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REPRODUCTIVE HEALTH PROJECT IN SIERRA LEONE

Kåre Lode
Julie Sesay

SIK-rapport 2006:4

Senter for interkulturell kommunikasjon
Centre for Intercultural Communication
Centre pour la Communication Interculturelle

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Abstract: In close cooperation with the European Baptist Mission (EBM) and the Baptist Convention in Sierra Leone (BCSL), the Norwegian Baptist Union (NBU) is preparing to send a mid-wife as missionary to Sierra Leone. In order to include the target group in the planning this feasibility study was organised in June 2006.
The team visited officials in Freetown before they went to Lunsar, the target area that was 120 km north of Freetown. Sierra Leone has the highest under fives mortality and the highest mother mortality rate in the World. The Lunsar area has a far higher mortality rate then the average of the country.
The joint initiative from the BSCL, NBU and EBM was very well received by local authorities and by local health authorities. After long meetings with grassroots organisations, in particular women's associations, the outline of a project was decided. The mid-wife will work in close cooperation with the Community Health Centre in order to train traditional birth attendants and Maternal Child Health Aids who are part of the Public Health. She will also provide individual kits for these two categories. The project will also rehabilitate the Community Health Centre, which was heavily damaged during the war.
She will also work with the Baptist Union Women's Association in Lunsar, teaching nutrition for children and pregnant women. The women of this association have experience in educational work in the local community. They will in their turn share the knowledge about nutrition with other women and women's groups in the area.

Key words : reproductive health, empowerment, nutrition, infant mortality

Sierra Leone – Abbreviations

AIDS	Acquired immunodeficiency syndrome
BCSL	Baptist Convention Sierra Leone
BEHL	Baptist Eye Hospital Lunsar
CHASL	Christian Health Association of Sierra Leone
CHC	Community Health Centre
CHO	Community Health Officer
CPA	Child Protection Association
DHO	District Health Officer
DMO	District Medical Officer
EBM	European Baptist Mission
ECOMOG	Economic Community of West African States' Monitoring Group
FGM	Female Genital Mutilation
HIV	Human immunodeficiency virus
IMF	International Money Fund
IMR	Infant Mortality Rate
IPRSP	Interim Poverty Reduction Strategy Paper
LBWA	Lunsar Baptist Women Association
MCH	Mother and Child Health Assistant
MMR	Mother Mortality Rate
NBU	Norwegian Baptist Union
NGO	Non Governmental Organisation
NRS	National Recovery Strategy
PCM	Project Cycle Management
PPA	Planned Parenthood Association
PRSP	Poverty Reduction Strategy Paper
RUF	Revolutionary United Front
STD	Sexual Transmitted Diseases
STI	Sexual Transmitted Infections
TBA	Traditional birth attendant
UK	United Kingdoms
UNAMSIL	United Nations Mission in Sierra Leone
WHO	World Health Organisation

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REPRODUCTIVE HEALTH PROJECT

0. FOREWORD

The Baptist Union of Norway (BUN) has a long tradition of mission in Africa, in particular in the Democratic Republic of Congo where the mission started in the early 1920s. A few years ago the cooperation with the church in Congo changed character. BUN is no longer sending new missionaries to that country, but keeps close relations with their partners through regular visits and through financial support for development projects. The relation with the Baptist Church in North Congo has developed an unique expertise for cooperation with a partner who works in a transitional period from a terrible war to a situation where it is possible to organise ordinary development work.

As BUN had a couple who were ready to go abroad as missionaries they contacted the European Baptist Mission (EBM) which is an umbrella organisation for 17 Baptist mission organisations within Europe. BUN is a member of EBM. EBM has been operative in Sierra Leone since 1979. BUN,s engagement in Sierra Leone will be carried out in close collaboration with the EBM.

The education and experience of the missionaries were, as we shall see, also well fit for the situation in Sierra Leone. The wife is a mid-wife by profession, the husband is a mechanics with a long experience from social work, and he is a good athlete. The Baptist Convention of Sierra Leone (BCSL) had suffered a lot during the war in that country, and was faced with a number of challenges from a society that has still yet not recovered from the effect of the war. They needed some well qualified human resources for some time.

The missionaries will arrive in Sierra Leone in September 2006 and they have a contract until the Summer 2009. After the arrival they will first use some months to learn the Krio language and the culture. During this period they will discuss their activities with all stakeholders in Lunsar and elaborate a detailed project document.

The partnership between the two churches is a lucky one, and has been well prepared. Some leaders of the BCSL have been in Norway. The office mamager in BUN visited Sierra Leone in 2004 and the missionary couple has visited Lunsar and know the place and the challenges. Three groups of volunteers from Skien in Norway has been in Lunsar to rehabilitate the dwelling house of the missionaries that was seriously damaged during the war.

It was decided to organise a feasibility study before the missionaries arrived in Sierra Leone. Right from the beginning, the intention was to study the possibility of two different projects. If this study had a positive conclusion, it will also indicate the main lines of the projects. The final project will have to be more elaborated by the missionaries in dialog with the target groups and local organisations and resource persons.

The BUN and the BCSL put together a project team that should study both of the possible projects. The present report deals exclusively with the reproductive health project. Another report is dealing with a youth project.

The team consisted of:

- Lise Kyllingstad, project coordinator in BUN and social worker by education. (team leader)
- Julie Sesay, Vice-president of the Women's Union in the BCSL
- Kåre Lode, consultant with long experience as missionary and from development work in Africa
- James Kamara, coordinator of Social Services of BCSL, long education in development from Germany
- Rev. Mohamed Mansaray, coordinator of Church Ministries in BSCL
- Alfred Kamara, nurse at the Eye Hospital (participated most of the time when the team was in Lunsar)

The report has been written by Kåre Lode, but the other team members, in particular Julie Sesay, have had some written contributions and all members have read and commented the manuscript.

The situation in Sierra Leone was sensitive. The meeting with the international community and in particular with the world of NGOs had not been easy for the population. This report has a chapter on this experience. It was obvious that we were in a situation where we first of all had to listen. But the dialog was constructive and there was an openness and very explicit and polite invitation to cooperation.

Because of these strong expressions of priorities and conditions from various groups and persons as well as because of the experiences they have had with the NGOs, we have found it useful to reflect this by using in the report some of the notes from some of the conversations as they are, and we have also found it right to reflect the seriousness of the groups and persons we talked with in the list of our programme and conversations/meetings. (see appendix 3)

1. SUMMARY

Sierra Leone has recently been through a long and devastating war. The Baptist Convention of Sierra Leone suffered heavy losses as well as other individuals and organisations. However, the BCSL had an experience of being an actor on the social and developmental arena in the country and they do have organisational capacity to do more than they currently do if resources are available. On the other hand The Norwegian Baptist Union has a good experience from Congo to work with a partner during the war an after the war. BUN had a well-educated couple, who wanted to become missionaries and they accepted to go to Sierra Leone to expand the work that EBM already is doing in this country. She is a mid-wife and he is a mechanics with experience from social work and he is an active athlete.

BCSL and BUN decided to undertake a feasibility study in order to organise a project in the Lunsar area, which is located some 120 kilometres North-East of Freetown. The project should be conceived such that the missionaries could use their skills and professional background in line with priorities expressed by the population, the authorities and professionals in the areas of interest. It was decided to organise two projects. This report presents a Reproductive Health Project with pregnant women and children under five years of age as target groups.

It soon became very clear for the project team that Sierra Leone has gone through a very frustrating period when they were dependent on international NGOs of good will that set the

agenda and that knew best what should be the priorities. We needed to listen to people's experiences and priorities rather than tell what the BUN could offer. This was in line with our attitude so it was not difficult to carry through. However, we were impressed by the level of organisation of the women, both on community level and in the Baptist Convention. It was such an impressive encounter that we have put the notes from some of the conversation directly in the report just as they are.

We did not meet the women's organisations within the Muslim Community and the Catholic Church. They did not have a significant aspect of development on their programme. The individuals from these two communities who wanted to participate in such common activities did it through local community organisations.

On the other hand, there are a number of really disturbing elements that are representing risks. There was heavy fighting in the Lunsar area during the war. Young people from the area participated on both sides. We talked with the Assistant Operations Director of Help a Needy Child International and with the Representative of Red Cross in Port Loko. Both organisations had reintegration of child soldiers on the programme. We also talked with a person who was involved in the national DDR program in Port Loko and who know the outcome of last year's evaluation of the DDR programme. It seems that it is right to say that the reintegration was not as successful as one could expect. Knowing that specialised international NGOs consider 60% success in reintegration (40% failure) is about the best result they can hope for, we have good reasons to think that less than one-half of the child soldiers who got the opportunity have been successful.

A number of frustrated young people without hope are in the area. The number of street children is increasing. The misuse of drugs and organised prostitution and robbery is also increasing. There is food shortage in Sierra Leone. The Lunsar area has plenty of available land for agriculture and there is an extremely high percentage of unemployment.

It was relatively easy to identify the outlines of a project where the Norwegian mid-wife could use her competence in the best manner. Sierra Leone has the highest Maternal Mortality Rate (MMR) and the highest Infant Mortality Rate (IMR) in the world and the Lunsar area is the worst in Sierra Leone. The Community Health Officer (CHO) said that his local statistics showed 10% MMR and 40% IMR. All groups and individuals we talked with, from the Director General of Medical Services, to simple members of local women's associations let us understand that the highest priority was a combination of training and equipping of mid-wives and related agents, and organised mass sensitising on nutrition for pregnant women and for children under five years of age, and sanitation.

Officials in Freetown, in Port Loko and in Lunsar as well as the women's groups in Lunsar have expressed the obvious need for training and refreshing Traditional Birth Assistants and for Maternal Child Health Aid, and that they get the necessary kits for their work. The missionary has expressed interest for training. We therefore recommend that part of her job will be to provide training and provide kits in the Lunsar area in close cooperation with the community health centre.

This centre needs rehabilitation. We therefore recommend that this rehabilitation should take place at an early stage of the project.

The same health authorities have expressed the need for information about nutrition for pregnant women and for children 0-5 years and for sanitation. The women groups in Lunsar strongly expressed the same need and their willingness to do the sensitising if they got the training. We therefore recommend that the missionary should train the church women and the community women to do this sensitising. This work should be based at the BC.

Two structures should be made for the project:

- A steering committee based in Lunsar with members from the Baptist Women's Association and from the community. The moderator of the Baptist Convention in the Lunsar area should be a member.
- A combined advisory committee for the reproductive health project and the youth project, based in Freetown with a representative from the European Baptist Mission, the coordinator of the social ministries, the coordinator of the church ministry and representatives from the Youth Union and from the Women's Union. The General Secretary has a right in officio to be present in all committee meetings.

Both committees should try to have an equal number of members from each sex.

There are some good reasons to link the project to the Baptist Convention in Lunsar. It would facilitate the relations with the BUN because of the already existing routines for mutual information. The visit made it clear that when the meeting with the community women's association was about to fail because for political reasons it was difficult to gather all associations under the same roof, the Baptist Church building Ebenezer was accepted by all as an neutral place. Finally, the Baptist Women's Association in Lunsar is rather big, and they have experience in running development activities.

2. BACKGROUND

2.1 Sierra Leone

2.1.1 History

The Republic of Sierra Leone is a country in West Africa. It is bordered by Guinea on the north and Liberia on the south, with the Atlantic Ocean on the west. The name Sierra Leone was adapted from the Portuguese name for the country: *Serra Leoa*. The literal meaning is "Lion Mountains".

The relations with Europe started in 1462 when the Portuguese explorer Pedro da Cintra landed and named the country. During the 1700s Sierra Leone was an important centre of the Transatlantic Slave Trade. In 1787 Freetown was established as a haven for former slaves who had been living in London. The first settlement was the capital, Freetown. In 1808, Freetown became a British Crown Colony, and in 1896, the interior of the country became a British Protectorate.

The Crown Colony and Protectorate joined and gained independence on April 27, 1961. Sir Milton Margai (1895-1964) was the first prime minister.

Sierra Leone became a one-party state in the early 1970s. From 1991 to 2000, the country suffered greatly under a devastating civil war, with the Revolutionary United Front (RUF), led

by Foday Sankoh, attacking government soldiers and civilians indiscriminately (Sierra Leone Civil War). This resulted in tens of thousands of deaths and the displacement of more than 2 million people (well over one-third of the population) many of whom became refugees in neighbouring countries. A military coup on May 25, 1997 briefly replaced then President Ahmad Tejan Kabbah with Major Johhny Paul Koromah. Kabbah was reinstated in March 1998 after the junta was ousted by the Nigerian-led ECOMOG forces.

The Lomé Peace Accord, signed on July 7, 1999 in Lomé, Togo offered hope that the country would be able to terminate the period of civil chaos that had engulfed it, and rebuild its devastated economy and infrastructure. As of late 1999, up to 6.000 UNAMSIL peacekeepers were in the process of deploying to bolster the peace accord.

In May 2000, the situation in the country deteriorated to such an extent that British troop were deployed in Operation Palliser to evacuate foreign nationals and establish order. They stabilised the situation, and were the catalyst for ceasefire and ending of the civil war. The war ended in 2002. United Nations peacekeeping forces withdrew at the end of 2005.

2.1.2 Politics and Administrative Divisions

The head of state and government is the president, who is elected every five years (most recently in May 2002). He appoints and heads a cabinet of ministers. The Sierra Leonean parliament is unicameral, with 124 seats. 112 members are elected concurrently with the presidential elections; paramount chiefs from each of the country's 12 administrative districts fill the other 12 seats.

Local Government elections were held in 2004 (for the first time since 1972), electing 456 councillors sitting in 19 local councils.

Sierra Leone is divided into three provinces and one area, and subdivided into 14 districts.

A civilian UN office remains to support the government. Mounting tensions related to plan 2007 elections, deteriorating political and economic conditions in Guinea, and the tenuous security situation in neighbouring Liberia may present challenges to continuing progress in Sierra Leone's stability.

The Paramount Chiefs still keep a formal position in the administration, the strength of which is illustrated by the fact that they have 12 members in the Parliament. The corresponding chiefdoms are often referred to as administrative units.

2.1.3 Geography

Much of Sierra Leone's coastline consists of mangrove swamps, with the exception of the peninsula on which the capital city Freetown is located. The rest of Sierra Leone is mostly plateau (about 300 m above sea level) covered by forests, with mountains in the northeast of the country with the highest point Loma Mansa 1948 m. The climate is tropical, with a rainy season from May to December.

Major cities are the capital Freetown, Koidu (Sefadu), Bo, Kenema and Makeni.

Rainfall along the coast can reach 495 cm a year, making it one of the wettest places along coastal, western Africa.

2.1.4 Economy[1]

Sierra Leone is an extremely poor nation with tremendous inequality in income distribution. While it possesses substantial mineral (diamonds, titanium ore, bauxite, iron ore, gold, chromite), agricultural, and fishery resources, its economic and social infrastructure is not well developed and serious social disorders continue to hamper economic development. About two-thirds of the working-age population engages in subsistence agriculture. Before the war, subsistence agriculture engaged about two-third of the working population, but following the end of the war in 2002, there has been substantial labour movement to other productive sectors, especially diamond mining. However, output in cash crop production (coffee, cocoa, groundnuts, and palm kernels), particularly in the country's east, has recently increased.

Manufacturing consists mainly of the processing of raw materials and of light manufacturing for the domestic market. Alluvial diamond mining remains the major source of hard currency earnings, accounting for nearly half of Sierra Leone's exports. The fate of the economy depends upon the maintenance of domestic peace and the continued receipt of substantial aid from abroad, which is essential to offset the severe trade imbalance and supplement government revenues. The IMF has completed a Poverty Reduction and Growth Facility program that helped stabilize economic growth and reduce inflation. A recent increase in political stability has led to a revival of economic activity, such as the rehabilitation of bauxite mining.

The environment has suffered from rapid population growth pressuring the environment, over harvesting of timber, expansion of cattle grazing, and slash-and-burn agriculture has resulted in deforestation and soil exhaustion, civil war depleting natural resources and over fishing.

2.1.5 Poverty Reduction Strategy Paper (PRSP)[2]

Since the mid-1980s Sierra Leone has suffered dramatic economic decline. It has gone through a ten-year brutal armed conflict, with ever-worsening poverty. An interim PRSP (IPRSP) was finalised in 2001 and a National Recovery Strategy (NRS) in 2002, to support transition from peacekeeping to peace-building, and to equitable growth and sustainable development. The current PRSP covers the years 2005-2007. About 26 percent of the population is food poor, and cannot afford a basic diet; 70 percent live in poverty. The 2005-2007 PRSP provides bold sectoral policies and institutional reforms to achieve economic growth, providing food security, job opportunities, basic social services and effective social safety nets.

The PRSP states that: Sierra Leone's poor social indicators reflect the low level of human development, with especial poverty among rural women. Maternal mortality, infant mortality and fertility rates are among the worst in the world. Contraceptive prevalence remains low, as does female school attendance.

Pillar 2 in the PRSP relates to income and production: strategies, and programmes for food security and job creation through pro-poor sustainable growth. Food shortage is seen as the most important determinant of poverty. Food security is at the hearth of poverty reduction: it contributes to reduced child malnutrition and mortality and improved maternal health.

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[1] From "THE WORLD FACTBOOK"

[2] The information here is picked from the official PRSP for Sierra Leone

One main point under Pillar 2 is Food security strategy empowering poor rural and urban households to improve the food consumes, and encouraging farm families to produce more. Government will support small-scale subsistence farmers, who dominate agriculture, to diversify and increase production…

Pillar 3 states that: The overall goal for health care is equitable access to affordable basic services and restructuring delivery mechanisms, especially for the poor and vulnerable. Care will focus on maternal, infant and under-five mortality; malaria and communicable diseases, HIV/AIDS and other STDs. Devolution of health management will encourage community participation. The next point starts with a statement that there will be an increase in access to safe water and sanitation.

Dealing with implementing of the programme the PRSP states that "NGO's, civil societies and community-based organisations will continue to play an important part."

On page 61 the PRSP states that: "Port Loko and Kenema districts, which amounted for 9.8 and 8.9 of the sample population, recorded the highest contribution to poverty of 11,5 percent and 1.1 percent respectively." The Lunsar area is part of the district of Port Loko.

2.1.6 Demographics and Health

There are about 14 ethnic groups living in Sierra Leone, which together make up about 99% of the population. The most important tribes are the Temne (mostly in the north) and Mende (central and south), both forming about one-third of the population. There is a sizeable number of Krios, descendants of enslaved Africans, freed in London in the late 1700s and later retuned to West Africa. Other groups include the Limba, Susu, Madingo, Kono, Yalunka. The ethnic groups are distinct in some of their music, traditions, cultures. At the same time, there are many overlapping traditions.

Although English is the official language, it is understood by only a minority, as most people speak their ethnic group's own language. The Krio language, based on English and African languages, is however spoken by most of the population. Islam and Christianity both claim many adherents in Sierra Leone, though Muslims are more numerous. Sierra Leoneans also adhere to traditional African religious practices. The World Fact book indicates 60% Muslims, 30% indigenous beliefs and 10% Christians.

Sierra Leone is the worst nation in the world for infant mortality, having the highest Maternal Mortality Ratio (MMR), or risk of maternal death, of any country. The MMR of Sierra Leone, according to a report from the World Health Organisation in the year 2000, is 2,000 maternal deaths per live 100,000 births. The extremely high MMR is principally due to a lack of capacity to deal with obstetric complications such as haemorrhage, obstructed labour, ectoptic gestation, puerperal sepsis, and complications caused by unsafe abortion. Those situations were aggravated by the rebellion and the detrimental effects on distribution of reproductive health services due to the massive displacement of people, destruction of medical infrastructure and hospital equipment, rural inaccessibility, poor and disadvantageous accessibility to basic medical service.

The World fact book gives an average life span of a Sierra Leonean is 38 years for men and 42 years for women, whereas the PRSP states that: Life expectancy at birth declined to 34,3 years in 2002 from 42 years in 1990. It is 35.6 years for female and 33.1 years for male. In

2002, infant and under-five mortality rates were estimated at 165 and 284 deaths per 1,000 live births, compared to 185 and 323 respectively in 1990. The maternal mortality rate during 1985-2002 was estimated at 1,800 deaths per 100,000 live births. Child mortality rates are directly linked to the incidence of poverty. Urban mortality rates are lower relative to rural rates. High rates of mortality are also negatively correlated with the levels of a mother's educational attainment.

Fertility rates are also high. The fertility rate for women for the period 2000-2005 is estimated at 6.5. High fertility rates are associated with rural residence and low socio-economic status. The age at first childbirth for girls is low. The contraceptive prevalence rate also remina low at 4 percent.

The proportion of the population undernourished in 1999/2001 was estimated at 50 percent, compared to 46 percent in 1990/92. The sanitation situation is also unsatisfactory. Hardly any rural village has adequate pit latrines, posing serious health and environmental problems for the communities. (for statistics, see appendix 1)

2.1.7 Education and Poverty

On page 76 the PRSP states that: School attendance across households improves with the income of the household. School attendance is higher among males than females for both poor and non-poor households, rising among males from nearly 50 percent in the poorest households to over 70 percent for the non-poor. For females, it rises from about 33 percent to 60 percent.

At 31 percent, Sierra Leone's adult literacy rate is one of the lowest in the world. Adult literacy rates by gender are much lower outside the Western Area. Four out of five male are literate in the Western Area compared to 1 in 13 female in the Northern Region and 1 in 10 female in the Eastern Region. According to the survey results 18 percent of adult females (above 18 years) can read English, compared to 35 percent for adult males; while 20 percent of female adults and 37 percent of male adults can do written calculations.

The survey also shows that 2.3 percent and 1.4 percent of males and females attended adult literacy classes, respectively. The reasons for not attending literacy classes for both males and females include non-availability, large number of household chores (8 percent males and 16 percent females) and lack of caretakers for children.

2.2 Baptist Convention of Sierra Leone (BCSL)

2.2.1 The Church

The BCSL had until a few years ago its main centre of interest in the Lunsar area where the church's headquarter was located. During the war the headquarter was de facto transferred to Freetown and it is most likely that it will remain there. The BCSL has about 10 000 baptised members. In addition there are a large number of non-baptised adults who go regularly to church. Including the children the total number of people belonging to the BCSL is about 40 000. The BCSL suffered heavy losses during the war when most of its installations in Lunsar were destroyed. However their international partners were faithful and with funding mainly from America, most of the buildings have been rehabilitated to a relatively high standard.

The Baptist Convention is divided into eight church districts with a total of 96 churches, of which some 25 are located in Freetown. The number of churches is rapidly increasing.

The central administration is divided into Social Services and Church Ministries. Church Ministries run the activities that are not classified as social services. It has two organised subgroups at national level, on area level and on local church level. These are: Women's Union and Youth's Union. In the organogram these groups is part of "Coordinate Associations & Auxiliaries Programs".

2.2.2 Women's Union

Women's union has about 5000-6000 members. It has a strong leadership and has as main objective to assure a viable gender perspective in the priorities, the life and the activities of the church. The Women's Union takes initiative and run projects that has an obvious dominant interest for women.

2.2.3 Youth's Union

The youth's union is organising Youth (15-25 years) and young adults (26-35 years). Each area organise its own programme according to local priorities and interests. Common activities tend to be: evangelism, gospel bands, choirs, leadership training and capacity building for local youth leaders. These programmes and organisation gives practical experience and theoretical training to some 400-500 young throughout the country. Sport, in particular football is also very common. They use it as a tool to gather the youth around something that is considered to be positive. After the war, football was risky and local youth leaders in BCSL asked for support from national level, but now it tends towards local responsibility again. No girls are playing football in this setting. They prefer volleyball. Sport, both football and volleyball, is used as a connector when there is a local conflict. The event is a neutral happening that brings people from all groups together, and people find their ways to settle local and personal conflicts.

2.2.4 BCSL's Policy for Development

BCSL's Strategic Plan 2006-2010 starts with a statement on development of which we shall quote the last part:
" The Baptist Convention has walked with the people of Sierra Leone through the emergency and now we are ready to walk the road of reconstruction and development.

The Poverty Reduction Strategy Paper of the government of Sierra Leone lists Health and HIV/AIDS, Water and Sanitation, Education, Governance, Security/Conflict, Resource Management and Food Security as the major development concerns for the country. BCSL shares these concerns and we are confident we can make a significant contribution in reducing poverty through addressing issues of food security, health, HIV/AIDS and education."

In other words, the BCSL expresses a strong support to the PRSP of the government of Sierra Leone.

More specifically we will quote two points from Goal 5: Increase access to quality health services:

- train community based organisation on primary health care;
- improve access to and use of safe water and good hygiene practices;

This shows a very positive attitude towards primary health and sanitation, which are important aspects of a reproductive health project.

2.2.5 Agriculture

With support from Baptist World Aid 400 bushels of seed rice were given to four Baptist Area Associations and to four village communities in order to develop seed banks as a food security drive. They also supported Cassava Cultivation Projects in five communities. One cassava grater was purchased in addition to the two previous ones. Finally the Baptist World Aid financed two computers and the set up of internet in the church office in order to improve the communication with partners overseas.

2.2.6 Safe drinking Water

Tear Fund Holland has funded a water well project at Makomp in Marampa Chiefdom (Lunsar) providing safe drinking water to the entire community.

2.2.7 Capacity Building

Tear Fund Holland and UK also have funded the participation of the coordinator of social services in BCSL at a ten days church/community empowerment programme in Kenya. In November 2005, Tear Fund conducted and funded a workshop for 30 persons from Sierra Leone and Liberia on Community empowerment. The workshop was held in BCSL's conference centre in Lunsar. Tear Fund also has financed and carried through in 2005-2006 training programme for church member staff especially those involved in development activities. Coaching exercises on Strategic Plan, Project Cycle Management (PCM), Peace Building, HIV/Aids and Community empowerment were conducted and funded by Tear Fund.

2.2.8 Secondary Schools

BCSL runs four secondary schools with the following statistics:

School	Boys	Girls	Total	Teachers
Scarcies Baptist Secondary School	504	125	629	22
Allen Town Baptist Secondary School	413	301	714	45
Gbendembu Baptist Secondary School	292	79	371	19
Samu Baptist Secondary School	347	66	413	15
Total	1556	571	2127	101

The national quota system for recruitment of teachers makes it in fact impossible to recruit new teachers, whereas the number of students is increasing. The Baptist schools used to be of high quality, and they still are, but it is getting more and more difficult to maintain the level of quality, because they do not receive any support for schools from abroad any more.

2.2.9 Vocational Training

The BCSL also runs a vocational institute with 25 teachers and 256 students. The institute gives training in Tailoring, Carpentry, Secretarial Studies, Home Economics, Computer and Agriculture. During the year 2005-2006 the institute got training materials from the Finnish Baptist Union and from the Ministry of Agriculture, Forestry and Food Security the Institute got animals of various kinds for breeding.

2.2.10 Primary Schools

Finally, in the educational sector the BCSL runs 22 primary schools of which 17 are approved. These schools have 154 teachers of whom 107 are trained and 47 untrained. The approved schools have a total of 6776 children on the school roll. Five schools are not yet approved. They have 13 teachers of whom 4 are trained and nine are untrained. The total number of children on school roll in the unapproved schools is 673.

2.2.11 Medical Work
On the medical sector the BCSL runs an Eye Hospital in Lunsar, a health centre in Nonkoba (Lunsar area) and two health centres in the Kambia District.

So far the main sources for outside financing have been: EBM, Baptist World Alliance, Tear Fund Holland and Evangelische Entwicklungsdienst.

Comments: this short presentation of BCSL is describing an organisation that has survived the war, with its structures, its creativity, its active role in the society, and that has a credibility internationally in a way that old partners have contributed massively to rehabilitation of infrastructure.

2.3 Victims of the Care of the International Community and the NGOs

2.3.1 NGOs and Empowerment
Sierra Leone received massive support from the international community after the war was over. Many of the NGOs were certainly professional and did a good job. The problem seems to arise when the professionals who are doing a good job, set the agenda because they think that they know best, they have the money and have short deadlines for reporting on successes. With a large experience from several countries in Africa, including countries that are in a transitional period, politically, socially and economically, the editor of this report has never experienced something near to the widespread feeling of frustration towards the World of NGOs that came to help them whether they wanted to be helped or not.

This experience is an excellent illustration of the meaning of the word "empowerment", where the project team shows respect for people, listens to their priorities instead of trying to convince them about the superiority of our strategy. We will illustrate this by using some of the comments we got from people with whom we talked.

2.3.2 No more Reconciliation
On June 13 the team asked the BCSL – Youth Executive Committee for their opinion about the possibility to include reconciliation as a main objective of the project. The answer was very clear:

"After the war, a number of international NGOs were established and started to work in Sierra Leone, and a number of local and national NGOs got funding for their activities. This was the golden period for reconciliation. It was for a shorter period of time easy to get funding for activities that pretended to facilitate reconciliation. When the donors thought that reconciliation was achieved, or that their funding dried up, these activities stopped. In a way people were fed up. Please no more reconciliation."

Our comments: Nevertheless we understood later on that the reconciliation was far from achieved. The need was there. But the issue could no more be approached by foreigners. It was not possible to talk about the issue in political terminology. The nearest one could come was to talk about activities that could be a contribution towards the stabilisation of the society.

2.3.3 Setting the Agenda by Use of Money
In order to better understand the reason why people have had enough of men and women of good intentions who are coming to Sierra Leone to solve the problems for the people we shall

present the story of Josephine Isatu Conteh a 45 years old qualified nurse whom we met in Lunsar on June 22.

"She fled to Freetown in 2000 in order to avoid he war. Thinking of what this war was doing to the children she returned to Lunsar in 2001 before the war was over. She founded an organisation called Child Protection Association (CPA) together with two other women. They took care of 150 children of various age and background. The resources were not sufficient for the need. Then came an international NGO Action for Children in Conflict, they invited her for cooperation concerning "sexual abused girls" because that was their priority. The CPA had to choose 50 girls of that category and trained them in skills like gara-tie dyeing, hairdressing and tailoring and gave them kits to start the work. This lasted for one year and then the Action for Children in Conflict was out. Then in 2003 the NGO War Child came to the area. They approached her for cooperation. The priority for War Child was to get land for playing games. She arranged that for them, but the land was never exploited for War Child changed priority and left the area. However they are still promising to finance the plans. Then came Right to Play and wanted her cooperation. She participated in several training sessions and became Star Coach. They organised plays for children. She wanted to introduce HIV information, but then all of a sudden the Right to Play left last year. For the moment the CPA is following up it's own priorities without any international partner with their own priorities. Together with two other women, Josephine Isatu Conteh has a day care centre for 30 children who used to be guides for blind beggars. They get one meal every day and some education. Her association has six members, each contributing with half a dollar a month. So for the moment she and her two helpers are struggling along without help from NGOs".

Her story makes it possible to understand that people are not always convinced that it is good idea to let foreign "experts" set the agenda.

2.3.4 Listening and Being Good without Knowing

The team met with the leaders and some members of all the various women's associations in Lunsar on June 22, 2006, a total of 41 women. We had listened to their presentation of their work for more than one hour and had not yet told anything about the profile of the projects that could be organised. Then one woman stopped the proceedings and said with some surprise and some joy "this is the first time since the war that we are all gathered in one place and that foreigners just listen to what we are doing, we use to be told what we should do. Another thing is that now we know of each other and we can certainly do more if we cooperate between us." This was followed by applause from all the women in the audience. Then we continued to listen to the presentation of their work, followed by some priorities for further actions. Finally the project coordinator of the BUN presented their tentative plans that were so close to their priorities that it was easy to adapt.

2.3.5 Frustration, Partnership, Values and Church Profile

The president of the board of the BCSL said in a debriefing meeting on June 24, 2006:
"The needs for missionaries are there, and we are grateful for this opportunity. We have seen NGOs coming, they tell us things and at the end of the day they will have done nothing".

"The Church expects that missionaries who are doing social work, also will witness about Jesus. Successful partnership is based on mutual respect. We used to look to America for values, but we don't do that any more as they are bullying the whole world. We have an experience with missionaries who wanted to decide because they had the money. They got

frustrated and left when they realised that it is not possible to run a church by the use of money. Your approach has been different."

2.3.6 Feasibility Study and Empowerment

The three Sierra Leonian members of the project team insisted strongly on the fact that a feasibility study of this kind was new to them, and that it was a very positive experience. They repeated this in the debriefing meeting with the top leaders of the church on June 24, 2006:

"This exercise should be organised every time when a missionary comes, in order to strengthen the impact of their presence and their work."

These comments give a clear indication about the approach that is wanted in Sierra Leone. This approach was indicated by the Norwegian Baptist Union as the one to be used for this feasibility study and it fell natural for the team members.

2.4 LUNSAR

Lunsar is an administrative area in Porto Loko district. The area covers the area of Marampa Chiefdom. The total population of the Marampa Chiefdom is 37 567 (2005 cencus) of which 19 673 live in the city of Lunsar. The city of Lunsar is situated 120 km North-East of Freetown. A new paved road makes it easy to drive between the two cities in less than three hours.

There are 22 formal schools and one informal school, with a total of 9 934 children. The city has five secondary schools, one Public, one Muslim and three Catholic, one for boys, one for girls and one vocational school. There are three Hospitals, one general Catholic Hospital, one specialised Eye Hospital, run by the BCSL, and the Public Community Health Centre. In addition there are a few local health centres in some villages.

In a country that has the highest MMR in the world and the highest IMR in the world, Lunsar is the worst area. According to information from the Community Health officer, the MMR is about 10% and the IMR is about 40%.

A few kilometres from Lunsar a huge project of extraction of iron ore was functioning until about 1985. People are still dreaming of those glorious days when salaries were high and jobs abundant. A representative for Red Cross indicated an unemployment rate of 80%, in an area where land for agriculture is free.

Before the war BCSL had it's headquarter here. The number of buildings is impressive, and most of it has been fully rehabilitated after the war. During the war BCSL moved it's headquarter to Freetown, which led to a decrease in activities in Lunsar.

3. METHODOLOGY AND HYPOTHESIS

3.1 Metodology

The methodology consists mainly of three elements:

- Interviews
- Listening to people's experiences
- Documents (including internet)
- Observations

The present project does not fit in an already defined an organised structure. Therefore we have been very explicit and detailed in the information, trying to give a good background for the considerations we have made. We think that we have been true to the main ideas as the various persons and groups whose contributions we have used as a base for our analysis expressed them. However, we cannot guarantee that we have got correct all the details, but we have tried our best. This means that in case that there should be a problem, we are responsible for the version we have used and not the contributors who could in some cases have expressed themselves slightly different. On the other hand the honour of the contribution belong to those who made it.

We worked in Freetown June 13-17, in Lunsar June 18-22 and then again in Lunsar June 23-26 (the consultant left Sierra Leone on June 25). The same group worked simultaneously on another project concerning the youth, so the time was shared between the two projects.

The team met with the BCSL's leadership and the board of the Social Ministries in the beginning of the work where the outline of possible projects and formalities were discussed and by the end the team had a debriefing with the church's leadership in order to inform of the main findings and the recommendations.

3.2 Hypothesis

The best use of the Missionary would be either to train midwives and related personnel or to have a more general approach to reproductive health.

4. SOME MAIN ASPECTS OF REPRODUCTIVE HEALTH

by Julie Sesay

4.1 The formal Levels

1. The hospitals have one operating theatre and trained staff capable of performing 24 hours comprehensive essential obstetric care for a community of 150 000 – 200 000 people. Trained skilled personnel staff it. – Doctors, CHO, SEN, SECHN, sisters, midwives etc
2. A peripheral Community Health Unit or Community Health Centre is staffed with a Community Health Officer plus a trained and qualified midwife and nursing aids. It serves a community of 30 000-40 000 people.
3. The Maternity Health Post has a Maternal Child Health Aide (MCH) who works in a health post/maternal post together with Traditional birth attendants (TBA) for a community of 5000 people

Cases that cannot be taken care of adequately on the lowest level shall be referred to the level that is competent for the case.

TBAs are to be trained and assigned to work together at the maternity posts with the MCHs.

4.2 Maternal Mortality in Sierra Leone

The main causes for maternal mortality are:

	Cause	%
1.	Severe bleeding	25%
2.	Indirect causes	20%
3.	Infections	15%
4.	Unsafe abortions	10%
5.	Eclampsia	20%
6.	Obstructed labour	5%
7.	Other direct causes	5%

(Source: WHO Safe Motherhood 2004)

Factors that influences maternal mortality in Sierra Leone:

- Poverty, medical cost charge, patient cannot afford money to pay
- Poor nutrition
- Ignorance
- Unavailability of trained personnel
- Late diagnosis
- Frequency of birth intervals

4.3 Reproductive Health

- Reproductive health care talks that help them to understand the value of sexual and social behaviours in order to postpone the onset of sexual activity, delay childbearing and protect themselves from unwanted pregnancies and STI/HIV
- Access to information and services that allow women to protect themselves against pregnancies and STI/HIV.
- Treat STIs as a means of preventing the transmission of HIV. This should be incorporated into the reproductive health care programmes.

Reproductive health is about more than just reproductive organs, reproduction is about how social and sexual behaviours and relationship affect health and create ill health. It has to be understood within the context of relationships between men and women, communities and society since sexual and reproductive behaviours are governed by complex biological, cultural and psychological factors.

Reproductive health requires a continuum of care be provided to meet the health needs of individuals throughout their lifespan. Good reproductive health starts from childhood.

Circles of Reproductive ill health in Sierra Leone

Birth	
	Low weight – malnutrition – anaemia
	FGM
	Harmful traditional practices
	Unsafe sexual practice
	Sexual & gender violence
	STI/HIV
	Unsafe pregnancy
	Unregulated fertility
	Maternal & neonatal morbidity & mortality
	Infertility
	Cancer
Elderly	

Effective reproductive health care addresses these problems from birth with appropriate and culturally sensitive education and health care programmes.

Services for the prevention and control of STIs, including HIV should be incorporated into reproductive health care programmes, supported by energetic information campaigns and gender-sensitive promotion of condom use. Transmission of HIV from an infected mother to her infant also results in increased morbidity and mortality in young children undermining child survival efforts.

Social, cultural and economic factors that increase vulnerability to reproductive ill health in Sierra Leone.

- restrictions on information about sexuality, contraception disease prevention, condom and health care
- harmful restrictions such as ritual intercourse with a male relative after the death of the husband, of Female Genital Mutilation (FGM), ritual scarification, tattooing and blood letting
- early mamage
- inability to negotiate safe sexual practices
- discrimination against women in education, employment and social status.
- war, natural disaster, poverty, political oppression etc

4.4 Guide Principles in the Provision of Reproductive Health

1. Integrated approval treating reproductive health as an integral part of primary health care and solutions to reproductive health needs sought in the health sector and elsewhere. This includes recognising the empowerment and education of women and girls as key determinants in improving their health and supporting and promoting women's health. Providing holistic services.
2. Coordination of response collaboration with the ministry and other reproductive health service providers. This saves resources, improve logistics, avoid gaps in coverage and parent duplication of efforts
3. A gender approach

Activities
Training of health workers including awareness raising of reproductive health needs their roles and responsibilities in prevention treatment and documentation. It should include knowledge of human rights.

4.5 Safe Motherhood – what to look for in Lunsar

1) What is the overall health status of newborns?
2) What is the overall health status of pregnant women?
3) Are antenatal cares available in all villages in the Lunsar area?
4) What is the general outcome of pregnancies in the Lunsar area?
5) How many trained personnel available for reproductive health?

5. VISITS AND CONVERSATIONS

5.1 Meeting with the Executive committee of Women's Union, BCSL 13.06.2006

The executive committee was very clear that a project on reproductive health was the setting where the mid-wife could best use her competence in relation to one of the most serious problems the country was faced with. The Government did not care much about Lunsar even though the area suffered very much during the war. They would accept everything. This is one more reason for doing good research in order to find the most pressing needs. Again and again the members insisted that the activities should be sustainable and that all formalities with the authorities had to be in order and that the activities were carried out according to national health policy.

There would be three possible institutions to cooperate with in Lunsar. The Baptist Convention's own hospital, but it was an eye hospital with no maternity work. Therefore this could not be used. The Catholic Church has a general hospital of very high quality, with maternity work. However, there was no point in adding quality to an institution, which already had high quality. Her participation there would rather contribute to the quantity than to the quality. Moreover the Catholic Church did not accept all the components of a reproductive health programme. The recommendation of the Women's Union Executive committee was to work with the governmental Community Health Centre, because that had the highest potential for enhancing the quality of the services for the population. The committee was not sure whether or not the Centre was ready for cooperation but this cooperation would be the starting point for all kinds of sub projects such as training and up-dating of Traditional Birth Attendants. It would also be important to include a programme for work with children under five years, because women in the Lunsar area cared much more for the prenatal period than for the postnatal period. For this reason the work should be combined with education in nutrition and breastfeeding.

5.2 Visits and Conversations in Freetown

We first met the Executive Director of the Christian Health Association of Sierra Leone (CHASL), Mrs Marion Morgan. She said that CHASL was involved in a programme in Lundsar in cooperation with the Community Health Centre and the Catholic Hospital concerning clean drinking water, nutrition, breastfeeding and family planning.

The Director General of Medical Services said that: "…reproductive health is our headache." The authorities will try to implement a programme consisting of prenatal services, nutrition, care for children 0-5 years and vaccination. Malaria is a huge problem, but people will have to pay for health services. He insisted that in order to reduce the MMR they did not have to consider just some health aspects, but also cultural and economic factors. The priorities were:
1. Malaria has highest priority
2. Training of Traditional Birth Attendants (TBA), also in giving advice to pregnant women
3. Child mortality - nutrition
4. General infections (for children worm infections)

Direction for Midwifery and Reproductive Health gave information about the reproductive health project and about the need for follow-up training for various categories of midwives. They were responsible for the follow-up of midwives and related personnel, but they did not have the necessary resources to do so, and would appreciate if the BC project could help out.

The Acting Principal of the School of Midwifery informed about reproductive health and about formalities for acknowledgment of documents for the Norwegian mid-wife. She could handle these formalities. Christiana Williams, Acting Principal National School of Midwives, christianabwilliams@yahoo.co.uk phone +232-76762869

5.3 Visit to the Hospital in Port Loko 17.06.2006

According to I. J. Kargbo-Labour, District Medical Officer (DMO) in Port Loko, the Lunsar area has the highest child mortality in Sierra Leone. He will like to cooperate with the Norwegian mid-wife, but he will need a formal recommendation from central authorities which he has not got so far. Hopefully she could serve the entire district. They need kits and training for midwives of all categories, these are the main priorities.

He describes the situation in the health district. The MCH have two years of training before they are placed in the districts by central health authorities. They have no income. Some are waiting eight years before the salaries come. They are not from the village and have no family ties there. There are 60 in Port Loko district. Traditional Birth Attendants are from the villages, they have their income there and they just need some rice or other food when the job is done, that is all. 12 of the MCH work at the Health Centre, the others live in the villages. They usually have one room where they live and where the births are taking place. These need training and kits and salary. If they don't have a salary, the women will only come if there is a real complicated case. The MCH are selling drugs in order to survive, in a way they are doing the job of a physician, and are perceived as such by the local population.

The women have the right to get assistance for the delivery free of charge, but as we have seen they have to pay something to the MCH in the villages. The District Health Centre does not have any public support for running costs. There is no money for soap, drugs etc. The DHO gets 500$ a month from a personal friend in England to cover the most urgent of running costs, the rest has to be paid by the patients as payment for consultations. The doctor's salary is so low that he is not able to pay the lunch for his daughter in one month. 72 doctors have graduated from the University of Freetown the last years. 68 have left to work abroad only four are still working in Sierra Leone. The options for a doctor are: to leave the country, to accept bribery or to have a private clinic in Freetown where there are people who are able to pay.

5.4 Planned Parenthood Association Sierra Leone (PPA) 17.06.06

This is a British NGO. Aminata Cecilia Kargbo was fieldwork supervisor. She is a trained teacher and got 1-2 months of training before she started the work. They also had field workers called service providers. She worked in a clinic set up by PPA in Port Loko. It was the only clinic in the area. The work was not community based.

Many were afraid of their husbands and they do not dear to use family planning techniques or equipment. Therefore they keep using traditional methods as long periods of breast feeding. The women were more motivated than men. She motivated women and men for separate group discussions.

5.5 Contribution from Women's Union in Lunsar 17.06.2006

After a long introduction with presentation of the purpose of the visit, and a number of questions and comments for clarification, Lise Kyllingstad invited the women to present their opinions. What can the women do together with Anne and her husband? Could they say something about what the women could do concerning nutrition for children of 0-5 years?
30 women were divided into three groups to discuss the issues. Here follow the results of their work:

Group 1:
We need teaching in nutrition of children 0-5 years.
We need teaching in family planning. Often a woman gets pregnant because of lack of family planning. We get children when we should not have had them, because we are physically not ready. These children do not get the care that they should have. You loose so much blood when you give birth that you produce not enough milk for the baby. It doesn't get what it needs.

Group 2:
Not all pregnant women know that they have a right to get free immunization and medication. We all need health education. Young mothers suffer much. Young women get STI. They go without treatment and children are born with unnecessary defects. We need information about this.
We also need information about nutrition. There is some food that a pregnant woman needs and they need it also after the birth. But traditional beliefs prevent us from this food, as for instance eggs.

Many women work hard during the whole period of pregnancy until the day they give birth. Some are exhausted and die during the delivery. The men need the information that their wives need rest in a period before the delivery.

We know that HIV is here and STI. Somebody has to inform us about that and about how we can protect us.

Group 3:
If the pregnant women do not have the right nutrition, she will not have enough blood. Training of Traditional Birth Attendants will be good. Clean drinking water and sanitation are important. If we neglect this we will get diarrhoea, dysentery and so on. Some women

produce food that would have been excellent nutrition for their own children but they ignore it and sell it on the market. A family can avoid many expenses if they get good nutrition.

Final discussion after the presentation of the group works:
If we get this knowledge we will be able to teach others in a systematic way. They all clapped hands and said: “We can”. We will go to the villages and tell people how they can produce for sale and get a benefit, and we will tell them how to use this to get the right nutrition for pregnant women and small children.

What do the women in Lunsar do now?

1. We give a contribution each month. This is used to by firewood that we send to the villages in smaller quantities and sell it with benefit, or we use it to produce soap that we sell.
2. We do handwork
3. We evangelise in the community.
4. We organise seminars on Female Genitals Mutilation
5. Counselling and contribute to settlement of disputes in the family

5.6 Saint John of God Catholic Hospital 19.06.06

They are open for cooperation with the Norwegian missionary because they have an experience of cooperation with NGOs and others. They will be happy to include her in their activities. She will have to go through the hospital in Port Loko in order to avoid duplicate efforts. The hospital gets regular visits from doctors mainly from Italy. The hospital has three midwives. They have several health centres. Pregnant women are coming to the hospital for follow up. They have 20 births per month. The number is lower in the rainy season because most people have more money available in the dry season.

The hospital will start a programme for reproductive health, nutrition and community work in 2007. So far the hospital does not have any kind of decentralised service. The sick or other clients need to come to the hospital.

5.7 Visit to the Community Health Centre in Lunsar 19.06.2006

We talked with Mr. Sheiku U. Komora, Community Health Officer. He has three years formal professional training after secondary school and one year of practice before he became CHO. Reproductive Health is a priority. The CHC receive pregnant women and take care of them until they deliver. The next step is to undertake a programme for children 0-5 years. The centre runs a programme for vaccinating the children.

The CHC has organised a team that is visiting some villages in the area. There are 10 sections in Lunsar Health District, but they are not able to cover the whole area, by the team. In all of these districts there are TBA and MCH. At this point the Centre provide reproductive health services to 30% of the population. 70% are not reached.

The Centre is organising a programme for training of volunteer health workers, six women and eight men. The programme consists of immunisation, community sensitising, running under five clinic, treatment of minor bruises, nutrition surveillance. The volunteers need to have finished secondary school. They have on the job training. In addition they have teaching every Sunday after 2 p.m. and have to pass an exam. They have no salary, but will usually work with the centre until they can be enrolled.

Last February (2006) they were teaching 40 TBA and they attended birth. They talked with the Baptist Women Association about STI. When they had immunisation sessions they also gave health talks. People need help to understand better the nutrition issue.

They take care of the cases they can handle within the limits of their competence. If a case is beyond their competence they refer it to the CHO at the CHC. He might refer the case further to the DHO in case it is beyond the competence of the centre.

According to the governments policy the medication is free for all children 0-5, schoolchildren, pregnant women and pensioners. For the sake of transparency, the prices of the main drugs are published on papers on the wall, with indication of categories that have free medicine. Unfortunately, the drugs are coming irregularly and in insufficient quantities. There is no money for running costs. In order to get some income, the centre charges 1000 Leone for each consultation. The salaries are low and are not paid regularly.

According to the statistics at the CHC, the child mortality was 40% in Lunsar, and the MMR is 10% in Lunsar.

The tuberculosis is common in the area. 70% of the tuberculosis cases are HIV-positive. The HIV-positive who are still strong and healthy get information on how they can organise their life in order to remain healthy for a longer period of time. Those who are in phase 2 get medicine. Those who are in the third phase get help and comfort in the last period of their life.

Approximately 80% of the population has developed resistance against malaria drugs because they are taking 2-3 pills when they feel sick. There are drug sellers in the area who may have a tiny training but the population call them doctor. These people sell drugs to people who ask for and in the quantity that people ask for. They have therefore decided to pick out one of these for each chiefdom, and follow him up. All other drug sellers are banned.

The centre was partly destroyed during the war. The delivery room was completely destroyed and it has not been repaired so far. The conditions for the women who come for delivery are beyond any decent description. The centre in general and the delivery room in particular, needs rehabilitation. The family planning programme is stopping now. They tried to teach women who had many children or who were weak to use contraceptives.

The CHO underlined that the most important need were:

- training of TBA (these have not kits)
- follow-up training
- kits for the reproductive health workers

At this moment Lise Kyllingstad, the project coordinator of the Norwegian Baptist Union, and Julie Susey, member of the team, presented the possibility of organising a sustainable project for reproductive health in the area in close cooperation with the CHC. He was very interested and would appreciate very much the presence of the missionary at the CHC in order to enhance the quality of their services to the population. They would have to inform the DMO, the paramount chiefs and the headman of each village.

It was obvious that the needs the CHC presented were well in line with the competence of the Missionary, who shall come in September this year.

5.8 Other Visits and Conversations in Lunsar

Right after the arrival in Lunsar a meeting was organised in Ebenezer Church for the local church's leadership, including the women's association. There was a general presentation of persons and purpose. Some women gave a short presentation of the area with high unemployment, general poverty and a large number of women who are responsible for the household, either because the husband died in the war, or that he simply left. These women have to shoulder the husband's responsibility in addition to their own.

Then the team met the staff at the Baptist Eye Hospital in order to inform about the purpose of our visit and the staff expressed that they understood that the nature of the project, would not fit into the activities of the Eye Hospital.

The team had a conversation with the paramount chiefs in the Marampa chiefdom with mutual information. The chief promised his support to the projects.

The leader of CHASL's project in Lunsar said that they tried to help with empowerment of local communities. They give health talks in the villages and they are monitoring and give training to TBA. In some cases they also give kits to them.

The nurse in charge of the BCSL's health centre in Nokoba explained the community training in sanitation and environment.

Conversation about the youth and children in Gbom Limba with the pastor and teacher David S. Koroma, including statistics about the reproductive health situation. It is a good example on how a local church becomes a catalyst for empowerment of a local community.

5.9 Meeting with Women's Associations in Lunsar 22.06.2006

All women's associations in Lunsar were invited to a meeting with the team. For political reasons it was not possible to meet in the building that was intended for the meting, but the Ebenzar Church of the Baptist Convention was acceptable for all. 42 women met.

Trod Barka Women's Association had 55 members. They organised agriculture as a self-help project with membership contribution. They hired workers. Half of the benefits from sale the women kept for personal use, the other half was added to the capital

Marampa women Agricultural Cooperative. This is an umbrella organisation for 25 women's groups with a total membership of several hundreds. They stressed that they were self-reliance groups with farming as main activity and skill training as secondary activities. The target group was widows.

Lundsar Baptist women's Association has a membership of 102. The main activities are: Soap making, beadwork, micro credit loan, agriculture, poultry raising and selling wood. All give a monthly contribution.

Child Protection Association. Six members. Self funded by monthly contributions. Activities: taking care of street children, sexually abused girls and dropouts and poor blind and needy

children in a day care home with 30 beneficiaries. 50 sexually abused girls are given skill training in a centre.

Alarampa Women's Association. 25 members. Skills training funded through membership contribution.

Individuals who wanted to show some results of their training sometimes interrupted the presentation by the leaders. Because in addition to the main activities, that for most of the groups was income-generating activities, all of them organised some kind of training/ information/practical help that we have organised owing to themes:

Family planning:
They teach women how to avoid sickness. They are teaching how to prevent early and unwanted pregnancies, so that the women can wait until they want to have a child. Because women give birth at random, they try to give advice about child spacing, need of preventing unwanted pregnancies and the value of having only one partner.

Sexually abused girls:
For those who are married they call the husband, talk with them, give them condoms etc. These girls also get good information on what food they should give the children. They are also getting literacy training and counselling.

Child Nutrition:
Some have some small food to give to the children when they come home from school to sustain them until they have the main evening meal. Most of the women grow all the products that are needed in order to give a rich nutrition for the children.

Sewing:
Two women showed the nice dresses that they had made at home and thus they save money.

Peace Information:
Some groups give peace information before thy start to work

Literacy:
One group is involved in adult literacy. There is a need and a motivation, but they don't have enough trainers available.

General discussion on the women's associations:
There is no coordination for all the groups, except for the umbrella organisation, but they do help each other. Politics should not prevent people to work together. Membership is an individual decision that should not separate us. The politic arena should be an arena for community solutions, where ideas meet in order to find the best solutions. Politics should not divide us in friends and enemies. Politics is give and take. But still the politicians try to separate us. There are no religious barriers we all work together.

Poverty reduction and the role of men and women:
The Government says that they shall reduce poverty but they don't do it. We reduce poverty with our own efforts. Most of the women are working for their families. The men go to town, smoke, give big talk and come home without any money.

The joy of being listened to:
All of a sudden, one of the women said: “This is the first time after the war that an organisation is coming here to ask each individual group what we are doing. Now we know each other better. The visitors just sit and listen. This is our first experience of this kind.”

Priorities:
Finally the women indicated training of midwives and other categories of that kind and information about nutrition as high priorities.

6. ANALYSIS, CONCLUSIONS AND RECOMMENDATIONS

6.1 Elements of Risk

The Lunsar area is faced with a number of problems that were created or aggravated by the war. There was heavy fighting in the area, and local men and youth were active on both sides. The reconciliation has not reached the level of mutual accept and respect as it was hoped for. There is still some tension and animosity between these individuals and between their families.

The reintegration of ex-combatants, in particular the ex child soldiers, has not been a success. Because of poor organisation of that process a large number of young people have been immunised against reintegration and they represent a threat to the social stability of the area. There are other victims of the war. Among these are sexually abused girls and girl mothers, and people with various kind of physical and psychical handicaps caused by the war.

The percentage of children and youth who are not going to school is relatively high and so is consequently the level of illiteracy. However the feeling of shame seems to be stronger than the motivation to learn.

The unemployment is extremely high. Because of this and the looting and destruction of houses and tools for production, the poverty is knocking on most of the doors. The number of street children is increasing. These are not only the orphans, but some families are so poor that they cannot afford to give their children three meals a day. Some have lost the hope and they don’t care very much about their children.

There is still another group of marginalized children. There are many blind people in the area and some more are coming there for treatment at the eye hospital. Many of them are begging and they are using young children to guide them. These children do not go to school and the skill they are learning is begging.

The juvenile delinquency is increasing. Drug abuse, prostitution, theft and other kinds of unwanted behaviour are gaining space in the life of an increasing number of young people.

The Lunsar area is at high risk for social unrest.

6.2 Assets

Lunsar area has much available and unused land, which represents a potential for reduction of unemployment and poverty in the area.

There are a number of both primary and secondary schools. The religious bodies organise activities for children and youth. Sport is recognised on all levels as a positive element in the community, and there is a number of youth and of strong women's associations that are taking care of vulnerable groups and that are creating space for positive action in the community. We have certainly not met with all kinds of associations in the area, and there are NGOs both national and international represented.

6.3 Dividers and Connecters

We have not the impression that ethnic differences are important. People who fought against each other in the war are living together, but they still represent a kind of divider of decreasing importance. We have not seen or heard of any sign of religious belonging as dividers. On the contrary, the religious bodies: the Muslims, the Catholics and the Baptists have created activities and/or institutions, in particular the schools, that are common fields for all categories of people, regardless of religious belongings. We rather see the religious communities as interrelated connecters in the area.

The only divider we have noticed is political belonging. When the team wanted to meet with all organisations of the community youth, the city hall was closed for political reasons. The Baptist Church Ebenezer was considered as acceptable for all, and that church was used as meting place. Exactly the same thing happened when we wanted to meet all the community women's associations. It was not possible to gather in a conference hall in town, but it was possible in the same Church of Ebenezer.

The strongest connecter seems to be sport. All groups seem to have a positive opinion of the role of sport in the community. It has a value in its own right. It is considered to be a powerful element of stabilisation of the area by all individuals and groups that we have interviewed, and it has a large potential for rapid growth if there is a positive input. Sport is also creating a forum where it is possible to engage a dialog concerning economic activities and the future for unemployed youth who are living at risk.

6.4 Target Group

We have described a local community that is at a high risk, with a number of negative aspects and some of these aspects are increasing in volume and strength. On the other hand we have been impressed by the way youth and women and religious communities have organised themselves in order to fight against these negative aspects and are trying to help the marginalized.

The target group will be pregnant women and children under five and their mothers. In particular the ones who are living in the rural areas outside the City of Lunsar, and those who for geographical or other reasons prefer to go to the Community Health Centre instead of to the catholic hospital.

6.5 Sustainability

At a number of occasions the people we talked with stressed and repeated the point that all projects should be sustainable. They had learned from experience with the NGOs that started activities, often rather good activities in their eyes that ended when the NGO considered that

their job was done, or that they did not have funds to carry through their activities. This experience had the positive effect that people insisted on sustainable profile.

This of course is clearly in line with the attitude of BUN. The objective for the project is to give training during two years, and the kits that will make it easier to do a good job. This will hopefully be a lasting improvement of the services. The other main objective is to teach groups of women about nutrition and how to bring this knowledge on to other women. This will also hopefully be lasting skills and knowledge. There are no plans for any new structure that will need funds or help from abroad.

6.6 Relevance

It is certain that some young women have joined groups that are already engaged in activities that are considered to be negative for the individuals and for the society. The are other women who have lost hope and don't care any more, or they still want to, but life has been too difficult. On the other hand, we have met women's leaders who have organised activities, in some cases in a very strategic setting. Many of these realise that an improvement of the health situation for pregnant women and for children under five is within reach, but they need training and guidance and some input on how they can be tools to reach other women with this new knowledge.

If it is possible to motivate women who are not having any regular income to go for agriculture, it is highly relevant. There is a shortage of food in Sierra Leone, agriculture is a national priority, there is land available in Lunsar, and one youth association called"Young Investors" has identified agriculture as the activity in Lunsar that give the best benefit for their investments. It is also important to note that it is possible to produce locally the kind of food that is good nutrition for pregnant women and small children.

The approach is relevant because

- statistics show that the MMR and the IMR are extraordinary high in the Lunsar area.
- it is strongly wanted by professionals and the women in Lunsar.
- the PRSP indicates that the Port Loko district has the highest contribution to poverty in Sierra Leone.
- It adresses the concern in pillar three in the PRSP: "Care will focus on maternal, infant and under-five mortality, malaria and communicable diseases, HIV/AIDS and other STDs. Devolution of health management will encourage community participation."
- the BCSL has adopted that paper as guideline for it's own participation in the process.
- it is line with the policy and experience of the BUN that states that a project should be initiated locally, developed in cooperation, steered locally and get a profile that will eventually enable the local organisation to carry on with local resources if the project should continue.
- it is in line with the Norwegian Ministry of Foreign Affairs' PRSP. The plan of action talks about a focus on tuberculosis, malaria, immunisation and reproductive health and a priority to target groups like children, youth and women. It also give priority to food security and a policy of strengthening the primary industries and that a good channel for this kind of cooperation is through Norwegian voluntary organisations (NGO) and institutions in cooperation with similar organisations in the developing countries.

6.7 Recommendations

First of all we will repeat that this is a feasibility study and not a project document. In line with a policy to be extremely open to input from the target group and also from resource persons and authorities, a detailed project will be presented as the missionaries have had enough time to be sure that the profile of the project reflects local priorities. This may also have consequences for the budget.

There should be a feasibility study of this kind for all new missionaries coming to serve in the work of the BCSL in order to strengthen the impact of their work.

The work of the missionaries should be sustainable after their departure and should not create new dependencies. Therefore the project should be low cost, with no input of cash, but be based on competence building and some material support.

The main objective for this project is to contribute to improve the situation for pregnant women and for children under five and their mothers.

The main effort of the project towards this goal should be to provide a resource person who could contribute by training and equipping mid-wives and related personnel and teach women's groups about nutrition and how they can bring this knowledge on to other women in a systematic way and to enhance the quality of the services the CHC is doing in this sector

The details of this cooperation with the CHC and the women's group will have to be elaborated when the missionary is present in Lunsar.

Officials in Freetown, in Port Loko and in Lunsar as well as the women's groups in Lunsar have expressed the obvious need for training and refreshing Traditional Birth Assistants and for Maternal Child Health Aid, and that they get the necessary kits for their work. The missionary has expressed interest for training. We therefore recommend that part of her job will be to provide training and provide kits in the Lunsar area in close cooperation with the community health centre.

This centre needs rehabilitation. We therefore recommend that this rehabilitation should take place at an early a stage of the project.

The same health authorities have expressed the need for information about nutrition for pregnant women and for children 0-5 years and for sanitation. The women groups in Lunsar strongly expressed the same need and their willingness to do the sensitising if they got the training. We therefore recommend that the missionary should train the churchwomen and the community women to do this sensitising. This work should be based at the BC.

Two structures should be made for the project:

- A steering committee based in Lunsar with members from the Baptist Women's Association, from the Community Health Centre and from the community. The moderator of the Baptist Convention should be a member.
- A combined advisory committee for the reproductive health project and the youth project, based in Freetown with a representative from the European Baptist Mission

(EBM), the coordinator of the social ministries, the coordinator of the church ministry and representatives from the Youth Union and from the Women's Union. The General Secretary has a right in officio to be present in all committee meetings.

We recommend that because of the nature of this project, the majority of the members of the steering committee should be women. The advisory committee should try to have a equal number of members from each sex.

There are some good reasons to link the project to the Baptist Convention in Lunsar. It would facilitate the relations with the BUN because of the already existing routines for mutual information. The visit made it clear that when the meeting with the community women's association was about to fail because of political reasons it was difficult to gather all associations under the same roof, the Baptist Church building Ebenezer was accepted by all as an neutral place. Finally, the Baptist Women's Association in Lunsar is rather big, and they have experience in running development activities.

7. BUDGET

A. Rehabilitation of Lunsar community health centre - rough estimate.

ITEMS	QUANTITY	UNIT COST	TOTAL COST
Beds	5	300,000	1,500,000
Mattresses	5	80,000	400,000
Hard board	50	15,000	750,000
Cement	10	28,000	280,000
White wash	3	65,000	195,000
Paint (enamel)	40	32,000	1,280,000
Timber	55	12,000	660,000
Assorted nails	70pkts	1,500	105,000
Fillet	15bundles	12,000	180,000
Tables/cupboard	5sets	200,000	1,000,000
Doors	5	130,000	600,000
Locks	5	35,000	175,000
Mosquito wire net	5 roles	70,000	350,000
Windows	5	250,000	1,250,000
C.I sheets	6 bundles	200,000	1,200.000
Wash hand basin	1	150,000	150,000
Bed sheets	10	15,000	150,000
Pillows	5	12,000	60,000
Chairs	5	35,000	175,000
TOTAL			**LE 10,810,000**

Estimate cost for the Community Health Centre Rehabilitation
LE 10,810,000 = 23.421,67 NOK = 23.500 NOK
Transport from Freetown to Lunsar by truck LE 3,000,000 = 6.500 NOK
Wages LE 4,000,000 = 8.666,82 = 8.700 NOK
Total 38.700 NOK

1 $ = 6.50 NOK

B. Kits
These kits are used both for midwives and MCHAides. They are available in Sierra Leone at UNICEF's Office
Midwifery drug kit, catalogue No 9902217 = 230,41$ = 1.497, 67 NOK= 1.500 NOK
Midwifery equipment kit, catalogue No 9902218 = 168,99$ = 1.098,44 NOK = 1.100 NOK
Midwifery supplementary kit, catalogue N0 9902224 = 14,52$ = 94,38 NOK = 95 NOK
Total for one set of kits for Midwives and MCHAides 2.695 NOK

A TBA kit can be prepared in Sierra Leone at the cost of 80$ = 520 NOK

13 sets of kits for midwives and MCNAides x 2.695 35.035 NOK
20 kits for Traditional Birth Attendants x 520 10.400 NOK
Total kits 45.435 NOK

Budget Summary

	2007	2008	2009	Total
Rehabilitation of Community Health Centre	38 700			38 700
Didactic equipment for training	5 000	1 000	1 000	7 000
Kits for midwives and MCNAides	35 035			35 035
Kits for Traditional Birth Attendants	10 400			10 400
Transport	15 000	15 000	10 000	40 000
Salary	120 000	160 000	110 000	390 000
Miscellaneous	8 000	9 000	6 000	23 000
Total	232 135	185 000	127 000	544 135

Comments to the budget:

- Most of the training will be practical, but it will probably be useful to purchase some didactic materiel
- There are 10 MCNAides, the centre and the missionary should have one set each, and there is one set extra, just in case it should be needed.
- There are 18 TBA + one set for the centre, and one set for the missionary
- She will have to travel a lot to visit the MCNAides and TBA where the live, but so far there is no policy for the use of the vehicle
- Salary: 50% of salary from January 2007 to June 2007. 100% salary Juli 2007 – September 2009

Appendix 1

SIERRA LEONE GOVERNMENT
MINISTRY OF HEALTH AND SANITATION

UPDATED INFORMATION SHEET – MAY 2005

Please note that in some cases the information is less accurate than would be desirable and caution is advised in the use of the data. The sources for the information are provided at the end of the document.

DEMOGRAPHIC AND OTHER GENERAL INDICATORS

	ESTIMATES 2000/2	2005 ESTIMATES
Population[3]		6,372,698
Infant Mortality Rate	170/ 1,000	150/ 1,000
Under fives Mortality Rate/Ratio	1,800/100,000 Live Births	1,500/100,000 Live Births
Life expectancy at Birth	42 years	45 years
Average Completed Fertility	5,9 births/ woman	5,9 births/ woman
Disability Prevalence	7,0/ 1,000	7,0/ 1,000
Population per functioning hospital	162,000	39,829
Population per Doctor	17,333	54,000
Population per Professional Nurse	8,581	6,516
Population per Environmental Health Officer	25,366	52,235
Population per Peripheral Health Unit (PHU)	12,470	7,936
Underweight Prevalence	27,2%	28%
Stunting Prevalence	33,9%	40%
Wasting Prevalence	9,8%	5%
Prevalence of HIV/Aids	0,9%	3,4%
Access to Health Services	40%	60%
Access to Safe Water	54%	42,8%
Access to Sanitation	20%	29,6%

MORBIDITY (ILLNESSES)

Principal Causes of Morbidity (illnesses) in General population over 5 yrs

1. Malaria
2. ARI
3. Malnutrition
4. Onchoceriasis (River Blindness) and other Eye Conditions
5. Skin Diseasis
6. Leprosy/ Tuberculosis
7. Anaemia
8. Sexually Transmitted Infections
9. Hypertension
10. Psychosocial trauma

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[3] The population of Sierra Leone is now estimated between 6,000,000 and 7,000,000. For health planning we use an estimate of 6,732,698, based on the 1985 Census Figures and the Annual Growth Rate.

Principal Causes of Morbidity (illness) in the Under fives

1. Prematurity
2. Malaria
3. ARI
4. Infantile Diarrhoea
5. Malnutrition
6. Ophthalmic Neonatal
7. Worms
8. Skin diseases
9. Wounds
10. Measles

Most Important Epidemic Prone Diseases

1. Cholera
2. Measles (UNDERFIVES)
3. Meningitis
4. Lassa fever
5. HIV/AIDS

NUMBER AND DISTRIBUTION OF FUNCTIONING HOSPITALS AND PERIPHERAL HEALTH UNITS

	20	*02*	*2004*	*/5*
	HOSPITALS	**PHUS**	**HOSPITALS**	**PHUS**
Sierra Leone	**32**	**372**	**59**	**803**
Eastern Province	**3**	**67**	**12**	**210**
Kailahun	0	5	4	576
Kenema	3	52	6	91
Kono	0	10	2	62
Northern Province	**5**	**121**	**14**	**298**
Bombali	1	6	3	66
Kambia	0	20	2	36
Koinadugu	1	15	1	52
Port Loko	3	40	5	75
Tonkolili	0	40	3	69
Southern Province	**5**	**149**	**10**	**258**
Bo	1	50	3	82
Bonthe	2	18	3	34
Moyamba	1	51	3	95
Pujehun	1	30	1	47
Western Area	**19**	**35**	**23**	**37**

HEALTH SERVICE UTILIZATION RATES

	EST 2002	**EST 2004**
Percentage of Births attended by trained health personnel	41,7%	43,0%
Percentage of women (15-49) who attended Antenatal Clinic at least once	68,9%	65%
Percentage of women using modern contraceptive methods	3,9%	5,0%
DPT immunisation coverage (12-23 months)	**55,5%**	**59%**
Measles immunisation coverage (12-23 months)	**51,7%**	**53%**
Polio immunisation coverage	**61,2%**	**60%**
Percentage of under fives children with Malria treated with anti malarial drugs	60,9%	65%

HUMAN RESOURCES (KEY PERSONNEL)

	ESTIMATES 2002	***ESTIMATES 2004/5***
Doctors	300	118
Professional Nurses & Mid/wives	606	1062
Environmental Health Officers	204	122
Community Health Officers	284	132
Lab Technicians	40	46
Lab Technologists	7	6
Pharmacists	12	13
Dispensers/Druggists	110	117
Radiographers	12	8
Nutritionists	12	4

Number of NGOs Active in the Health Sector 123

Sources:
The above information was compiled from various sources including:

Ministry of Health and Sanitation Planning and Information Office data
Multi-Indicator Cluster Survey 2
PHC Operational Handbook

Appendix 2 Documents consulted

- Chasletter, volume 26 no 1 June 2006 edited by CHASL
- Christian Health Association of Sierra Leone (CHASL) – ANNUAL REPORT 2005
- Focus for Effectiveness (BCSL Strategic Plan 2006 – 2010)
- Poverty Reduction Strategy, Plan for action of the Norwegian Ministry of Foreign Affairs (from the Ministries web site)
- Poverty Reduction Strategy Paper Sierra Leone (from World Bank web site)
- Report of the Church Ministries Departement to the 32rd Annual Convention (…) 24th-27th January2006. Baptist Convention Sierra Leone
- Report of the Coordinator of Social Ministries (to the Annual Convention 24-27.01.06)
- Reproductive Health Division – PCM Hospital
- ***Safe Motherhood Data for Port Loko District***
- Sierra Leone Government – Ministry of Health and Sanitation – Updated Information Sheet – May 2005
- Sierra Leone – Wikipedia, the free encyclopedia http://en.wikipedia.org/wiki/Sierra_Leone 15.06.2006
- The Constitution and Bylaws of the Baptist Convention (Sierra Leone) Revised Constitution 2003

Appendix 3

Program and name of participants in meetings

Date/hour	**Place/name of participants**
June 12	Travel from Oslo to Freetown. Met at the heliport by Hans Oosterloo at 1800
June 13	Team members present: Lise Kyllingstad, Kåre Lode, Julie Sesay
0950- 1040	***Talking with the Secretary General of BCSL***, information and introduction to the main office Solomon Kambell, Secretary General BCSL
1530- 1715	***Women's Union Executive Committee*** Discussion on the projects, mainly the reproductive health project Linda Koroma, President of Women's Union Executive Committee Julie Sesay, Vice-president of Women's Union Executive Committee Josephine Sisey, missionary, resource person Aicha Oosterloo, member of Women's Union Executive Committee Hanna Dixie, member of Women's Union Executive Committee Aisata Kamara, member of Finance Committee Jane S. Conteh, resource person
1900- 2010	***Representative of EBM*** (Lise Kyllingstad and Kåre Lode only) General conversation about the projects and formal relations Hans Oosterloo, representative of EBM Aicha Oosterloo
June 14	Team members present: Lise Kyllingstad, Kåre Lode, Julie Sesay, James Kamara
1100- 1140	***Christian Health Association of Sierra Leone (CHASL)*** General information about the projects and the role of CHASL Mrs. Marion Morgan, Executive Director of CHASL
1145- 1210	***Christian Council of Sierra Leone (CCSL)*** Information about the projects and the role of CCSL Mr. Sahr Kemoh Salia, General Secretary
1225- 1310	***Director General of Medical Services*** Information about the reproductive health project and the policy of the government Dr. Noah Conteh
1515- 1555	***Direction for Midwifery and Reproductive Health*** Information about the reproductive health project and about the need for follow-up training for various categories of midwives. Mme Makalay Mansaray, Senior Public Health Sister Rugiate Karil, Senior Coordinator EmOc Sebora Kamara, World Health Organisation, Manager
1600- 1640	***School of Midwifery*** Information about the reproductive health project and about formalities for acknowledgment of documents for Anne. Christiana Williams, Acting Principal National School of Midwives, christianabwilliams@yahoo.co.uk tlf +232-76762869 Sebora Kamara, World Health Organisation, Manager
June 15	Team members present: Lise Kyllingstad, Kåre Lode, James Kamara
1000- 1010	**Conversation about the church and the war** (Lise Kyllingstad and Kåre Lode only) K.S. Kamara, treasurer of BCSL
1030-	***Meeting with Board of Social Services***

1145	Presentation of projects and purpose of the visit. Discussion on formalities. Solomon E. Kampbell, Secretary General BCSL Tannie Barbington Johnson, President BCSL Aiah Teddy M'bayo, member Hope Baptist Church Mohamed Mansoray, church ministries coordinator Sebora Kamara, World Health Organisation, member of board of Social Services K.S. Kamara, treasurer BCSL
June 16	Team members present: Lise Kyllingstad, Kåre Lode, James Kamara, Mohamed Monsoray
0700- 1000	Travel from Freetown to Lunsar
1100- 1220	***General presentation in the church of Lunsar*** of team members, purpose for visit and brief presentation of program. Meeting chaired by Rev. Umaru Sankoh. Greeting from the BCSL in Lunsar by Madame N'yillah Koroma, Vice-President of LBWA. Attendance mainly local church leaders and leadership in women's union. 24 participants, of whom 13 women
1330- 1430	***Project team*** Revision of local program, focus on priorities
1435- 1525	***Baptist Eye Hospital, Lunsar (BEHL)*** Short presentation of purpose of visit, informing that the BEHL will not benefit directly from the project, followed by a visit of facilities. Present: Samuel M. Coker, Cataract Surgeon Isatu E. Sesay, Cataract Surgeon and Surgeon in charge Alfred A. Kamara, Ward Supervisor/SECHN Paul Kabia, chasier/dispenser Paul Lamin Kamara, Drop making technical Lamin Y Kamara, Ibianou Saidu, book keeper Agnes Isatu Kamara, Ward nurse Teudoe Sesay, Ward Cleaner Abu Tuary, Security Ibrahim Bangura, compound cleaner Hassan Borbor Bangura, Theatre assistant/cleaner John Dean Sankoh, Theatre supervisor Amidu Katina, Outpatient evangelist
June 17	Team members present: Lise Kyllingstad, Kåre Lode, James Kamara, Alfred A. Kamara, Mohamed Monsoray
1000- 1100	***Hospital in Port*** *Loko* (Mohamed Monsoray was busy making appointments for three other persons in Port Loko) Short presentation of the purpose of the visit and conversation about the problems in the public health sector in general and in Port Loko health district in particular. Dr. J. Kargo-Labour, District medical officer (DMO)
1205- 1225	***Planned Parenthood Association Sierra Leone (PPASL)*** The activities are finished. A former employee told us about her experiences Aminata Cecilia Kargbo, Fieldwork supervisor
1420- 1500	***Nokoba Health Centre*** (Kåre Lode absent)
	The nurse in charge explained the community training in sanitation and environment Osman Kamara

1520- 1550	***Paramount chiefs*** (Mohamed Monsoray absent) Information of purpose of project and the paramount chief committed himself to do what he could in order to facilitate the work. Paramount Chief Kobbo Queen the second Chiefdom speaker, Pa Alhadie Lamin Kabia Pa Kapri Lawyer Kanu Rev. Dr. J. S. Mans
1700- 1840	***Baptist Convention Women's Union of Lunsar*** (Mohamed Monsoray absent) Presentation of purpose for visit and presentation of participants followed by group discussions about the preferences of the women. Isatu G. Sesay, Secretary General of BCSLWU in Lunsar Yilla Korkoma, President of BCSLWU in Lunsar Elisabeth Sankom , Vice-president of BCSLWU in Lunsar Rugiatu Jusu, Treasurer of BCSLWU in Lunsar Aminata Kamara, Secretary of BCSLWU in Lunsar Esther Kamara, Deaconesse Fudia Kabba, President Ordinary members present: Adamsay Koronia, Fatmata Kamara, Kadiatu Koroma, Marie S. A. Kamara, Ramatu Fofana, Fatmata Kamara, Sayrah Turay, Adama Koroma, Rosaline Y. Bangura, Mariama P. Kamara, Sayrah Turay, Aminata Conteh, Margaret Kargbo, Fatmata T. Kamara, Mamusu Kamara, Namina Koroma, Ibiana M. Kanu, Mbalu Koroma, Salay Bangura, Sayldie Salima, Florence K. Bangura, Posseh Kamara, Marie A Kamara.
June 18	***Sunday – Free***
June 19	Team members present: Lise Kyllingstad, Kåre Lode, Julie Sesay, James Komara, Mohamed Monsoray
0830- 0950	Briefing and planning, revising the programme for the rest of the time in Lunsar, with all members of the team.
1000- 1135	***Lunsar Health Centre*** The Community Health Officer in Charge explained the activities in the reproductive health sector and Lise presented he idea of Anne working in relation of the centre. Sheku U. Koroma, Community Health Officer in Charge
1415- 1440	***Saint John of God, Catholic Hospital*** Presentation of purpose for visit. Anne is welcome to work with them. Br. Peter L. Dawoh, Hospital director
June 20	Team members present: Lise Kyllingstad, Kåre Lode, Julie Susay, James Kamara, Mohamed Monsoray
1610- 1630	***CHASL – Lunsar*** Presentation of purpose of visit and presentation of activities of CHASL. Israel Shaka Turay, Local community worker
June 22	Team members present: Lise Kyllingstad, Kåre Lode, Julie Sesay
0715- 0755	***Jordan Baptist Church in Gbom Limba*** (only Kåre Lode) Conversation about the youth and children in Gbom Limba with the pastor and teacher David S. Koroma
1000- 1025	***Child Protection Association*** The chairman of the organisation told us her story of helping of mainly the victims of the war. Josephine Isatu Conteh, qualified nurse
1030-	***Community of Women's Groups in Lunsar***

1155	The women were invited to present their activities. This took most of the time. Then a short presentation of the reason for our visit followed. Fatmata Konteh Kabia, leader of Trod Barka Women's Association Fatmata Jalloh Fofanah, leader of Marampa women Agricultural Cooperative Kadiatu Sambais, leader of Talapso Association Cyillah Komorah, leader of Lundsar Baptist women's Association Josephine Isatu Conteh, leader of Child Protection Association Fatmata Bangura, leader of Alarampa women's Association Other members present: Fudia Kabba, Amie Kamang, Kadiatu Kamara, Maria S.A. Kamara, Kobassay Sankoh, Isatu Koroma, Yaboom K Cobankay, Elisabeth Sankoh, Mariama T. Bangura, Marie Conteh, Augusta I. Kamara, Kadie Thomay, Kadiatu Umaro, Marie K. Bangura, Isatu Kargbo, Fatmata Kamara, Ramatu Bangura, Julliet Manah, Mariama Kamara, Mabinty Konteh, Mariatu Kobankay, Matinty Sone Ibrahim, Isatu Kobankay, Memuta Kamara, Fatmata Kobala, Kadiatu Sesay, Abie Sankoh, Fatmata Sankoh, Alama Kabia, Abalu Bangura, Zainab Sesay, Marie P. Kamara, Kadia Tarawallie, Isatu Koroma, Ramatulia Jalloh.
June 23	Team members present: Lise Kyllingstad, Kåre Lode, Julie Susay, James Kamara, Mohamed Monsoray
1420-1650	***Final meeting of project team*** Elaborating the conclusions
June 24	Team members present: Lise Kyllingstad, Kåre Lode, Julie Susay, James Kamara, Mohamed Monsoray
1015-1230	***Debriefing meeting with the church's leadership*** Debriefing, discussion about the conclusions and the terms of cooperation Solomon E. Kampbell, Secretary General BCSL Tannie Barbington Johnson, President BCSL

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