative and qualitative terms).

Effectiveness was assessed by taking into account the following parameters: *i) achievement of the specific objective; ii) outreach of the aid delivered (i.e. to all the population targeted); iii) side-benefits besides aid delivery (coping-capacities development, community organisation strengthening, local initiatives boosted, etc.)*; and *iv) monitoring: systems of measurement put in place.*

i) Achievement of the specific objective. Most final reports studied were impressive in the amount of what was accomplished, but almost no one backed **those results with appropriate technical indicators** beyond a list of consultations made, or actions performed, or tables showing number of cases found overtime, with no explanation on whether those cases registered meant either a positive or a negative trend of the disease.

ii) Outreach of aid delivered: Overall coverage was found to be reasonably satisfactory, although the extent of the health care delivered wasn't always so clear, as many INGOs didn't seem to have not a capacity to run rehabilitation interventions. For instance, Red Cross agencies, Caritas..., appeared to be good for downright immediate emergency actions, but they seemed to lose a grip with reality when they were appointed to carry out reconstruction and/or rehabilitation actions (e.g. CRE project in Northern Nicaragua, where some 150.000 E were spent in building a nice health centre which, nearly one year later, laid still empty and idle).

iii) side-benefits besides aid delivery: Health support never went alone. Generally **good training and health education** activities accompanied health care in most interventions. However, some questions remained unanswered: are six months enough time to set up a sound epidemiological surveillance and monitoring system sufficiently viable as to allow local institutions to continue it with a near-similar degree or effectiveness? Even though assuming the MOH in charge could appoint staff in a permanent way to accomplish the targets set up by the operation, and perhaps to increase the budget allocated to that specific program, how could they provide for the amount of transport an INGO could incorporate in the operation for the control and surveillance of, say, a dengue or malaria outbreak?

Under ECHO regulations, local transport is subcontracted -as ECHO doesn't allow for purchase of vehicles-, and paid by with ECHO resources. It means that a health-related operation (e.g. that of ASB in the Dept. of Olancho, Honduras) could rent 6 vehicles at once to carry out detection and supervision of the health care network dealing with the epidemiological surveillance system. The achievements were impressive, but once the operation finished, those vehicles disappeared from the regional MOH office.

VI.5. COST-EFFECTIVENESS

(as established on the basis of the quantitative elements identified under the previous issue).

Technically addressing cost-effectiveness of an intervention on health such as ECHO is usually funding is rather difficult, and can only be meaningfully carried out for specific, highly defined, components of a relief programme, and even then, great care is needed to distinguish between outcome indicators (i.e., malnutrition) and process indicators (patients seen). Further complication emanates from the impreciseness in the account of direct and, particularly, of indirect beneficiaries; different degrees by which aid gets to the beneficiaries, etc., not the least the formidable difficulty issuing from the fact that comparing humanitarian costs of delivering relief with those of achieving the same results with other means can be extremely intricate. This should entail a rather different approach to ECHO partners than the one which is being currently adopted.

Notwithstanding the fact that many local players from those countries where ECHO usually finances humanitarian aid, consider most ECHO-funded interventions to be highly expensive in terms of input allocated/output achieved, the aim of this study is to basically assess to what degree ECHO-funded projects gave "value for money" to some extent. Under the assumption that ECHO is only financing INGO's considered sufficiently efficient to having signed the CCP/FPC[7], it can also be assumed as a starting point -later it will be outlined whether or not this evaluation agrees with that assumption- that ECHO chose those INGO's which showed a relevant degree of efficiency in past operations, and after careful assessment of the proposals submitted for a specific intervention, ECHO decided to fund them.

Therefore, it can be further assumed that all INGO's were somehow homogeneous when it comes to cost-efficiency. Hence, the assessment of how much of the budget an INGO allocates to

[7] CCP/FPC: "*Contrat-cadre de Partenariat*", or Framework Partnership Contract.

direct costs (i.e., money directly spent on the beneficiaries), and *indirect costs* (i.e., budgetary lines used for paying overhead costs, staff, visibility, administration, etc.) might be used as a proxy for cost-effectiveness analysis. To that purpose, and on behalf of a certain logic, which costs should be placed within the range of "*indirect*", and which ones of "*direct*" to the beneficiaries have been arbitrarily established by this evaluation. The former ones are settled as follows:

1. Personnel costs, both expatriate (which include overhead costs) and local*.
2. Visibility costs*.
3. Evaluation, monitoring and audit costs*.
4. Administrative costs**.

* Extracted from the total budget prior to including administrative costs.

** Drawn from the overall total budget spent.

Although *transportation and communication* costs are not explicitly "direct", they have been kept under that category in the belief that deliverance of relief must come at a cost, which means sufficient logistic support to be efficient. Costs of personnel, both expatriate and local, are considered as indirect, albeit those quite often reflect a good or bad management tool to effectively carry out an intervention. We have not intentionally entered into muddy grounds by implying that the expatriate/local staff expenditure ratio may affect the outcome.

Hence, a key has been set up by which projects committing up to 20% of their budget to indirect costs would be rated as fairly high cost-effective. Between 20% and 30% would be deemed as reasonably cost-effective; from 30% to 40% would be considered low cost-effective, and from 40% upwards, the operation should not simply be financed unless specific humanitarian reason recommended otherwise. (Remark: rates have been drawn from final financial reports as endorsed by ECHO, and not from proposals).

Less than a third of all operations studied had a reasonable ratio of expenditure between budget lines spent directly on improving the population welfare, and those use for keeping the "machinery working". And even one fourth of the whole, had such disparity between institutional costs and expenditure aimed at the beneficiaries, that it raised concerns over whether ECHO should finance them at all (one intervention -CRE in Nicaragua- was placed out of the study, because it meant just the subcontracted construction of a Health Centre with no other objectives involved, and CRE had spent 26,2% in indirect costs just for that construction).

Furthermore, when the projects considered to be highly cost-effective, according to the aforesaid criteria, were cross-checked with those having scored high in effectiveness (i.e. achievement of the specific objective, outreach of the aid delivered, and side-benefits attained), no strict direct relationship between them could be found.

All in all, **nearly 60% of all health interventions evaluated were low cost-effective in terms of budget allocation**. Even though ECHO "*Fiche de suivi d'operation*" includes a question about cost-effectiveness to be assessed in the analysis of the demand, almost the totality of analysis of operations made by ECHO didn't enclose any cost-effectiveness estimation in the final report evaluation. Only operations assessed by the Honduras ECHO expert -around one fourth of the total- included also a plain mention to cost-effectiveness appraisal in the analysis of the demands.

VI.6. EFFICIENCY

(planning and mobilisation of aid, operational capacities of the partners, the strategies deployed, the systems of control and auto-evaluation set up by the partners).

i) Quality of planning and mobilisation of aid: Most INGO's were solid and experienced health-related organisations, with long track record in Central America, and had proven and effective strategies in place. Not surprisingly, they were able to set up **good systems of epidemiological surveillance, vectoral control, or functioning health care services**[8].

ii) The timing of interventions: considering that almost all INGO's requested ECHO to amend the length of the operation, nearly half the interventions showed no convincing reasons to request an

[8] It is worth noticing that the only intervention which rated "low" or "very low" in every parameter was the Spanish Red Cross project in Nicaragua.

extension (raining season, delays caused by the institutional counterpart, lack of commitment by the population of beneficiaries, etc.).

iii) Financial management: changes in the budget allocation were not always found consistent with sound financial explanations, although ECHO eventually accepted them all.

iv) Logistics management: Logistics were apparently well planned and designed, and effectively added to the achievements. Almost all partner INGO's showed expertise in handling logistic requirements.

v) Monitoring mechanisms: Just three operations out of nineteen -all developed in Nicaragua- showed what might be described as an impressive quality of monitoring and measurement mechanisms put in place. The remaining 16 interventions **omitted to include any indicator** in both their proposals or reporting documents.

ii) Reporting quality: less than half of all operations produced good quality of reporting, with well structured proposals and reporting papers. ECHO deployed recently new proposal and reporting formats, substantially improving the old ones, which were considered by the majority of INGO's to be too basic a tool for consistent presentation and reporting. The old format was clearly less demanding in the amount and the quality of information requested on both proposals and reports. This particularity notwithstanding, **less than half of all operations** evaluated submitted what was considered by the evaluation team as high-quality documentation, both in the proposals and the reporting. Almost with no exceptions, documents showed a surprising lack of method: no editing dates were added to the papers, and sometimes it took pains to ascertain when and by whom a specific document was written.

Turning to the "*Fiche de suivi d'operations*", no assessment made by ECHO on the projects' implementation, carried any mention to the lack of performance indicators found in the great majority of the operations evaluated. This, when in the guidelines of the revised CCP/FPC it was stressed that:

> *- State the indicators you will use to assess your performance in delivering these benefits. **(Not applicable for emergencies)**.*
> *- Indicate and justify the results obtained compared to the specific retained indicators in the initial proposal (taking into account the modifications agreed with ECHO).*
> Revised FPC reporting guidelines 11.02.98

VI.7. PERSPECTIVES and VIABILITY

(emergency, protracted crisis, rehabilitation..., the feasibility of setting up development and/or co-operation policies which could eventually replace humanitarian aid as having been provided)**.**

Probably one of the most controversial and thoroughly discussed issues addressed by the evaluation. A few elements are deserving being put into perspective:

1. *The intervention's perspective:* Although expecting viability of an immediate acute emergency's reaction is rather out of question, as it was the case with the first and second decisions, with a duration ranking from 3 to 6 months, the Global Plan was a meditated, strategic, and structured delivery of aid, which took nearly 5 months from the moment the INGO's submitted their proposals to ECHO, to the start-up phase. All operations were confined, in strict observation of the CCP/FPC, within 6 months, "*except in very special circumstances...*".
2. *The Global Plan:* It was considered by many as a *rehabilitation programme*, and very few rehabilitation programmes can bear the limits of a 6-month length -systematic approval of two-month extensions notwithstanding-, and pretend reaching a basic degree of viability.
3. *The strategies involved:* A short-term operation, up to six months, has a strategy to last for exactly that time. Sequential short-term projects financed by ECHO have therefore an independent operational framework, and cannot be included into a strategy of longer-term approach.

When the above is agreed upon, **no health-related intervention assessed was found to have a relevant evidence of viability**. No intervention based on epidemiological surveillance system strengthening -80% of all health-related projects- can be expected to achieve a durable result in a six-month period. Even CRE intervention in Nicaragua, which solely consisted in building a health centre to be later transferred to the local MOH, was experiencing serious problems when it was known that MOH might decide to allocate the staff already committed to that centre, elsewhere.

Around 90% of all people interviewed coincided that almost all health programmes financed by ECHO would collapse shortly after the INGO would stop its support. Although some key players consider this shortcoming mostly related to the poor response local institutions deliver after termination of the operations, in reality it seems to be caused by a lack of funding those institutions chronically face.

No person interviewed could clearly answer to the question of whether ECHO funded operations were exclusively humanitarian emergency, or rehabilitation, or a mixture of both, or... "*There is a void nobody fills...*" (MOVIMONDO Dr. L. Rossini, 19-03-01).

In the ECHO 1999 Global Plan, in chapter No. 3 it was written down that "*...ECHO is strengthening its co-ordination with other EC services present in Central America (DGRELEX and DGDEV) in order to assure a greater complementarity of programmes in the aftermath of Mitch*". DGRELEX representatives in Brussels declared: "*There are no links between ECHO and EC development services which could fill the gap between emergency and development*"(January 9, 2001). And also: "*There is a blurred perception on where ECHO starts and where it ends. If ECHO is only about emergency, it should already be out; if ECHO is humanitarian, why now after 2 years? On which basis decisions about when to enter and when to leave...? EC should eventually decide for once what it really wants ECHO to be, and set up clearly cut guidelines"* (Karen McHugh, Food Security Honduras, February 2, 2001).

No word of actions having been taken by ECHO in order to approximate INGO's funded with other services of the E.C., could be heard. It seemed to rely entirely on INGO's responsibility to search that contact and win E.C. services -mainly DGDEV and B7/6.000- acceptance. As a reminder, B7/6.000 is currently co-financing health operations in Nicaragua to: OXFAM in Matagalpa and RAAN, GVC in RAAN and Honduran Mosquitia, and Health Unlimited in RAAN independently from the Global Plan's outcome.

VI.8. VISIBILITY.

The proportion of the overall budget spent on visibility was on average 1,22%, within a range going from 2,03% to 0,17%. Very few seemed to be happy with the quality of the visibility achieved with that money. A good share of partner INGO's felt that the visibility implemented, as it was conceived so far, was futile, besides being disappointing, and didn't reflect the actual impact of ECHO interventions. The abusive use of stickers, T-shirts, caps, etc. didn't improve too much the knowledge many beneficiaries had on ECHO and the EU. Nearly 90% of those interviewed had a clear information about the INGO working in that area, but less than 60% had the same knowledge about ECHO-EU.

Moreover, there seemed to be a lack of information regarding ECHO activities as perceived by the respective MOH's. ECHO's very low profile regarding national health authorities seemed to affect the notion they had about ECHO-funded actions.

Almost all INGO's approached declared they would welcome a clear-cut attitude of ECHO concerning visibility: to **establish clear guidelines, designed in co-ordination with the partner** INGO's, in order to accomplish a visibility valid for both.

VI.9. HORIZONTAL ISSUES: GENDER, LRRD, SECURITY...

a) Gender

- Only one single mention of "gender" can be traced throughout the Global Plan document (Chapter 6.2 Methodological approach). Partner INGO's declared having taken very much into account the gender issue when planning their interventions. Although no specific reference within many of the proposals could be found, some field interviews provided the information that at least some of the operations had tackled the problem. Components about gender issues included in the demands were not scrutinised in ECHO's "*Fiches de suivi d'operations*".

- Albeit gender is an issue which doesn't seem to bear a negative burden as far as health-related interventions are concerned -for many various reasons, maternal-child care tends to be one of

the specifically addressed target groups-, just **one fourth of the projects deliberately included components specifically aimed at women**.

b) LRRD

For a "continuum" to be successful, three principles need to be followed:

1. A hierarchical and time-bound sequence between emergency, rehabilitation and development.
2. A continuous focus on the same beneficiaries.
3. A concept of "integral approach".

The II provision of the revised CCP/FPC states to: "*Establish the linkage between relief, rehabilitation and development with a view to helping the population regain a minimum level of self-sufficiency...*". The ECHO 1999 Global Plan document reads: "*Most of the selected projects include an element with a long-term perspective...*". This inclusion could not be found in most proposals reviewed.

The Global Plan focused on PRRAC[9] as the natural link between ECHO actions and a longer-term approach. Although ECHO had already included PRRAC into its "*Fiches de suivi d'operations*" as a desirable link, there was only one single mention to ECHO found in a November 1999 600-page PRRAC document[10]. According to the PRRAC established strategies, INGO's have only access to a small component -"*Local Initiatives Fund*"-, which considerably limits their possibilities to arrive at a durable and comprehensive action.

VI.10 ECHO DISASTER PREPAREDNESS: DIPECHO

It is relevant to point out the overwhelming lack of information about DIPECHO's activities many sources expressed such as E.U. Members States, some INGO's under the Global Plan, local and national authorities not directly involved in disaster preparedness, etc. This was all the more remarkable knowing that the E.C. issued an appeal on February 2000 through its Website, encouraging Members States and INGO's to use this means to disseminate initiatives aiming at disaster preparedness. Under its Second Action Plan DIPECHO allocated 3.500.000 E to 10 organisations, 7 of which were already involved in ECHO 1999 Global Plan.

It was unequivocally believed by many that the answer to ECHO's phasing out in a future should imply **DIPECHO's weightier presence in Central America**. And DIPECHO should therefore become the logical counterpart to those humanitarian organisations focused on both emergency and rehabilitation issues. Although reviewing DIPECHO performance is out of the scope of this evaluation, some conclusions and recommendations on it will be added to the chapters below.

VII CONCLUSIONS:

1. Impact.

ECHO operations meant a significant impact for the well-being of the target populations, both as a result of the first and second decisions, and the Global Plan. The systematic lack of indicators encountered made sometimes very problematic to properly assess the degree of the impact reached. The operations contributed openly to diminish the risk of epidemiological outbreaks, and substantially improved the health situation of the vulnerable population.

It seemed, therefore, that the discusion laid not so much in whether or not ECHO interventions had a sufficient impact, but on measures taken to assess the degree of this impact, and on whether this impact had durable effects in the targeted populations. A health-

[9] PRRAC: "*Programa Regional de Reconstrucción de América Central*" (Regional Reconstruction Plan for Central America).

[10] "*Diagnóstico final de necesidades*" ACR/B7-3130/1B/1999/0302. November 1999.

related operation's general objective may or may not be achieved, but how substantially it will contribute to reduce human suffering and for how long, can only be assessed by means of sound and thoroughly applied performance indicators. ECHO failed to explicitly request its partner organisations to employ and implement them.

The beneficiaries clearly expressed their satisfaction by the way the projects had improved their purchasing economies, and didn't feel that they had grown any dependency.

Most interventions included a disaster preparedness component.

2. Relevance.

In general terms, ECHO correctly identified needs and showed a fairly good choice of beneficiaries. It could be that in order to reach the maximum amount of population, ECHO might have sometimes devalued the coherence of the aid delivered (i.e., building water systems and not latrines, or constructing a health post and not providing a water supply system or sanitation to that same population). As a whole, a majority of operations showed a correct design of strategies and a fair deal of logic in the way the interventions were planned.

3. Co-ordination and Coherence.

Co-ordination with other humanitarian players wasn't the strongest asset for nearly half of the assessed INGO's, which seemed to endorse an old claim made by several international players, that most ECHO partner INGO's appeared to only look after their little parcel of land where they deploy their activities, with a lack of apparent interest on different approaches.

Albeit slowly improving, ECHO partners in the field still showed a worrying inclination to work in an isolated way, as if sharing with other humanitarian players their little "fiefdoms" might affect their protagonism and, thus, their ability to generate more funding. For them, co-ordination appeared to equal to "overlapping prevention" and little more. ECHO might partly to be blamed on this. Sometimes, it seemed to encourage -though maybe unwillingly- this attitude by treating funding as if it was a "gift" to the INGO's.

It seemed that what many INGO's understood by a beneficiary's participatory involvement was not exactly what ECHO had in mind when its provisions were written. ECHO in the field didn't seem to play a role in reinforcing a true beneficiary participation. ECHO seemed to have a leaning to work closely enough with the INGO's and much less -provided there is sometimes any contact- with the local counterparts.

4. Effectiveness.

That most specific objectives were achieved didn't say too much, for lack of sufficient objectively verifiable indicators, and not only parameters: no indicators determined, no way to assess the quality degree of the operation, let alone to quantify it. Fair degree of achievements in the amount of specific objectives reached in the health-related interventions were identified, but no tools could be found to quantify the level of success.

It appeared that the Global Plan was rather effective in reaching the objectives proposed, but less in the coverage attained. The Global Plan also showed a fair share of positive effects achieved within the target population.

However, many INGOs had not a capacity to run rehabilitation interventions. For instance, Red Cross agencies, Caritas..., appeared to be good for downright immediate emergency actions, but they seemed to lose a grip with reality when they were appointed to carry out reconstruction and/or rehabilitation actions (e.g. CRE project in Northern Nicaragua, where some 150.000 E were spent in building a nice health centre which, nearly one year later, laid still empty and idle).

5. Cost-effectiveness.

Neither ECHO nor the INGO's showed a great concern about cost-effectiveness issues. Otherwise, tools for their analysis would have been in place from the very beginning of

the emergency appeal. The lack of a proper bookkeeping focused on activities instead on financial expenditure lines, made a proper approach to analysis impossible.

The absence of performance indicators both in the proposal and in the final reporting also hampered any effort to make any analysis on costs and achievements.

Taking a rather insufficient version of a proxy exposed, for cost-effectiveness analysis, some observations could be drawn:

1) that agencies which rated best concerning cost-effectiveness shared some common characteristics: *a)* had a previous permanent presence on the ground, and *b)* had access to their own funds.

2) that a higher proportion of the budget spent directly on the beneficiaries didn't necessarily mean better results.

ECHO has so far neither means nor tools to work on cost-effectiveness, and therefore has no strength to make any request to its partner agencies in order to grow cost-consciousness.

6. Efficiency:

The Global Plan made manifest a good planning capacity of ECHO partners, but showed a difficult to accept lack of respect for sticking to the time frame agreed upon. What sense does it make to set up a tight and strict package of measures limiting the out-of-control extension of operations, when two thirds of all interventions requested an extension, and nearly 50% of all had no convincing reason for that?

Logistics used in the operation showed to be well planned as a whole.

The monitoring skills of the majority of INGO's were shocking. Without properly designed indicators, most final reports ended up being a list of activities performed with no analysis of the actual achievements (e.g. lowering acute diarrhoea morbi-mortality rates could be achieved by building drinkable water systems, but the indicator to monitor and/or evaluate to what extent that objective was reached is not the number of wells dug in the process, but the actual decrease of acute diarrhoea cases over time).

Although ECHO experts in the field were found to be exceptionally competent and sound professionals, they seemed to be lacking of a considerable amount of relevant instruments and proper training to perform their tasks in the most efficient way. The fact that the lack of indicators contained both in the proposal and in the intermediate and final reporting wasn't remarked in the "*Fiche de suivi d'operations*", when it was clearly stated in the CCP/FPC, raised some concerns over the suitability of that tool -the "*fiche...*"-for performance follow-up. The quality of the reporting, with very few exceptions, was of a rather low quality.

7. Viability.

It seemed almost incontestable that, as much as the interventions financed within the first and second decision could almost disregard the search for viability, a rehabilitation approach such as that embodied within the Global Plan, with a well planned strategy and methodology, and with a specific and clearly cut aim of seeking durability, could not hide its responsibility in failing to attain that.

It seemed understandable that within a timeframe of 6 to 8 months, no health-related operation could pretend to reach a minimum degree of viability.

8. Visibility.

Visibility in the Global Plan was expensive, badly planned and satisfied no one. The present way of addressing it seemed to be working no more -provided it ever worked in the past...

9. Horizontal issues.

a) Gender:

ECHO didn't appear to be seen too concerned about the gender problem in developing countries. It was not shown in the Global Plan as a priority or one of the strongest interests. However, partner INGO's declared having taken very much into account the gender issue when planning their interventions.

In a general sense, gender is an issue which doesn't seem to bear a negative burden as far as health-related interventions are concerned -for many various reasons, maternal-child care tends to be one of the specifically addressed target groups.

b) LRRD:

Linking with other E.C. services appeared to be more of a singular initiative of an INGO, than a concerted action between ECHO, its partners and the E.C. development institutions. Initial PRRAC expectations didn't seem to address all concerns showed by the INGO's.

IX RECOMMENDATIONS.

IMPACT.

1. ECHO experts could sit down with its partner NGO's in the field -both European and local- and set up a comprehensive and agreed upon list of performance indicators to be of common use in those operations with specifically shared patterns (communicable diseases control, improvement of the health care services, etc.).
2. Activities for disaster awareness, preparation and mitigation could also be discussed with partner NGO's, so they could incorporate this component no matter the time span allowed for the operation.

RELEVANCE.

3. The issue of what partnership actually means for both ECHO and its partner INGO's should be addressed. Either ECHO trusts its partner INGO's or it doesn't. One or another answer will infer a totally different framework and strategy to be developed. It seems that what is in discussion is not so much whether or not ECHO partners were more or less competent, which it seemed according to these findings that they generally were. It rather is whether or not ECHO would accept taking the leading role in humanitarian emergency response and share its goals with its partner organisations. ECHO could make an extra effort in redefining the number of health-related International Non Governmental Organisations signing the CCP/FPC, with criteria agreed upon in advance with them, and then carefully screening which ones are actually capable to carry out the kind of humanitarian medical actions ECHO wants to share with them.

CO-ORDINATION AND COHERENCE.

4. For many INGO's, co-ordination seemed to be tantamount to not overlapping. ECHO might start thinking of financing pools of INGO's, each with different expertise and skills, to carry out integral medical relief to the populations in need. For that, ECHO would need partners that were not afraid to diminish their profile in favour of reaching a superior impact. ECHO could end the seemingly repeated practice of allocating its funds not on needs assessed, but on the amount of INGO's willing to pick up a "piece of the cake" (this said with the most respectful of intentions).
5. Participation of beneficiaries should involve not only the beneficiaries by taking an active role in the project implementation, but also by participating in the choices made, study of alternatives, the decision-making process and the way funds are spent -no matter the latter is little less than anathema to many INGO's. ECHO could request the INGO's to provide with detailed explanations on how they were going to incorporate the beneficiaries in their operations' different stages, in their

strategies and plans of action. ECHO experts in the field should consider this point as one which had to be closely follow and supervised, and accordingly design appropriate tools to make it happen.

Concerning INGO's local partner organisations, ECHO could also care more about the way its European partners interact with local ones -as ECHO might be lawfully responsible of a partner's subcontracted services delivered to the beneficiaries-, and integrate them in an effort to shaping the humanitarian actions towards a better fulfilment of needs. ECHO could give more of a say to local partner organisations, thus giving ECHO a better insight on how needs were met.

EFFECTIVENESS.

6. The evaluation identified reasonable achievements in the amount of specific objectives reached in the health-related interventions, but had no tools to quantify the level of success. ECHO should work hard with its partner organisations in order to set up an agreed upon collection of performance indicators and commit all operations to stand by them. Regular workshops between ECHO HQ's and partner INGO's representatives to discuss specific performance indicators and effective ways to collect information needed for them.
7. ECHO could rethink the contents of its CCP/FPC regulations, in order to allow partner INGO's to leave to their counterparts in the field, some essential items once the operation is over. As ECHO becomes the final proprietor of all non-perishable goods purchased with ECHO financing, those guidelines already in place but very seldom reinforced, which require ECHO partners to declare all non-perishable goods purchased with ECHO funding and communicate how are they going to dispose of, could turn into an excellent instrument of assuring a higher degree of durability. Vehicles should be purchased -as they are in many cases- and not rented. Communication items, computing material, etc. for use of the INGO, should also be purchased, and therefore would stay with the beneficiaries and not with the INGO, as it is now the norm, once the project finished.

COST-EFFECTIVENESS.

8. As it has already been mentioned, the absence of performance indicators both in the proposals and in the final reporting, hindered any attempt to make an analysis on costs and achievements. ECHO could work with its partner INGO's in order to bring forward a structured design to raise awareness concerning cost-consciousness.

   Firstly, ECHO could modify the way financial reporting is required now. ECHO, and therefore partner INGO's, should start also recording expenditure by activities performed and not only by financed items as it is done now. This would allow evaluators to have a full range of comparative data easy to quantify and cross-check at their disposal. Secondly, ECHO could encourage partner INGO's to make more use in their proposals of instruments apt to objectively record appropriateness, efficiency, impact, etc.

   Nevertheless, the evaluator admits that in terms of contribution to the well-being of the populations in need, too many parameters are to be considered, and some of them are beyond quantification. For instance, infant mortality rates[11] and maternal mortality rates[12]. The amount of determinants influencing both an infant or maternal death are so varied and difficult to measure, not to mention that many of them can act as cofounders (e.g. conditions which can artificially lead us to think that they are affecting the outcome, when they actually are not), that making the assumption that so many lives were saved by this or that intervention is often risky and misleading.

EFFICIENCY.

9. ECHO has to make up its mind: either sets up strict regulations limiting the timeframe under which an operation must be carried out, and then extensions would be exceptionally accepted, or shows a flexible "*à la carte*" approach and each operation becomes entitled to design itself the

[11] IMR: the number of children under 1 year-old dead per every 1.000 live births.

[12] MMR: the number of maternal deaths per 10.000 live deliveries.

desirable length for its intervention to have an actual impact, and therefore strict boundaries must be abandoned. The present stand does no good either to ECHO, nor to the partner INGO's, let alone to the beneficiaries, and also diverts considerable amount of resources by forcing INGO's to stick to sometimes irrational and constraining time parameters.

10. ECHO could develop what it is already contained in the revised CCP/FPC, and perhaps make an extra effort to design more training tools to improve ECHO experts' skills in monitoring and evaluation. This, together with giving more empowerment to those experts in the field, would always be the most adequate tools to monitor how far already prevailing and new regulations were being fulfilled.
11. A suggestion might be organising workshops with all ECHO partners at every country where ECHO is acting, to broaden and deepen their information about performance indicators, cost-effectiveness instruments, etc., and commit partner INGO's to comply with accordingly.

PERSPECTIVES AND VIABILITY.

12. ECHO could face viability in two ways: duration and methodology:

a) Duration: a health-related intervention which aim is striving to improve the health conditions of the population, besides the life-saving and life preserving commitment, should not accept strict time restrictions and boundaries. A health-related intervention must be lengthy enough to secure that both its objectives will be clearly achieved, and show beyond any doubt that the results will be sustained within a reasonably timeframe after the intervention is finished.

b) Methodology: this kind of operations should bear implicit to the proposal: i) a detailed, deep and thorough health needs analysis, ii) a clearly stated intervention strategy, and iii) a monitoring methodology with a set of objectively verifiable indicators, both quantitative and qualitative.

Conversely, no proposal belonging to this category would be accepted by ECHO unless it clearly and unmistakingly would define: 1) a handing over strategy, exactly determining who, how, and when this process was going to take place 2) a phase-out methodology and 3) a budget line allocated to a three-month process by which the intervention would be taken over by another longer-term institution or donor. This, to allow for viability once the operation would be completed, regardless of whether or not ECHO, under very specific humanitarian basis, might eventually commit itself to continuing funding the intervention for another period.

VISIBILITY.

13. Visibility ought to be subject of a shared, multidisciplinary approach rather than a marginal action carried out by the partner INGO's at its own risk. Visibility guidelines should be enclosed in a Global Plan to be further discussed an agreed upon with the participant INGO's. Partner INGO's could pool their budget lines and design together with ECHO a coherent, consistent and effective instrument, with the help of a professional of the communication sector, who would be appointed and paid for that.

ECHO should bear very clearly in mind that allowing a partner INGO to spend up to a 2% of the total budget in visibility, not only means an outrage to the beneficiaries, but also shows a lack of concern about the necessary proportion between the need of being noticed and the money spent on it.

HORIZONTAL ISSUES.

A) Gender:

14. Who among those having had the responsibility to design and set up the Global Plan for Central America, has developed previous experience and expertise in tackling gender issues in very complex socio-cultural environments like the ones ECHO is currently working? The question applies not only to ECHO staff both at HQ's and in the field, but also to the partner INGO's members working as well in the field.

When it comes to gender issues, in as much as many other matters, ECHO needs the backstopping of well trained professionals. That, or cease to endorse badly defined and envisaged actions, on something as extremely sensitive as the plight of millions of under-privileged, under-educated, sexually harassed, overworked, and in many cases enslaved human beings, both in Central America as in other regions of the world. Therefore, ECHO could take a more energetic action to favour participation of women at every level of the implementation.

B) LRRD:

15. ECHO could play a paramount role in connecting the partner INGO's to other longer-term financing lines such as DGDEV -both line B7/6.000 and Food Security-, DGRELEX -PRRAC, etc. It seemed to make very little sense that ECHO partner INGO's were constrained to fend for themselves when it came to securing a logical continuation to the operations already in progress, and there is a obvious need for a more integrated approach within a longer, more development-driven framework.
    ECHO seems to ignore the social implications entailed by the support it gives to the populations targeted. As far as health-related interventions are affected, ECHO can be morally accountable for not having tried enough to secure that the alleviation in suffering attained by an emergency or rehabilitation intervention could have a lasting viable aftermath.
16. The evaluator got the feeling that ECHO has somehow got an inclination to look at PRRAC as the scapegoat for the needs ECHO has failed to continue meeting, due to, not only its obvious limitations in mandate, but also its shortcomings in strategy, methodology, and accountability. Exactly like the partner INGO's have been bearing all the blame for failing to respond with their initiatives, drive and resources, to the populations ECHO decided to stop helping, when it clearly knew form the start no other donor or institution would take over.

ECHO DISASTER PREPAREDNESS: DIPECHO

17. DIPECHO could develop a more straightforward protagonism in disaster preparedness, maybe by detaching itself away from the limited ECHO strategy concerning disaster preparedness, and taking a leading role in those disaster-prone regions, a case in point is Central America, where ECHO prepares itself to leave. This would entail substantial strengthening of DIPECHO's weight in Brussels, with a consistent increase in budget and staff.
    An answer from DIPECHO to the Central American region could be the setting up of a permanent regional office with enough capacity and means to address a fair share of the shortcomings in disaster preparedness this region still endures. This could be done taking very much into account the need for experienced and well trained personnel in disaster preparedness and prevention issues.

X LESSONS LEARNED.

1. Accepting a proposal submitted when ECHO knows -or could make the necessary analysis to know- that completion of its goals, technically speaking, would reasonably take longer than the maximum period ECHO is prepared to finance, no matter the period so stated in the proposal be shorter, should be careful weighted against the harm it can cause to ECHO if the results end up being of a poor quality. Very often not doing something is better than doing it badly, and ECHO ought to strengthen its capacity for cost-opportunity analysis, beyond the unavoidable answer ECHO must give to acute emergency disasters.
2. Partnership is a concept ECHO seems to be at odds with. Partnership is about a two-way trust, and neither ECHO nor the partner agencies show a proactive commitment to each other. How could ECHO avoid this tortuous feeling of always being in disadvantage face to its partner INGO's, which forces ECHO to give in to proposals not always very solid, and then start building a true relationship based on shared goals and humanitarian commitments?
3. ECHO has apparently learned that problem-sharing is something more rewarding and effective than a vertical approach to a difficult question, and ECHO seems to have started the right path towards achieving it with its partner INGOs in the field. But very often it looks as if this sharing

commitment stops short of reaching ECHO HQ's. Thus, it happens to be left to the ECHO expert's good will and experience to develop it. Different ECHO expert's personalities, expertise and cultural background bring in different attitudes. ECHO would benefit a great deal if it incorporated this process at a decision-making level.

4. It seems obvious that ECHO could profit from all the knowledge and skills its partner INGO's have developed all around the world. From ways to design, plan and analysis to monitoring tools, strategies set up, effectiveness, and so on, ECHO's partner INGO's could bring an endless source of expertise to ECHO.