

**EVALUATION OF OXFAM'S PUBLIC HEALTH PROGRAMME  
IN LIBERIA**

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## **Acronyms:**

IDP	Internally Displaced People
ADD	Acute Diarrhoeal Diseases
SHPM	Senior Humanitarian Programme Manager
PC	Programme Co-ordinator
PSM	Programme Services Manager
PHC	Public Health Co-ordinator
TTL	Technical Team Leader
PHTL	Public Health Team Leader
MRD	Ministry of Rural Development
SMT	Senior Management Committee
FGD	Focus Group Discussions
GBV	Gender Based Violence
Watsan	Water and Sanitation
PH	Public Health
WASOMs	Water and Sanitation Committees
ERM	Emergency Response Manual
INGO	International Non Governmental Organisation
LNGO	Local Non Governmental Organisation
UNICEF	
ACF	Action Contra Faim
MSF	Medicins San Frontier
ECHO	European Community Humanitarian Office
CBM	Community Based Management

## **Executive Summary:**

This evaluation covers the water, sanitation and health promotion aspects of the Liberia Public Health Programme, which was funded by OFDA and ECHO for the period from August '03 to April '04 and November '03 and April'04 respectively. The main aim of the project was to protect public health of war affected people. The evaluation was conducted over a period of two weeks (28/04 –12/05/2004), by a team of six Oxfam public health staff headed by Daudi Bikaba, a Public Health Engineering adviser from the Humanitarian Department.

Oxfam GB timely conducted assessments and the designed responses were appropriate. However because of the difficult context in which the OFDA and ECHO funded projects started, which also created lots of logistics constraints and because of the fluid situation and movement of the displaced people in widely spread areas where Oxfam worked, SPHERE standards were not largely met.

It was difficult to assess the impact of the work as much of it had just been completed or was in the process of being completed particularly the technical aspects of latrines and wells of the ECHO funded project. However, as part of this evaluation, attempts were made to gather information from communities and different stakeholders and compared with baseline reports. Information collected showed that beneficiaries had more knowledge and practiced hand washing, proper storage and use of safe water, on the use of ORS, proper use and maintenance of latrines where they existed and diarrhoea was considered less of a problem, but the respondents had little change in their knowledge and treatment of malaria. Overall, there were no reported outbreaks of communicable diseases in the project area within the project timeframe. The Liberia Public Health Programme activities were widely commended by different stakeholders like the beneficiary communities, ECHO, ACF, MSF, UNICEF and Ministry of Rural Development. Beneficiaries praised the response, which was covered by this evaluation that it really had a positive change in their lives and widely prevented the spread of water and sanitation diseases in the project areas where Oxfam worked.

The scale of programme implemented was felt to have been appropriate, although perhaps somewhat ambitious for the short timeframe in the ECHO funded project, which precipitated the need to seek extension. There were many delays in the implementation of both the OFDA and ECHO funded projects, which resulted in the majority of the work being rushed to be completed in the last 1-2 months of the projects' life despite a one month no cost extension for the ECHO funded project.

Staffs were recruited as early as December 2003. Delayed implementation of ECHO funded project portrayed inefficient use of time and resources. The rush resulted in few examples of substandard work in the areas visited and also meant that not all of the community structures like water and sanitation committees and community motivators, which Oxfam established in camps and villages to promote sustainability were functional to the level expected.

Whereas delays in implementation of the public health projects was attributed to logistical constraints, the evaluation established that ambitious proposals/plans and late start of especially the ECHO funded project (five months project implemented in three months) poor planning and integration among the field and support sector teams, were largely responsible for the late completion of project outputs. This may largely be overcome in future by having all inclusive/joint plans at both programme and field level and planning of outputs that are more realistic within projects' timeframes.

On technical grounds, the quality of work was felt to be generally satisfactory though there was need to improve and substantial amount of work remained to be completed under the ECHO funded project. There was need to review designs for hand dug wells to minimise possibilities for drying up and producing turbid water, make chlorination of wells more effective and also mobilise communities to dig new pits and re-use materials available to replace any latrines that fill up.

There are gaps in sharing information between the different teams/sectors on one hand and utilisation of the gathered information among the team on the other hand. The monitoring of impact of water, sanitation and health promotion activities could be improved if information gathered by the community motivators and Oxfam's field team is analysed on weekly basis, used to inform responses and does not only focus on process but also impact. The Liberia programme has developed a good monitoring framework, which if used in future, will improve the monitoring of both process and impact of Oxfam's public health responses in Liberia. Management should enforce the monitoring framework and senior management should monitor fieldwork through regular field visits.

At community level, participation in some of the programme activities appeared to have been low except in camp cleaning days and training and management for water facilities. Initially community members were not widely involved in the design and choice of activities, but had been key in identifying problems and site selection. Most of the work done in the camps was through paid labour/contractors. Improvements need to be made in community participation to promote ownership and sustainability of interventions. This could be gradually introduced through collection of locally available materials and volunteering labour in latrine building, repair and construction of new water points.

Oxfam identified the most appropriate public health community structures to work with at village and camp levels and this approach was considered to be largely effective. Furthermore the programme was felt to have laid some of the foundations for community based management (CBM) and changes in practice, although following such a short intervention period further work is required to consolidate and realise this potential. Linkages of such community structures with camp management and local authorities were found to be weak and need to be improved in future.

Gender and Protection have been well mainstreamed in public health delivery. Field staffs feel confident to discuss human rights issues with communities largely because of the training that has been conducted with both staff and community leaders on protection issues. There are still issues on how reported human rights issues can be followed up, which will need addressing to avoid frustrations that are arising from offenders not being reprimanded.

In terms of co-ordination, Oxfam's experience analysis of the links and need for Public health was appreciated and well respected by different INGOs, LNGOs and government departments involved in the sectors within the country. The head of ECHO in Liberia felt that Oxfam was playing a significant role in public health in Liberia. Oxfam's experience and respect within the sector led UNICEF and MRD to consider it as one of the lead INGOs on policy technical committee within the co-ordination group. Oxfam GB in Liberia is however letting itself down by not regularly attending meetings and co-ordination obligations, which in turn has started raising tensions with main co-ordination bodies like MRD and UNICEF. The evaluation also observed weakness in co-ordination at field level among agencies. There was little information sharing among organisations at field level and incentives for community volunteers are still a sticking issue, which need to be resolved and harmonised among the different actors.

The handover process and exiting of the humanitarian projects in all project areas was unclear and not well defined. There seemed to be no exit strategy. Contracts of all programme staff were terminated and a few were re-interviewed, which led to a lack of continuity in technical staff and programming although there had been some discussion about rehiring all of them when funding was secured.

There are 12 sections in this evaluation report and throughout the report recommendations for action have been developed for future PH programmes based on the themes. The write up is divided up as shown in the table of content and in relation to the terms of reference.

## **1.0 Introduction:**

The initial ToR for the evaluation of the public health programme in Liberia for the period August 2003 to April 2004 were very broad, however after discussions with the Senior humanitarian programme manager and the Project Co-ordinator, it was agreed that the main purpose of the evaluation was for internal learning, with the aim of identifying lessons for future programme design and implementation. The full terms of reference are attached in appendix 1.

## **2.0 Background:**

When the Liberia conflict escalated between June to mid August in 2003 and government troops clashed in the suburbs and the capital city of Monrovia, several hundreds of thousands of people were displaced from the Montseraddo IDP camps and the suburbs of Monrovia. Relative calm was restored in Monrovia and its surrounding shortly after a peace agreement between the warring parties was signed on the 11 August and the peace keeping forces started arriving in Liberia. Aid organisations and agencies started gaining access to the displaced people towards the end of August of 2003.

Oxfam conducted assessments in August in camps located on the outskirts of Monrovia (Jahtondo, Wilson and Seigbeh) and Salala camp, which is 80 km outside Monrovia. Oxfam submitted a proposal to OFDA to implement an integrated public health project in the assessed camps for three months but later extended the proposal to cover a total of nine months (August 2003 – April 2004). As more people returned to the camps, the needs grew by leaps and bounds beyond the initial proposal of 3 months.

Even when there was relative calm in Monrovia and the surroundings, several tens of thousands of people remained camped in institutions like SKD stadium, Masonic lodge, Bright and Thompson compounds due to uncertainty of security outside Monrovia.

From late August to mid September 2003 humanitarian INGOs working in health and WHO reported, non – laboratory confirmed cases of cholera in the city and peri-urban Monrovia areas. Oxfam followed the report of an outbreak of cholera with an assessment in the last week of September 2003. The assessment was carried out in cholera hot spot areas (SKD stadium, Soul Clinic, police Academy, Oxygen factory, Duport Road, and Mount Barclay camp, which was the proposed site to relocate the displaced from the city centre.

Oxfam submitted a proposal to ECHO to reduce the risk of cholera and other acute diarrhoeal diseases in the above-mentioned areas starting in November, when cholera was expected to peak due to rains, but also develop preparedness for the following rainy season, which starts in May.

This evaluation covers the projects funded by both ECHO and OFDA for the period August 2003 to April 2004.

## **3.0 Methodology used.**

Methods used in this evaluation included:

- Reviewing key documents, such as the project proposals, interim and draft final reports to ECHO and OFDA, monitoring reports, internal memos, and sitreps. Advisors' visit reports, end of deployment and hand over reports.
- Meetings with all key Oxfam staff of the Liberia programme.

- Community meetings and focus group discussions in Mount Barclay camp Police academy and Duport road communities for the ECHO funded project and Salala, Jahtondo and Wilson camps for the OFDA funded projects.
- Discussions with Community motivators in Salala, Jahtondo and Mount Barclay camps.
- Meeting with the director of community services in the Ministry of Rural development (MRD)
- Meetings with other Actors and partners like UNICEF, ECHO, CONCERN, ACF, MSF-F and EDEN
- Visits to Salala, Jahtondo, Wilson, Mount Barclay camps, and Police Academy and Duport Road programme areas.
- Observations of water systems, latrines, practices like hand washing and general environmental health situation and discussions with groups of people, particularly targeting groups of women on their own and talking to children and key people within the communities like the community motivators and leaders.
- SWOT analysis with Oxfam's Public health staff.

#### **4.0 The Public Health Projects:**

The OFDA funded project had the following specific objectives:

The project's stated aims were to protect and promote public health through a variety of interventions for war affected people. The priority being to ensure that adequate water and sanitation complemented by hygiene promotion existed to minimise the risk of serious outbreaks of water sanitation and hygiene related diseases but also mainstream gender and protection issues.

The ECHO funded project had the following aim and specific objectives:

The project overall aim was to contribute to meeting critical public health and protection needs of people affected by conflict in Liberia.

The project's stated specific objective was to reduce cholera and acute diarrhoeal diseases (ADD) by 25% in IDPs and host communities by increasing knowledge of the dangers, causes and prevention of cholera to protect and promote public health through a variety of interventions of the displaced people. The priority being to ensure that adequate water and sanitation complemented by hygiene promotion existed to minimise the risk of serious outbreaks of water sanitation and hygiene related diseases but also mainstream gender and protection issues.



### Water, Sanitation and health outputs achieved -August 2003 to April 2004

Objectives	Number of Beneficiaries	Planned Outputs as per Proposal	Activities completed by April 2004.
Access to Safe water Provision	56,000 ECHO	16 new wells 20 rehabilitated wells 150 wells chlorinated 72 pump attd. trained	20 new wells with hand pumps <sup>1</sup> 21 wells rehabilitated No records of wells chlorinated 70 Wasom members trained
	150,000 OFDA	40 new wells 20 rehabilitated wells	31 new wells fitted with h/pumps 15 wells rehabilitated
Access to latrines and bath shelters	ECHO	330 latrines stances  60 bath access	205 new stances (semi-permanent) 40 new stances at institutions <sup>2</sup> 80 bathrooms provided
	OFDA	400 latrine stances	785 <sup>3</sup> new latrine stances provided 640 latrine stances rehabilitated 401 emergency stances provided 98 new bathrooms provided 250 bathrooms rehabilitated
Improved awareness and hygiene practices	ECHO	2750 Hygiene kits 80 trained motivators	3,015 Hygiene kits distributed 82 Community motivators trained 5 Wasoms(70pple) established & trained
	OFDA		
Location _OFDA			
Salala camp	25,306		22 new wells with hand pumps 1 well rehabilitated with h/pump 1 piped water scheme providing about 200,000l/day 270 new stances (semi-permanent) 252 emergency latrine stances <sup>4</sup> 78 bathrooms provided
Jahtondo	18862		5 new wells with hand pumps 5 wells rehabilitated 295 new stances (semi-permanent) 205 stances rehabilitated 120 emergency latrine stances <sup>5</sup> 74 bathrooms rehabilitated
Wilson Camp	27,630		2 new wells with hand pumps 7 wells rehabilitated 180 new stances (semi-perm'nt) <sup>6</sup> 135 stances rehabilitated 19 emergency latrine stances <sup>7</sup> 46 bathrooms rehabilitated.

<sup>1</sup> Two wells seen were not yet complete at time of evaluation

<sup>2</sup> These were built in permanent material but about 40% of the work was not complete.

<sup>3</sup> 40 of these latrine stances, which were constructed in temporary shelter location were closed in November 2003

<sup>4</sup> All these temporary latrines were not functional by the time of the evaluation.

<sup>5</sup> Only 20 emergency latrine stances were still functional at evaluation time. The rest had been closed and replaced with semi-permanent latrines.

Seigbeh Camp	16,630		2 wells rehabilitated 280 stances rehabilitated 10 emergency latrine stances <sup>8</sup> 106 bathrooms rehabilitated
SKD, International and Bright schools	16,000 <sup>9</sup>		40 new stances 20 stances rehabilitated 24 new bathrooms provided 24 bathrooms rehabilitated
<b>Total</b>	<b>104,428</b>		
<b>Location-ECHO</b>			
Mt Barclay camp	15,515		6 new wells with h/pumps 4 wells rehabilitated 100 new latrine stances provided 40 new bathrooms built 14 Wasom members trained
Soul Clinic IDP camp and community	19,908		2 new well with h/pump in comm. 1 well rehabilitated 105 new latrine stances provided 4 new stances for Institution 40 bathrooms built. 14 Wasom members trained
Chicken Soup Factory	15,000		4 new wells with hand pump 4 wells rehabilitated 4 new stances for at Market 14 Wasom members trained
Struggle Island	7,600		1 new well with h/pump. 3 wells rehabilitated 8 new stances for Institution 14 Wasom members trained
Police Academy	19,240		3 new wells with h/pump. 2 wells rehabilitated 8 new stances for Institution 14 Wasom members trained
DU Port Road	21,057		4 new wells with h/pump. 7 wells rehabilitated 16 new stances for Institution 14 Wasom members trained
<b>Total</b>	<b>98,320</b>		

## 5.0 Management Issues

Overall management was out of the scope of this evaluation and at the time of the evaluation, an audit was under way. Details of how the Liberia programme was managed may be covered in the audit report. Only management issues directly linked to programme delivery are covered in this evaluation report.

<sup>6</sup> 50 stances well full and closed by evaluation time

<sup>7</sup> All 19 emergency latrine stances were closed at evaluation time.

<sup>8</sup> All 10 emergency latrine stances were closed at evaluation time.

<sup>9</sup> At evaluation time, all the IDPS at this location had been moved to IDP camps.

## 5.1 Decision making:

Decisions were made by the SMT, which consists of the Senior Humanitarian Programme manager, Programme co-ordinator, Programme Services Manager (PSM), Public Health Co-ordinator (PHC), Technical Team Leader (TTL), Public Health Team Leader (PHTL) that sat once a week with minimal consultations with field staff. Decisions taken in SMT meetings were either communicated through memos or Team Leaders were expected to pass on such decisions to other staff.

Interviews/discussions with staff and managers revealed the following management issues:

The Liberia programme structure had so many management layers and there were overlaps and cross over in roles and responsibilities, leading to situations where line management was not respected but also inconsistent and/or delayed decision-making that was crucial to programme delivery. As an example, the request to ECHO for a one month no cost extension was made few days to the end of the project life with limited consultations with programme delivery staff on whether one month would be enough to complete the remaining work.<sup>10</sup> There was also confusion among the different sectors (logistics in particular) as to whether the extension was for the month of May or April.

Some delays experienced in programme delivery can be attributed to inconsistent decision-making and unclarity on who was responsible for decision - making within the SMT on particular project delivery issues<sup>11</sup>. In some situations, managers were either too busy, not in country or having different priorities. As an example, a request for \$30 from field staff for a pump spare part, that required urgent approval from the different layers of the SMT could easily take a week to go through the chain of approval. Implications of such a management structure to an emergency response are numerous and could have been avoided by spreading authorisation levels down the ladder in the earlier stages of projects implementation. The authorisation process was reviewed in the last quarter of the project life after programme delivery was so much behind schedule, which later led to a rush to complete project outputs.

Because of the many management layers, communication and feedback <sup>12</sup>on crucial programme issues did not timely reach field staff and likewise top management felt that they were not timely and well informed about what was happening in the field.

There were limited field visits by the SMT and monitoring of programme delivery in relation to inputs, impact and cost benefit was weak. Decisions like the stoppage of incentives to community motivators were taken without wider consultations and consideration of the implications it could have at field level, at a crucial time of programme delivery. The number of active community motivators in Salala camp for example, immediately dropped from sixty to forty within the first week when the decision to stop incentives was communicated to the motivators.

A very high demand on SMT's time to write proposals, sitreps, monthly and donor reports, in country co-ordination meetings, organisational demand from the RMC and Oxford to provide programme updates and teleconference, inductions e.t.c. left little time for the managers to visit the field.

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<sup>10</sup> The remaining amount of work in the ECHO funded project is unlikely to be properly done and completed by the end of May.

<sup>11</sup> Based on the memo written to logistics by the SHPM in April about procurement and prices of cement and the discussions thereafter between logistics and the PC. It was unclear who was responsible for taking that decision. (SHPM or PC )

<sup>12</sup> SWOT analysis with the Public Health staff.

## Lessons and Recommendations:

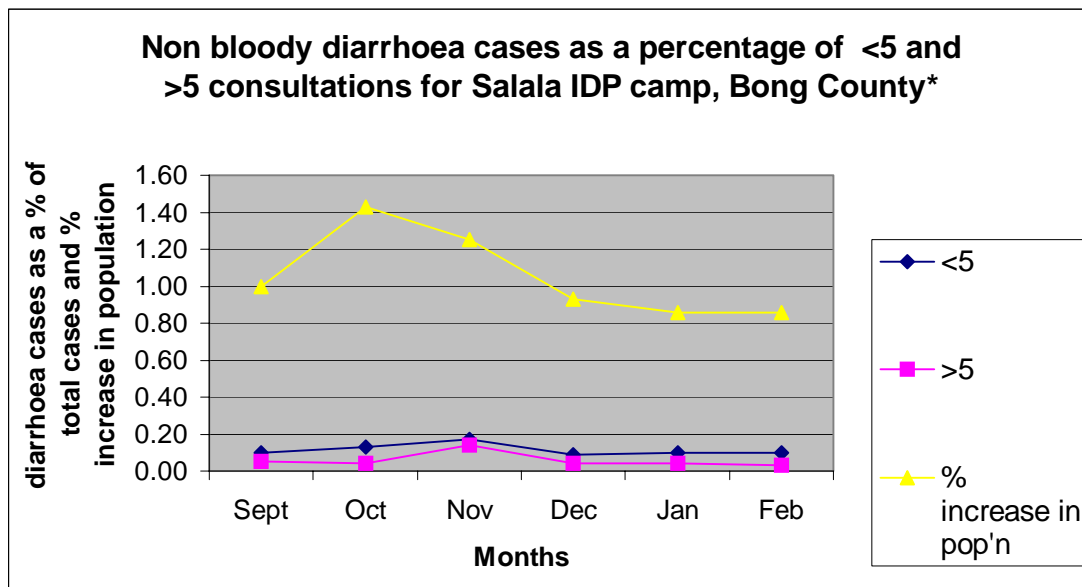
- The structure was being reviewed at the time of the evaluation, however it should not have been acceptable to continue for that long. A review of such a dynamic programme (including management) should in future be done every six months.
- Different Managers' field visits should also be built into plans that are drawn at the beginning of implementation. The SMT (managers in the new structure) should visit the field on rotation basis.
- Clear roles, responsibilities, tasking and delegation among the SMT will in future minimise overlaps and crossovers and streamline decision-making responsibilities.

## 6.0 Findings:

### 6.1 Impact

The evaluation did not seek to determine lasting changes in the lives of the target population but rather whether Liberia programme did what was set out to be done. Although it is difficult to assess the impact of the work as much of it, particularly the technical aspects of the latrines and wells, bed net distributions and training of water and sanitation committees were completed within the month of the evaluation, the project did tremendous work under the difficult prevailing conditions. One of the indicators helpful for determining impact on people's lives in an emergency is the mortality and morbidity rate. There was no outbreak of communicable diseases in the project area during the period when Oxfam implemented the public health projects. There has been a lot of movement of people but instead of increase in communicable diseases, there was a general reduction in diarrhoea in the populous camps of Salala and Jahtondo as evidenced by data provided by medical INGOs in the graphs below.

#### Non bloody diarrhoea – Salala camp September 2003 – February 2004<sup>13</sup>

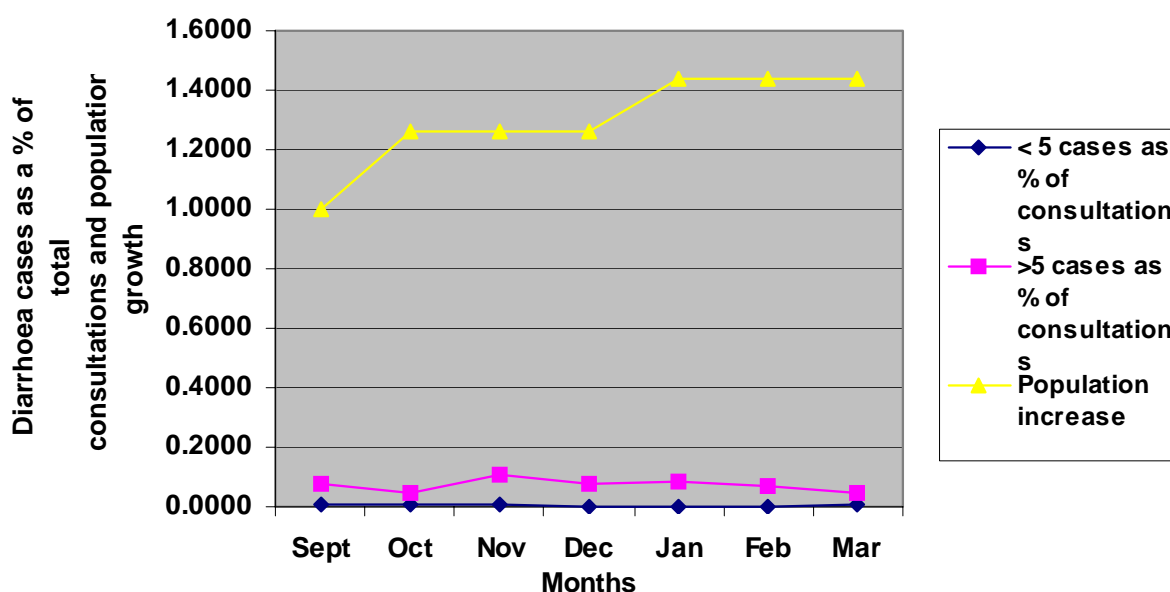


#### Non bloody diarrhoea – Jahtondo IDP camp Sept 2003 – March 2004<sup>14</sup>

<sup>13</sup> Data provided by MSF-F and graph got from DEC report

<sup>14</sup> Data provided by World Vision and graph from the DEC report.

**< 5 and > 5 diarrhoea cases as a % of total consultations in Jahtondo IDP camp from Sept 2003 to March 2004 against population increase\***



The above graphs are mainly from the OFDA funded project areas and are collated by monitoring reports based on information collected by community volunteers at community level. Because of a late start, baseline information on ECHO funded project was collected and analysed in late February<sup>15</sup>, much later than the cholera peak times, however information collected by the community motivators indicate reduction in diarrhoeal diseases<sup>16</sup> in the project area, especially Mount Barclay camp, which now accommodates the displaced who were previously camped in cholera hot spot areas in the city of Monrovia.

Also, talking with people in the camps and resettlement areas the impression is that outbreaks of disease have been averted. In the camps, the provision of latrines has had an impact on peoples lives, as those who have access to the latrines are generally using them; however the impact will only be for a short time as the latrines are fewer and were filling up very fast due to a higher user ratio. Potties are widely accepted and used for disposal of children faeces and have been successful in reducing backyard defecation, which was a public health risk in the closely built IDP camps at the initial stages of the project.

When the evaluation team questioned and observed people, and asked groups of children in the camps to tell us their hygiene habits, the responses indicated that people generally had good understanding of the main public health principles, good hygiene practices and the use of ORS.

<sup>15</sup> ECHO project baseline report.

<sup>16</sup> Information had been collected but it had not been fully analysed for all ECHO project areas. Only about 60% of the planned outputs had been achieved.

## 6.2 Effectiveness

Assessments were timely conducted using appropriate tools like the ERM and SPHERE. The first assessment was done in August when people who had been displaced from the Montsarrado camps were just starting to return to the IDP camps. The major second assessment done within Monrovia and peri-urban areas was in response to an outbreak of cholera. Assessments conducted were timely, identified the major problems and the designed responses largely met the objectives. There were less consultations with wider sections of the communities in the initial stages of the emergency response but this improved in later stages of programme delivery.

The specific objectives of the OFDA and ECHO funded public health responses were respectively stated in the proposals as:

1. To ensure that target communities have increased and sufficient access to potable water, proper sanitation facilities for faecal disposal and bathing, create awareness to good hygiene practices and play a role in the working of the protection system.
2. To reduce cholera and acute diarrhoeal disease by 25% in IDPs and host communities by increasing knowledge of the dangers, causes and prevention of cholera and acute diarrhoeal disease through the provision of hygiene kits, improving access to potable water better sanitation, chlorinating wells and household chlorination and health promotion.

The set objectives were largely met especially in the OFDA project though a reasonable part of the construction work of latrines and wells and distribution of items like mosquito nets were not completed until April. Baseline information and monitoring information gathered and reports seen, which combined both proxy indicators and statistics from medical agencies and organisations suggest that the response largely met the objectives (see graphs below)

Based on interviews, field visits and focus group discussions held with communities in the operational areas, the following indicators gave an indication of the effectiveness and perceived impact of the response:

- The ECHO funded project reached about 98,000 people compared to a planned population of 56,000 people with the same resources. The resources may have been spread too thin and therefore not meeting the desired SPHERE standards. On the other hand, the OFDA funded project reached a population of about 104,000 out of a planned 150,000 people.
- About 95% of physical infrastructure construction was achieved on the OFDA funded project.
- About 60 percent of physical infrastructure construction had been completed at the time of the evaluation on the ECHO funded project. The main reason for a low output achievement was due to a late start. Programme delivery that was due to start in November '03 and finish in March '04, did not effectively start until Feb'04. A five months' project was implemented in three months including a one-month no cost extension.
- Beneficiaries were generally happy with Oxfam's response and they felt the projects had improved their lives with clean water, access to latrines and disposal of human excreta in a dignified way. The camps were perceived by the communities to be cleaner and healthier than they were three to six months ago. During transect walks, camps were observed to be clean and free of faeces, and solid wastes.

- Water systems and over 90% hand pumps on wells in all the operational areas visited were functional and used by the intended users. Even where there are alternatives unprotected sources, communities preferred to use water from protected sources for drinking.
- Communal latrines, which were separately built for males and females are used and well maintained by the beneficiaries and are actually filling up fast because of higher user ratio. Potties that were distributed as part of the hygiene kit are popular, valued, widely accepted and used for disposal of children faeces and have been successful in reducing backyard defecation, which was a public health risk in the closely built IDP camps.
- Practice of hand washing after use of latrines and before eating was appreciated and has been adapted by over 90% of the samples interviewed, including children. This percentage indicated an improvement from 85% that was recorded in a monitoring report for Jahtondo camp<sup>17</sup> for the period of mid October to end of November 2003.
- Mosquito nets are widely accepted though there were operational difficulties and differences in their use.
- Generally, protection was considered in programme delivery through inclusion of men, women in designing and siting of public health facilities.
- Communities are aware of their entitlements and Oxfam staff and community motivators are always on the look out and report any protection issues like GBV and other human rights abuses.

Initial programme delivery planning was done and followed up with reviews but the plans were not all inclusive of the different support sectors. The review plans later got disjointed and did not take place for a long time after December last year.

There was a rush in completing the work before the project ended and as a result, quality was affected in some few instances as evidenced by some wells that were drying up and producing turbid water in Salala and Jahtondo and a leaking headwall in Duport road. In the cholera-affected areas (ECHO funded project) a number of dug wells were not yet lined and many latrine superstructures were incomplete in Mount Barclay and Duport road areas. **This situation was attributed to late starting of the ECHO funded project but mainly due to the fact that the planned outputs were ambitious in a widely spread area and in a situation with challenging logistics and getting in supplies. Implementation of the ECHO funded project, which was planned for five months was done in only three months. The 60% achievement at the time of the evaluation was realistic within the implementation period.**

#### **Lessons and Recommendations:**

- Much as the needs in this particular case were high and proposals were driven by immense needs more than anything else, in future, the Liberia programme should present realistic and achievable plans and proposals based on experience and context to avoid jeopardising Oxfam's relationship with donors. RMC and Oxford should provide more guidance based on institutional memory.
- Better communication with donors in terms of timing and progress of work could have either led to revision of outputs or increased time for implementation to compensate for the delays at the start of the project.

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<sup>17</sup> From Jahtondo and Wilson camps, monitoring reports from Mid October to end of November

### 6.2.1 Safe water Provision:

Oxfam GB is the lead agency responsible for water supplies in Jahtondo, Mount Barclay IDP camps, cholera hot spot areas like Soul clinic, Police academy, and Duport road areas and jointly with MSF-F in Salala camp. In addition, Oxfam has assisted with water provision in other camps like Wilson and Sewgebe by constructing more wells.

Liberia being one of the countries with the heaviest rainfall in Africa, has a lot of water but the main health concern is the quality of water. To meet the immediate water requirements of the displaced and cholera affected areas, different approaches like pumping, treatment and distribution was done in Salala and chlorination of wells in cholera hot spot areas as hand dug wells were constructed.

Hand dug wells are the most widely used and accepted technology for water provision in Liberia. The use of hand-dug wells fitted with hand pumps for longer-term supplies is a sensible decision. Chlorination of pumped water and wells as initial response to quickly meet the water requirements of the displaced, also made sense considering that construction of a well takes about 2 weeks to complete.

From available data and from observations in the field, water provision largely meets Sphere standards in terms of quantity, quality and distances in only Salala camp. Records of water available that were kept by field staff are based on pumping times. Water availability data<sup>18</sup> collected and presented is not collated with amounts of water actually used by the beneficiaries. The data was misleading as 8 hr or more of pumping was assumed and yet in transect walks, a number of pumps were observed to be locked during the day. This makes water availability figures for the camps questionable. All water points were located within acceptable distances though the quantity of water available and distances may change as camps keep on receiving new displaced people.

Due to increasing numbers of people moving to the camps where Oxfam is working, Sphere standards have not been met in other camps like Jahtondo and Mount Barclay where Oxfam is the lead water provider. Proposals did not consider allowances for contingency for increased numbers of people to be served. The overall total numbers of IDPs to be supported in the different camps were difficult to estimate, which made planning to meet Sphere standards difficult.

Oxfam's presence in Liberia for several years gave the organisation an edge over other water providers in hand dug well construction. The programme is well equipped and the quality of work is higher as evidenced by the higher number of wells that provide water even in the dry season. However, below are areas that might require review/improvement:

- I. The design and construction method used for hand dug wells does not use porous concrete rings in the water bearing layers and the size of the gravel packing used in some of the wells is too big. This might be responsible for the few wells drying up and producing turbid water in Salala and Jahtondo.
- II. MRD requires that logs of newly constructed wells are maintained<sup>19</sup>. From records available, this is not being done and may create an information gap for future maintenance and well construction programmes.
- III. Site and well safety precautions during construction are inadequate and expose dangers to especially children who live close to the wells. The fences are inadequate and in the case of mount Barclay camp, one well had been left for weeks without lining it and stood the risk of collapsing with the coming rains.

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<sup>18</sup> Analysis of existing Watsan facilities as of 27/04/04

<sup>19</sup> From Guidelines for well and latrine construction in Liberia.



### **6.2.2 Chlorination of wells.**

Discussions with the Public health co-ordinator and other Oxfam staff, who were involved in the activity of pot chlorination of traditional wells in the cholera risk areas revealed that the exercise was not very successful for the following reasons:

- Chlorination started late when the cholera outbreak was already under control.
- It was difficult to maintain residual chlorine especially at peak hours when water was drawn very fast. Water from different wells had different chlorine demands depending on the organic content and quantities of required chlorine were difficult to control.
- Pot chlorination required close monitoring to achieve the necessary contact time.
- Chlorine monitors required intensive training.

Other actors in the water sector like UNICEF, MSF-F and ACF collaborated Oxfam's experience. Whereas all the different actors agree that chlorination needs to be done during a cholera outbreak, there was need to review how it is done to achieve maximum effect.

Further, recent studies have confirmed that most contamination happens at household level. An effective chlorination exercise could in future include direct chlorination of water being taken home with a strong message of leaving the water for at least 30 minutes before drinking it to ensure complete chlorination. This could be accompanied with household monitoring to check whether there would still be some residual chlorine.

#### **Recommendations:**

- More work/presence of Oxfam in camps due to increasing numbers of IDPs in the camps.
- In future water availability figures should be accompanied with surveys and discussions with communities on how much they are using.
- Well logging should be done as best practice and to conform to MRD guidelines.
- The technical team leader and the Public health engineer should review the designs of hand dug wells to include the use of porous rings within aquifer layers and conduct refresher on -job training for technicians in well construction techniques.
- Improve site safety precaution measures. Oxfam's well construction manual gives guidance on well safety measures that should be enforced as a matter of good practice.
- Oxfam should review or study different ways of chlorination before the next cholera outbreak, which usually peaks in June/July.
- Flexible responses should be supported with budgets and contingency stocks.

### **6.2.3 Sanitation:**

Oxfam is responsible for sanitation by provision of latrines and bathhouses in Montsarado camps, Mount Barclay, Soul clinic and all the cholera high-risk community areas and institutions that were hosting IDPs..

The technology for excreta disposal facilities varied from communal blocks of 5 or 6 blocks constructed in temporary or semi permanent materials that were separated for men and women to permanent and semi-permanent ventilated improved pit latrine (VIP) for institutions and markets. From October 2003, when temporary latrines filled, blocks of latrines constructed in semi-permanent materials replaced them. In the circumstances the choice of technology was appropriate at the different stages.

The initiatives of changing design and use of plastic sheeting and mats to zinc sheets for latrine superstructure, was appreciated by the communities and has largely solved the previous experiences of repeated theft and/or damage of plastic sheeting from latrines. *This was identified by the evaluation as a good practice of learning from previous experiences and improving.*

Oxfam has not been able to meet SPHERE standards of 20-users/drop hole in all the project areas. A user ratio of 50 users/stance was adapted in the initial stages of the response and this user ratio gradually improved to just over 40 users/hole in Montesarado camps. Because of increasing population within the camps and an initial large user ratio, latrines were filling up so fast and will need replacement as long as the IDPs are in the camps. This is however an indication that the latrines are used and maintained by the communities. Specific families were signed cubicles and they were responsible for cleaning them.

The big self-supporting plastic squatting slab for latrines, has been effective in providing a convenient solution that results in an easy-to-clean latrine that can be constructed fast. It was observed that the plastic slabs were removed and reused when the latrines were full.

There are concerns of smell and there have been attempts to install vent pipes in the plastic slab to reduce smell. The holes are however covered and the concept of air circulation only works for a short time when the latrines are being used and therefore it is not very effective. The hole needs to be covered when the latrine is not in use to minimise fly breeding.

There are also no locking facilities for more privacy when latrines are in use.

### **Bathrooms**

Two roomed bathrooms were constructed as part of the sanitation response. One concern with bathrooms was that wastewater from the bathrooms was not given the attention it deserved. Ponds of wastewater and clogged soak pits were a common feature at locations where there was no natural drainage.

### **Recommendations:**

- Since the slab and materials for the superstructure can be reused, communities should be encouraged to dig pits and replace latrines when they fill.
- Provide locking facilities inside doors.
- The engineer should provide a simple design to fit the pipe without going through the slab.
- Oxford Technical advisers should investigate provision of for fitting a vent pipe on the plastic slab for future purposes.

### **6.2.4 Health Promotion**

Health promotion was carried out in all camps, cholera risk areas and host communities where Oxfam was operational. The approach adapted in health promotion was largely message focused and creating awareness. This was done through reactivation, selection of new and training of community motivators, who in turn passed on the messages to the community. Towards the end of the projects, water and sanitation committees (wasoms) were also formed and trained in health promotion, use, management and maintenance of water and sanitation facilities.

The training covered a wide range of Public Health topics, like disease transmission routes, water borne and sanitation related diseases, causes, control and treatment of diarrhoea (using ORS), personal and environmental hygiene, latrine use and maintenance, hand washing, water storage and water point management and the use of bed nets for mosquito control.

The community motivators use approaches like house visits, printed posters with all the relevant messages, songs and drama within the communities. The evaluation team visited 20 houses in Salala, Jahtondo, Wilson, Mount Barclay and Perry town camps and police academy community. In all the visited houses, household members clearly articulated the messages passed on them by the community motivators. In Salala camp, one elderly woman pulled out one small poster with the messages and pictures and told the evaluation about the messages on the poster. The hygiene messages were broad and many rather than few, presented in phases and targeted to different age groups and gender to ensure specific results within the short time of intervention.

The health promotion team and mainly the community motivators were also involved in distribution of hygiene kits and bed nets. Unfortunately where such distributions have been done, the team was more focused on distributions without due consideration of outcomes/results of such distributions. Monitoring of outcomes/results was limited despite a good monitoring framework developed by senior management in Liberia.

Practice of hand washing after using the latrine and availability of washing facilities at latrine blocks varies from camp to camp. The best coverage was in Salala camp, which was over 98% and the worst coverage was in Mount Barclay camp with less than 50%. A difference in coverage was attributed to different levels of completion of latrines and increasing populations. There were some hand washing containers in the warehouse, which if distributed will improve coverage as latrines under construction are completed.

A large plastic barrel of forty litres fitted with a tap and installed on a stand was used for hand washing. This was however proving to be a problem to communities in Montserrado camps that have to keep constant watch over the container for fear of being stolen. The containers are kept indoors at night and therefore hand washing does not happen for night users. Over 90% of the hand washing containers observed had enough water for washing hands and were in use but none of the barrels was full of water. Women fill the containers but with not more than 20 litres at a time.

Not all the Water and sanitation committees and community motivators interviewed were operational. The motivators were confident in what they were trained on but in all camps and host communities visited by the evaluation team, issues of incentives, lack of means of identification and lack of respect from some of the community leaders and other sections of the community were raised in Salala, Jahtondo, Wilson, Mount Barclay and Police academy. Whereas community leaders and the community largely appreciated the role of community volunteers, the concept of voluntarism was not well perceived and accepted by motivators, community leaders and the community at large.

Use of children as health motivators was not well understood by parents and community at large. The community saw the 'children motivators' as being employed/used by Oxfam without getting incentives like the adult motivators

**Concerns/observations:**

- The health team were focused mainly on creating awareness and giving messages.
- Community motivators were working for long hours. They considered the services they provided to the community as employment since they have been paid incentives and therefore the concept of volunteerism and possible continuity when Oxfam exits has been lost.

- The promoters and technicians and community motivators had limited skills in participatory approaches.
- Despite a good monitoring framework prepared in Monrovia, the promotion team at field level are more focused on distributions without due consideration to monitoring outcomes/results.

***Recommendations:***

- Use few key hygiene messages at a time and target men, women and children using different methods, house to house visits, songs, community meetings, drama, child to child methods etc as appropriate in each setting.
- Monitor outcomes and use the information collected to adjust and inform promotion and hardware activities. Mobilise affected communities to do thing for themselves and Oxfam should play more of a facilitation role in more settled camps.
- Address the issues of incentives.
- Hygiene promoters together with the technicians and engineers should make consultations with the communities to come up with appropriate and acceptable hand washing facilities.

**6.2.5 Protection**

Oxfam in Liberia is involved in wider advocacy on protection issues through the protection advisor but protection was also operationalised within the public health projects covered by the evaluation.

Protection was well mainstreamed and integrated within the PH programme. Staff and community volunteers were keen to report any form of violence to relevant authorities and were all aware of protection and human rights issues. By using staff to monitor human rights issues, staff saw themselves not only as service providers but also advocates.

Areas where protection has been well mainstreamed and has achieved the desired impact within the public health programme include:

- Siting of water and sanitation facilities so that the vulnerable users like women are not at risk.
- Reviewing and using designs of sanitation facilities that promote more privacy for women and with the different sexes using different facilities.
- All staff signing to Oxfam's internal sexual code of conduct.
- Hygiene promoters creating awareness on entitlements and advocating for equitable aid distribution to all segments of the population where Oxfam is working.
- Oxfam's hygiene promoters being trained in basic monitoring of protection issues.
- Training of some community motivators in protection issues

The public health team picked up several protection issues, provided feedback on beneficiaries' awareness of rights and free aid. In all camps visited over 90% of protection issues raised were gender based violence related. It was in only in Mount Barclay camp where robbery and theft were common.

Whereas there is enthusiasm among staff and community motivators to report protection issues to camp management, follow up of reported cases within the camp is still weak. This is attributed to weak camp management structures, lack or weak and corrupt police system, limited understanding of local authorities on how to deal with such cases and cultural attitudes.

Observations:

Latrines and bathing facilities were separate for men and women however, some of them were either close to each other and it was not clear which one belonged to which sex.

Training in protection issues did not include partners like EDEN and PICOL.

***Recommendations:***

- Mark sanitation facilities to clearly show which ones are supposed to be used for men and women.
- Expand training in protection issues to cover all Oxfam's partners, community leaders and local authorities where Oxfam is working.
- Lobby other implementing organisations to train their camp management staff in protection issues.

**6.2.6 Beneficiary Participation:**

Because of the emergency nature of the response and the rapidly changing situation, there was limited consultation with communities at the beginning of the response on needs and the targeted beneficiaries. In a focus group discussion in Jahtondo, community stated that there was limited consultation by Oxfam with the community leaders in the initial stages of the programme under review. Whereas this limited consultation was understandable at the initial stages of the response, it was allowed to continue for a long time into the programme, which raised doubt in appropriateness in some activities carried out. Communities cited distributing one bed net per family and a large hand-washing barrel, which requires watching, as some examples where more consultations with them would have made difference to their lives. Consultation with communities however improved in the later stages of the projects especially in the area of siting facilities and designs of latrines that are acceptable to the different sectors of the communities.

Owing to the rapidly changing situations within the displaced population over the period under review, the programme would have benefited from a better assessment/monitoring and analysis of changing needs and priorities and flexibility in target communities.

Participation of beneficiary communities in project delivery is also weak and needs to be strengthened. There is a very high dependency of beneficiary communities on NGO's even on simple things that could be done by the community. The approach currently being taken by the community motivators is more of message delivery and education save for a few campaign days when communities clean their environment. This approach is not promoting sense of ownership and sustainability. The large geographical spread of the areas where Oxfam is working also means that the few health promoters cannot give all the support the community motivators need. The health promoters are few compared to the large areas and are playing more of supervisory role rather than understanding community needs. Community motivators continue using the same approaches (message delivery) all the time and need to be equipped with skills to approach communities in different ways. This argument may be valid for the health promoters and technicians, who are supervising and working with the community motivators and do not seem to notice any gap. **A more radical approach of mobilisation and facilitation needs to be introduced so that communities can move to a more proactive way of meeting their PH needs.**

## Recommendations

- Since communities are relatively more settled in most of the camps visited, Oxfam needs to move to an approach of mobilisation and facilitation so that communities can move to a more proactive way of meeting their Public Health needs that promotes ownership.
- Field teams should be given training and equipped in participatory and different community mobilisation approaches.
- Future projects should continually assess the needs of the communities where we work and either use the information to adjust our responses or lobby other actors where gaps are identified.

### 6.2.7 Co-ordination:

Mechanisms for co-ordination and collaboration between the various different organisations in the watsan and health sectors have been put in place. The UN agency responsible for co-ordinating the watsan and health promotion relief work for IDPs, UNICEF, arranges and co-chairs regular co-ordination meetings with the Ministry of Rural Development. UNICEF also serves the watsan sector with some limited resources and funding of other actors.

Based on differences in approaches and quality of responses in the field, which are not supported by any clear central government policies, Oxfam GB lobbied other actors and agencies to put in place clear policies and standards. UNICEF and MRD formed a technical task committee within the watsan co-ordination group to address issues of policy change and standards. As one of the leading watsan actors in Liberia, Oxfam GB is part of the watsan co-ordination group and the technical watsan committee.

Despite structures for coordination and policy change being place, co-ordination and sharing of information among the different actors, was cited to be weak by over 70% of the INGOs, LNGOs and agencies that the review team visited. Examples of both good and poor practice in national and field-level co-ordination and collaboration were seen during the course of the evaluation. Examples of poor practice included:

- Gaps in communication among NGO's in the field on one hand and staff with management on the other hand resulting in duplication, e.g. distribution of blankets to the same beneficiaries by UNHCR, LWF and Oxfam. The review team interviewed one trader who was binding bales of blankets that were bought from beneficiaries after a third distribution by Oxfam.
- Oxfam was not been regularly attending co-ordination meetings at national level<sup>20</sup>. Even when Oxfam attends, there was no consistency of the people attending and the co-ordination bodies of those meetings felt that there was no follow up with action points. Oxfam as one of the lead INGO's in watsan provision is a core member of the Policy technical committee but did not attend a workshop organised by UNICEF and MRD to determine the ToR for the committee.
- Middle or senior management does not regularly attend camp co-ordination meetings.
- There are variances in incentives given to community volunteers by the different actors in the same camps. The variances are so big even for similar activities that it is creating disharmony among the volunteers and actors. There is no common stand among organisations working in Salala camp.
- In Salala camp the field staff cannot directly get access to medical data/statistics to inform their responses. Such data can only be got at national level.

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<sup>20</sup> Attendance list of co-ordination meetings kept and provided by UNICEF

## ***Recommendations***

- Prioritise co-ordination meetings at both national and field levels and have dedicated staff responsible for those meetings and any follow-ups.
- Need for information sharing and feedback from staff in the field to management and vice-versa.
- The issue of incentives for community motivators/volunteers should be discussed and harmonised at co-ordination meeting with other actors.

### **6.2.8 Integration of the public health response:**

The public health responses under review were designed to integrate the various sectors to maximise health benefits. Management put in a lot of effort to achieve integration and a lot of ground was covered in the OFDA funded project. Integration among the field teams however, still requires improvement as evidenced in especially the ECHO funded project where the health promotion and watsan teams did not work well together and so opportunities to compliment each other were lost. The field teams will need more guidance to think and work outside their 'sectors' to promote information sharing and information based responses.

In the ECHO funded project, the technicians and public health promoters held few joint planning meetings at the beginning of programme delivery. Thereafter the two teams planned their weekly activities independent of one another<sup>21</sup>. For a very dynamic situation that exists in Liberia, initial plans were useful but required regular reviews and updating.

Information between the two teams at field level needs to be improved and strengthened. For instance, monitoring information gathered by the motivators and promoters from the field like non-use of a water point due to deteriorating water quality, which would require immediate action from the technician went to the hygiene promoter in form of a report, then to the hygiene team leader and to the public health co-ordinator before any action is taken. Likewise the engineers/technicians were not upfront in sharing information on numbers and where latrines were to be constructed despite the fact that the health promoters were expected to mobilise and organise beneficiary communities.

Few programme meetings involving all implementers of the different sectors in the two projects were conducted. Through interviews, it was evident that field staff knew the importance of integration however, joint plans and meetings were limited and field staff mentioned that they expected their co-ordinators and team leaders to arrange such joint plan and meetings.

HIV/AIDS is not only related to public health but is also a protection issue, especially among mobile communities living in camp situations. Within the programme evaluated, HIV/AIDS got little or no attention.

### **Recommendations:**

- The technicians and health promoters should initially have a common understanding of programme delivery and knowledge of Oxfam approaches through induction. Inductions and joint planning are already happening but they need to be followed up.
- The teams should also share information through conducting joint plans, regular meetings and joint monitoring and reviews. Integration should be included in public health staff objectives and therefore become a performance issue<sup>22</sup>.

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<sup>21</sup> See SWOT analysis notes that was done with the public health field implementation team

<sup>22</sup> See SWOT analysis notes as presented by staff.

- Gather relevant information on a step-by-step basis and programme delivery decisions should be based on continuous collection and analysis of information.
- Mainstream HIV/AIDS both internally and externally in future projects and within the Liberia programme. A visit by the HIV/AIDS HSP or any other specialist will help the programme to mainstream HIV/AIDS.

### **6.2.9 Monitoring**

Monitoring of any programme is essential for assessing the effectiveness and efficiency of response. Monitoring of a public health programme should include monitoring practices and community participation in addressing the identified public health issues. It also provides information regarding the impact of the programme for planning future programme activities.

Within the OFDA and ECHO funded projects key sources to verify the progress of the programme against the indicators set were detailed, these included health centre records from within the IDP sites including morbidity and mortality data, survey and monitoring reports. However some morbidity and mortality data sources e.g. from some field clinics could not easily be accessed by field staff. Further, even when some of that data was obtained from communities and willing field clinics, there was no evidence that such data has been used to inform course of action by either the technicians or health promoters.

At field level, community motivators record their activities detailing each person they talk with and a brief outline of the topic for the week. The information gathered by the motivators is in a form of a KAP survey. This is then compiled into a snappy narrative report from the motivators. Health promoters on the other hand interviewed every month about 15 - 20 households in their respective areas of operation and fill out a KAP survey form. The forms are neatly and regularly filed however analysis was readily available. Information collected was relevant and could be more useful if it was collated with what the motivators collect on daily basis and most important if was used to inform action. Monitoring reports were written from information gathered by the health promoters but such reports were irregular.

Despite Liberia programme having a well-written and detailed monitoring framework, monitoring activities for the evaluated projects seemed to be unstructured and unsystematic. It was evident that field staffs were not using the monitoring framework.

#### ***Recommendations:***

- The Public Health Team should collaborate with other agencies working in health, such as clinic health workers, on a weekly basis to share information and plan activities for the following week in response to this information.
- SMT should roll out the monitoring framework to the field and follow up its implementation by visiting the field on a regular basis.

### **7.0 Sustainability/Connectedness:**

Since August 2003, Oxfam's response has gradually moved from first phase emergency to more sustainable approaches and systems. Water provision gradually moved from chlorination of wells and pumping to construction of hand dug wells with hand pumps, which is a better mid and longer-term option. Likewise there has been a shift from temporary latrines and bath shelters to more semi-permanent structures. Construction of such facilities using local contractors within the camps has contributed to skills being left in the community and will likely promote sustainability. Designs for sanitation facilities that have been used, promote the re-use of materials like the slab and superstructure.



This is intended to promote sustainability even in humanitarian interventions. The evaluation was not able to establish whether this approach is acceptable to the beneficiaries.

Community structures like water and sanitation committees and community motivators have been formed and trained in operations and management of water, sanitation, and health promotion and protection issues in all areas where Oxfam is operation. The formation and training of such community structures was however done towards the end of the project in March.

The community structures were planned to continue assisting communities in public health and protection issues even when Oxfam exits from those areas. The water and Sanitation committees in the camps visited are either unknown by communities and non-functional or very weak and do not have authority as they are not linked to existing established structures like local or camp management authorities with exception of established villages (cholera hot spot areas) where a high organisation was observed. In all cases community motivators were paid some incentives, which made sense at the start of the response but has also meant that the motivators will not continue serving the communities when Oxfam exits as evidenced by the drop out of the motivators when they received communication from Oxfam that incentives will no longer be paid at the end of the project .In some situations like Mount Barclay (ECHO funded) there were outright clashes between the water and sanitation committees and block leaders on one hand and overlap and un-clarity of roles between the water and sanitation committees and the community motivators on the other hand.

There were some attempts within the community to maintain latrines, fill hand washing facilities with water and clean the environment and in some situations/camps like Wilson, there are caretakers of communal latrines but these arrangements may not last long if Oxfam does not establish acceptable working policy with community motivators who live and work closely with communities. The leadership of a block (in a camp) that uses the water point manages the operation of the hand-pump in the camp. Either the block leader or a pump minder unlocks and locks the hand pumps at set hours. These hours do not appear to be set in accordance with the needs and agreed by all the users. At many of the pumps seen in Jahtondo, Salala, Wilson camp and Police academy the pump minder closed the pump “to allow it to rest”. Allowing longer operating hours at most pumps where there is no constraint of the well running out of water could substantially increase Water Supply. It would also help if block leaders and local authorities understand the operations and maintenance of the wells and hand pumps.

Jahtondo, Wilson, Salala and Mount Barclay camps, which were visited by the evaluation team are highly populated with about 20,000 people in each camp. Wascoms committees formed consisted about 16 members and equally few community motivators. When the evaluation team asked the motivators in Salala to prepare their daily activity timeline, it was established that the motivators are working for about 30 hours a week, which deviates from voluntary work and as a result they are demanding for continued payments. In Jahtondo camp, the water and sanitation committee, which includes the six hand pump mechanics was found to be more active, however without incentives, the committee and the pump mechanics were reluctant to continue assisting the communities.

Government assisted by UNICEF have established a technical committee composed of main actors and INGOs in the water, sanitation and health sectors to review standards and guidelines for humanitarian responses that will lead to long term approaches and sustainability. Oxfam is a member of the technical committee but has missed to attend some of the main meetings in which policy issues on sustainability are being mapped.

## **Recommendations:**

- Review the current ‘workload’ of community motivators by increasing their numbers so that they volunteer for fewer hours in a week so that their roles are not seen as full time employment.
- Roles and responsibilities for the WaScoms and motivators should be clearly agreed within the communities and the structures should be linked with existing camp and local authorities.
- Prioritise attending technical committee meetings and influence exit policies like having community structures and determining how such structures should function and be supported by local authorities.
- Consider training in operations and maintenance of pumps to cover a wider community and camp authorities.

### **7.1 Working with Partners:**

For many years, Oxfam has worked with EDEN and PICOL as partners in Water, sanitation and health promotion. Over the years, these local NGOs should have developed capacity in the public health sector to support and work with Oxfam in case of any scale up. The relationship between Oxfam and the local NGOs is however, still essentially contractual rather than true partnerships.

Within the period of consideration, the two local organisations were again given some very small grants of \$26,000 and \$10,000 to EDEN and PICOL respectively to implement water and sanitation and public health promotion activities in Perry town camp, which is located close to Wilson camp where Oxfam was directly implementing a similar response. The population of the camp grew from 3,000 to 15,000 at the time of the evaluation and most of the residents of the camp came from the cholera hot spots.

The funds given to the local NGOs were inadequate and yet they were working in a cholera risk environment.. The partners were put in a situation where they were promoting what they could not provide. As an example, PICOL promoted hand washing but there were no hand washing facilities that were provided even at latrines. SPHERE standards were not met and an integrated public health approach was compromised in this particular camp.

There was very little interaction between Oxfam’s technical staff and the partners and in a discussion with Oxfam’s technical staff, it was evident that most of them never knew that partners implemented a public health programme in one of the camps. Whereas Oxfam had large quantities of large plastic squatting slab in store the partners were left with no choice but to use concrete slab for latrines. The concrete slabs took long to cast and it was difficult to get cement.

### **Recommendation:**

- Partners provide an added capacity for Oxfam to scale up in an emergency and Oxfam, should determine their future role in emergencies so that they plan accordingly.
- Any future emergency/humanitarian interventions by partners should be fully supported with enough resources to meet SPHERE standards and facilitate health promotion.
- A thorough evaluation of the partners’ response in Perry town should be done to help inform decisions of any future relationship between Oxfam and the partners in humanitarian responses.

## 8.0 Efficiency:

There were different approaches and technologies used at different stages of the emergency and in different locations. At the initial stages of the emergency, water provision involved more of treatment of surface water in Salala, Tankering and chlorination of water in wells, in cholera affected areas like SKD, Mosaic Temple water and later focused on hand dug well construction equipped with hand pumps. In terms of latrine construction, there was progression from temporary latrine structures using plastic sheeting as superstructure, to semi permanent structures using zinc and local poles to permanent VIP structures in institutions that accommodated the IDPs. Owing to the nature of the emergency, it was justified and appropriate that different approaches were taken at different stages.

As expected, the civil war disrupted of production, trade and supply of commodities and materials for a number of months. The initial response depended largely on importation of materials by Oxfam and other Aid agencies and needless to say, this raised costs in terms of sea and airfreight and handling.

There was and continues to be a shortage of locally produced materials like cement and other construction materials. Coupled with a high demand for such materials, costs shot up. One prefabricated concrete ring from a private firm in Monrovia cost \$35, which raised the cost of constructing a 10m hand dug well including an Afridev pump to about \$1,100 without labour. A simple 2-access semi-permanent bath shelter cost about \$ 350 labour inclusive. Laundry slab costs about \$340. A semi permanent 5-stance latrine cost about \$600 and a four stance permanent institutional latrine cost about \$2,000. In all cases contractors were used to construct the facilities and labour costs were about 15% of the total cost without including staff supervisory costs. These were estimates as actual costs incurred were yet to be produced from financial records.

Delays were experienced in getting concrete rings for protecting wells mainly because there was one supplier providing relatively quality rings that most of the organisations working in the water sector placed orders with suppliers. Competition for the rings was high, which not only resulted in higher costs but also delivery of rings that were not properly cured. Out of five new well sites visited, three broken concrete rings were observed. This a high damage ratio for reinforced rings. Further a substantial amount of materials like sand, stone aggregates and unused concrete rings were observed to have been left at construction sites in Salala, mount Barclay and Du Port road (school) areas. More people could benefit if such materials were collected and used where needs have not yet been fully met .

Oxfam has ring moulds in the warehouse and would have reduced the effects of competition and costs for the rings and control of quality by fabricating concrete rings. This could also have an added value of leaving skills and capacity within the communities and contributing to replicability.

Whereas the shift from use of plastic sheeting and mats as covers for the latrine superstructure and bath shelters to zinc sheets appears to be expensive in the short run, plastic sheeting was often stolen from superstructures and required frequent replacement. The zinc superstructure on latrines cannot easily be stolen and can be re-used on a new pit when the latrine fills. The new design is acceptable and appreciated by the users especially women. As women interviewed in Jahtondo put it, *'the shift form plastic sheeting to Zinc has improved our security and dignity. Plastic sheeting used to be ripped off latrines, rendering them useless as they could not provide the required privacy. Men also used to cut the plastic sheeting and peep at us when we were taking a bath or defecating.'*

### ***Recommendations:***

- Do a cost benefit analysis and compare use of rings from suppliers with the production of rings.
- Promote the re-use of the materials for the latrine superstructure to justify the high costs
- Future projects should ask for community contributions in form of unskilled labour for digging latrines, wells and other construction requirements.
- Collect and put to use elsewhere any materials that remains at any site.

### **9.0 Relevance/Appropriateness:**

Oxfam is one of the few INGOs involved in water, sanitation and health promotion activities in Liberia. Oxfam's involvement in Liberia for several years has helped the organisation to understand needs, practices of the communities and also design appropriate programmes. Other INGOs involved in watsan and health promotion programmes in Liberia include; ACF, Concern and MSF.

Assessments and health risk identification for the projects under review were carried out using existing Oxfam tools. The response especially under the OFDA funded project has been appropriate in terms of addressing the type of need in the target area, based on using Oxfam's previous experience in Liberia in water supply, sanitation and hygiene promotion. In terms of safe water provision, there was a progressive shift from chlorination of wells and surface water treatment and distribution that were used to meet the immediate needs of the beneficiaries to hand dug wells that are a mid term to long term solution and widely accepted and used in Liberia. In sanitation, there was also a progressive shift from quick temporary latrines to semi-permanent structures. In either case the progressive shift was relevant and appropriate.

Other needs, such as food security, shelter and curative health were covered by other agencies. The scale of the immediate response was also appropriate but due to continued increase in population in camps, the response did not achieve Sphere Standards especially in sanitation.

Due to late starting, the ECHO funded response didn't entirely address the initial, first peak cholera outbreak. The response however put in place facilities that will in future mitigate future cholera outbreak risks.

There was also one case in Police Academy village (one of the cholera hot spot areas) where only safe water in form of a protected well was provided. Indiscriminate excreta disposal in this particular community posed a higher risk to a cholera outbreak and should have been given priority. This demonstrates one of the few lapses in analysis of needs and design of appropriate response that need to be strengthened. Lapses were partly caused by limited consultation with communities on needs.

### ***Recommendations:***

- Use Problem tree analysis to identify key health risks in designing future responses.
- Consult with a wider section of the beneficiary communities at the initial stages of design of responses.
- External donor approval processes may have caused late starting but for the future, Oxfam should consider the time it takes to get donor funds while making decisions to respond to tightly time bound response like responding to cholera.

## **10.0 Human Resources:**

A rapid scale up of humanitarian response following massive displacement required recruitment of many new local and international staff. There was a high number of international staff initially, who were intended to build the capacity of local staff. About 80% of key management positions and senior management was composed of international staff. Human resources policies like performance management were introduced and there was marked progress in building capacity of field staff but a high international senior management staff structures often created a difficult relationship between international and local staff and left very little management capacity among the local staff. Staff like the technical team leader who was deliberately targeted to benefit in management training by coaching did feel any gains.

As a result of the completion of the OFDA and ECHO funded projects, the Liberia programme was in a process of reducing the number of local staff at the time of evaluation. Staff morale was low and many questioned the approach of re-interviewing all staff some of which had been interviewed 5-6 months before. Many staff interviewed felt that senior management did not believe in performance management, which they had introduced.

### ***Recommendations:***

- Performance management should be entrenched so that staff can feel the value of it.
- Senior positions should have local counterparts to build capacity of local staff in management.
- Try a different training approach of secondment to other cross border Oxfam programmes or direct training courses.

## **10.1 Training and Inductions:**

To meet the high needs of the displaced people, Oxfam GB scaled up its operations in Liberia. Many new staffs were employed to implement a scaled up programme. During discussions with staff, it was raised that inexperience of most of the local staff in emergency responses and Oxfam approaches, contributed to the delay to complete ECHO funded project.

It was however established by the evaluation team that Oxfam carried out many trainings for staff and community structures to improve the quality of programme delivery. Trainings carried out included;

- Training/induction in humanitarian approaches.
- Planning and budget monitoring.
- Training and mentoring in protection leading to the formation of a protection technical team.
- Trained community motivators, caretakers and water and sanitation committees

Some of the training was done towards the end of the project cycle and therefore benefits of the training could not be realised within the project life. Loss of incentives was also leading to loss of trained manpower within the communities. Gaps were also identified in the process of information gathering and use of information collected.

### ***Recommendations:***

- Provide more training of Public health/technicians in monitoring/analysis of information and its use, using existing materials like ERM, PHP guidelines, and SPHERE e.t.c.

- Equip staff and community motivators with more participatory approaches. Oxford Public Health Adviser could conduct such training
- Conduct follow up training.

## **11.0 Programme Support:**

### **11.1 Logistics:**

The Oxfam GB programme under evaluation had a well staffed logistics sector in Monrovia headed by an international logistician, supported by international donor accountant, finance officer, programme support manager and the logistics team in Oxford. There were reasonable checks and balances in place under the prevailing circumstances in the Monrovia offices. However, according to discussions with different staff, problems of logistics, hampered the progress of the project.

Externally, suppliers of locally produced materials took a long time to meet supply requests and few or only one supplier would be available to supply the required materials. As a result, procurement requirements for at least three quotations could not be met for some of the materials and timely implementation was affected by lack of materials on the market. In one instance, about a month of Oxfam implementation time was lost due to absence of cement on the market. At the time of the evaluation a number of latrine structures were still incomplete because of shortage of zinc sheets and roofing nails on the market.

Internally, disjointed planning and poor forecasting on the side of programme delivery and limited information sharing among the different sectors affected the rate of implementation. Logistics and the different field and finance sectors need to co-ordinate more and plan together. *There was improvement in including all the relevant departments in planning towards the end of the projects covered by the evaluation but this has to be sustained as a matter of good practice and for the sake of improving effectiveness in programme delivery.*

There was reliance on the local market at a crucial time of the programme delivery when the private sector had been disrupted by the war and there were limited materials available on the open market and competition for such materials was high. With careful planning and forecasting, the bulk of required materials could have been sourced outside the country before the private sector recovered.

Large stocks of materials still in the warehouse- utilised and field staff were not regularly informed of what was available in stores and could not plan to use the materials accordingly. As an example, there were large stocks of plastic slabs in store and yet partners (EDEN) ended up using concrete slabs on the latrine they built at a time when cement was a scarce commodity in the country.

The evaluation also identified gaps in records kept for materials and equipment in the field stores. Records kept did not clearly show how and where equipment and materials were being utilised in the field. The stores were said to be under the control of public health promoters and technicians with little or no support or training from the central logistics sector.

### ***Recommendations:***

- Better planning and co-ordination among the different sectors in the future will improve quality and rate of programme delivery.
- A situation where 3-4 weeks of waiting for cement and other materials could have been avoided if procurement of the necessary materials in bulk was done when there

was chance. Improvement in planning and interaction among the technical, finance and logistics teams will in future reduce delays in material delivery.

- Produce and share monthly stock records and they should form part of programme planning meetings.
- If there are no donor implications, give out half the quantity of plastic slabs to organisations that may use them in the camps. It may increase the coverage of latrines, which is still low.
- Systems in the Monrovia warehouse should also be used in the field stores and those stores should be monitored by the logistics sector in Monrovia, who should also provide training

## **11.2 Finance and Funding:**

OFDA and ECHO funded the projects under evaluation. These donors have funded a number of Oxfam projects before and ECHO on the ground in Liberia has expressed interest in continuing to fund Oxfam programme in Liberia. The evaluation identified two concerns regarding funding:

- a) Tendency to write and present to donors ambitious and very short term proposals that put a lot of pressure on the programme to complete implementation within the short project life.
- b) Proposals not taking into account time required for donor approval processes leading funding gaps and late starting.

Senior management and field staff recognised improvement in financial procedures and financial management and a lot of progress in terms of budget monitoring for the different sectors and training middle management staff but such gains were undermined by a high turnover of the finance officer post.

The presence of a donor accountant on the programme and a finance officer has strengthened donor reporting and budget monitoring but improvement is required in relating financial expenses to outputs on ground, looking at different ways of improving cost effectiveness and understanding field finance related issues like payments of labour.

### ***Recommendations:***

- Seek for longer term planning and funding for like one year and longer. Based on experience, mobilisation and supplies take a long time and greatly influence quality of programme delivery.
- Improve awareness of donor processes and requirements among SMT and field staff.
- Finance sector should visit the field to help in relating expenses to outputs.

## **12.0 Security:**

Oxfam GB in Liberia operates a stringent security management policy, under the responsibility of the Country Programme Manager. The day-to-day management of security issues rotates among the SMT. Security updates and gathering and sharing security information was an area where staff seemed to be fully involved as evidenced in contributions and sharing of different staff in the regular weekly staff security meetings.

The Liberia programme considers security management as a first priority but as the political and security situation in Liberia continues to show signs of improvement, lapses in adhering to security guidelines are likely to occur especially if staff consider some items on the guidelines outdated. Such lapses had started to occur as evidenced by irregular radio

communication by staff in the field to Monrovia, contrary to the security guidelines and communication radios not working in the field due to lack of charged batteries.

***Recommendations:***

- The SMT should ensure that security guidelines are regularly updated as appropriate so that they remain relevant and adhered to.

**Conclusion**

Overall, the evaluation team felt that the evaluated projects largely achieved objectives set and contributed to the Goal. For various reasons, delays in programme delivery were experienced and all project outputs were not completed within the projects' timeframes but mechanisms were put in place to complete what had not been completed. There is room for improvement in some areas as highlighted in the report but the Liberia programme team did very hard to attain all the achievements highlighted in the report under difficult and fluid situations. Any shortcoming in programme delivery that may have been highlighted in this report should be taken as a lesson for improvement of future projects.



## **Appendix 1**

### **Terms of reference for evaluation of public health programme in Liberia**

Location: Peri-urban Monrovia, Montseraddo, and Salala

Duration: 2 weeks (15<sup>th</sup> to 30<sup>th</sup> April 2004)

Reporting to: Senior Humanitarian Programme Manager

Oxfam purpose: To work with others, to overcome poverty and suffering

Job purpose: To identify and document, key strengths and weaknesses out of the current humanitarian programme planning and implementation, that OGB Liberia can learn from, for future programme planning and management

#### **Background and context :**

Following the cessation of hostilities between the former GoL and the various warring factions in Liberia in August 2003, the country was left with a large number of internally displaced people (IDPs), most living in and around Monrovia. To address the serious humanitarian conditions the IDPs were living in, Oxfam GB has been implementing a multi-donor funded public health programme in four main IDP camps and one peri-urban community environment, in and around Monrovia, since August 2003. The donors contributing to the programme include OFDA; UNICEF; DCI and Oxfam Ireland; ECHO; and Oxfam GB. The programme focuses on water and sanitation provision; hygiene education, malaria control and prevention. The programme integrates humanitarian protection and gender mainstreaming as key elements in design, planning and implementation. The programme ends by end of April 2004.

To learn from the programme planning and implementation process so far over the last eight months, Oxfam GB Liberia will be commissioning an evaluation exercise within April 2004.

#### **Evaluation objectives:**

1. Determine and consolidate the extent of achievement of aims and objectives for the whole programme. Assess the impact and sustainability of the interventions.
2. Assess the effectiveness and efficiency of the programme delivery mechanism and public health technical approaches to the achievement of programme aims and objectives.
3. Review the extent of integration and impact of humanitarian protection and gender in programme implementation.
4. Review the programme contribution in achieving broader policy and practice changes

#### **Evaluation methods:**

- Documents review, Programme proposals; Programme reports (sitreps, donor reports, monthly reports, technical weekly reports); Liberia humanitarian reports; Oxfam GB public health guidelines; concept notes; reports from technical advisor visits Nov and Dec; gender advisor visit March. Public health review document 2002. 2 days
- Individual interviews with key staff; community intermediaries and partners 2 days
- Focus group discussions at camp and community levels 4 days
- Field visits and observations 2 day
- Report draft production 3 days
- Consultation and revision 1 day
- Contingency 1 day

- Travel either side of the trip 2 days

**Specifications for the evaluation team:**

An evaluation team of 4 people will be supported by the Oxfam GB Liberia team to undertake the exercise. The team should exhibit the following competencies:

- Experience in humanitarian programming
- Knowledge of public health approach to emergencies
- Knowledge of Liberia humanitarian and political context
- Earlier experience in evaluation and/or humanitarian programme reviews
- Strong analytical and report writing skills. Should be able to write firm and convincing reports
- Experience in integration of humanitarian protection, gender and diversity issues

## Appendix II

### Itinerary

- 28/04/2004. Arrival in Monrovia, Briefing by the programme co-ordinator
- 29/04 Briefing in Monrovia by the SHPM, PSM, and the Protection Adviser.
- 30/04 Briefing by Public health co-ordinator, Technical Team Leader and attended inter agency watsan meeting.
- 01 – 02/05 Reading key documents and briefing by the Public health engineer.
- 03/05 Visit to Salala camp by the evaluation team and FGD with communities
- 04/05 Visit to Jahtondo and Wilson camps (Montserrado) and FGD with communities, and community volunteers and visit to the Warehouse
- 05/05 Visit to Mt Barclay camp, Police Academy and Duport road areas
- 06/05 Meeting with key PH staff (SWOT analysis) and UNICEF Watsan co-ordinator
- 07/05 Meeting with the Director of Social services in the MRD, meeting the Watsan Co-ordinator of Concern and meeting with Oxfam's logistics manager and co-ordinator.
- 08/05 Visit to Salala camp and discussions with the community volunteers
- 09/05 Analysis of collected data.
- 10/05 Meeting with EDEN (local Partner) and visit to Perryton camp. Meeting with watsan logistics co-ordinator for MSF-F. Oxfam's finance officer.
- 11/05 Meeting with the ECHO representative  
Evaluation team debrief with the SMT in Monrovia.
- 12/05 Meeting with the watsan co-ordinator for ACF  
Fly to Oxford.
- Report finalised.

## **Appendix III**

### **SWOT ANALYSIS FOR THE LIBERIA PROGRAMME (07/05/2004)**

**A public health team of thirteen people including five hygiene promoters, five technicians, one public health engineer, a public health team leader and a technical team leader evaluated Oxfam's public health programme for the period August 2003 – April 2004, using SWOT analysis. Below are the recordings:**

#### **A: STRENGTHS**

OFDA Funded Project:

1. Achievements:

Generally achieved a high percentage of the expected / intended outputs: This varies from sector to sector and from camp to camp: There was debate on the average outputs but it was agreed that if consideration is given to outputs and outcomes then achievement was estimated at over 75%. Achievements were attributed to the following enabling factors:

- Competent staff who were experienced in Oxfam's ways of working.
- Had resources available like materials, funds and logistics.
- Staff were committed and hardworking

2. Acceptance of beneficiaries

Most of the beneficiaries were familiar with Oxfam's responses. Participation of beneficiaries was good and estimated to be about 80%. There was debate among the team on particular type of participation and involvement.

3. Management

It was felt by the field team that management support was good and facilitated programme delivery. Management support was good in the following areas:

- Flow of supplies
- Guidance by line management in one to one
- Knowing the code of conduct
- Information flow on security through meetings and briefings
- On time payments of salaries

4. Planning and Reporting

Joint programme planning and reporting was initially good until December, when planning meetings were discontinued.

5. Monitoring

Good programme monitoring systems were established.

ECHO Funded Project:

1. Good initial planning, which was done once as team
2. Despite the short time frame, the health promotion sector achieved over 75% of what was expected of them, though overall achievement of objective is estimated to be about 60%
3. Good guidance in terms of one to one
4. Hard working and competent staff
5. Gender balanced team.

## **B: WEAKNESSES**

Generally there is poor feedback from line managers to field staff on decisions made by the senior management committee.

OFDA Funded Project:

- Weak sharing of information among the different departments e.g. stock monitoring reports
- Limited choices and availability of materials on the market
- Uncoordinated planning and involvement with different departments like logistics and finance in programme delivery
- Staff commuting long distances
- No budgets for unforeseen circumstances and therefore limited flexibility
- Programme delivery is more project donor driven than need driven
- Budget monitoring
- Difficulty in controlling quality and getting materials that meet the specifications on the market
- Limited awareness across the different relevant departments and sectors about specifications of materials and tools that are used by the PH team, which at times leads to delivery of wrong materials and delays in replacing them with the right ones.

ECHO Funded Project:

- Unclear (to field staff) reporting requirements and formats.
- Untimely and delayed delivery of materials
- Poor planning especially on the engineering side with a lot of time spent by the technicians in the office with the line manager, in programme delivery planning and re-planning and hence effectively allowing very limited time for field implementation.
- Poor community participation in the following areas:
  - Siting of wells and latrines
  - Late and or little mobilisation/sensitisation of communities and a disjointed approach by the technicians and health promoters
  - Inconsistency in the policy for incentives as a motivation for community motivators
- A public health integrated approach was not followed by the watsan and health promotion field teams
- Limited exchange of information within the team even though there were some Oxfam experienced members among the field team.
- Short project timeframe considering difficulties experienced and time spent for entry to new urban communities.
- Uncoordinated sharing of resources like vehicles, resulting in loss of programme delivery time.
- Delayed payment of semi and unskilled labourers that resulted into threats to staff and at times stoppage of work and therefore loss in programme delivery time.
- Lack of facilities like computers for report writing

## **C: OPPORTUNITIES**

- There was access to help the most needy
- Staff had 100% life insurance and medical cover and therefore less worries
- Security was relatively calm during the implementation period
- Funds were available and donors positively responded to the call to assist the most needy
- Appropriate skills for public health responses were available in-country

- There were training opportunities for staff and beneficiaries
- Oxfam's track record in working with displaced people in public health sector.
- Freedom of expression within the Oxfam environment
- Oxfam's gender equity policy
- Acceptance of Oxfam by the beneficiaries as Oxfam was in country and working with them before.

#### **D: THREATS**

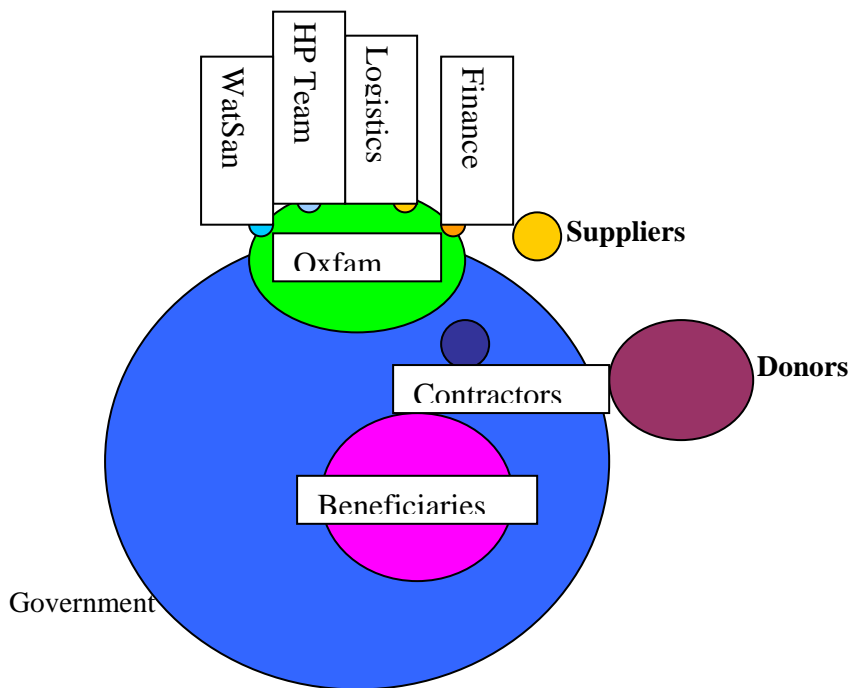
1. Insecurity was and is still a threat to programme delivery in the following ways:
  - Disarmament created a lot of anxiety among the ex-combatants. Roadblocks were and are still common and therefore delays in programme delivery.
  - Demonstration within the city and camps
  - Arms conflict (not sure I got this explanation)
2. Unstable economy
  3. Dis-continuity in programme delivery due to gaps in funding that could lead to beneficiaries being exposed to public health risks.
  4. Staff travelling long distances every day and expected to return to Monrovia within set time periods (speeding to catch up with time was cited as a particular threat)
5. Delayed delivery or unavailability of materials to meet commitments
6. Few communication facilities e.g. radios for field staff
  7. Delayed payments of incentives to field semi-skilled and unskilled labour that exposes field staff to possible violence.

#### **Recommendations for Improvements for future projects:**

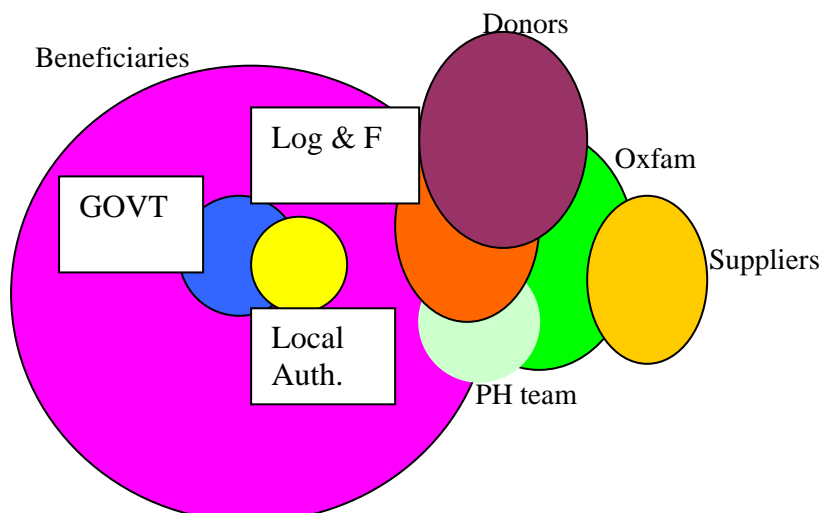
1. At the beginning of any project, let staff get a common understanding of the project, the required reporting requirements and formats and the initial plans should also determine and indicate who will be responsible for the different reports and provide training and facilities to produce the reports.
2. Involve logistics and finance while planning public health programme delivery and conduct regular joint programme meetings and reviews
3. To overcome untimely deliveries, besides planning together with logistics and finance, all materials for the planned activities should be drawn out of the proposal at the initial programme delivery planning meeting and suppliers' requests for bulk purchases immediately written. The technician/hygiene promoters should write clear descriptions for the materials requested and where quality is unknown, sample should be presented to the specialists (technicians and hygiene promoters) to assist in making decisions on quality.
4. Improved communication systems like provision of more hand set radios coupled with better co-ordination and inter-sectorial planning will address the difficulties experienced in sharing resources like vehicles.
5. To improve community participation in programme delivery, there will be need to co-ordinate with other actors in any given location to harmonise participatory approaches. Oxfam should also explore alternative ways of motivating volunteers like food for work. **Further, the field teams should be given training in participatory and community mobilisation approaches.**

6. Community mobilisation and sensitisation should always come first before the hardware, to prepare communities in operations and maintenance and general management and acceptance of public health facilities.
7. To ensure integrated public health programme delivery, the technicians and health promoters should initially understand the proposed programme and have a common understanding of programme delivery and knowledge of Oxfam approaches through induction. The teams should also share information through conducting joint plans, regular meetings and joint monitoring and reviews. Further, prioritisation should be promoted at the different levels and integration should be included in public health staff objectives and therefore become a performance issue.

Compiled on  
07/05/2004.



**The technical team Perspective of the relationship of the different stakeholders in Oxfam's Liberia programme**



**Health Promoter's perspective of the relationship of the different stakeholders in the programme.**

From discussions and the above Venn diagrams, it is apparent that the field teams need to have a common understanding of the programme and there are gaps in terms of teamwork and working in an integrated way.