



Final Evaluation of the Integrated Health Project. Freetown, Sierra Leone

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Aid Works



Executive Summary

GOAL Sierra Leone's integrated Health (IH) project aimed to contribute towards a decrease in child mortality and morbidity. The project focused on systems strengthening and community-level behaviour change, targeting improved maternal and child health, to complement child protection and empowerment interventions. It was co-funded by the European Union and Irish Aid, and was implemented in 42 out of Freetown's 64 city sections from 2012 to December 2016. The objectives were to:

- Increase capacity of the District Health Management Team (DHMT) in the Western Area to manage maternal and child health services;
- Contribute to strengthening health systems in the 42 city sections in Freetown;
- Improve community management of leading causes of infant and child morbidity (diarrhoea, malnutrition, malaria and poor reproductive health practices); and
- Empower citizens to access health services by informing them of their rights.

The purpose of the final evaluation was to provide an assessment of the changes to target groups and assess project performance in relation to the project's plans. The evaluation was conducted between January and March 2017 and questions were based on five evaluation criteria defined by the Organisation for Economic Co-operation and Development. The questions were:

Relevance/design

1. Was the IH project aligned with the national priorities, as outlined in the Basic Package of Essential Health Services (BPEHS)?
2. Did the project effectively address the priority needs of the target population, including the most vulnerable households?

Effectiveness

3. To what extent were the project's specific objectives achieved?

Impact

4. Did the project achieve the intended results?
5. How has the project contributed to delivering the Free Health Care Initiative (FHCI) in the Western Area?

Efficiency

6. To what extent did the project represent value for money?

Sustainability

7. How sustainable are the results of the project?

Relevance/design

The project was well aligned with Ministry of Health and Sanitation (MoHS) priorities, as outlined in the BPEHS and FHCI. The holistic and integrated approach to addressing maternal and child health allowed the IH project to contribute directly towards the majority of BPEHS components.

The IH project logframe was developed with a large number of indicators, making it a challenge to regularly monitor data throughout the duration of the project. No facility-level data that monitored demand creation was collected regularly. Neither was a clear theory of change developed at the start of the project, which may have informed the selection of indicators.

The choice to implement the project within Western Area Urban was well documented and based on clear evidence. The selection of specific city sections was carried out in collaboration with the DHMT, as well as other partners such as Action Contre la Faim (ACF). External projects working concurrently supported a comprehensive approach towards maternal, neonatal and child health (MNCH). Beyond a few of the facility management committees (FMCs) and a select group of care group volunteers

(CGVs), peripheral health unit (PHU) staff and community members were not involved in determining priority needs or designing activities for the project. However, FMCs' input was sought in those communities where they were already formed and active with prior UNICEF funding. Lessons learnt from the UNICEF project were incorporated into the design of the IH project.

Effectiveness

The support and training the IH project provided had a greater effect in building the capacity of the PHUs and community structures than at the DHMT. Opportunities remain to develop health systems capacity and for strengthening systems at strategic and operational levels.

The project contributed to strengthening the health system at community level, focusing on community structures and adaption of the community care model. The adoption of this model facilitated the cascade of information to a wider audience, including hard-to-reach groups. This proved to be much more effective, both in terms of time and money, than having the IH staff focusing on house-to-house visits.

Training of PHU staff, FMCs and CGVs in health and nutrition improved both knowledge and skills. CGVs supported women in the community to change their health-seeking behaviour and improve the health of their newborn and other children. Caregivers increased their knowledge on nutrition and health but also changed their behaviour, exclusively breastfeeding for six months, and increasing use of health facilities for both curative and preventative services. The IH project did not specifically target men in the community. Awareness of the FHCI was evident and demand for services increased at PHUs.

Impact

Overall the IH project has contributed to delivering FHCI in the Western Area. Training of PHU staff, which the project facilitated, increased the knowledge, skills, practice and confidence in nutrition and diagnosis and treatment of childhood illnesses. Sexual reproductive health training raised greater awareness among communities of the benefits of family-planning services, reduced stigma among men and women, and resulted in more people using contraception.

Membership of the FMCs remained fairly static, which helped members implement what they had learnt through the training. The number of care groups working across the 42 city sections increased. Regular meetings between health facility and community structures improved service provision and demand. However, interaction between the DHMT and community structures was limited. The cohesiveness of both FMCs and CGVs led them to support caregivers financially if they had to pay for drugs. These well-developed community structures were particularly important during the Ebola crisis and floods in September 2015. Overall a total of 52 micro-gardens were established, with mixed results.

The uptake of breastfeeding in IH project communities was acknowledged at the national level at events and on the radio, giving women a sense of recognition. Traditional birth attendants (TBAs) were encouraged to participate in activities to support caregivers. However, not being able to practise as a TBA led to a loss of income.

Although unplanned, the Ebola response allowed an increased focus on infection prevention control at the PHUs and among community health workers (CHWs) and health workers. This in turn increased awareness and understanding of good hygiene practices within the wider communities.

In addition to emergencies – Ebola and flooding – the main challenges were stock-outs of FHCI drugs and delays in replacing stock, and the reallocation of staff to other health facilities. Stock-outs continually forced patients to procure and pay for drugs outside of PHUs. Without the support of the IH project to support the transportation of FHCI drugs it is likely that this will have had a negative impact on project results.

Efficiency

Value additions in strengthening community structures, systems and capacity are evident in the IH project. The project benefited from co-funding provided to GOAL through Irish Aid and supplementary activity funding from the WASH Consortium, as well as resources from other international non-governmental organisations (NGOs). The true cost of the project's implementation is therefore difficult to calculate due to the number of international NGOs supporting the area.

The Ebola response benefitted from the community structures developed by the IH project. The project also provided benefits to ACF and Concern Worldwide. All FMCs provided time and basic maintenance support. Good practices were noted in FMCs going beyond basic support, such as monitoring health facility attendance.

It is difficult to fully assess the efficiency per result, because the structure of the expenditure report does not align with the project results. Analysing training costs as a measure of project's economy, the highest cost per participant was for PHU training. The majority of this training focused on integrated management of acute malnutrition. The outputs achieved from the infant and young child feeding training of trainers showed good value for money, due to the number of participants who received training from the trainers. The value for money of the micro-gardening activities was not clear. It is too early to gauge whether the deployment of the CommCare app has improved efficiency.

The indirect costs were lower than 30 per cent, a standard benchmark for NGO indirect costs. The project used a large number of national rather than international staff, meaning that institutional knowledge is more likely to stay in the country.

Sustainability

The length of the project allowed time for GOAL to develop relationships, knowledge and understanding of community groups. The longevity of the project also allowed FMC and CGV structures to achieve recognition, giving them important standing within their communities and increasing their resolve to continue their work once the project cycle ended.

The lack of a clear exit strategy and reliance on the MoHS to absorb the CGVs under the new CHW policy weakened the sustainability of the project. The capacity of PHU staff to correctly manage malnutrition has improved, but with the current policy of frequent mass staff transfers, institutional memory is adversely affected. While the FMCs and CGVs stated that they will continue to meet, it is likely that some continued input will be needed to keep them motivated. The 2015–20 BPEHS now formally recognises the role of the FMCs, the DHMT is unlikely to provide support due to their limited resources and competing priorities. However, by employing national staff to implement the project, GOAL has ensured capacity is more likely to be retained within Sierra Leone and the healthcare system.

Recommendations for GOAL

- Continue to use the IH approach
- Advocate for standardised incentive payments
- Monitor technology deployment carefully
- Ensure supply chain support for the DHMT and PHUs
- Explore methods of ensuring sustainability
- Increase involvement of men in MNCH activities

Lessons for repeating the project

- Strengthen project design and planning
- Strengthen monitoring
- Invest in a wider health systems approach

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Acronyms

ACF	Action Contre la Faim
ANC	Antenatal Care
BFCI	Breastfeeding Friendly Community Initiative
BPEHS	Basic Package of Essential Health Services
CGV	Care Group Volunteer
CHC	Community Health Centre
CHO	Community Health Officer
CHP	Community Health Post
CHV	Community Health Volunteer
CHW	Community Health Worker
DHCC	District Health Coordination Committee
DHMT	District Health Management Team
DHS	Demographic Health Survey
EU	European Union
FCC	Freetown City Council
FGD	Focus Group Discussion
FHCI	Free Health Care Initiative
FMC	Facility Management Committee
KAPB	Knowledge, Attitudes, Practices and Behaviour
GAM	Global Acute Malnutrition
GoSL	Government of Sierra Leone
HICAP	Health Institution Capacity Assessment
ICCM	Integrated Community Case Management
IH	Integrated Health
IPC	Infection Prevention Control
IMAM	Integrated Management of Acute Malnutrition
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
ITN	Insecticide-Treated Net
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
M&E	Monitoring and Evaluation
M2M	Mother to Mother
MCHP	Maternal and Child Health Post
MNCH	Maternal, Neonatal and Child Health
MoHS	Ministry of Health and Sanitation
MUAC	Mid Upper-Arm Circumference
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Co-operation and Development
ORS	Oral Rehydration Salts
OTP	Outpatient Therapeutic Programme
PHU	Peripheral Health Unit
SAM	Severe Acute Malnutrition
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UN	United Nations
USAID	United States Agency for International Development

1. Background

In April 2010 the Government of Sierra Leone (GoSL) introduced the Free Health Care Initiative (FHCI), which removed user fees for all pregnant and lactating women and children under five years of age (under-fives), enabling free healthcare at point of access in all government health facilities. At the same time the government also introduced the 2011–2015 National Health Sector Strategy, which prioritises the delivery of the Basic Package of Essential Health Services (BPEHS).

Within the first month of the FHCI's launch, the number of women and children seeking healthcare more than doubled across the entire country, and quadrupled at the national children's hospital in Freetown.¹ In 2015, the United Kingdom's Department for International Development (DFID) reported that 1.3 million young children received treatment for malaria; 126,477 women delivered their babies in a health facility, an increase of 30 per cent compared to the previous year; 20,135 maternity complications were managed in health facilities, with a 60 per cent drop in the fatality rate in these cases; and the number of new users of modern family planning increased by 140 per cent.²

Although considerable progress has been made in improving maternal and infant morbidity and mortality, Sierra Leone continues to have some of the world's poorest health indicators and is ranked 181st out of 188 countries and territories on the United Nations (UN) Human Development Index.³ The leading causes of death among under-fives are acute respiratory infections, malaria and diarrhoea.⁴ Health indicators show the infant mortality rate at 107.2 per 1,000 live births, the under-five mortality rate at 160.6 per 1,000 live births, and a maternal mortality ratio of 1,100 per 100,000 births.⁵ Further gains are likely to have been eroded with the Ebola crisis in 2014–15, the effects of which are likely to last for years to come.⁶

Malnutrition

In Sierra Leone, some 7 per cent of children aged 6–59 months suffer from global acute malnutrition (GAM). The highest GAM rates in the country were found in slum areas (9.6%) and the western region⁷ (8.4%). Severe acute malnutrition (SAM) was also highest in the Western Area Urban slum at 2.2 per cent.⁸ Malnutrition is related to a complex mix of multiple causes including child feeding practices, the type of care provided to the child during illness, and exclusive breastfeeding for the first six months of life. Prevention and ensuring adequate treatment of malnutrition are strongly linked to access, community acceptance of health services, and capacity of health staff to effectively treat and provide preventive services. High rates of GAM mean that under-fives are more vulnerable to morbidity and mortality. Mortality increases significantly among infants with malnutrition compared to those who are not malnourished.⁹ A 2011 UNICEF nutrition survey also highlighted that the critical period for the onset of malnutrition was between the ages of six and 23 months, and that it was necessary to focus on infant feeding practices and other maternal care practices.

¹ Department for International Development (2010) *Reducing maternal and child mortality in Sierra Leone, 2010–2015*

² www.healthpovertyaction.org/wp-content/uploads/downloads/2015/06/Healthy-Revenues-extractives-industry-Sierra-Leone-report-June-2015.pdf

³ www.hdr.undp.org/sites/all/themes/hdr_theme/country-notes/SLE.pdf

⁴ www.who.int/gho/countries/sle.pdf?ua=1

⁵ www.hdr.undp.org/sites/all/themes/hdr_theme/country-notes/SLE.pdf

⁶ www.undp.org/content/undp/en/home/librarypage/mdg/mdg-reports/africa-collection.html

⁷ Western Area Urban and Western Area Rural

⁸ UNICEF (2011) Report on the Nutritional Situation in Sierra Leone

⁹ IASC (2010) Management of Acute Malnutrition in Infants Project Technical Review

Malaria

Malaria is the most common cause of illness and death in Sierra Leone.¹⁰ According to the 2008 Sierra Leone Demographic Health Survey (DHS), more than 24 per cent of under-fives had malaria in the two weeks before the household survey. A 2011 UNICEF nutrition survey found that the leading cause of mortality in children was fever (29%). Community-based risk reduction behaviour remains poor, with only 26 per cent of under-fives and 27 per cent of pregnant women sleeping under insecticide-treated nets (ITNs). Delay in seeking treatment for malaria is a significant contributor to mortality. In the 2008 DHS only 15 per cent of children with a fever received an anti-malarial drug within 24 hours of onset of symptoms, and less than 2 per cent of under-fives received appropriate drugs within 24 hours.¹¹ While poor health-seeking behaviour is often a factor, limited availability of malaria treatment in health facilities is also a significant challenge. The GoSL Millennium Development Goal (MDG) Report for 2010 estimated that access to malaria treatment nationally was only 29 per cent. This was identified as a critical area to address to tackle the burden of malaria-related morbidity and mortality.¹²

Diarrhoea

According to the 2008 DHS, 13 per cent of under-fives had diarrhoea in the two weeks before the survey. The rate was highest (18%) among children aged 6–11 months. However, unlike malnutrition and malaria, the statistics for community-based diarrhoea management are fairly positive. Almost half of children with diarrhoea were taken to a health facility or sought treatment from a provider. The survey also indicated that the majority of mothers (91%) knew about oral rehydration salts (ORS) packets. In the two weeks before the survey, 73 per cent of children with diarrhoea were treated with ORS or recommended home-made fluids. However, although more than half of children with diarrhoea (55%) were offered increased fluids during the episode of diarrhoea, 25 per cent received less or no fluid at all. Some 6 per cent of children with diarrhoea received no treatment or change in fluid intake.¹³

UNICEF's 2011 nutrition survey estimated that diarrhoeal disease was a significant contributing factor in child mortality. Diarrhoea was cited as a cause of death in 8 per cent of under-fives – second after fever – in slum areas of Freetown.¹⁴

Sexual reproductive health practices

Findings indicate that mortality rates at all ages of childhood show a strong relationship with birth spacing. Under-five mortality is three times higher among children born less than two years after a preceding sibling than among children born four or more years afterwards.¹⁵ In Sierra Leone, 62 per cent of females marry and bear children before the age of 18, and 27 per cent before the age of 15.¹⁶ Early onset of child birth is strongly linked to maternal and infant mortality. Around 36 per cent of women have unmet contraception needs, most relating to child spacing.¹⁷ Additionally, although more than 85 per cent of pregnant women attended antenatal care (ANC) services at least once in their most recent pregnancy, only 42 per cent delivered in a health facility.¹⁸

¹⁰ GoSL (2009) *Government of Sierra Leone (GoSL) National Health Sector Strategic Plan 2010–2015*

¹¹ GoSL (2008) *Demographic and Health Survey (DHS)*

¹² GoSL (2010) *Millennium Development Goal Report*

¹³ GoSL (2008) *Demographic and Health Survey*

¹⁴ UNICEF (2011) *Report on Nutritional Situation in Sierra Leone*

¹⁵ GoSL (2008) *DHS*

¹⁶ UNICEF (2010) *A Glimpse into the World of Teenage Pregnancy in Sierra Leone*

¹⁷ UNICEF (2011) *At a Glance: Sierra Leone – Statistics*,
www.unicef.org/infobycountry/sierraleone_statistics.html

¹⁸ GoSL (2008) *DHS*

1.1 Integrated Health project

GOAL's integrated health (IH) project focused on systems strengthening and community-level behaviour change, targeting improved maternal and child health, which complement child protection and empowerment interventions. It was funded by separate European Union (EU) and Irish Aid funding streams, and was implemented in 42 out of Freetown's 64 city sections from 2012 to December 2016.

Achieving the full benefits of the FHCI requires addressing inefficiencies, overcoming shortages and building on the experience gained since its introduction. Meeting these challenges and contributing to the reduction of infant and child mortality was the main goal of the IH project. The project sought to promote positive community-based health and social change by engaging with communities on issues of sexual and reproductive health and health-seeking behaviours, to improve maternal and child health outcomes. It focused on three key causes of infant and child morbidity and mortality – namely, malnutrition, malaria and diarrhoea – at community level in the Freetown programme areas.

The project addressed these main causes of infant and child mortality and morbidity through strengthening links between peripheral health units (PHUs), the District Health Management Team (DHMT) and community members. Additionally, GOAL worked with the Ministry of Health and Sanitation (MoHS) and facility management committees (FMCs) to empower families by informing them of their right to healthcare under the FHCI, and to advocate for better services.

Specific activities targeted pregnant women and young mothers (under 24 years of age) with children under five. The project was implemented in collaboration with:

- The DHMT;
- Non-governmental organisations (NGOs) Restless Development and Marie Stopes International; and
- Community-based volunteer groups, such as FMCs, care group volunteers (CGVs) and community health volunteers (CHVs).

The overarching goal of the project was to contribute towards 'a decrease in child mortality and morbidity' across 42 of Freetown's city sections, with the following specific objectives:

- To increase capacity of the DHMT in the Western Area to manage maternal child health services;
- To contribute to strengthening health systems in the 42 city sections in Freetown;
- To improve community management of leading causes of infant and child morbidity (diarrhoea, malnutrition, malaria and poor reproductive health practices); and
- To empower citizens to access health services by informing them of their rights.

2. Introduction

2.1 Objective

The purpose of the final evaluation was: (1) to provide an evidence-based analysis of any changes to the target communities that could be attributed to the IH project's interventions; and (2) to assess project performance and delivery in relation to specific objectives that contribute to the broader goal of reducing child morbidity and mortality.

This evaluation provides an independent assessment of the project's implementation approaches so that lessons and recommendations can shape and inform the design of future activities and GOAL Sierra Leone's new Country Strategic Plan.

The primary audience for this report is GOAL Sierra Leone's Senior Management Team, the MoHS and the EU. The deliverables were developed with a view to providing information beyond the main audience, including the DHMT, PHU staff, NGOs, community-based organisations and other implementing partners. Additional deliverables include a publicly available podcast summarising the results of the evaluation.

2.2 Assessment questions

The main assessment questions drew out findings regarding facility- and community-based healthcare provision from community members (with a particular focus on young mothers and pregnant women as beneficiaries), community-based organisations and volunteers, staff at PHUs, and the DHMT.

The table below was developed in collaboration with GOAL to summarise the questions and provide a more detailed description of the line of inquiry. The evaluation team recommended revisions to the original questions, aligning with the Organisation for Economic Co-operation and Development's five evaluation criteria and key project documentation (the proposal and logframe).

Table 1 Evaluation questions

Question area ¹⁹	Request for offer proposed question	Final new question
<p>Relevance</p> <p>The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor</p>	<ol style="list-style-type: none"> 1. Was the Integrated Health (IH) project aligned with national health priorities? 2. Were targets in line with national standards in this sector (if available)? 3. Did this project effectively reach the most vulnerable households? 4. Did the project address priority needs of the target population? 	<ol style="list-style-type: none"> 1. Was the project aligned with the national priorities, as outlined in the Basic Package of Essential Health Services? 2. Did the project effectively address the priority needs of the target population, including the most vulnerable households?
<p>Effectiveness</p> <p>A measure of the extent to which an aid activity attains its objectives</p>	<ol style="list-style-type: none"> 5. Were the monitoring mechanisms effective in providing timely data to inform programming decisions? 6. To what extent did the project meet its targets and deliver outputs? 	<ol style="list-style-type: none"> 3. To what extent were the project’s specific objectives achieved?
<p>Impact</p> <p>Positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended</p>	<ol style="list-style-type: none"> 7. To what extent did the project achieve intended outcomes and impact? 8. What was the performance against the project indicators? 9. Are there unplanned impacts as a result of this project? 	<ol style="list-style-type: none"> 4. Did the project achieve the intended results? 5. How has the IH project contributed to delivering the Free Health Care Initiative in the Western Area?
<p>Efficiency</p> <p>Measures outputs – qualitative and quantitative – in relation to inputs. It is an economic term that signifies that the aid uses the least costly resources possible to</p>	<ol style="list-style-type: none"> 10. What evidence is available/can be determined on the cost-effectiveness of the intervention? 11. What evidence is available that efficiencies were sought in project design? 12. Were adequate human and financial resources applied in delivering project outcomes? 13. Were outputs delivered in a timely fashion? 	<ol style="list-style-type: none"> 6. To what extent did the project represent value for money?

¹⁹ Definitions from: www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

Question area ¹⁹	Request for offer proposed question	Final new question
achieve the desired results	14. Was technology deployed to improve efficiency?	
Sustainability Measures whether the benefits of an activity are likely to continue after donor funding has been withdrawn	15. To what extent did the programme use established institutions/mechanisms to ensure sustainability at the end of the project? 16. To what extent were relevant partnerships/capacity developed to ensure sustainability? 17. Was a sustainable exit strategy developed?	7. How sustainable are the results of the project?

2.3 Approach and methodology

Before arriving in Sierra Leone the consultancy team undertook a systematic desk review of the available literature. The insight gained from this was used to identify any information gaps and focus areas for stakeholder-based data collection in-country. Quantitative data was used for specific question areas, which GOAL made available before and during the field visit.

The country visit focused on obtaining qualitative data through semi-structured key informant interviews (KIIs) and focus group discussions (FGDs) with selected communities and other relevant stakeholders. The data collection methods and tools are listed below in Table 2. On completion of the primary data collection, a validation workshop was held with GOAL to outline the main findings and preliminary recommendations. Following on from the validation workshop, in-depth analysis and interpretation were conducted with a final report produced outlining the evaluation's conclusions, lessons learnt and recommendations.

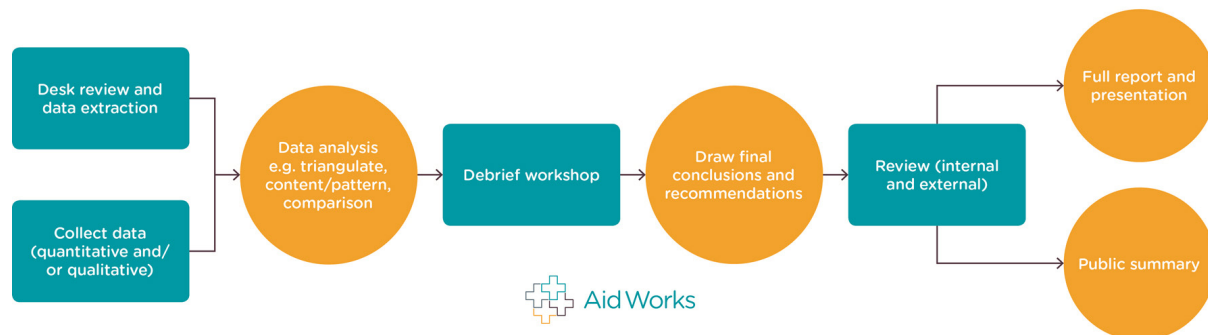
Table 2 Summary of data collection methods and tools

Activity	Completed	Data collection tools
Document review	<ul style="list-style-type: none"> – All relevant project documents – Donor programme documents – GOAL documents 	Key findings template
Key informant interviews	Eight interviews covered: ²⁰ <ul style="list-style-type: none"> – Community health officer (or representatives) from five peripheral health units (PHUs) – Action Contre la Faim – GOAL staff – District Health Management Team 	Semi-structured interview guidelines (see Appendix I)
Focus group discussion	Around 135 participants in total: <ul style="list-style-type: none"> – Caregivers from five communities – Care group volunteers from five communities – Facility management committees from five PHUs – GOAL staff 	Focus group guidelines (see Appendix II)
Community visits	Allen Town, Grassfield (Wesleyan), Kroobay, Susan's Bay (Marbella) and George Brook	

²⁰ See Appendix III for list of key informants.

2.4 Analysis and reporting

Figure 1 Aid Works standard evaluation process



The team developed standardised KII and FGD guides to capture data in a systematic manner. An overall analysis framework was populated for each question to support triangulation of data from the different sources. Findings were presented to and validated with the GOAL team during a debrief presentation at the end of the visit.

2.5 Limitations

The evaluation was primarily qualitative in nature, collecting subjective information on the efficiency, effectiveness, strengths and weaknesses of the IH project. Some of the limitations of the evaluation included:

- Heavy reliance on qualitative data and memory of past experiences, potentially leading to recall bias, particularly when considering the impact of the Ebola outbreak on the ability to continue project activities;
- Changes in staff at GOAL, the DHMT, key partners such as Marie Stopes and Restless Development, PHUs and among some of the FMC volunteers, meaning that some of those involved in the project's implementation have now left or been transferred, therefore reducing institutional knowledge.

However, the team collected a large evidence base, using a systematic approach to record and analyse information across sources. Where possible, information was triangulated with secondary sources to reduce bias and cover gaps where they existed. Secondary sources include GoSL documents, GOAL reports and surveys. A list is provided in Appendix IV. The validation process was essential to confirm that field-observation generalisations were correct, and the debrief presentation provided GOAL with the opportunity to comment on the preliminary findings, conclusions and recommendations.

3. Research Findings

3.1 Relevance

Alignment with national priorities

The BPEHS aims to ensure that everyone in Sierra Leone has access to a basic level of essential healthcare service delivery. It includes both primary and secondary services, with primary healthcare delivered from four levels of increasing clinical skill and capacity (three levels of formal health facilities and one of community-based services). All primary healthcare facilities are referred to as PHUs. These are split into three different standardised types of facilities, each with a clearly defined function: maternal and child health post (MCHP), community health post (CHP), and community health centre (CHC). All three types of PHU offer some level of preventive and curative care, and all are supposed to be open 24 hours a day, or have a staff on call for services out of office hours. MCHPs and CHPs only provide out-patient services, with a limited number of beds used for observation. Patients requiring further supervised care are referred to a CHC or hospital. The number of staff per PHU is dependent on population size.²¹

According to the BPEHS, all CHCs are expected to offer in-patient services, but not all currently have the space or capacity to do this. They are also the first level of health facility to have both a laboratory and pharmacy, and therefore have a higher diagnostic and treatment capacity than the simpler MCHPs and CHPs. Under the IH project, GOAL supported 19 of Freetown's 39 functioning CHCs.^{22, 23} Support consisted of mentoring and supervision from GOAL field staff, with five health promoters and one field supervisor covering the 19 PHUs. On-the-job training, training on MoHS protocols such as integrated management of acute malnutrition (IMAM) and routine joint supervision with the DHMT were part of IH project activities.

The CHC in-charge is a community health officer (CHO), who in addition to overseeing the management and clinical care at the CHC also supervises lower levels of care within his or her catchment at the MCHPs and CHPs, and community health workers (CHWs). By supporting higher-level health facility staff and increasing their clinical and management capacity, it was intended that the lower cadre of staff at the MCHPs and CHPs would also benefit through cascade training and improved support supervision visits from the CHO.

The BPEHS is made up of services that are cost effective and evidence based. Likewise, the IH project was designed to be cost effective yet have a large impact by strengthening existing community structures, such as the FMCs, and incorporating new low-cost community-based approaches, such as the care group model, to address issues primarily related to maternal and child morbidity and mortality.²⁴

Through the community-based activities and PHU-level support, the IH project directly supported nine out of the 14 components listed in the 2010 BPEHS. Table 3 below shows the planned activities of the project, as well as the observed activities that have directly contributed to supporting BPEHS components. Supporting essential drugs and supplies and emergency care were not part of the planned activities, but it was necessary for GOAL to do so. The 2010 BPEHS components that were not directly supported by the project include mental health/non-communicable diseases, oral health, ear, nose and throat, and audiology, eye care, and disability.

²¹ MoHS (2010) *Sierra Leone Basic Package of Essential Health Services*

²² The initial proposal was to support 18 peripheral health units (PHUs), but a new health facility was established and GOAL expanded to support a total of 19 PHUs and 19 facility management committees (FMCs).

²³ Action Contre la Faim (ACF) supports the remaining 20 community health centres for nutrition-related activities.

²⁴ Interview with GOAL SL senior management and Integrated Health (IH) project staff

Table 3 Main building blocks of the 2010 Basic Package of Essential Health Services supported by the Integrated Health project, and observed contributions made by GOAL

BPEHS components supported by IH project	Observed IH project activities	Identified through primary research	Identified through secondary research
Maternal and newborn health	Antenatal care	–	✓
	Family planning	✓	✓
Child health and immunisations	Integrated management of childhood illness	–	✓
Infant and young child nutrition	Community nutrition	✓	✓
	Micro-nutrient supplementation – Vitamin A	–	✓
	Treatment of clinical malnutrition	✓	✓
School and adolescent health services	Youth-friendly sexual and reproductive health information, education and communication	–	✓
Control of communicable diseases	Control of malaria	✓	✓
	Control of sexually transmitted infection and HIV/AIDS	–	✓
Environmental health interventions	Hygiene promotion – Infection prevention control	✓	✓
Health education	Development and dissemination of health education materials (e.g. infant feeding)	✓	–
	Broadcast of radio discussion programmes	✓	✓
	Community sensitisation meetings	✓	–
	Conducting health talks in clinics	–	✓
	Community volunteer training on health topics, care group model (conflict resolution, monitoring and evaluation, etc.)	✓	✓
	Monitoring and evaluation of knowledge and behaviour change using knowledge, attitudes, practices and behaviour surveys	–	✓
Unplanned activities		–	–
Essential drugs and supplies	Logistics only – transportation of drugs to PHUs	✓	–
Emergency care	Ebola, flooding	✓	–

The BPEHS was revised in 2015. While it maintained much from the original 2010 BPEHS, the new document was developed in parallel with the country's post-Ebola health sector recovery plan and National Health Sector Strategic Plan (NHSSP) 2015–2020, which were designed to strengthen public health facilities to a point where they could achieve the full BPEHS by 2020. Unlike the 2010 BPEHS, which outlined components by program area, the revised 2015 BPEHS is presented by level of service delivery (i.e. the full range of services available in each level of the health system). The purpose of this was to 'realign conceptualization of the package towards integration and away from verticalization by program/disease.'²⁵ The revised BPEHS was built around the five priority pillars of the health sector recovery plan: patient and health worker safety; health workforce; essential health

²⁵ MoHS (2015) *Sierra Leone Basic Package of Essential Health Services*

services; surveillance and information; and community ownership. The essential health services pillar incorporates the original 14 components of the 2010 BPEHS, plus an additional three: blood services, diagnostic imaging, and the control and management of other diseases with epidemic potential.

In addition to the nine components from the 2010 BPEHS outlined above, the IH project activities also served to strengthen the control and management of other diseases with epidemic potential. This was primarily done by strengthening two pillars: community ownership, and surveillance and information. Community ownership was greatly increased through the activation and support of the FMCs and CGVs, training at the community level on social mobilisation and advocacy for the MoHS to formally incorporate CHWs into the health system. Surveillance and information was enhanced by supporting PHUs to increase accurate and timely reporting, as well as improved support supervision capacity at the DHMT level.

Target population

The FHCI is a national policy that the president of Sierra Leone introduced in 2010. It aims to provide free healthcare to all pregnant and lactating women, as well as children under five.²⁶ Free malaria testing and treatment for everyone is also included under the policy.

Achieving the FHCI requires addressing inefficiencies, overcoming shortages and constantly building on the experience gained since its introduction. The policy relies on the following components:²⁷

- **Drugs and equipment** – the continuous availability of equipment, drugs and other essential commodities;
- **Health workforce** – adequate numbers of qualified health workers;
- **Governance** – strengthened and effective oversight and management arrangements;
- **Infrastructure** – adequate infrastructure to deliver services;
- **Communication with the general public** – more and better information, education and communication to stimulate demand for free quality health services;
- **Monitoring and evaluation (M&E)** – a comprehensive M&E system; and
- **Financing** – sufficient funds to support the FHCI.

The MoHS identified maternal and child health, the focus areas of the IH project, as priority areas of concern, both through the BPEHS and FHCI. Data from the DHS, UNICEF and the GoSL 2010 MDG report was used to narrow down the focus of activities to primarily address malnutrition, malaria, diarrhoea and sexual reproductive health (SRH).

From 2009 to 2011 GOAL supported 12 PHUs and community-based nutrition services in 27 city sections through a UNICEF grant. The intention of the IH project was to extend the project to include a further 15 city sections and six PHUs to cover a total of 42 out of 64 city sections in Freetown. The selection of the additional 15 city sections was based on the following criteria: (1) priorities of the GoSL; (2) community acceptance of the intervention; (3) population; and (4) capacity of PHU staff (staff with lower capacity were prioritised first). GOAL worked with the DHMT to identify which additional city sections and PHUs met this criteria.²⁸ In 2014, when Action Contre la Faim (ACF) was planning its nutrition project in Western Area Urban, it consulted GOAL and the DHMT to ensure there was no duplication of effort and support.

The CHOs represent the DHMT and PHU staff on the FMCs, in the role of secretary. The level of involvement in identifying initial health priorities varied among the PHU in-charges. Staff at Mabella PHU said the CHO had met GOAL and the FMC at the start of the project to discuss the most urgent

²⁶ GoSL (2009) *Free healthcare services for pregnant and lactating women and young children in Sierra Leone*

²⁷ Oxfam Policy Management (2016) *FHCI independent evaluation*

²⁸ Focus group discussion (FGD) with District Health Management Team (DHMT) members, 27 February 2017

needs. However, the CHO was unavailable for the KII and the respondent did not know any more details about the meeting.²⁹ The CHOs at Allen Town and Wesleyan said they were not involved in any decision making, but recommended involving PHU staff more in identifying priorities in any future programming.³⁰ The CHOs for Kroobay and George Brook PHUs had arrived within the last few months of the project and were therefore not around during the start-up phase.

An FMC composed of members of the catchment community oversees each PHU. The FMCs have an integral role in supporting the BPEHS and FHCI. Their main responsibility is to liaise between community members and health centre staff. According to the 2015 version of the BPEHS, FMC members are expected to work together with PHU staff to develop a facility investment plan for each PHU, agree on the use of performance-based finance funds, and may contribute community materials and labour to infrastructure improvements at PHUs (e.g. construction and repair of wells and latrines, housing for PHU staff, PHU structure construction and rehabilitation, etc.).³¹

FMCs were active in all of the communities visited during the assessment. While some had been formed before the start of the IH project, others were only activated by GOAL in 2012, and all 19 of them became more involved with the support of the IH project. Ward councillors and the DHMT selected members from across the PHU catchment areas from various community structures such as schools, religious institutions, youth groups, women’s groups, and so on.

Some FMCs said GOAL and the DHMT consulted them when prioritising health needs in the community. For example, the FMC for Mabella PHU said that they were invited to a meeting with GOAL and the DHMT before the start of the project to identify major health problems in the area – to which the FMC responded that there were ‘too many sick children’.³² The FMC for Kroobay also said that GOAL met them at the beginning of the IH project, informed the FMC that they had a set package of interventions they could bring to the community, and asked the FMC to identify what activities to prioritise.³³ The FMCs for Allen Town, Wesleyan and George Brook PHUs said they were not involved in identifying the priority needs for their communities. It was not clear what factors determined whether or not FMCs were invited to attend initial discussion meetings.

Table 4 Role of statutory and community structures³⁴

Structures	Description
Peripheral health units (PHU)	<ul style="list-style-type: none"> – CHO oversees management and clinical care at the PHU, supervises lower levels of care within their catchment, such as MCHPs, CHPs and community health workers – Provides maternal health services – Liaises with community structures such as the FMC – Weekly/monthly reporting of health data
Facility management committee (FMC)	<ul style="list-style-type: none"> – Members of the catchment community – Liaises between community members and health centre staff – Regular meetings with PHUs and CGVs

²⁹ Key informant interview (KII) with Mabella PHU outpatient therapeutic programme (OTP) nurse, 31 January 2017

³⁰ KII with Allen Town PHU in-charge, 28 January 2017; and Wesleyan PHU in-charge, 30 January 2017

³¹ MoHS (2015) Sierra Leone Basic Package of Essential Health Services, 2010

³² FGD with Mabella FMC

³³ FGD with Kroobay FMC

³⁴ BPEHS 2010–15; KII with GOAL; FGD with FMCs and community group volunteers (CGVs)

Care group volunteers (CGVs)	<ul style="list-style-type: none"> – Identify and sensitise caregivers – Actively screening nutrition (detection and referral to PHU) – Promote and support health and nutrition messages (e.g. exclusive breastfeeding, complementary feeding, handwashing) – Encourage caregivers to use PHU – Regularly meet FMCs and caregivers
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CGVs were female volunteers who conducted house-to-house visits, where they met on a one-to-one basis with pregnant or lactating women, or mothers with children under 24 months old, in their community. These visits were carried out on a daily or weekly basis, depending on the level of support needed. They also conducted twice monthly group sensitisation³⁵ meetings with the women they supported, referred to as caregivers. The CGVs encouraged pregnant women to attend the PHU for ANC and delivery. They also provided information on the importance of completing childhood vaccinations, the benefits of exclusive breastfeeding, hygiene promotion, family planning, using ITNs, polio vaccination, deworming, vitamin A, and the real causes and effects of malnutrition.³⁶

The CGVs also identified and referred malnourished children to PHUs for screening and nutritional support. This applied to all under-fives in the community, not just those from families that a CGV directly supported. Some CGVs were trained to do nutritional screening themselves and were provided with mid upper-arm circumference (MUAC) tapes, while others reported suspected cases of malnutrition to other CHVs for screening. Cooking demonstrations were conducted to encourage complementary feeding, using locally available foods. The care groups were made up of 10–15 members and each CGV was responsible for 15 households. The number of care groups per section varied across the 42 city sections, with some having wider household coverage than others. This meant that some FMCs and PHUs had several care groups feeding into them.



Photo 1: Volunteer Caregivers, Allentown

The CGVs were self-selected. At the start of the project GOAL called a meeting with the women of the communities, where they explained the CGV role and asked for volunteers. No set criteria were provided during the assessment for this role, but volunteers said they were expected to be of childbearing age and to have had experience of being a mother themselves. As with the FMCs, some of the care groups said they had taken part in initial stakeholder consultations to identify priority needs within their community, but it was unclear how GOAL decided which communities were consulted.³⁷ Some CGVs, also known as mother-to-mother (M2M) groups, had been established since 2010.³⁸ The care group model replaced the M2M structure to allow wider coverage and greater impact by increasing the number of support groups.

None of the caregivers from the FGDs were involved in initial planning meetings to identify priority needs and neither were they involved in selecting the CGVs or FMC members. However, they were

³⁵ Sensitisation refers to awareness-raising activities.

³⁶ EU IH Quarterly Reports; FGD with CGV groups

³⁷ FGD with Susan’s Bay CGVs, George Brook CGVS

³⁸ FGD with Grassfield CGVs

all supported by a CGV and were all aware of who their representatives were on the FMC and the role the FMC played within their community. The CGVs identified pregnant and lactating women within their communities and approached them. They explained the job of the CGV and the support they could give to the women.

Building on the Breastfeeding Friendly Community Initiative (BFCI), which included a dietary diversification plan as part of its commitment to safe, nutritious foods for mothers, infants and young children, GOAL worked with some of the communities to establish micro-gardens in the city sections. Limited land availability was an issue in many sections. In slum settings, where land was scarce and often infertile, GOAL introduced ‘sack gardens’. In this setting CGVs were encouraged to grow nutritious foods in sacks around their homes. GOAL provided seeds and tools, as well as helping with laying out the plots, where applicable. To strengthen ownership, community members were asked to contribute something to the process (e.g. land rental fee or cost of the sack).

3.2 Effectiveness

The overall objective identified in the IH project logframe was ‘to contribute to the reduction of infant and child morbidity in Freetown by 2015’. The project was designed to increase the capacity of the DHMT, strengthen health systems, improve community management of infant and childhood illnesses, and increase awareness of health rights provided through the FHCI as seen in Table 5.

Table 5 Integrated Health project logframe outlining four key objectives and results

Results	Objectives	Overall objective
1. 18 PHUs have adequate capacity to offer and accurately report on service delivery	1. To increase capacity of the DHMT in the Western Area to manage maternal child health services	To contribute to reducing infant and child morbidity and mortality in Freetown by 2015
2. Increased involvement of community structures including the development of community health committees to act as civil society forums through 18 PHUs in 42 city sections in Freetown	2. To contribute to strengthening health systems in the 42 city sections in Freetown	
3. Increased capacity of community health systems in 42 city sections in Freetown that support GoSL services in addressing the leading causes of infant/child mortality	3. To improve community management of leading causes of infant/child morbidity (diarrhoea, malnutrition, malaria, poor reproductive health practices)	
4. Increased knowledge of mothers on their healthcare rights.	4. To empower citizens to access health services by informing them of their rights	

The results and objectives describe support provided to the DHMT, developing the capacity of PHU and community structures, community management and empowerment of citizens. The logframe had a total of 30 indicators collecting data for the results, objectives and overall objectives. None of these indicators included a measure to quantify an increased demand in maternal, neonatal and child health (MNCH) services. The logframe indicators focused on:

- Survey data on under-five morbidity/mortality;
- Supervision systems;
- Feedback mechanisms;
- Knowledge, practice and perceptions; and
- Functionality of the caregiver groups.

Increasing capacity of district health management teams in maternal, neonatal and child health

Health in Sierra Leone is decentralised across 13 districts. Freetown is divided into two areas: Western Urban and Western Rural. A DHMT manages each district. The DHMT is headed by a district medical officer who oversees implementation of national health policies and activities such as district health plans, disease prevention, treatment, health promotion, data collection and management at the PHUs.³⁹ Through the UNICEF-funded project GOAL worked to support the Western Urban DHMT with MNCH activities in 12 PHUs across 27 sections. This was increased to 18 PHUs under the IH project in 2012. However, in 2013 another PHU was added with the building of a new health centre in Portee. Therefore a total of 19 PHUs were supported in 42 sections across Freetown.

The DHMT was involved with the initial design of the IH project and continued to support it for its duration. During the project the District Health Coordination Committee (DHCC) was formed by the DHMT and Freetown City Council (FCC). The DHCC, a multi-stakeholder structure, is oversees health service delivery at district level, which includes supporting planning, coordination and monitoring, advocacy for health services, and community liaison.⁴⁰ In February 2013, district nutrition coordination meetings were established. These monthly meetings coordinated with key nutrition partners – GOAL, DHMT, Helen Keller International and ACF – to plan joint monitoring and supervision of nutrition activities in PHUs in the Western Urban Area.⁴¹ GOAL also attended and contributed to the annual district planning meetings.⁴² Although operational support was provided to the DHMT through the IH project, there is no evidence to suggest that there was a specific capacity-building plan identified as part of its implementation plan.

Social mobilisation staff from the DHMT were engaged in the IH project and participated in related activities such as radio, community sensitisation activities and designing materials.⁴³ DHMT staff also supported GOAL during training sessions. GOAL encouraged and supported the DHMT to conduct joint monthly supervisory visits to PHUs. And GOAL also helped to rationalise the PHU supervisory checklists, amalgamating a number of forms into one, which helped to make the supervisory visits more effective.⁴⁴ However, the DHMT was subject to competing priorities from other partners and on a number of occasions was unable to accompany GOAL on supervision visits.⁴⁵ The joint district nutrition coordination meetings with the DHMT and partners appeared to be more effective in helping to coordinate nutrition activities. In 2014, with the start of its nutrition project, ACF worked with GOAL on proposal development, thus reducing overlap. In addition, ACF and GOAL worked with the DHMT to identify what areas each would cover, to avoid duplication. GOAL and ACF also worked together to support joint supervisory visits to the PHUs with the DHMT.

Supporting peripheral health units

The focus of supervisory support on building capacity is more evident at the PHU and community levels. All the PHUs the IH project supported provided basic emergency obstetric care. Support provided to the PHUs was through staff training on nutrition, management of neonatal and childhood illnesses, infant and young child feeding (IYCF) and training of trainers. Training was in the

³⁹

www.who.int/profiles_information/index.php/Sierra_Leone:Structural_organization_of_health_information

⁴⁰ EU IH Quarterly Reports

⁴¹ *Ibid.*

⁴² KII with GOAL

⁴³ KII with Social Mobilisation, EU IH Quarterly Reports

⁴⁴ Interview with GOAL

⁴⁵ EU IH Quarterly Reports

form of taught courses and refresher training sessions on integrated management of neonatal and childhood illnesses (IMNCI), IMAM and on-the-job training, as seen in Table 6 below.

Table 6 Training provided by the Integrated Health project

Training programme	PHU staff	FMC	CGV
Integrated management of acute malnutrition	✓	–	–
Integrated management of neonatal and childhood illnesses	✓	–	–
Infant and young child feeding	✓	✓	✓
Health institution capacity assessment		✓	✓
Training of trainers	✓	–	–
Youth-friendly sexual reproductive health services	✓	–	
HIV and sexually transmitted infection training	–	–	✓
Community-based management of acute malnutrition (including mid-upper arm circumference)	–	–	✓
Free Health Care Initiative	–	✓	✓

IH project staff, field supervisors and health promoters, were assigned to support specific PHUs. IH project staff were trained nationally, with the minimum requirement of a nursing certificate. In addition to supervisory support, they conducted six-monthly checks, using standardised tools, to measure the quality of service provided to patients and accuracy of diagnosis and treatment.

Training on SRH, with a particular focus on young people and confidentiality, was also provided to all the PHUs. The PHUs visited were keen to state that their facilities had a separate room that could be used for private consultations.⁴⁶ During this period George Brook PHU had a separate office built specifically for family planning, which the DHMT funded.⁴⁷

Community structures and feedback

FMC members come from a range of backgrounds such as religious leaders, teachers, social workers, traditional birth attendants (TBAs) and local councillors. There are up to 15 members, each representing a specific geographical area, which together make up the catchment area of the PHU. Support and development of FMCs was delayed until 2013, after elections in 2012, to avoid any misconception that the IH project had a political agenda. Training and support was provided to FMCs on:

- The FHCI;
- IYCF;
- Monitoring of community health services;
- Group dynamics;
- Reporting and conflict management;
- Participatory planning;
- Leadership and governance;
- Resource mobilisation and management;
- Collaboration and coordination;
- Monitoring and evaluation;
- Supervision; and
- Development of action plans.

⁴⁶ FGD with FMCs and PHUs

⁴⁷ FGD with George Brook FMC

In 2015, the Health Institution Capacity Assessment (HICAP), a training tool developed by Concern Worldwide, was used with the FMCs to help assess each group's performance. The HICAP is a participatory self-assessment tool that chiefs or local leaders implement and update on a regular basis.⁴⁸

FMCs interviewed said that they were active and that a member of the group would visit the PHU on a regular basis, sometimes even daily.⁴⁹ George Brook FMC was known in the area⁵⁰ for being proactive. Some of the less active FMCs were encouraged to go on exchange visits to see examples of good practice to act as an encouragement.⁵¹ The FMC respondents appeared to have strong and positive working relationships with the CGVs and PHU staff. They felt that their communities and PHU staff respected them, and that they could positively influence health outcomes in those communities.

A previous evaluation recommended that GOAL implement the care group model.⁵² The care group model aimed to extend CGV groups across the 42 sections. Each CGV would be trained in IYCF, nutrition, hygiene practices and MUAC, and referrals to PHUs, and would be responsible for up to 15 caregivers. Therefore the total number of women reached per CGV group at any one time was 225 women and their respective households.

Figure 2 Description of the care group model

Care group model definition

A care group comprises 10–15 volunteer, community-based health educators who regularly meet project staff for training and supervision. They are different from typical mothers' groups in that each volunteer is responsible for regularly visiting 10–15 of her neighbours, sharing what she has learnt and facilitating behaviour change at household level.

Care groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behaviour change communication. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.⁵³

IH project staff would also conduct regular observation visits with CGVs to ensure that the correct information was being delivered and any MUAC referrals were appropriate.⁵⁴ By the end of the project 110 CGV groups had been established, reaching 27,605 pregnant mothers and mothers with children under 24 months, and 110,442 under-fives.

None of the volunteers received any financial contribution other than a travel and food allowance. Some support was provided by in-kind contributions such as seeds, tools, and t-shirts with health messages.

Feedback mechanism

A feedback mechanism was established across all the relevant statutory and community groups during the IH project. The aim was for community representatives and PHU staff to meet routinely to

⁴⁸ Concern Worldwide (2011) *Breaking the Mold: A Toolkit for the Replication of an Effective Urban Health Model*

⁴⁹ FGD with FMCs

⁵⁰ KII with George Brook PHU

⁵¹ KII with GOAL; FGD with George Brook FMC; EU IH Quarterly Reports

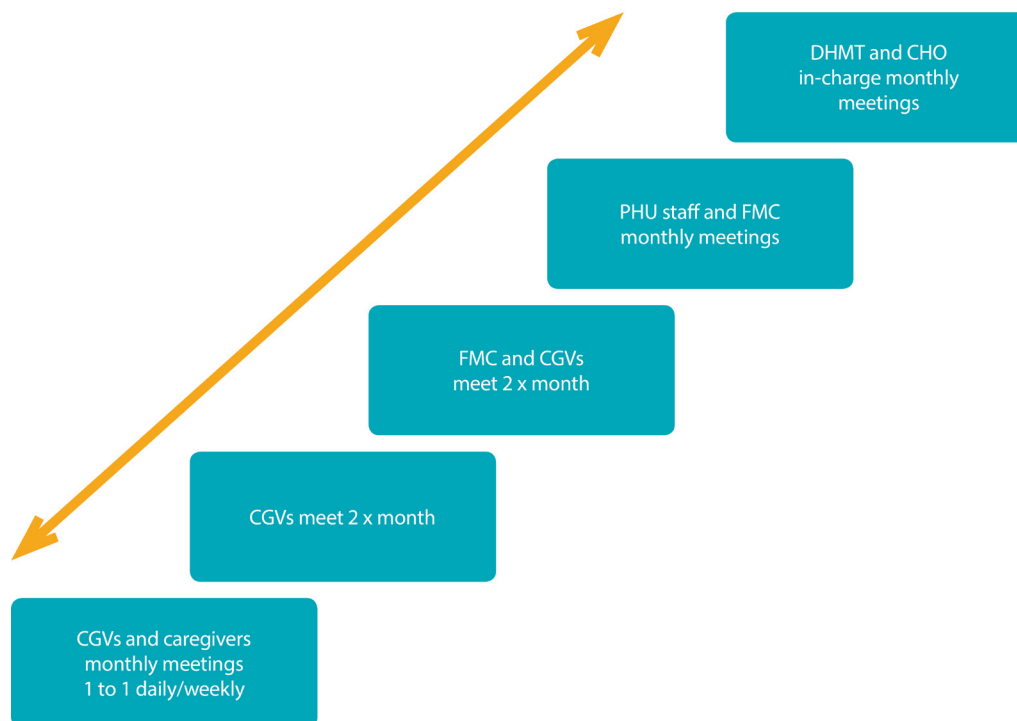
⁵² GOAL (2011) *Part B Proposal Document EU November*

⁵³ caregroups.info/criteria/

⁵⁴ EU IH Quarterly Reports

monitor service provision, improve quality and address issues as they arose. Staff from PHUs and community groups all agreed that the various group meetings were useful and happened on a regular basis. As Figure 3 below shows, the various groups could exchange information and raise issues.

Figure 3 Feedback mechanism



The FMCs said that they did not have regular meetings with the DHMT. However, they could always write to them or visit the office in Klinetown if necessary, and the CHO acted as a local DHMT representative.⁵⁵ Through the care group model interviewees said that there was a good reach into the community, including hard-to-reach groups, to be able to pass on relevant and necessary information:

Previously Marie Stopes wasn't as effective [with family planning] as they were not able to access hard to reach groups in the community, but GOAL used the community structures to disseminate information.⁵⁶

The FMCs could also raise issues with the PHU regarding patient satisfaction.⁵⁷ If PHU staff had acted inappropriately, FMCs could also request that the staff member be removed. Two such cases were spoken of during the interviews.⁵⁸ However in such cases the staff in question were removed and placed in another health facility without any further disciplinary procedures to actually address the cause of the problem.

All CGV FGD participants said they had a strong working relationship with the FMCs and 'worked together hand in hand.' They also felt that the staff at the PHU respected them, and were confident of their skills and ability to support pregnant and lactating women in their community.

⁵⁵ FGD with FMCs

⁵⁶ FGD with Susan's Bay FMC

⁵⁷ FGD with FMCs

⁵⁸ KII with GOAL, FGD FMC

Community management of child health

Through training PHU staff, FMCs and CGVs, women in the community were encouraged and supported to change their health-seeking behaviour and improve the health of their newborn and other children. Information and support was provided through one-to-one visits to the home with IYCF materials, group discussions, community meetings, and food demonstrations on complementary feeding using local food sources. Further support was provided through interventions such as: radio slots discussing breastfeeding; celebration events; health messages on billboards;⁵⁹ a malaria campaign and mass ITN distribution in 2014; hygiene practice promotion; and sanitation activities provided by the Freetown WASH Consortium.

Caregivers stated that they had changed their practice on breastfeeding and exclusively breastfed their babies, without introducing water, up to six months old. They had increased their knowledge on food preparation and nutritious local foods, and understood real causes of malnutrition and malaria rather than local health beliefs and superstitions.⁶⁰ Many of the women interviewed said they had exclusively breastfed their youngest child, with the majority continuing past six months to one year and beyond. Mothers who had older children said that their youngest child had been much healthier than previous children, because they had been exclusively breastfed.⁶¹

All babies and toddlers who accompanied their mothers to the FGDs were observed to be looking healthy and well nourished. All caregivers, apart from one mother, said that they had delivered at the PHU (46 out of 47). The mother who had not delivered at the PHU said that it was during flooding when no one was available at the PHU.⁶² As an added incentive to deliver at the health facility, new mothers were provided with ITNs, blankets⁶³ and health cards.⁶⁴ By-laws in some of the areas the IH project meant that mothers could be fined 500,000 Leones (approximately US\$67) for not delivering at the health facility.⁶⁵

The primary recipients of the IH project were mothers-to-be and new mothers with children under two years of age. Men were not specifically targeted in the project. In 2013 a barrier analysis was conducted and men and mothers-in-law were identified as strong influencers on exclusive breastfeeding and complementary feeding practices. Husbands often dictated the kind of food to be cooked and sometimes would not give enough money to buy the food needed to cook diverse meals. In some households women required a man's approval to attend a health facility. The activities identified to address these two groups were to have action-oriented group sessions for other family members such as: (1) involving in-laws and other relatives in care group discussions on the importance of food varieties; (2) involving other relatives and husbands during care group visits and meetings; and (3) developing radio programmes that involved mothers-in-law and husbands encouraging mothers to give nutritious complementary foods to children aged between six and 23 months.^{66 67} In 2013 the BFCI was launched in 12 communities to include the wider community in supporting breastfeeding.⁶⁸

The Ebola outbreak (August 2014–May 2015) and flooding (September 2015) disrupted and delayed the IH project. Although its implementation was either temporarily stopped or hindered, volunteers

⁵⁹ KII with PHUs; FGDs with FMCs, CGVs, caregivers; EU IH Quarterly Reports

⁶⁰ Local health beliefs were that malnutrition was caused by having sexual intercourse while still breastfeeding and malaria was caused by eating oranges.

⁶¹ FGD with CGVs

⁶² FGD with Kroobay caregivers

⁶³ Concern Worldwide provided insecticide-treated nets and blankets.

⁶⁴ FGD with PHUs

⁶⁵ FGD with FMCs; FGD with CGVs

⁶⁶ FGD with GOAL

⁶⁷ GOAL (2014) internal document

⁶⁸ EU IH Quarterly Reports

could still be mobilised through the community networks the project had established. Due to the trust developed with IH staff during the project, volunteers were willing to promote health and hygiene messages, and encourage people to return to health facilities.

Demand for services

The MoHS, at national level, and the IH project both promoted the FHCI and services for pregnant and lactating women and under-fives. During caregiver FGDs, women stated they knew what services they were eligible to receive. However, drug stock-outs remained a challenge under the FHCI, which forced patients to go outside of health facilities to purchase treatment, even when eligible for free care and treatment.⁶⁹

In the assessment, respondents all said that use of the health facilities had increased. Caregivers stated that although they went to a health facility frequently, it was for preventive measures such as children's vaccinations and growth monitoring, rather than for treatment. Due to Ebola the use of health facilities declined both during and after the outbreak.⁷⁰ It took time to persuade communities to use health facilities again.⁷¹ Figure 4 can be used as a proxy to show that in the case of three of the PHUs, demand at the health facility increased.⁷² However, George Brook PHU shows a decline in outpatient department figures. This runs counter to discussions held with the FMC and PHU, as they have a large catchment area, around 28 paid staff and a busy outpatient department.⁷³

Figure 4 Outpatient department figures for five peripheral health units (2012 and 2016)

⁶⁹ KII with GOAL; FGD with FMCs; FGD with CGVs; FGD with caregivers

⁷⁰ Witter S., et al. (2016) *The Sierra Leone Free Health Care Initiative (FHCI): process and effectiveness review*

⁷¹ KII with PHU

⁷² Data provided by M&E DHMT Western Area

⁷³ Interviews with PHU in-charge and FGD with FMCs at George Brook PHU

3.3 Impact

The four results of the IH logframe focused on the PHUs' ability to accurately report on service delivery, development of FMC and community structures, capacity of the communities to address infant and child mortality, and an increased knowledge of citizen's health rights, as outlined in Table 5 above.

Peripheral health units: increased capacity and reporting

Training of PHU staff through the IH project increased their capacity in nutrition and diagnosis of childhood illnesses. Their improved knowledge and skills led to better diagnosis and reporting.⁷⁴ There was also a greater awareness of making family planning accessible to young people. PHU staff in interviews reported that their knowledge and skills in detecting and treating malnutrition had improved. For example a nutritionist in Mabella PHU said:

*I have learned a lot... how to use OTP [outpatient therapeutic programme] tools, z-score, MUAC and the use of different terminology, e.g. readmission, defaulter. It has increased my knowledge and confidence.*⁷⁵

Quality of malnutrition referrals by CGVs improved after they received training on MUAC.⁷⁶ However, IH staff identified that some women were attending numerous nutrition sessions in different PHUs once a child had been referred for malnutrition treatment. The IH project addressed this by arranging to hold nutrition days in different PHUs at the same time to prevent duplication.

GOAL developed monitoring tools for the IH project to measure user satisfaction and outpatient therapeutic programme (OTP) diagnosis and treatment by PHU staff. The tools were designed to be used at each of the 19 PHUs twice a year. A study undertaken on behalf of GOAL reported that 92.9 per cent of respondents considered that PHU staff had a good attitude towards service users; 83.6 per cent described the consultation services PHUs offered as 'good'. The OTP assessment reviewed case histories of children aged between six years and 59. The results showed 93.2 per cent of all children diagnosed with severe malnutrition met the admission criteria, 87.7 per cent being provided with the right amount of ready-to-use therapeutic food; 82.2 per cent of children were also found to have been appropriately discharged.⁷⁷ However, it is unclear if reporting and accuracy of reporting improved during IH project.



Photo 2: Wesleyan Peripheral Health Unit, Grassfields

⁷⁴ KII with ACF – specifically regarding nutrition; KII PHUs

⁷⁵ KII with Nutritionist, Mabella PHU

⁷⁶ KII with PHU

⁷⁷ Macarthy, J. (2015) *Report on Formative Research on Care-Seeking Behaviour*

PHU staff were also trained by Restless Development and supported by Marie Stopes on reproductive health services, with a particular focus on youth-friendly services. PHU staff, CGVs and caregivers said that awareness of family-planning services was greater, there was less stigma and more people were using contraception. Women said that they faced little or no resistance from their husbands in using SRH services. Youth-friendly services were now available and the number of teenage pregnancies had been reduced.⁷⁸ This was corroborated by a 2016 FHCI evaluation, which showed that fertility rates for young people aged 15–19 had fallen from 146 per 1,000 women in 2008 to 125 per 1,000 in 2013. All other age groups showed much smaller reductions in fertility.⁷⁹ Although couples were encouraged to come to the PHU together for consultations, men were less likely to come into the health facility. In one instance, the PHU left condoms outside the health facility building so that they were easily accessible.⁸⁰

Community structures

Although there were changes, overall membership of the FMCs remained fairly static.⁸¹ Training provided to the committees increased knowledge, skills, confidence and group cohesiveness. FMCs said that the communities in which they worked respected them. FMCs could participate in meetings with PHU staff, feed back concerns, follow up with malnutrition cases in the community, address conflicts and develop action plans.⁸² Involvement of FMCs in PHU activities has restored community confidence in the PHUs.⁸³

The care group model enabled wide coverage of trained volunteers throughout the community through a developed network of CGVs and caregivers, as Table 7 and Figure 5 below show.

Table 7 Total number of facilities, groups and beneficiaries supported by Integrated Health project

Facilities, groups and beneficiaries	Number supported
City sections	42
Peripheral health units	19
Facility management committees (FMCs)	19
FMC members (approx.)	285
Caregiver volunteer groups (CGVs)	110
CGVs trained and supported (approx.)	1,650
Pregnant women and mothers with children under 24 months	27,605
Children under five years	110,442

⁷⁸ KII with PHU, FGDs CGVs; FGD with caregivers

⁷⁹ Witter S., et al. (2016) *The Sierra Leone Free Health Care Initiative (FHCI): process and effectiveness review*

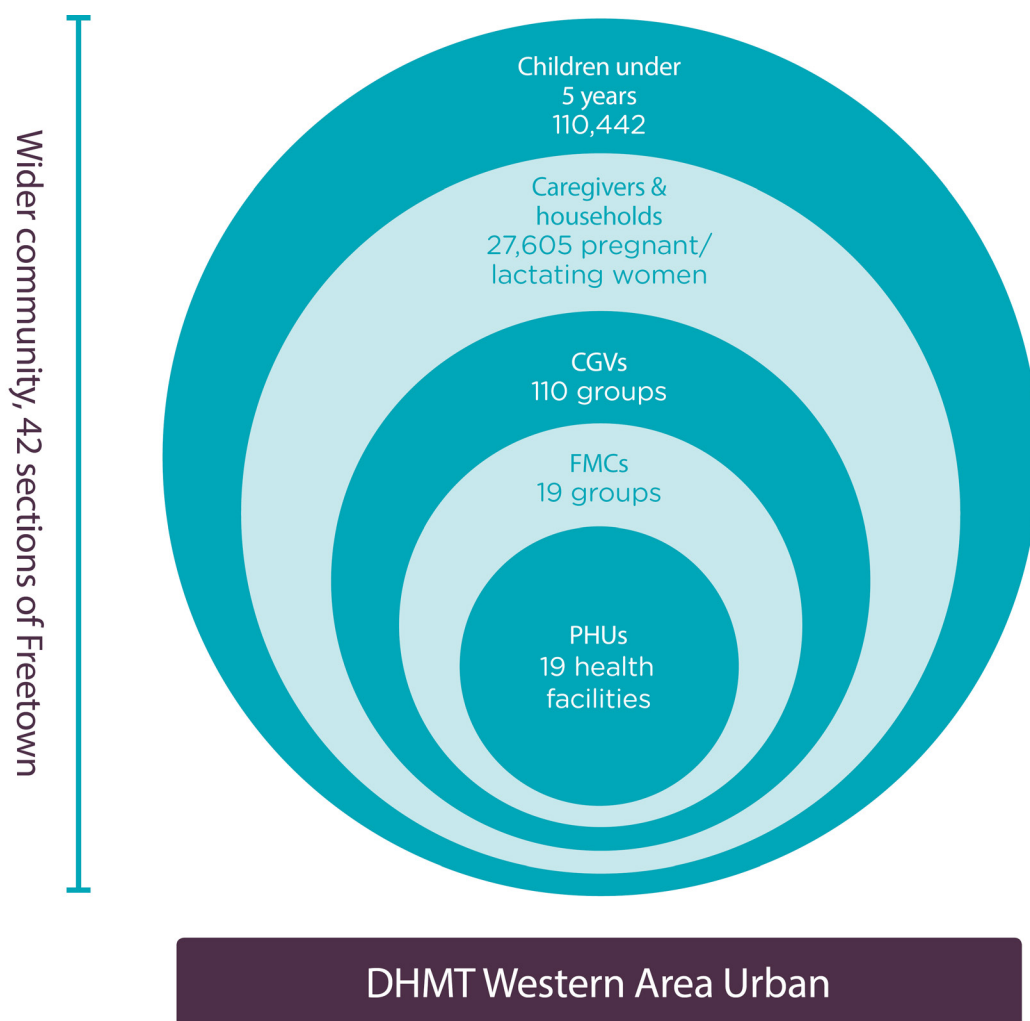
⁸⁰ KII with PHU

⁸¹ FGD with FMCs

⁸² *Ibid.*

⁸³ Macarthy, J. (2015) *Report on formative research on Care-Seeking Behavior*

Figure 5 Reach of Integrated Health project-supported communities through care group model



There was also a sense of pride in the work that the CGVs had achieved. This was clear during FGDs at Susan’s Bay with CGVs who had been on the radio to promote breastfeeding messages and ‘put Susan’s Bay on the map’.⁸⁴

This reach into the community was particularly important during the response to the Ebola outbreak and flooding. The established groups and trust they had developed helped partners to mobilise communities through the FMCs and CGVs with health education messaging and infection prevention control (IPC), and to support quarantined homes.⁸⁵ Towards the end of the IH project, CGV groups were encouraged to send representatives to quarterly PHU meetings.⁸⁶

There were examples of FMCs and CGV groups raising funds to support women if they needed to pay for treatment.⁸⁷ In addition, two FMCs raised funds to carry out activities, such as monitoring services.⁸⁸

⁸⁴ FGD with Susan’s Bay CGVs

⁸⁵ KII with GOAL; FGD with CGVs; EU IH Quarterly Reports

⁸⁶ EU IH Quarterly Reports

⁸⁷ FGD with FMCs; FGD with CGVs

⁸⁸ EU IH Quarterly Report

Addressing infant and child mortality

During the course of the IH project three knowledge, attitudes, practices and behaviour (KAPB) surveys were conducted in 2013, 2015 and 2016. The 2015 survey was delayed due to the Ebola crisis. The final KAPB survey, conducted in December 2016, is still being analysed and therefore some results are not yet available. Communities reported that mortality of both mothers and children had reduced. While data is not available for maternal mortality, the KAPB surveys show that between the start of the project and 2016 the death rate for under-fives fell from 0.85 per 10,000 per day to 0.21 per 10,000 per day. The 2013 DHS showed a decline in child mortality, but little change in neonatal mortality.⁸⁹ The KAPB surveys showed that nutrition had improved, with an increase in exclusive breastfeeding from 45.95 per cent to 71.90 per cent, much higher than reported in the DHS 2013 at 24.5 per cent. Prevalence of stunting in children had also fallen from 8.1 per cent to 3 per cent. Under-fives sleeping under an ITN had more than doubled during the project period from 41.7 per cent to 91.61 per cent.

Table 8 Results from knowledge, attitudes, practices and behaviour surveys (2012–2016)

Indicator		Results*		
		2013	2015	2016
Mortality	Crude mortality rate (total deaths/10,000 people/day)	0.6	–	0.23
	Under-five death rate (/10,000/day)	0.85	–	0.21
Anthropometrics	% prevalence of severe stunting	8.1%	–	3.0%
	% prevalence of global acute malnutrition	–	–	6.30%
Health and nutrition	Exclusive breastfeeding (up to six months)	46.0%	–	71.9%
	% of children still being breast fed at one year (12–15 months)	–	–	72.5%
	% of women who had given birth in previous 12 months whose deliveries were at a health facility and attended by a skilled attendant (doctor, midwife or nurse)	–	80.5%	82.5% ⁹⁰
	% of women who had given birth in previous 12 months who made 4+ visits to antenatal clinic	87.5%	84.2%	83.1% ⁹¹
	% of respondents who had heard of the Free Health Care Initiative	95.0%	96.20%	95.6%
	% of respondents reporting that malaria is transmitted by mosquitoes	87.9%	91.12%	96.6%
	% of households in which youngest child under five years slept under an insecticide-treated net in the previous 24 hours	41.7%	91.6%	75.1%
	% of households offering more liquid than normal the last time their child under five years had diarrhoea	45.4%	87.3%	61.5% ⁹²
	% of respondents who could name at least two causes of and two means of preventing malnutrition	19.2%	36.3%	–
	Hygiene	% of respondents reporting handwashing after defecation	81.6%	–
% of respondents reporting handwashing at three or more key times		56.3%	79.9%	81.4%

* 2015 results have been substituted when 2016 results are not available

⁸⁹ www.mamaye.org/sites/default/files/evidence/Facts%20and%20figures%20_%20SL%20DHS%202014.pdf

⁹⁰ Measured as % of women who had given birth of their youngest child at a health facility and attended by a skilled attendant

⁹¹ Measured as % of women who had attended 4_ visits to antenatal clinic for the last pregnancy

⁹² 'illness' measured rather than 'diarrhoea'

Awareness of the Free Health Care Initiative

All of the participants could identify who and what the FHCI was for.⁹³ The baseline survey showed that awareness of FHCI was high at 95 per cent, which is consistent with other research.⁹⁴ If users had any questions regarding charges they could speak to the CGVs or FMC to address them with the PHU.

The micro-gardens were primarily to supplement household diets and provide food for CGVs when undertaking cooking demonstrations. It was hoped that once they were more established, excess yields could be sold as a small income-generating activity. However micro-gardens were slow to be established. They received little support from the Ministry of Agriculture, Forestry and Food Security in 2013, and recruitment of a specialist agriculturalist trained to work in an urban setting was delayed until February 2014.⁹⁵ Overall, 52 micro-gardens were established. Some CGVs said that their micro-gardens worked well and they consumed the produce grown in the home as well as using it in food demonstrations.⁹⁶ However, other groups struggled, competing with a difficult growing environment, such as in the slum area, and also wild pigs.⁹⁷ The flooding in September 2015 damaged 19 micro-gardens and the remaining gardens had to postpone their harvesting schedules.⁹⁸

External challenges

The major challenge to the IH project was provision of FHCI drugs. PHUs could monitor drugs and request supplies. Distribution of pharmaceuticals in Sierra Leone still operates under a push system,⁹⁹ and all health facilities are limited to a specific allocation of drugs on a quarterly basis. A 2016 report stated that there was still a significant mismatch between the quantities of drugs and medical supplies health facilities received and the quantities they actually needed.¹⁰⁰ Further delays were also experienced with transportation of drugs from the DHMT to the PHUs. Due to the challenge of drug supply and potential impact on provision of care at health facilities and the IH project, GOAL provided logistical support in delivering drugs from the DHMT to the 19 PHUs.

Stock-outs also impacted the delivery of services to the PHU. While the IH project encouraged women to use health facilities, at times there would be no drug supply and the CHO would write a prescription for the patient. The patient would then have to procure the drugs from an outside source known locally as a 'pepper doctor'.¹⁰¹ The patient not only had to pay, but also risked getting sub-standard drugs. In addition, the patient might not bother to return to the PHU, but would rather go back to the pepper doctor.¹⁰²

Staffing was also a problem, with staff being moved from PHUs. In January 2017 there was a mass re-deployment of health staff across the country. One PHU said that they mitigated some of the moves by training a number of staff members to work in different sections of the health facility. This

⁹³ KII with PHU; FGD with FMCs; FGD with CGVs; FGD with caregivers

⁹⁴ Witter S., et al. (2016) *The Sierra Leone Free Health Care Initiative (FHCI): process and effectiveness review*.

⁹⁵ EU IH Quarterly Reports

⁹⁶ FGD with Susan's Bay CGVs; FGD with George Brook CGVs

⁹⁷ FGD with caregivers

⁹⁸ EU IH Quarterly Reports

⁹⁹ A 'pull' system for drugs was supposed to be implemented for FHCI, but in practice a 'push' system is still in operation.

¹⁰⁰ Witter S., et al. (2016) *The Sierra Leone Free Health Care Initiative (FHCI): process and effectiveness review*.

¹⁰¹ A pepper doctor refers to someone who has no clinical training and is selling drugs they are not certified to handle.

¹⁰² KII with PHU

lessened the impact when someone was off sick or re-assigned to another PHU.¹⁰³ Some PHUs also required caregivers to buy an exercise book to record child health data. This was in addition to the health record cards the MoHS provided. In some instances PHU staff refused to see or treat a child unless the service user had purchased a book.

In addition, other unforeseen challenges were emergencies: the outbreak of Ebola and severe flooding. The longevity of Ebola meant that the project had to be postponed and IH project staff were re-assigned to other activities to help with the crisis. This also led to a six-month no-cost extension until December 2016. Sierra Leone was officially declared Ebola-free for the second time in March 2016,¹⁰⁴ nearly 18 months after the outbreak was recognised. Fear of using health facilities took time to overcome: some interviewees said that even after the crisis, caregivers were scared of taking their children to the PHU if they had a fever in case malaria was misdiagnosed as Ebola.¹⁰⁵

Table 9 Challenges to implementing the Integrated Health project

Objective	Area of challenge	Reason
Increased capacity	Lack of ownership by District Health Management Team	<ul style="list-style-type: none"> • Many actors delivering projects, resulting in competing priorities • Other partners paying higher daily sitting allowance
	Drug supply	<ul style="list-style-type: none"> • Availability of drugs (stock-outs) • Cost incurred to patients purchasing outside of peripheral health unit (PHU) • Cost-recovery drugs
	Staffing at PHUs	<ul style="list-style-type: none"> • PHU staff moved throughout the project • Countrywide staff re-deployment in January 2017¹⁰⁶
Strengthening health systems	Elections in 2012	<ul style="list-style-type: none"> • Training of facility management committees delayed until 2013 as groups were suspicious of political agenda
Improved community management of leading causes of infant and child morbidity	Nutrition	<ul style="list-style-type: none"> • Challenge for working mothers to exclusively breastfeed • Micro-gardens affected by flooding, local environment and wild pigs
	Emergencies disrupted and delayed project implementation	<ul style="list-style-type: none"> • Ebola (August 2014–June 2015) • Severe flooding (September 2015)
Empowered citizens	Service users made to buy exercise book to record child health data	<ul style="list-style-type: none"> • PHU staff refused to see or treat children unless service users bought book

¹⁰³ KII Susan's Bay PHU

¹⁰⁴ Sierra Leone was first declared Ebola free on 7 November 2015.

¹⁰⁵ FGD with caregivers

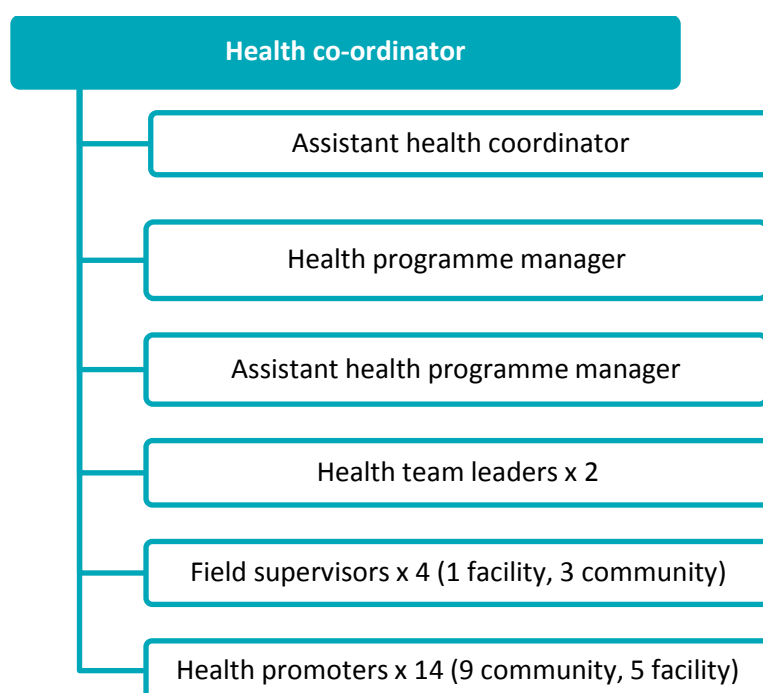
¹⁰⁶ Occurred after the end of the project, however will have detrimental implications to the sustainability of the project

3.4 Efficiency

Resources

The IH project organogram in Figure 6 below shows the technical staff involved in the project. The majority of staff focused on the community level. Originally the plan was to have one health team leader. An additional health team leader was added later in the project to focus on data management.¹⁰⁷ The project benefited from additional staff on a short-term basis, funded by the WASH Consortium. It was difficult to identify a micro-gardening specialist who was familiar with working in an urban environment. As mentioned above, implementation of micro-gardens scheme was delayed until one was finally appointed in February 2014.¹⁰⁸

Figure 6 Organogram of Integrated Health project staff



Using data from the most recent financial report (November 2016), total spend was €889,281 allocated under the EU budget, out of an overall spend of €1,080,782, meaning that 18 per cent of the total expenditure was co-funded via Irish Aid. Major cost drivers were national staff salaries, and local office and direct programme costs, representing 72 per cent of the total expenditure to date. Other budget lines were all under €100,000.¹⁰⁹ Some 83 per cent of human resource salary payments were for staff, with €393,546 spent on national staff and €76,732 spent on international staff.

Table 10 Project cost drivers

Budget category	Actual (€)	Percentage of total spend
National staff salaries	393,546	44
Local office	136,151	15
Direct programme costs	118,315	13

¹⁰⁷ GOAL email feedback

¹⁰⁸ KII with GOAL

¹⁰⁹ GOAL (2016), *EU IH Financial Report Q14 November 2016*

Using the direct programme costs budget line, it is possible disaggregate the expenditure related to the project results as shown below. The majority of the direct programme costs were spent on building the capacity of the PHUs. No direct programme cost could be linked to Result 2.

Table 11 Direct programme costs¹¹⁰

Result	Budget line	Actual (€)
Result 1	Capacity building of new peripheral health units	64,968
Result 3	Baby-friendly community initiative	1,550
	Mother-to-mother members attending drama training	10,035
	Staff attending infant and young child feeding training of trainers	4,283
Result 4	Gardening activities	11,599

Analysis of the outputs produced by the direct programme cost budget lines is shown in Table 12. At the PHUs, IMAM training was provided to 38 health facility staff members in 2013, 75 in 2015, and 57 in 2016. An average of 40 health staff members were trained in IMNCl each year (120 in total). The number of CGVs who attended drama training was 264 (54 in 2013 and 210 in 2016). IYCF training of trainers had a total of 22 staff on two training courses in 2012 and 2016. Eight ACF staff also benefited from this training. These staff then trained 686 participants in 2012 and 2016. Food demonstrations and gardens were noted to have mixed results.¹¹¹

Table 12 Result outputs per direct budget line

Result	Activity	Participants	Cost per participant (€)
Result 1	Peripheral health unit training	290	224.03
Result 3	Mother-to-mother members attending drama training	264	38.01
	Staff attending infant and young child feeding (IYCF) training of trainers	42	101.97
	Participants trained by staff attending IYCF	696	6.15 ¹¹²
Result 4	Number of food demonstrations	0	-

The expenditure has been disaggregated by direct, indirect and administrative costs. It shows that indirect costs were 27 per cent and administrative costs were 9 per cent (see Figure 7). The proportion may change slightly in the final project financial report.

Costs classified as direct costs are technical salaries, travel, equipment, vehicle costs, consumables and direct programme costs. Costs classified as indirect costs are administrative and support staff salaries, international staff,¹¹³ office rent, other services, and other costs.

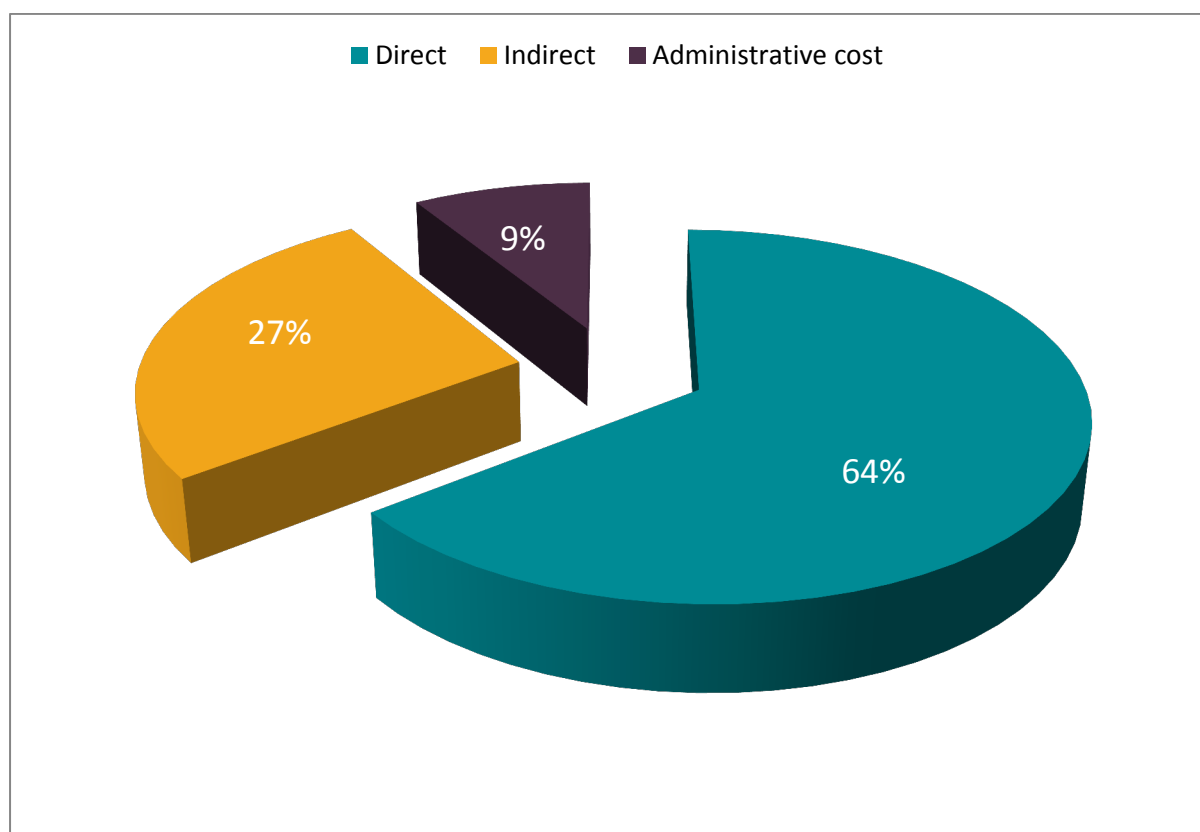
¹¹⁰ *Ibid.*

¹¹¹ GOAL email feedback: FGDs with CGVs

¹¹² No costs were stated in the expenditure report for IYCF training; the denominator used is the cost of IYCF training of trainers, as a proxy.

¹¹³ Country director, assistant country director programmes, financial controller, assistant financial controller, M&E advisor, logistics coordinator.

Figure 7 Proportion of actual costs up to Q14



Efficiencies

For capacity building of PHUs, GOAL coordinated training with ACF. GOAL also conducted joint supervision visits between ACF, GOAL and the DHMT.¹¹⁴ All PHUs visited reported some support from other NGOs including ACF, Christian Health Association Sierra Leone, Concern Worldwide and Save the Children. Examples of support included provision of blankets for new mothers, equipment, borehole rehabilitation and solar panels.¹¹⁵ ACF and Save the Children provided incentives to the DHMT. However, the various NGOs provided different incentive amounts.¹¹⁶

At the community level, Concern Worldwide implemented its HICAP tool in two city sections.¹¹⁷ GOAL has been trained to ensure the same model is used across all communities.¹¹⁸

The majority of FMCs provided non-financial contributions in terms of supporting facility cleaning and maintenance. Some supported mobilising communities for mass campaigns and provided land for facilities. One FMC reported raising money for patients to buy drugs when there was a stock-out, and monitoring the attendance of PHU staff.

Care group training created a ripple effect in communities, helping to pass on messages to other community members.¹¹⁹ However, micro-gardens did not experience a similar ripple effect.¹²⁰ This was partly because households found it difficult to buy seeds and several gardens were lost to

¹¹⁴ KIIs with GOAL and ACF

¹¹⁵ KIIs with PHUs

¹¹⁶ KII with GOAL

¹¹⁷ *Ibid.*

¹¹⁸ GOAL (2015) *Implementation Report: May–July 2015*

¹¹⁹ KII with GOAL

¹²⁰ *Ibid.*

flooding.¹²¹ One CGV noted that their gardens were successful; here GOAL provided seeds, tools and training.¹²²

The Ebola emergency response was able to use the community structures the project had created to act quickly.¹²³ For example CGVs were used to supply quarantine groups with supplies and raise awareness in the community.¹²⁴ FMCs also contributed to other activities such as the malaria campaign and mass distribution of ITNs.¹²⁵

The WASH Consortium provided funding to GOAL, which complemented the project. The WASH Consortium support funded staff salaries on a short-term basis, IPC activities, facility infrastructure, and costs associated with the hygiene component of the care group training.¹²⁶

Technology

No specific technology was deployed for the project. In June 2016, worldwide GOAL has started to use CommCare app,¹²⁷ a user-definable application that can collect a range of survey or case management data. A number of international NGOs working in development settings use it.¹²⁸ Its benefits are that real-time data can be collected by mobile phone or tablet, and tools can be adapted by the in-country team with little technical knowledge of developing apps. However, there is a cost per user and if scaled up it could become quite expensive. If the long-term strategy is to hand over systems to the MoHS, the user fees may become a barrier for the government in sustaining the system.

International NGO Ehealth is customising District Health Information 2 (DHIS2) software for a disease surveillance. Ehealth and Vaxtrac are working to support the implementation of an electronic immunisation registry system in 50 urban health facilities in Freetown. The first group of facilities launched a pilot phase in November 2016, which will run until May 2017.

3.5 Sustainability

Community level

The IH project was designed to strengthen and build on the capacity of the local health services and community health structures already in place.

At the community level, MoHS-endorsed structures such as the FMCs and CHVs were used. Although the care group model is not one the MoHS currently advocates, it is designing a CHW policy that will apply to all categories of community-based health volunteers, including CGVs, and will formally incorporate them into the health system. Throughout the IH project GOAL spent significant time with the MoHS advocating for the draft CHW policy to incorporate the wide range of CHWs, standardise training and address the different needs of urban and rural areas. During February 2017, the MoHS and its partners finalised the CHW policy. In Western Area Urban, the DHMT decided that only 10 CHWs would be absorbed per PHU. This has resulted in many CGVs who have been involved in the IH project being left out, which may leave them demotivated and unwilling to continue providing their services

¹²¹ FGDs with CGVs

¹²² *Ibid.*

¹²³ KII with GOAL; FGD with community

¹²⁴ FGD with community

¹²⁵ FGD with FMC; KII with GOAL

¹²⁶ KII with GOAL

¹²⁷ www.commcarehq.org

¹²⁸ www.coregroup.org/component/content/article/261

Caregivers said they had continued to receive support from the CGVs since the end of the IH project, and that their FMCs remained active. The caregiver FGD participants felt confident in the advice they received from the CGVs and said they would continue to practise exclusive breastfeeding and complementary feeding. As one respondent from Kroobay pointed out, ‘think of the economy, infant formula is very expensive. I would prefer to exclusively breastfeed.’¹²⁹ However, they were concerned that the perceived improvements in child health and decreased mortality within their communities would not continue if the CGVs and PHUs no longer received external support, and were advocating for GOAL’s continued work.

The CGV FGD respondents said their skills and capacity had been significantly strengthened and that strong relationships had been formed with the women in the community and FMC members. All respondents in this category were positive that they would continue their work, despite the IH project coming to an end. Some respondents from Allen Town felt the workload of supporting 15 households was too much.¹³⁰ This could be because Allentown is the largest catchment area in terms of geographical spread and some of the households are further apart than in other areas. None of the other CGVs felt their workload was too heavy and were confident that they could continue to schedule household visits and group meetings around their other daily activities and responsibilities. However, all groups raised the issue of potential for loss of earnings through time dedicated to volunteering and participating in various meetings and training activities. There was general agreement that the incentive received to cover transport and food costs was insufficient. Some respondents commented that family members – although supportive of them as CGVs – did not feel they were adequately compensated for their work. However, incentives can have a significant impact on any budget and are not sustainable in the longer term.

Some of the CGV respondents had started micro-gardens to supplement their diets and those of the mothers they supported, as well as to use for cooking demonstrations. While some of the gardens were successful, most respondents felt they would be unable to continue without support from GOAL in the form of seeds.

Table 13 Areas of sustainability and potential challenges

Area	Factors supporting sustainability of activities	Challenges to sustainability
Increased knowledge and awareness	<ul style="list-style-type: none"> Empowered and increased confidence among staff, volunteers and community members Community cohesion Increased knowledge remaining in the community 	<ul style="list-style-type: none"> Peripheral health unit (PHU) staff transferred to other health facilities Volunteers demotivated by lack of motivation and financial support
Increased use of PHU/health services	<ul style="list-style-type: none"> Greater community awareness of what services are available or free By-laws fining women for home delivery Traditional birth attendants and traditional healers not promoted or encouraged 	<ul style="list-style-type: none"> Stock-outs continue to force patients to procure drugs outside of PHU, who do not then return Poor-quality drugs provided outside of PHU Cost involved in purchasing drugs

¹²⁹ FGD with Kroobay caregivers, 1 February 2017

¹³⁰ FGD with Allen Town CGVs, 28 January 2017

District Health Management Team	<ul style="list-style-type: none"> • Staff trained • Supervision visits with Action Contre la Faim 	<ul style="list-style-type: none"> • Lack of staff buy-in • Lack of transport for supervision • Pull from other partners
Health outcomes	<ul style="list-style-type: none"> • Changed behaviour in nutrition, using insecticide-treated nets, oral rehydration salts, family planning 	<ul style="list-style-type: none"> • New mothers not informed of health messages • Messages not reinforced by community or PHU staff

The FMC members included in the assessment were also clear in their response that they would continue to function beyond the IH project. They felt the support and training they received under the project had increased their confidence, knowledge and standing in the communities. Some, such as those in Kroobay and George Brook, had already been formed before the start of the project and therefore had experience in functioning without external support. They acknowledge, though, that the PHU staff and DHMT did not have the resources or capacity to provide them with support, including refresher training. There was concern about what would happen when new members were needed for the FMC but no resources were available to provide them with the same training on health messages, as well as community mobilisation, conflict resolution and effective communication.

FMCs are now formally acknowledged in the 2015–2020 BPEHS and are expected to work together with PHU staff to develop a facility investment plan for each PHU, agree on the use of additional funding and contribute towards PHU repairs.

Training was done using standardised MoHS materials; for example, the MoHS designed the IMAM protocols at the PHUs and sensitisation cards used by the CGVs. GOAL has advocated that the MoHS should incorporate IMAM into pre-service clinical training, to ensure all PHU staff are trained in this aspect, regardless of whether or not they work in an NGO-supported facility.

Peripheral health unit staff

At PHU level, a minimum of two staff from each health facility participated in training of trainers to carry out cascade training to other PHU staff. Some of the PHU in-charges mentioned staff turnover as a sustainability issue. The CHO for Allen Town was particularly concerned about this and advocated that the MoHS should only exchange staff with specific training in areas of nutrition and so forth for other staff who had also received similar specialised training, so that the facility would not lose the ability to care for patients effectively.¹³¹

District Health Medical Team

The DHMT received support in carrying out routine supervision visits to the facilities. It was also supported in developing its annual work plans. However, the team continued to suffer from limited access to transportation, making it dependent on support from partners to visit facilities. GOAL staff acknowledged that while the DHMT had a strong strategic plan, it did not have the means or resources to roll out activities.¹³² The FCC has to reach agreement on funding for workplan activities, which tends to place an emphasis on treatment and curative services as well as infrastructure items, rather than prevention and community sensitisation. Therefore the DHMT is not expected to have the capacity to continue training community groups without the IH project's support.

¹³¹ KII with Allen Town PHU

¹³² FGD with GOAL staff

Exit strategy

There was no clearly documented exit strategy for the project. However, meetings were held with all communities before the end of the project, informing them that funding was coming to an end shortly. Supportive supervision and mentoring visits to the PHUs were gradually reduced over time in an attempt to increase their independence.

The IH staff GOAL employed to support activities in the field were all national staff from Sierra Leone, ensuring the training and skills they received would be retained in-country and would benefit future activities within the health sector.

4. Conclusions and Recommendations

4.1 Conclusions

Relevance

The project was well aligned with MoHS priorities as outlined in the BPEHS and FHCI. The holistic and integrated approach to addressing maternal and child health allowed the IH project to contribute directly towards the majority of BPEHS components.

The IH project logframe was developed with a large number of indicators, making it a challenge to regularly monitor data throughout the duration of the project. No facility-level data that monitored demand creation was collected regularly. Neither was a clear theory of change developed at the start of the project, which may have informed the selection of indicators.

The choice to implement the project within Western Area Urban was well documented and based on clear evidence. The selection of specific city sections was carried out in collaboration with the DHMT, as well as other partners such as ACF, to reduce duplication of activities and maximise coverage, outputs and impact.

Other projects working alongside the IH project and GOAL (e.g. WASH, EPI, malaria mass campaign/distribution of ITNs in 2014) enabled and supported an even more comprehensive approach towards MNCH.

Beyond a few of the FMCs and a select few of the CGVs, PHU staff and community members were not on the whole involved in determining priority needs or designing activities for the project. However, FMCs' input was sought in those communities where they were already formed and active. Lessons learnt from the UNICEF project were incorporated into the design of the IH project. For example, the M2M structure was replaced with the care group model to allow wider coverage and greater impact through the increased number of support groups.

Effectiveness

The support and training the IH project provided had a greater effect in building the capacity of the PHUs and community structures than at the DHMT. PHU staff and community members had a number of targeted training and refresher sessions, as well as on-the-job support. Support was provided to the DHMT through regular co-ordination meetings, annual district planning, liaising with FCC, and supporting transportation of drugs to PHUs and for supervisory visits. However, the DHMT is continually challenged by the competing priorities from different partners. Furthermore, there is a significant difference between partners over daily allowances offered to the DHMT.

The project contributed to strengthening the health system at the community level, focusing on community structures and adaption of the community care model. The vast majority of health systems-building activities were focused on the facility and community levels, and related to service delivery. Although there were delays in the training of community groups due to 2012 elections this does not appear to have had adverse consequences in developing community structures. The adoption of the community care model facilitated the cascade of information to a wider audience, including hard-to-reach groups. This proved to be much more effective, both in terms of time and money, than having the IH staff focusing on house-to-house visits.

Training of PHU staff, FMCs and CGVs in health and nutrition improved both knowledge and skills. CGVs supported women in the community to change their health-seeking behaviour and improve the health of their newborn and other children. Other interventions and campaigns beyond the IH project also supported this. Caregivers increased their knowledge on nutrition and health but also changed their behaviour, exclusively breastfeeding for six months, and increasing use of health facilities for both curative and preventative services. Men in the community were not specifically

targeted during the IH project. However, a barrier analysis highlighted that men and mothers-in-law were strong influencers on exclusive breastfeeding and complementary feeding practices. It is unclear if actions were put in place to address these specific barriers.

The IH project strengthened health systems in 42 city sections of Freetown, improved community management of infant and childhood illnesses, and increased awareness of FHCI. However, while efforts were made to increase the capacity of the DHMT, opportunities remain to develop health systems capacity and for development at more strategic and operational levels.

The IH project and the MoHS continued to promote FHCI throughout the duration of the project. Awareness of the FHCI remained high and demand for services at PHUs increased.

Impact

Overall the IH project has contributed to delivering FHCI in the Western Area. In total 19 PHUs were supported by the IH project. Training of PHU staff, which the IH project facilitated, increased the knowledge, skills, practice and confidence in nutrition and diagnosis and treatment of childhood illnesses. Monitoring tools that IH project developed measured: (1) ability of staff in OTP diagnosis and treatment; and (2) user satisfaction. The OTP assessment review showed that 93.2 per cent of all children diagnosed with severe malnutrition were diagnosed appropriately. The user satisfaction survey showed that over 83 per cent described consultations PHUs offered as 'good'. However, the research could not show if the PHUs had improved their ability to accurately collect and report data in a timely manner.

SRH training, with a particular focus on confidential youth-friendly services, raised greater awareness among communities of the benefits of family-planning services, reduced stigma among men and women, and resulted in more people using contraception. Interviewees reported a reduction in teenage pregnancies.

Membership of the FMCs remained fairly static, which helped members implement what they had learnt through the training. The care group model enabled a wide coverage of trained volunteers throughout the community. The number of groups working across the 42 city sections increased. Regular meetings between health facility and community structures improved service provision and demand. However, interaction between the DHMT and community structures was limited. The cohesiveness of both FMCs and CGVs led to them supporting caregivers financially if they had to pay for drugs. These well-developed community structures were particularly important during the Ebola crisis and flooding, as GOAL had the trust of the community members and could therefore mobilise groups quickly to support IPC activities.

Through increased knowledge and skills and behaviour change, capacity to address the leading causes of childhood illnesses – in particular, nutrition – has improved at the health facility and community levels. This has led to a reduction in the prevalence of stunting and the under-five death rate. More women are exclusively breastfeeding, hygiene practices have improved and more under-fives are sleeping under ITNs. All groups interviewed could identify who was eligible for FHCI.

Overall, a total of 52 micro-gardens were established, with mixed results. Recruitment of an agriculturalist with skills in urban gardening was delayed. Some CGVs stated that their gardens had been successful and they used surplus produce to help with the food demonstrations to caregivers; whereas others said that the environment had not been conducive to growing produce. Micro-gardens were also impacted by the Ebola outbreak and flooding.

The IH project was positively impacted in unplanned ways. The uptake of breastfeeding in IH project communities was acknowledged at the national level at events and on the radio, giving women a sense of recognition. Group and community cohesion was instrumental in quick mobilisation during emergencies, increasing IPC activities and supporting community members with payment of drug

costs during stock-outs. TBAs were encouraged to participate in activities to support caregivers. However, not being able to practice as a TBA led to a loss of income.

Unforeseen challenges also impacted the success of the project. In addition to emergencies – Ebola and flooding – the main challenges were stock-outs of FHCI drugs and delays in replacing stock, and the reallocation of staff to other health facilities.

Stock-outs also impacted the delivery of services at PHUs. Throughout the IH project stock-outs continually forced patients to procure and pay for drugs outside of PHUs. This exposed them to poor-quality drugs and was a disincentive for them to return to the health facility. Without the support of the IH project to support the transportation of FHCI drugs it is likely that this will have had a negative impact on project results.

Efficiency

Value additions in strengthening community structures, systems and capacity are evident in the IH project. There was added value for the donor because of contributions from other funding sources. The project benefited from co-funding provided to GOAL through Irish Aid and supplementary activity funding from the WASH Consortium. It also benefitted from resources from other international NGOs. The true cost of the project's implementation is therefore difficult to calculate due to the number of international NGOs supporting the project area.

The IH project itself benefitted other projects. Evidence shows that the Ebola response benefitted from the community structures developed by the IH project. The relationship between ACF and GOAL has shown that the IH project also provided benefits to ACF. And GOAL collaborated with Concern Worldwide on the use of the HICAP tool.

All FMCs provided time and basic maintenance support. Good practices were noted in FMCs going beyond basic support, such as monitoring the health facility attendance.

It is difficult to fully assess the efficiency per result, because the structure of the expenditure report does not align with the project results. Analysing training costs as a measure of the project's economy, the highest cost per participant was for PHU training. The majority of this training focused on IMAM. The outputs achieved from the IYCF training of trainers showed good value for money, due to the number of participants who received training from the trainers. The value for money of the micro-gardening activities was not clear. The 2015 floods destroyed several gardens and FGDs stated that results were mixed. Success was linked with the provision of seeds.

The indirect costs were lower than 30 per cent, a standard benchmark for NGO indirect costs. The project used a large number of national rather than international staff. This means that institutional knowledge is more likely to stay in the country and is also more cost effective.

Several organisations were involved in developing primary healthcare mobile data solutions for the project area, including GOAL's implementation of CommCare. It is too early to gauge whether the deployment of the CommCare app has improved efficiency.

Sustainability

The length of the project (2012–16) allowed time for GOAL to develop relationships, knowledge and understanding of community groups. This ensured good reach into the communities through community networks, allowing information to cascade down throughout the community and enabling the impacts to be felt more widely. The longevity of the project also allowed FMC and CGV structures to achieve recognition, giving them important standing within their communities and increasing their resolve to continue their work once the project cycle ended.

Although unplanned, the Ebola response allowed an increased focus on IPC at the PHUs and among CHWs and health workers generally. This in turn increased awareness and understanding of good hygiene practices within the wider communities, especially for handwashing.

Considerable training was provided to PHUs and volunteers. Knowledge and understanding of MNCH has improved within the communities, particularly in relation to the benefits of exclusive breastfeeding and IYCF. The capacity of PHU staff to correctly manage malnutrition has improved, but with the current policy of frequent mass staff transfers, institutional memory is adversely affected.

While the FMCs and CGVs stated that they will continue to meet, it is likely that some continued input will be needed to keep them motivated. Although the 2015–20 BPEHS now formally recognises the role of the FMCs, the DHMT is unlikely to provide support due to limited resources at this level, especially for transport costs. This potentially creates a widespread financing gap of small amounts for each FMC. It is unlikely that the DHMT will continue to train new staff or expand training to other areas, for the same reason. The likelihood of the DHMT continuing activities reduces as it is paid incentives by other NGOs. Supervision and mentoring are also expected to be less frequent without the support of GOAL or another partner, such as ACF.

By employing national staff to implement the project, GOAL has ensured capacity is more likely to be retained within Sierra Leone and the healthcare system. However, the lack of a clear exit strategy and reliance on the MoHS to absorb the CGVs under the new CHW policy weakened the sustainability of the project.

4.2 Recommendations

Recommendations for GOAL

Continue to use the Integrated Health approach

- Continue the care group model approach and promote it to partners and the MoHS.
- Continue to work with the existing community groups established in the 42 city sections and, where possible, provide motivational support.
- Advocate to the MoHS, DHMT and FCC on the importance of preventive services and combining interventions at the PHU and community levels.
- Involve existing groups and volunteers to identify needs and develop future projects.
- Advocate for community-based projects to have a long project period, as was the case for the IH project, which was a factor in reinforcing behaviour change.

Advocate for standardised incentive payments

- If working in the same district with another NGO, advocate for standardised incentive payments and schemes.

Monitor technology deployment carefully

- Monitor improvements and lessons from the deployment of the CommCare app.
- Assess the app's performance before full rollout has occurred. Such an assessment should be in relation to other data collection apps being deployed in Sierra Leone and should outline the sustainability risks and appropriateness of the solution.
- Explore the FMCs' use of the CommCare app to monitor the attendance of health facility staff.

Ensure there is supply chain support for the DHMT and PHUs

- Continued support for the transportation of PHU drugs is likely. This is also an opportunity for drug and stock management support.

Explore methods of ensuring sustainability

- Explore the sustainability of key volunteer groups through micro-finance initiatives.

Ensure greater involvement of men in maternal and child healthcare activities

- Consult men in any future barrier survey to establish if they should be included in a specific training programme.
- Ensure men are questioned as part of ongoing monitoring and evaluation to measure any changes in knowledge and behaviour.

Lessons for repeating the project

Strengthen project design and planning

- Develop a full costing of the project, taking into account additional resources from which the project has benefited.
- Develop an organogram showing how staff support the project.
- Develop a clear theory of change before implementation.
- Develop an exit strategy before implementation and update the document regularly.
- Explore an improved approach to micro-gardens. Ascertain their feasibility in urban settings and include an expert to help plan and implement the activity.
- Review the usefulness of the HICAP tool for further projects.

Strengthen monitoring

- Future projects should have a facility-based indicator to measure demand. Using a facility-based indicator or data is an opportunity to improve PHU data quality and reporting.
- As part of the improved approach to micro-gardens, document successes and learnings from the activity.
- Reduce the number of indicators for monitoring results and objectives.

Invest in a wider health systems approach

- Invest in health systems development at the DHMT. Ensure coverage of all health system pillars, mapping the support that the DHMT has received.
- Advocate for the development of health systems support at Western Area DHMT to address issues of ownership, coordinating priorities, support with supervision visits, and training of PHUs and community structures.
- Work towards – or advocate for – simplifying support by only having one NGO per facility and catchment area.

5. Appendices

Appendices available on request

- 5.1 Appendix I: KII guides
- 5.2 Appendix II: FGD guides
- 5.3 Appendix III: Key informants
- 5.4 Appendix IV: List of documents