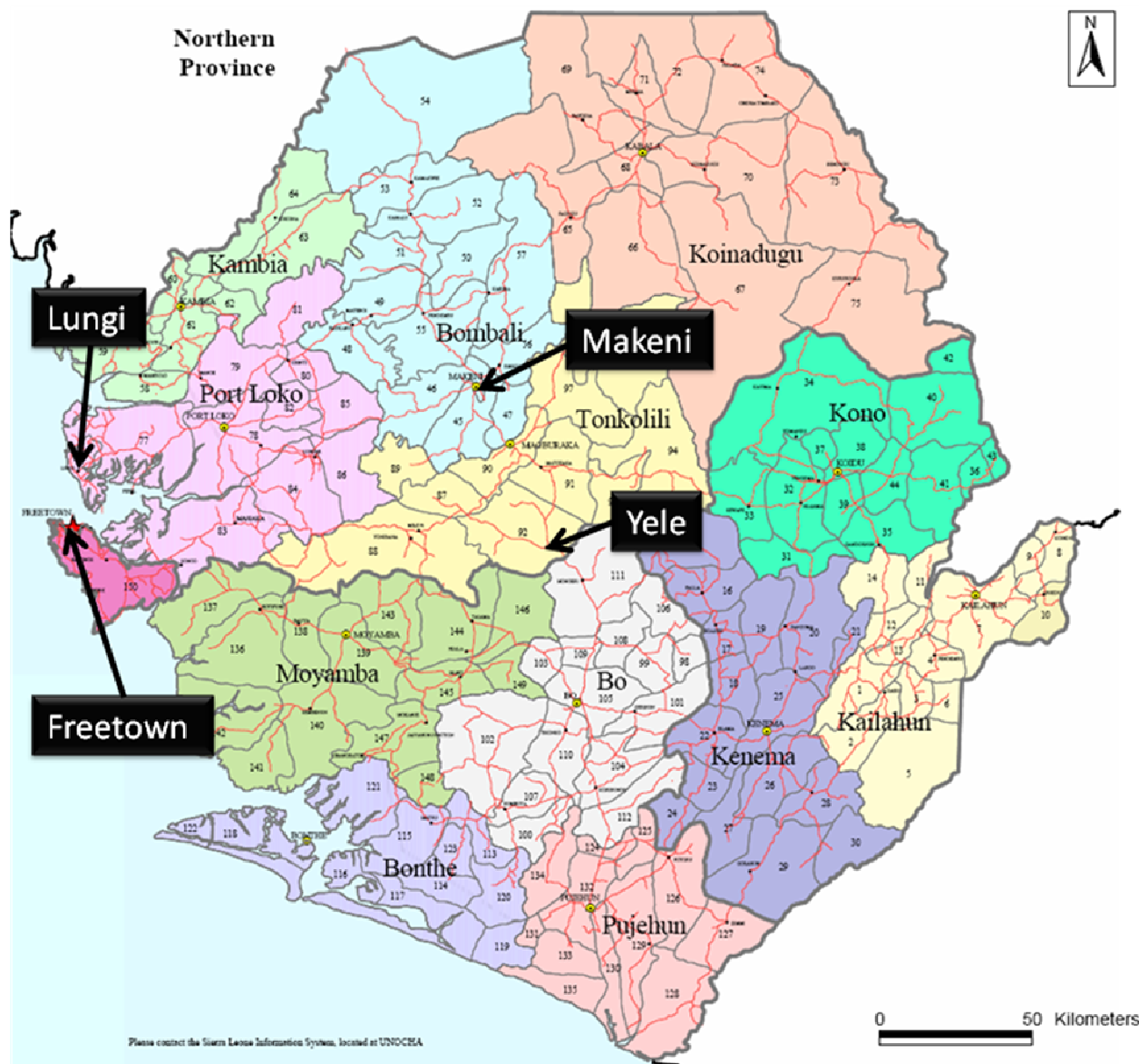


**Annual Report  
Lion Heart Foundation**

**2008**



## **The ambitions and core values of the Lion Heart Foundation:**

*We work on the sustainable development of health care, economical activities and knowledge transfer in Sierra Leone, with the aim to support the local population as well as the local economy in developing themselves. Our mission will be fulfilled when over time we will make ourselves redundant.*

### **The Lion Heart Foundation stands for:**

#### **Open and trustworthy**

Transparency and openness towards each other and the world around us form the basis for trust, a responsibility we are acutely aware of and which drives our actions.

#### **Passionate and involved**

The success of the LHF is dependent on the cooperation with each other and the collaboration with our local partners and the population of Sierra Leone. This solidarity drives each, energetically and passionately, to bear responsibility for the final results. What we do we want to do well. We respect the differences in background, culture and interests, stick out our necks, improvise, come up with unusual solutions and are entrepreneurial. It is this combination that makes us unique, and we are proud of that.

#### **Enterprising and delivering**

LHF is living proof that entrepreneurship and foreign aid (Best of Both Worlds) go well together. It is this inspired and creative entrepreneurship that has brought the LHF to where we find ourselves.

#### **Sustainable and realistic**

The belief in a better world starts with ourselves and the contribution we can make as a team. This is our firm belief, and we live up to that on a daily basis through our pragmatic approach – which is delivering. We share the sum of our extensive experience and passion with the population of Sierra Leone, as only a sustained development of medical care, education and economical activity will help the local population in escaping the poverty trap in which they find themselves.

#### **Millennium Development Goals**

Through the Best of Both Worlds program, the LHF contributes to achieving the following Millennium Development Goals (<http://www.un.org/millenniumgoals/>):

- MDG1: eradicate extreme poverty and hunger
- MDG2: achieve universal primary education
- MDG3: promote gender equality and empower women
- MDG4: reduce child mortality
- MDG5: improve maternal health
- MDG6: combat HIV/Aids, malaria and other diseases
- MDG7: ensure environmental sustainability

## 1 PREFACE

With a certain degree of pride I hereby present you with the third Lion Heart foundation annual report. By all measures 2008 has been a busy year, and this annual report provides you with an overview of all the activities, the financial overview as well as the plans for 2009 and beyond. Within the short span of three years both of the hospitals supported by the LHF have grown into professional organizations. In spite of the existing limitations, the number of treatments has risen sharply, the TFC has become the largest and most effective paediatric ward in the country and the quality of the medical care has improved. Many ambitions remain and there is still some way to go, yet if we can maintain the growth in patient numbers and quality, the efforts from both staff and sponsors will undoubtedly result in a lasting improvement of the healthcare in this country, which continues to have the highest mother- and infant-mortality rates in the world.



Major steps were made in the Best of Both Worlds programme, which was started in 2007. This programme aims to create employment, whilst becoming a sustainable source of income for the hospitals and schools in the region. Last May the palm oil press in Yele was started up, the first large press in the country: it receives fruit from some 1,500 local farmers! In addressing and improving employment, health care and education in such manner, a contribution is made towards establishing and securing the essential fundamentals of a society.

I owe a debt of gratitude to all staff members, volunteers, interested parties and sponsors for their enormous contribution to our projects. I am extremely proud of our team, which has worked in great harmony and has gone to great lengths. It is my sincere wish they all stay with our projects for a long time to come! We hope we can continue to rely on our sponsors until such time that the various projects start generating sufficient income to sustain themselves. The grant awarded by the Dutch Ministry of Foreign Affairs strengthens our conviction that the LHF is innovative and effective in its attempts to support the people of Sierra Leone escape from the poverty trap. Every Euro has been spent well and can be accounted for. We take great care to protect your confidence.

Passion, enthusiasm and professionalism are our essential characteristics. We start 2009 with confidence and zest.

Fred Nederlof  
Chairman

A handwritten signature in black ink, appearing to be 'Fred Nederlof'. The signature is stylized and written in a cursive-like font.

## 2 ACTIVITIES IN THE NETHERLANDS

### 2.1 Recommending Committee

The Lion Heart Foundation wishes to express its gratitude for the support it receives from its Recommending Committee, which consists of:

Mr Frits Bolkestein      Former European Commissioner for the internal market, taxation and the customs union

Mr Ivo Opstelten      Former Mayor of Rotterdam

Mrs Willemijn Verloop      Director War Child The Netherlands

### 2.2 Working visit Mr Frits Bolkestein

Upon his return from a 5-day working visit to Sierra Leone in September 2008, Mr Frits Bolkestein characterized the LHF projects as: "...an extraordinary and effective combination of activities that make a sustainable contribution to the realization of selected Millennium Development Goals in a country that currently has the highest child mortality rate. That is why I support the Lion Heart Foundation, and warmly recommend its activities. Through its Best of Both Worlds program, the LHF is committing itself to the development of healthcare, education and economical activity in Sierra Leone, one of the poorest countries in the world."



### 2.3 Fundraising

Many fundraising activities were run in 2008, the following were the most notable:

#### 2.3.1 Geldermalsen

This series of fundraising activities has been running in the wider Geldermalsen community, and is centred around the role that Mr Don Keus is playing as General Manager LHF in Sierra Leone. Mr Keus is a resident of Geldermalsen.



#### 2.3.2 LiINK membership drive

As part of its drive for new members, Dutch TV channel LiINK ran a video clip competition for charities. LHF finished 4th out of 150 competitors thus winning a

small prize.

### 2.3.3 Schokland-fund

This once-off fund was set up by the Dutch Government to support the realization of the Millennium Development Goals by 2015. In December 2008, Development Minister Koenders awarded the LHF a grant from this fund to the amount of € 2.1m.

## 2.4 Staff

### 2.4.1 Office Staff, The Netherlands

The following staff runs the office in The Netherlands:

Mr Fred Nederlof	- Founder and Chairman LHF
Mrs Simone Scholtz	- HR
Mrs Martine de Graaff	- HR
Mrs Pien Bax-Engelsman	- Office Manager
Mrs Caroline van de Graaf-Scheffer	- Fundraising & sponsor management

### 2.4.2 Expatriate staff



Although local staff is being developed, the need for external know-how remains high and thus the number of expatriate staff has risen again.

### 2.4.3 Nurses

The nursing team was expanded with the arrival of Mrs Margot Rozemeijer, wife of Mr Johan Luijting, controller at the MCH.

### 2.4.4 General Manager Magbenteh Community Hospital (MCH)

Mr Don Keus was appointed General Manager MCH for the period February 2007 – June 2008. During this period Mr Keus has implemented the organizational structure, managed the various LHF projects and maintained contact with the various local stakeholders. As of June, Mr Toine van Moorsel has taken over as General Manager. Previously Mr van Moorsel was the financial comptroller at MCH, and he currently combines the job of General Manager with that of LHF Treasurer.



## 2.4.5 Tropical Doctors

With the arrival of Mrs Karin Feddes, the MCH now has 4 tropical doctors.

## 2.4.6 Midwife

The inauguration of the MCH obstetrics ward marked the arrival of the first midwife, Mrs Kimberley van Hulst from The Netherlands. Kimberley was instrumental in further developing the ward and training the local midwives. Early September Mrs Zoë Vowles, an English midwife who joined via Voluntary Services Overseas, succeeded her.

## 2.4.7 Physiotherapy

Mrs Annelies Wolterink, the first physiotherapist posted to the MCH, arrived in the course of 2008. Mrs Ellenoor Vegter succeeded her after 6 months.

## 2.4.8 Controller

Throughout the better part of 2008, Mr Johan Luijting acted as the financial controller.

## 2.5 Project Postings

During 2008 a large number of volunteers were posted for short-term projects again. One of those, Mr Jan Meijer, has been closely involved since early 2007. He has been instrumental in getting running water in the Lungi hospital, has contributed to the construction of the palm oil press and has managed the roofing of the Lungi hospital. The LHF also extends its gratitude to Mr Guus Blaak, specialist in tropical crops, without whom the palm oil press and the associated farmers project in Yele would not have been possible. Mike Henderson also made a long-lasting contribution to the construction and start-up of the palm oil press.

## 2.6 Cooperation and Exchange Programme

### 2.6.1 Cooperation and Exchange Programme with Universities



Universiteit Antwerpen.

2008 marked the first internships for medical students, Ms Gerdien Kramer and Ms Rebecca Kowalczyk from the Vrije Universiteit Amsterdam undertook an 8-week internship at the MCH. In view of the positive response from the university, the LHF has requested it to consider a structural cooperation. These first internships were followed by internships by Ms Melanie Cook and Ms Freja Haak, both from the



The AfricAlive team, consisting of students from the Delft University of Technology, published a book on their expedition to various sustainable projects in Africa. The proceeds from the book will be donated to the LHF.

The students from the Delft University of Technology Expedition Sustainable Sierra Leone have continued to support the upcoming rehabilitation of the small-scale hydroelectric power station in Yele.

### 2.6.2 Cooperation with Yacht

Yacht, a leading player in secondment of interim managers and professionals, has been supporting the LHF since 2006 with both financial and human resources. During 2008, Yacht facilitated a marketing & communication workshop. Furthermore, Mr Jan Hendrik Ockels (CEO Yacht) and his wife Kathinka Peels (cardiologist) visited the LHF projects, and a group of consultants visited Yele to conduct a feasibility study on overhauling the hydroelectric power station.

### 2.7 Container Shipments

In 2008, the LHF shipped four 40ft containers and one 20ft container to Sierra Leone. The cargo consisted of various loads, such as solar panels, medication, roofing and fertilizer.

Various sponsors have enabled these containers to be shipped against reduced rates. As in previous years, the containers remained in Sierra Leone to serve as workplace or storage facility for the LHF projects.





### 3. ACTIVITIES IN SIERRA LEONE

#### 3.1 Magbenteh Community Hospital (MCH)

The Magbenteh Community Hospital (MCH) has a total capacity of 95 beds, distributed as follows:

- men's ward 24 beds,
- female ward 26 beds,
- paediatric ward 28 beds, and
- obstetric ward 17 beds.

Following a period of preparation, the obstetric ward has now been operational since April 1<sup>st</sup>.



Following a renovation and expansion of the existing Therapeutic Feeding Centre (TFC), the new TFC was inaugurated in June. Meeting the UNICEF-set criteria for hosting and treating mother and child, its new capacity is 120 beds.

As a result the MCH has grown into one of the largest and more advanced health- and training-centres in Sierra Leone.

The hospital disposes of 2 operating rooms, an outpatient clinic, a basic laboratory, a small x-ray department, a pharmacy and two warehouses - one of which also acts as UNICEF distribution centre for the Northern provinces. The hospital grounds cover more than 6 hectare and allows for future expansions and renovations. The grounds currently include a small compound with a 6-room guesthouse and 4 modest houses for expatriate staff on long-term postings.

During 2008 construction for the solar panel and water projects was kicked off. Once completed in 2009, these projects will cover a large part of the daily demand for electricity and clean running water.

## 3.2 Therapeutic Feeding Centre (TFC)

The TFC admits malnourished children and their mothers for a 6-week convalescence program.

### 3.2.1 Inauguration TFC



The new TFC is the result of a tremendous effort by staff, volunteers and three substantial sponsors. On June 17<sup>th</sup> deputy Minister of Health S.T. Koroma and the UNICEF Country Representative Mr Geert Cappelaere inaugurated it. The new TFC disposes of 3 wards with a total of 120 beds, an office, a store, an under-5 clinic, consulting rooms and a classroom.

### 3.2.2 Under-Five Clinic

With the TFC now up and running, all outpatient treatment for the under-five patients has been moved to the TFC. As the under-five clinic does not yet have preventive treatment such as vaccination, the need for such treatment will be evaluated in the coming year. It should be noted that the Government runs the vaccination program.



### 3.2.3 Innovation of the Medical Care

To speed up the recovery of the children, they are screened upon admission. Seriously ill children are first treated in the stabilisation ward for a few days, where they are fed and treated for diseases and infections. Those that have no further complications upon admission are immediately moved into the 'growth phase', where they get fed calorie-rich food to gain weight.

Serious malnutrition often occurs in families with many small children; mothers breastfeed the youngest baby whilst the other children don't get enough food or get fed unsuitable food. That is why the TFC now offers contraception to all mothers. A dedicated family-planning clinic has been opened within the TFC, where free consults and medicine is dispensed to patients as well as external visitors.

As malnourished children often show a lag in development, play therapy forms an essential element of the overall treatment. The LHF is very fortunate to have a volunteer specialised in the development of young children who is supporting the implementation of play therapy. Financial sponsoring will be looked for to continue this throughout 2009.

### 3.2.4 Results

The TFC has seen an impressive rise in admissions: 2008 saw a total of 922 children admitted vs a total of 307 children in 2007.

Peaks were seen in the period from July to September. Traditionally this period is called the 'hunger season': the new crops have yet to be harvested whilst the previous stocks are running out. For many this affects the certainty of a daily meal.

The results are encouraging: more than 90% of the admitted children recover and the mortality rate hovers around 8%. Unfortunately not all parents stay for the full treatment period. Approximately 15% leaves when their child has recovered considerably but has not yet reached the desired weight, thus increasing the risk for regression.



**Marca before and after treatment**

### 3.2.5 Community Outreach Programme

Many malnourished children reach the TFC too late, if they reach it at all. The main reasons are the unfamiliarity with the existence of the TFC and the inability for parents to transport their child.

This leads to a series of trial visits to the various peripheral health units (PHU's) in the district, and culminated in setting up a community outreach programme to allow early location of malnourished children. The community outreach programme now covers a total of 13 PHU's and the smaller villages surrounding each of these. Two full-time staff visit the PHU's once or twice a month to screen children for malnutrition and to train local staff.



Malnourished or seriously ill children are admitted to the TFC.



Research by the World Health Organization, UNICEF and other organizations indicates that for children without further medical complications, malnutrition can be treated at home. In co-operation with the authorities, the TFC is intending to start home treatment in at least three of the 13 PHU's. As part of the preparations, the Magbenteh Community Hospital and TFC have

trained up 13 local nurses in malnutrition home treatment.

### 3.3 Statistics

2008 has shown a substantial rise in the number of treated patients:

- The number of outpatients more than doubled to a total of 12,000 patients (12,411 in 2008 vs 5,884 in 2007).
- The expectation is that this number will grow to 15,000 in 2009.
- The largest growth was seen in the under-5 group - 5,408 patients in 2008 vs 756 in 2007. The free treatment being the main reason for the growth in numbers.

The rise in the number of patients has resulted in a rise in the number of laboratory tests and x-rays:

- Some 27,000 laboratory tests were performed for a total of 9,000 patients vs 17,500 laboratory tests for 4,500 patients in 2007.
- The most common laboratory test is the malaria-slide, followed by blood tests (Hb & leukocyte count), urine sampling and stools sampling.
- Some 1,000 x-rays taken were taken for a total of 900 patients.

Admissions doubled in comparison to 2007. For a large part this is due to the large number of admitted under-5 patients:

- Total number of admissions was 2,537 vs 1274 in 2007.
- Number of under-5 admissions was 1,053 vs 242 in 2007.
- The average admission period was 9 days, which leads to an occupancy rate of 72%.

#### 3.3.1 Surgery

A total of 739 operations were carried out vs approximately 500 in 2007.

- Most common operation is groin rupture (208).
- A total of 86 abdominal operations were carried out.
- A growing number of caesareans have been performed following the opening of the obstetrics ward (42 in the period April to December).



### 3.3.2 Obstetrics

With approximately 100 deliveries in the period April to December, the statistics show an increase in the number of deliveries.

- 50% of these were normal deliveries.
- 44% of these were through a caesarean.
- 6% of these were vacuum deliveries.

As the majority of the pregnant women is brought in whilst already in labour, unfortunately some 40% of the babies die before, during or right after the delivery.

### 3.3.3 Morbidity & Mortality

The most common diseases were:

- Malaria
  - 25% of the diagnoses for over-5 patients;
  - 49% of the diagnoses for under-5 patients.
- Bronchial infections
  - 6% of the diagnoses for over-5 patients;
  - 25% of the diagnoses for under-5 patients.

Other common diseases, particularly in the over-5 patients group, are:

- Venereal diseases (11 %);
- Gastric disorders (9 %);
- Urinary tract infections (8 %); and
- Typhoid fever (6 %).

The mortality rate over 2008 increased from 7.12 % to 11.72 %. The most probable cause for this is the rise in the number of under-5 patients admitted. As a rule the mortality in this group tends to be higher in this part of the world.

- Mortality under-5's: 14.15 % vs 14.35 % in 2007.
- Mortality over-5's: 10 % vs 5.5 % in 2007.
- The cause for the significant rise in over-5 patients mortality is not yet clear.
- What is clear is that in many cases, the deceased are late cases.
- Further analysis has indicated that more than 60 % of those who die in the MCH, do so within 48 hrs of being admitted.

### 3.4 Opening Obstetric Ward



Following a period of thorough preparation, the obstetric ward was opened on April 1<sup>st</sup>. The first couple of months were difficult as most patients only come to the hospital when all other options, such as local healers, have failed. This means that in many cases the baby cannot be saved and the MCH

staff are left with trying to rescue the mother.

To address this, the MCH started up a Ante Natal Care Clinic in October. The objective is to get women to visit the hospital much earlier in their pregnancy, and have them deliver in the MCH when potential complications are suspected. In the short period since then we have already seen a slight increase in the number of normal deliveries without complications. We hope this trend will continue.

### 3.5 Price List

Early 2008 a price list was drawn up listing the rates for medical care. It was reviewed and updated mid-year. The following basic assumptions apply:

- Emergencies will always be treated, even when the patient has no means to pay the bill.
- Care for under-5's is free of charge.
- Patients get charged for outpatient services (e.g. lab, X-ray, medication).
- Patients get charged a fixed fee per admission dependent on the diagnosis but independent of the treatment received.

### 3.6 Protocols

In February the first edition of medical protocols for the MCH was issued. Use of these protocols has resulted in a clear improvement of the quality of the medical care. The intention is to make these protocols subject to regular reviews and additions.

### 3.7 Quality Improvement Medication

2008 saw the introduction of an improved accounting system for all medication and medical supplies.

An important step is the cooperation with a new supplier, IDA, for all medication used in the MCH, which has not only resulted in cost savings but also in improved quality of the medication. IDA is a pharmaceutical non-profit organization from The Netherlands.

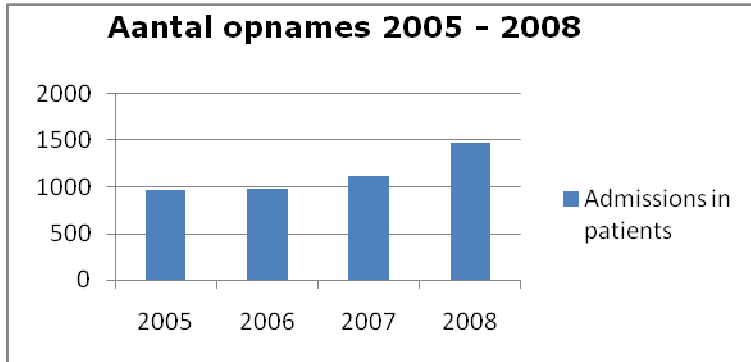
### 3.8 Cooperation with NGO's

As in previous years, the LHF has cooperated closely with the United Nations and various NGO's active in the region. Contact has been made with the UNFPA for the support of the obstetric ward and good progress was made in the cooperation with the World Food Programme and UNICEF. During 2008, the MCH hosted visits by various UNICEF delegations, such as Goodwill Ambassador David Beckham and UNICEF Executive Director Ann Veneman. The new warehouse, built with support from UNICEF, is being used as distribution centre for therapeutic foods for the Northern region of Sierra Leone. This gives the MCH a central role in fighting malnutrition in all surrounding provinces and sharing know-how and best practices with other NGO's. In August the MCH staff ran a malnutrition training session for War Child, which leads to referrals to the MCH in villages where War Child is active. The MCH has also built up a good cooperation with the local hospital in Masanga, approximately 1 ½ hrs driving from the MCH. Since the Masanga hospital does not always have the means to treat seriously malnourished children they refer these to the TFC.

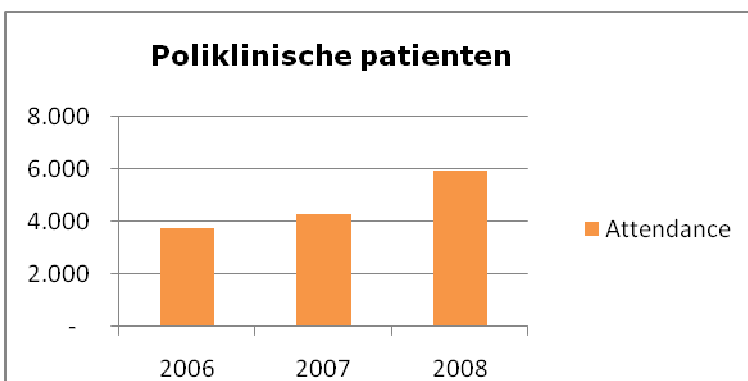


### 3.9 Bai Bureh Hospital

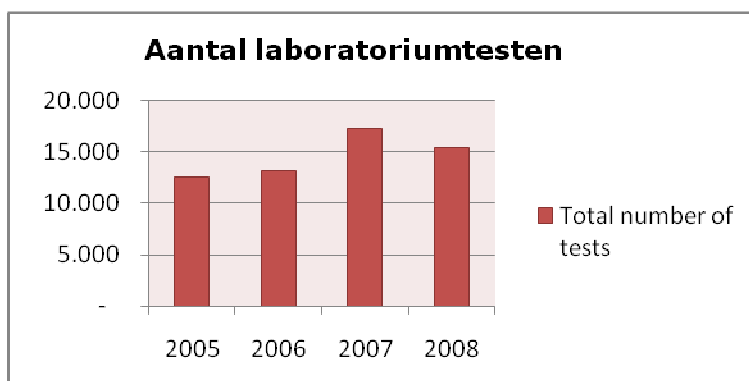
The Bai Bureh Hospital is located close to the Lungi international airport. It has a capacity of some 50 beds. The hospital is staffed with one medical doctor (Dr Hassan Sesay), who is supported by a medical assistant and a staff of 40 local employees.



- During 2008, some 1,480 patients were admitted to the Bai Bureh Hospital, an increase of 30% vs 2007.

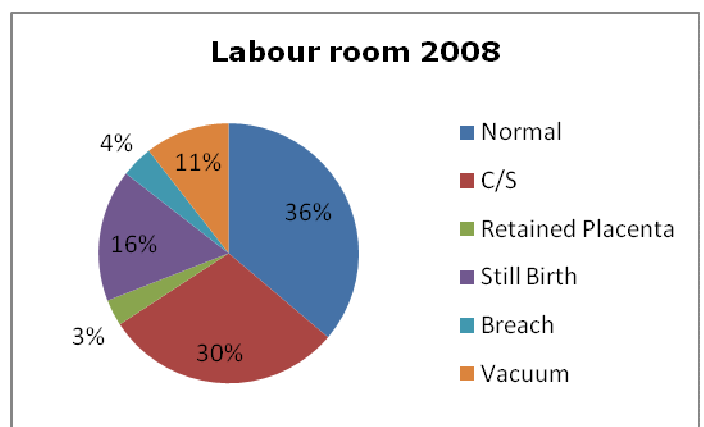
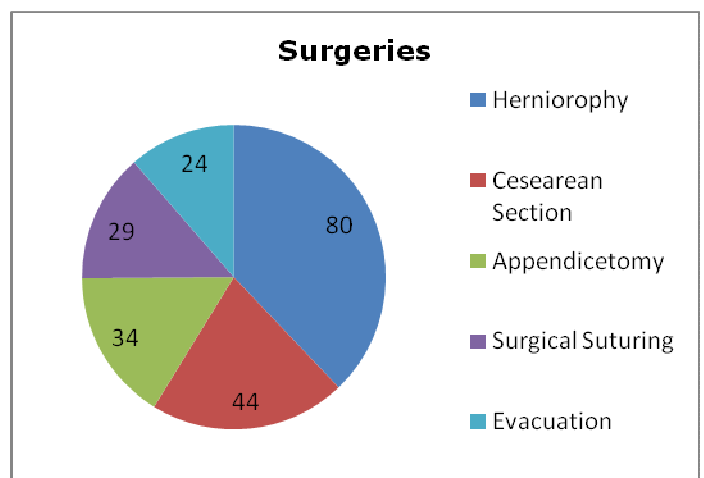
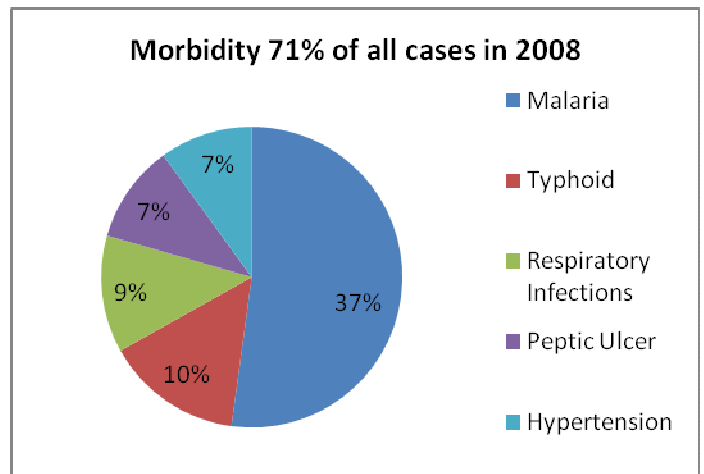


- Over the last three years, the number of ambulant patients increased from 3,780 to 5,941.
- A quarter of the patients is under the age of five.
- 45% of the patients is male, 55% is female.
- During 2008 some 15,000 laboratory tests were performed, which diagnosed 23 patients with tuberculosis.





- The main causes for treatment were:
  - Malaria 37%;
  - Typhoid 10%;
  - Bronchial infections 9%;
  - Gastric disorders 7%;
  - Hypertension 7%.
- A total of 276 patients underwent surgery.
- One third of the pregnancies ended with a caesarean. Some one on every seven infants is stillborn, primarily because many of the pregnant women are brought to the hospital too late.
- The building and the facilities are being renovated in phases. The phased renovation is dependent on financial resources becoming available.
  - In 2008 new roofing was installed under supervision of Mr Jan Meijer.
  - Cost of goods & materials have continued to increase, and exceeded the 2008 budget.
  - The costs for energy and maintenance exceeded the 2008 budget. This was caused by higher fuel prices and higher fuel consumption as a result of increased use of the diesel generator.
  - Staff costs for 2008 were 33% higher than budgeted for as a result of a general increase in salaries as well as an increase in staff numbers.
  - The hospital and the grounds are owned by the Kamara family, and are on a long-term lease until 2023.



## 4. BEST OF BOTH WORLDS PROGRAMME

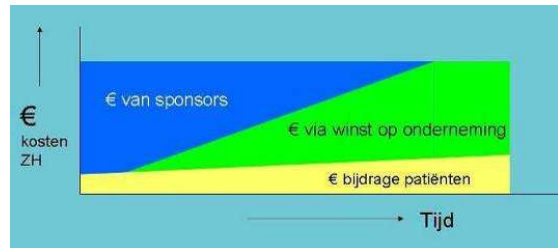
### 4.1 Introduction

In 2006, the LHF started preparations for the Best of Both Worlds programme. 2008 marked the start of the implementation.

The concepts underlying this ambitious programme is close cooperation with the local population and linking the development of economic activities with sustainable funding of welfare provisions such as health care and education.

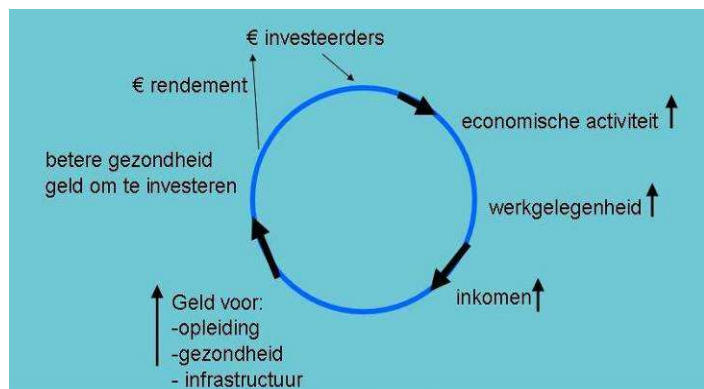
The Best of Both Worlds programme uses part of the profits made from commercial activities to support those social activities that cannot support themselves financially. As much as possible, this combination of activities will be implemented within the same geographical region to allow the local population to benefit from the results and thus stimulate further participation and eventual escape from the poverty trap.

Generally in developing countries, and in Sierra Leone in particular, health care and education cannot be funded from revenue alone. Partially as a result of the 10-year civil war, a large part of the population is penniless and cannot contribute enough to cover the operating costs. Most hospitals and schools are therefore structurally dependent on foreign sponsors to cover the substantial budget deficits. Through the creation of sustainable sources of revenue, the LHF hopes to contribute to resolving this problem.



### 4.2 Programme & Approach

Sierra Leone is a very fertile country with a large prospective agricultural area. Historically, Sierra Leone had many oil palm plantations, but due to the war many have not been tended for 20 years. Palm oil is still being produced, albeit on a small scale by local farmers using manual labour. This leads to a substantial loss of quantity and quality, whilst being very labour intensive.



Through the introduction of simple mechanisation, better varieties and improved agricultural management the average production per farmer will increase – a larger area can be tended and less palm oil is lost. It is expected that this will generate a higher income per family.



The new approach includes the structural financing of health care and education facilities in Sierra Leone through the start up of commercial projects. These projects must meet the following conditions:

- a good profit-earning capacity;
- a substantial size;
- offer investors an attractive ROI.

Following careful review of the feasibility and sustainability, the LHF has worked out business plans for a number of projects. Of these, one has successfully been implemented whilst two others are under preparation:

1. Palm oil press in Yele;
2. Rehabilitation Yele hydroelectric power station and setting up 30-40 micro-hydroelectric power stations;
3. Development of Lokomasama oil palm plantation.

These projects will result in:

- Sustainable economic development in the region;
- Create employment and improve the average income of the local population;
- Education and training of local farmers and local staff on the plantation;
- Improvement of palm oil quality and quantity for thousands of small oil palm plantations;
- Opening up of the region;
- Improvement of the health care;
- Development of social and economical infrastructure within the region.

### 4.3 Project 1: Palm Oil Press in Yele

Project 1 consists of 4 parts:

- Construction of a palm oil press;
- Support programme for local farmers;
- Development of a trial plantation and associated nurseries;
- Opening up of the region.

#### 4.3.1 Yele Palm Oil Press

Construction of the palm oil press started in 2007, and the press became operational in May 2008. It was inaugurated on November 14<sup>th</sup> 2008. In the rural area surrounding Yele, thousands of farmers tend small oil



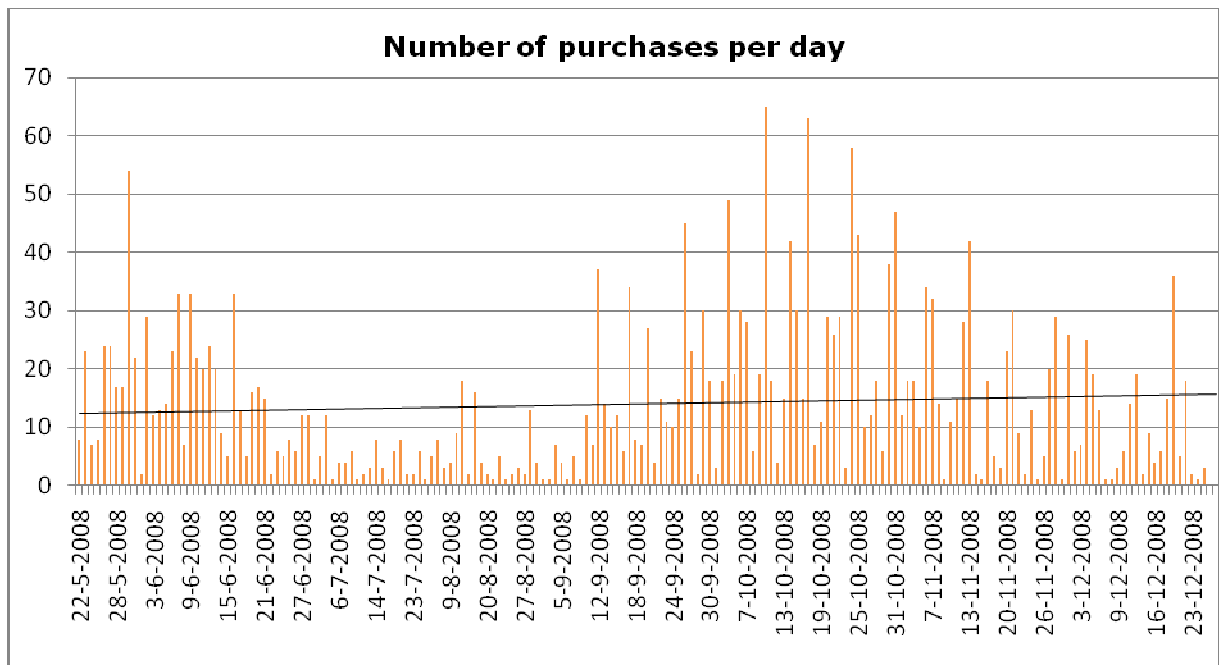
palm plantations (0.5 – 2 ha). They process the palm oil manually, as all palm oil presses were destroyed during the civil war. Hence most of the oil palm fruits cannot be processed in time, which results in lower palm oil yields and poorer quality. As a consequence, the farmers do not generate sufficient income and so cannot invest in the upkeep and expansion of their plantation, which leads to a further decrease of yield, quality and income. The economic development of the region has halted, as the local farmers do not have the ability to break out of this vicious circle.

The Yele palm oil press can process some 3 metric tonnes of fruit per hour, and

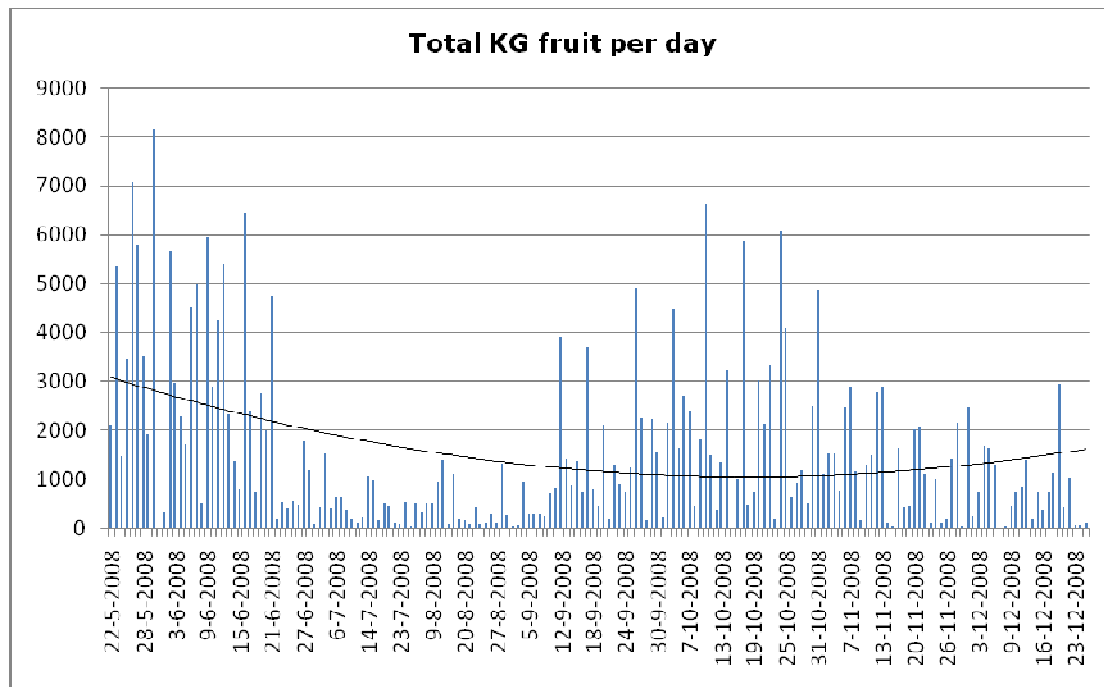


has a maximum palm oil output of some 5-6 metric tonnes per day. This makes it the biggest palm oil press currently operational in Sierra Leone. Besides palm oil, the press also produces soap and in 2009 small-scale production of bio-diesel will be started up. The palm oil press employs some 40 staff.

The palm oil press is owned and operated by Nedoil Ltd, a separate legal entity registered in Sierra Leone. The LHF is the major shareholder in Nedoil Ltd.



**Number of farmers that deliver fruit daily**



**Kilograms of fruit delivered daily**

### 4.3.2 Support Programme Local Farmers

The start-up of the palm oil press has stimulated the local farmers to look into improving and expanding their plantations. However, they lack the financial resources to do so. The results of a large survey conducted by the LHF amongst 3,000 farmers indicate the majority is looking for financial and technical support to improve their plantations.

The technical support required covers the provision of seedlings to replace inferior varieties and/or expand the plantations, the provision of tools and the delivery of specific training.

The LHF is looking for additional financial support to fund this support programme.

The programme will run for at least three years. Each year, farmers will receive some 60 new seedlings.

The intent of the programme is to break through the vicious circle by enabling farmers to generate more income. In turn this will result in more children going to school, improved healthcare, more food, improved infrastructure, etc.

The volume of oil palm fruits supplied to the palm oil press will increase resulting in more profits, which in turn will be used to finance the local hospital. In short: an opportunity for this region to escape the poverty trap and build a better future. The concept can simply be copied in other regions.

### 4.3.3 Nurseries and Trial Plantation

The main goals for the plantation project are improving the quality and quantity of palm oil produced and improving the management of the small plantations.

Most plantations grow the local Dura palm, which has a relatively low oil yield. As most farmers would like to replace this palm with higher yield varieties, the LHF has set up a plantation



with the Tenera palm (a cross breeding between the Dura and Pisifera varieties) to enable this. In a pre-nursery the seedlings are grown from seeds supplied by specialised research stations in Ghana, Honduras and Costa Rica.

In cooperation with a number of experienced oil palm experts a textbook has been developed to support the training of the local farmers. As it contains simple illustrations, the book can also be used to support the training of the relatively large number of illiterate farmers. In addition, advanced agricultural methods and technology will be introduced. Local surveyors have been hired to support the farmers on their plantations.

The intention is to run this part of the programme for at least three years. Each year, some 50,000 seedlings will be planted and distributed amongst the farmers. In total, this will add some 1,500 ha of agricultural area. If the project works out successfully, the continuation of the nurseries will be considered. However, in that case the farmers will have to start paying cost price for all materials and seedlings.

In 2009 a new trial plantation will be set up next to the palm oil press to cater for experiments with new varieties, optimal fertilisation and irrigation methods.

### 4.3.4 Opening Up of the Region

The success of the project is dependent on the construction and improvement of roads and bridges. This will allow delivery of the oil palm crop to the palm oil press by tractor or truck.

The opening up of the region will also be of benefit to the local population. The LHF is looking for additional funding to enable these essential infrastructure projects.

#### 4.4 Project 2: Rehabilitation Yele Hydroelectric Power Station

The Yele hydroelectric power station was put out of order during the civil war. At present people are dependent on diesel generators, which are too expensive for most of the population and small businesses. The diesel fuel, which is imported, is expensive, environmentally unfriendly and scarce around Yele. Therefore a small-scale bio-diesel production pilot was launched at the palm oil press to supply diesel for use within the LHF programmes.

With support from sponsors the power station could be renovated and provide electrical power to the village and immediate surroundings. The aspiration is to carry out the rehabilitation in 2009.

The capacity of the hydroelectric power station is relatively small, 2 x 250 kW. However this is sufficient to support the palm oil press, a water treatment facility, approximately 200 small enterprises, several schools and 500 households. The rehabilitation is not just important for Yele, but would serve as a pilot for the construction of similar power stations throughout the country. Many rivers have been identified where small power stations could be installed without negatively affecting the environment.

The exploitation is seen as the main challenge. To address this, the idea is to deliver electricity on the basis of pre-payment. Yele is seen as an ideal candidate to trial this approach. If successful, the approach could relatively quickly be rolled out to some 30-40 other sites, thus delivering sustainable electrical power to rural areas.

The LHF intends to participate in the exploitation of the Yele hydroelectric power station, and will use its share of any profits for the sustainable support of social services.

#### 4.5 Project 3: Development of Lokomasama Oil Palm Plantation

The purpose of this large project is to serve as example for similar projects in Sierra Leone and abroad. The oil palm plantations hold large potential for Sierra Leone and investors. As far as known, no similar initiatives are currently being planned.

The LHF plan calls for the Lokomasama plantation to grow to a size of 40,000 ha within 7 years. This will potentially create employment for 10,000 people, thus improving the quality of life of some 50,000 to 100,000 people. It is expected that the annual production will be some 150,000 tonnes of unrefined palm oil once the plantation reaches full growth.



### 4.5.1 Feasibility Study

In January 2008 the initial small-scale feasibility study was performed on an area of some 28,000 ha, the results of which were positive. It has therefore been decided to run a full feasibility study once funding for this becomes available, resulting in a bankable business plan.

This study will include a feasibility analysis for a 10MW power station, which will run on biomass and biogas left over after processing the palm fruit.

It is expected the health care in the region will get a boost, as the revenue generated by the Best of Both Worlds programme will supplement or even cover the operational costs of the LHF hospitals.

### 4.5.2 Environmental Effects

In contrast to the negative news coverage of oil palm plantations in Malaysia and Indonesia, the existing but untended oil palm plantations in Sierra Leone can be rehabilitated and developed without clearing rainforest or draining the soil. In fact, the oil palm originates from Sierra Leone.

The young trees will absorb more CO<sub>2</sub> than older trees.

The palm oil production process leaves no residual waste harmful to the environment.

### 4.6 Health Care and Education in Yele

Presently there is hardly any health care in the Yele region. The closest hospital is the LHF-adopted MCH in Makeni, which is too far.

Yele has a medical station with very limited and basic health care. The LHF is aspiring to man and supply this station, with the ultimate aim to have a small hospital in place within 5 to 7 years.

The operational costs of this will be covered from the revenue generated by the palm oil press.

The LHF already contributes to the improvement of the educational situation.

Many children do not attend school (anymore) as their families can no longer afford the school fees. Education in Sierra Leone is not free, and schools are fully dependant on fees and own contributions. The LHF believes that the future of Sierra Leone is dependant on the younger generations being educated.

For the last two years the LHF has supported the Junior Secondary School in Yele through the setting up of a school fund. Students qualify for support when their school fees cannot be borne



Students qualify for support when their school fees cannot be borne



by parents or family. Good results at the end of the year lead to fees being paid again for the following year.

It is the intention to next build contacts with the local universities in Sierra Leone. Internet facilities will be installed as soon as the hydroelectric power station is operational. In addition the school building will be renovated and equipped with better furniture.

There is a large desire to open up a Senior Secondary School. This will allow the children to complete their secondary schooling and obtain a certificate. In addition the setting up of a technical college is being looked into, as at present it is not possible to attend vocational training in this region.

The health care and education status in the Lokomasama region is equally poor. This region only has one, very poorly equipped, hospital in operation. Most schools are poorly equipped and of a low educational standard. Right from the start the oil palm project will allocate budget to support health care and education.

#### 4.7 Support

A major challenge in the realisation of commercial projects such as those described above is the total lack of infrastructural facilities such as: transport, roads, bridges and electricity. These facilities are essential to the success of projects. In principle the financing of such infrastructural facilities cannot be included in the business case for projects in view of the negative effect on the profitability, thus deterring potential investors. In general the government does not have the financial resources or has other priorities.

The LHF therefore appeals to other organizations (such as EU, the World Bank, NGO's and governments) to allocate resources within their existing programmes to address some of these essential infrastructural facilities that will enable further implementation of the Best of Both Worlds programme and delivery against a number of the Millennium Development Goals in one of the poorest countries of the world.

## 5. FINANCIAL OVERVIEW

### 5.1 Introduction

The following figures refer to the third financial year of the LHF, which was established on April 5<sup>th</sup> 2006.

All figures in between brackets refer to the previous financial year.

### 5.2 Income

Once again the sponsors have made substantial contributions to the financing of the operational costs and specific projects. In 2008 a total income of € 621.903 was received (2007: € 1,025,339).

In addition to this the LHF received sponsoring in kind, such as transport, containers, medication and dressing material. The total value of these, estimated at € 150,000; has not been entered in the financial overview.

### 5.3 Expenditure

- The LHF Board is unpaid, although the Chairman is active fulltime.
- Four employees are hired on a part-time basis.
- The office, including facilities such as telecoms and computers, has been made available by one of the sponsors free of charge.
- General costs cover the preliminary initial expenses, fund-raising, building and maintaining the website, etc.
- The LHF strives for minimal overhead. The 2008 overhead amounts to approximately 12% (2007: 14%).
- All administrative and financial procedures are being developed in line with CBF requirements, to allow for certification after 3 years.

## 5.4 Statement of Income and Expenditure

<b>Statement of Income and Expenditure 2008 and 2007</b>		<b>2008</b>		<b>2007</b>
<b>Income</b>		€		€
Gifts		<b>621.902</b>		<b>640.265</b>
<b>Expenditure</b>		€		€
Salaries	11,0 %	112.206	9,2 %	81.877
Office costs	0,6 %	6.457	0,4 %	3.645
Marketing & Communication	0,4 %	3.942	0,4 %	3.166
General costs	0,1 %	728	3,9 %	38.786
Travel costs medical teams	2,4 %	24.273	3,9 %	35.187
Staff members in Sierra Leone	23,8 %	243.093	21,2 %	189.540
Gifts for investment	11,7 %	119.300	24,4 %	217.809
Gifts to cover operational costs	50,1 %	511.896	36,2 %	323.777
Provisions for projects 2008 / 2007		-399.994		133.237
<b>Total Expenditure</b>		<b>621.903</b>		<b>1.025.339</b>

During 2008, the LHF and its sister organization SSLDF had several employees in Sierra Leone.

The wages for expatriate staff are based on PSO norms, and include travel and accommodation costs.

## 5.5 Balance Sheet

<b>Balance as of 31-12-2008</b>					
	<b>2008</b>	<b>2007</b>		<b>2008</b>	<b>2007</b>
<b>Assets</b>	<b>€</b>	<b>€</b>	<b>Liabilities</b>	<b>€</b>	<b>€</b>
Nedoil	0	-	Reservation gifts 2009 and 2008	58.808	435.431
Bank	54.860	319.053	Accounts payable	2.288	-
			Short-term obligations		10.384
			Other liabilities	4.187	-
Running account	32.419	126.762	Running account	21.996	-
<b>Total</b>	<b>87.279</b>	<b>445.815</b>		<b>87.279</b>	<b>445.815</b>

Explanation Notes Receivable: In April 2008 the LHF submitted an application for financial aid to support 7 projects. The total budget required to enable these projects for the first 5 years is € 5,283,779. It is expected that some 60% of this (€ 3,170,267) will be covered through gifts and partners. To our great joy the application was granted, and will cover 40% (€ 2.113.512) of the total project costs over the period from July 2008 through to December 2012.

## 6 PLANS FOR 2009 AND BEYOND

### 6.1 2009 Project Plans

A great number of projects have been identified and defined. With the support from Schokland fund now in hand, these long awaited projects can now be realised as soon as the additional 60% can be financed.

Project	Total costs	Already funded	To be funded
	€	€	€
<b>Magbenteh Community Hospital</b>			
Operating costs	703.000	400.000	303.000
Construction new OPD and renovation existing OPD	300.000	140.000	160.000
Garbage incineration	5.000	-	5.000
Laundry	2.000	-	2.000
Expansion outreach programme	150.000	-	150.000
Water hospital and community	25.000	-	25.000
Solar energy batteries	25.000	-	25.000
Security - entrance	11.100	-	11.100
Security - remainder of hospital	1.200	-	1.200
Renovation men's ward	5.200	-	5.200
OR recovery room & surgical ward	94.300	-	94.300
Expansion with 1 extra ward	60.000	-	60.000
Connection to electricity grid	PM	-	
Sewage water disposal plan	14.800	-	14.800
Expansion guesthouse	81.200	-	81.200
<b>Bai Bureh Hospital</b>			
Operating costs	150.000	50.000	100.000
Renovation	60.000	-	60.000
<b>Workshop &amp; Home Polio Patients</b>	270.000	108.000	162.000
<b>Yele Hydroelectric Power Station</b>			
Phase 1: public network	415.000	166.000	249.000
Phase 2: large-scale consumers	415.000	-	415.000
<b>Renovation School Yele</b>	76.800	30.000	46.800
<b>Community Health Post Yele</b>	44.000	17.600	26.400
<b>Support Programme Farmers</b>			
Nursery, training courses	150.000	60.000	90.000
Truck	20.000	16.000	4.000
<b>TOTAL</b>	<b>3.078.600</b>	<b>987.600</b>	<b>2.091.000</b>

### 6.2 Notes

#### **Magbenteh Community Hospital**

##### Operating Costs

In future the hospitals will have to generate sufficient income (from patients and government) to cover the operating costs. The Best of Both Worlds programme is intending to generate an alternative and sustainable source of income. The profit made by the palm oil press(es) will be transferred to the hospitals.

It is expected that for the next 4-5 years the operating costs of the hospitals will require external funding. For 2009 the operating costs have been budgeted for a minimum of € 853,000 whilst the optimal scenario calls for € 1,100,000.

With only € 450,000 of the 2009 budget having been secured, more funding is needed.

#### Construction new OPD

The number of patients treated at the hospital has grown substantially over the last 3 years. The OPD, the laboratory and the x-ray department have been shown too small to be able to handle these numbers. To keep up with the growth in the number of patients, a new OPD is required. The costs for the construction of a new OPD amount to some € 300,000. Some € 160,000 is still needed before kicking off construction. This includes an amount to renovate the existing OPD.

#### Garbage Incineration

Whilst it is permitted to bury hospital garbage in Sierra Leone, this is considered as too risky in view of infectious diseases spreading. In 2007 therefore a study looked into basic incinerator plants. Construction started in 2008, and will be completed in 2009.

#### Laundry

The hospital laundry was completed in 2008 with the tiling of the rooms and placement of professional washing machines. The water supply and drainage will be completed in 2009, whilst the transport of all laundry will be optimised.

#### Outreach Programme

Following the expansion of the TFC, the implementation of the Outreach programme is essential. Although a growing number of patients from the region are now finding their way to the MCH, many more are still unable to do so. To facilitate the provision of preventive and essential medical support, small outpatient clinics with a touring medical team are necessary. These will put additional burden on the operational costs, as this approach requires the hiring of more staff as well as the acquisition of four-wheel drives and off-the-road motorcycles.

#### Water Supply

The current water supply is insufficient in quantity and quality. New water wells will have to be drilled and the number of storage tanks will have to be expanded.

#### Solar Energy Batteries

A German sponsor has donated a large number of solar panels to generate electricity. Batteries are needed to be able to store the electricity that is generated during daylight.

#### Security

The main gate, as well as some other parts of the hospital grounds, will have to be renovated to provide better security.

#### Renovation Men's Ward

The floor tiling requires renovation, as has happened with the female ward and the obstetrics ward.

#### Expansion with Extra Ward

The hospital is overcrowded on a regular basis, whilst the expectation is that the number of patients will continue to grow. This requires the construction of a new ward with a capacity of some 30 beds.

#### Connection to Electricity Grid

It is expected that the Bumboona hydropower station will become operational in

2009. This will present the possibility to hook the hospital up to the electricity grid. The costs for this connection are not yet clear, but a provision has been made nonetheless.

#### Sewage Water Disposal

The current disposal set-up is unhygienic and incomplete, and requires expansion of the sewer system as well as new facilities.

#### Expansion Guesthouse

Experience has proven the need for an expansion of the guesthouse to cater for the rise in visitors.

### **Bai Bureh Hospital**

The Bai Bureh Hospital is located close to the Lungi international airport. It has suffered extensive damage during the war and has not been maintained by its previous owner.

To date the water supply has been renovated, the roofing has been renovated and the building has been painted on the exterior. The interior requires full renovation, including sanitary fittings, floor tiling and hospital furnishings as well as structural repairs and a new coat of paint. In addition the electrical circuitry must be changed out. The costs for this are estimated at € 60,000.

### **Workshop & Home Polio Patients Makeni**

Some 250 severely disabled polio patients live on the Makeni streets in abject poverty. Many have no accommodation, sleep the streets and beg in order to stay alive.

In spite of these challenges, they have united and prepared a plan that calls for the construction of a home and a workshop. This will offer them the opportunity to manufacture small articles that can be sold to generate income for food.

The costs for the home and workshop are estimated at € 270,000. The land was already acquired by SSLDF, LHF's sister organisation, some years ago.

40% of the estimated costs will be covered from the Schokland Fund contribution, whilst the funding for the remaining 60% is still being pursued. Once funding has been completed, the construction could be completed before end 2009.

### **Yele Hydroelectric Power Station**

This project has been described in detail in chapter 3. The project consists of two parts. The first part is the renovation of the turbine and the grid. 40% of the expected costs (€ 415,000) have been covered via the Schokland Fund, whilst the remaining 60% remains to be funded.

The second part consists of the installation of a second turbine, for which the concrete foundations are already in place. This second turbine will only be generating power for the palm oil press and the water treatment plant, and will act as a back-up to the first turbine. The latter was operational until some 20 years ago, after which no clean drinking water has been available in the region.

The repair of the water treatment plant will be an important step in combating infectious diseases. In 2009 a new study will investigate the options to get the plant operational in a cost efficient manner. The second turbine will be subject to a separate request for subsidy.

### **Renovation School Yele**

The Yele Junior High School is in urgent need of support, both constructional as well as educational.

The roofing requires renovation, the school furniture requires replacement and the building needs tiling and painting. In addition the school will be provided with Internet access. Furthermore the budget for children who cannot afford the school fees will be increased. Some € 40,000 is still required to cover all costs.

### **Community Health Post Yele**

Apart from a small, unmanned, clinic there is hardly any health care in Yele. The LHF would like to staff the clinic fulltime as well as supply medication. The intention is to use the clinic for emergencies and deliveries. In addition, transportation means will be acquired to transport seriously ill patients to the MCH.

### **Support Programme Farmers**

#### Nursery & Training

In 2008 the cultivation of seedlings and the training of farmers was started, whilst a support team was set up. This programme will run for at least another 2 years.

#### Truck

Transport is a big challenge. A truck to transport fruit to the oil press and deliver seedlings to farmers is therefore needed. It is estimated that a good second-hand truck will cost € 20,000 including transport to Sierra Leone.

## **6.3 Medical Policy 2009 and Beyond**

2008 has shown a substantial growth in the number of patients treated in the MCH.

In particular the growth in the number of under-5's admitted was spectacular. The inauguration of the new TFC and the start-up of the Outreach programme have certainly contributed to this. Consequentially, the focus for the LHF has shifted from keeping the hospital operational and improving the surgical facilities to attention for mother- and child-care and the basic health care.

The growth in patient numbers also means an increased workload for the medical staff. In view of the expected continuation of growth in patient numbers and in order to ensure the continuity of the health care, a third tropical doctor was posted to the MCH in January 2008. In addition a team of obstetricians set up the obstetrics programme.

Contrary to previous years, no surgical teams travelled to Sierra Leone. This was due to the high travel costs and the growing level of basic surgical support that is being provided by local staff.

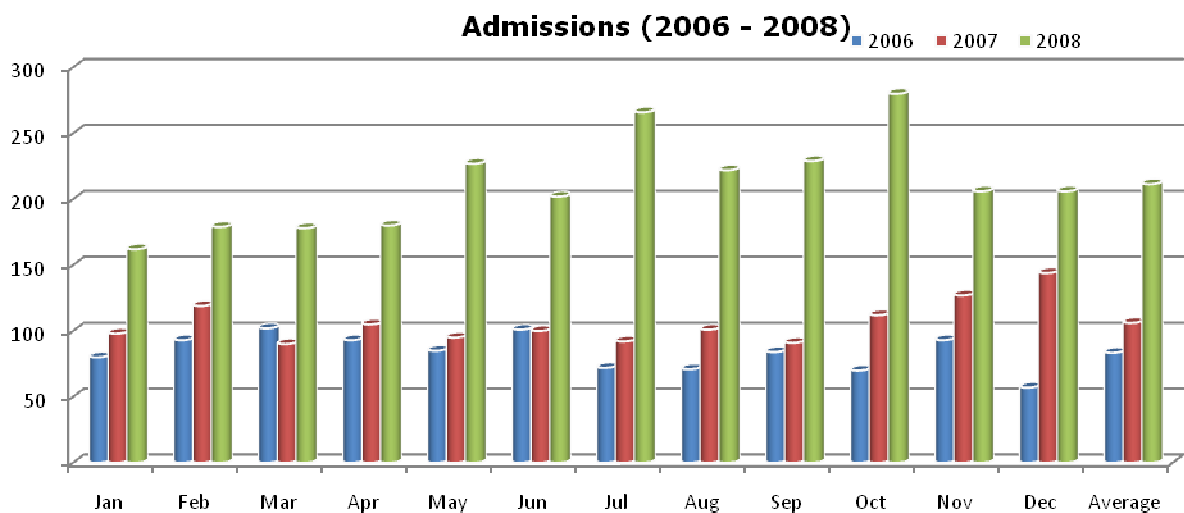
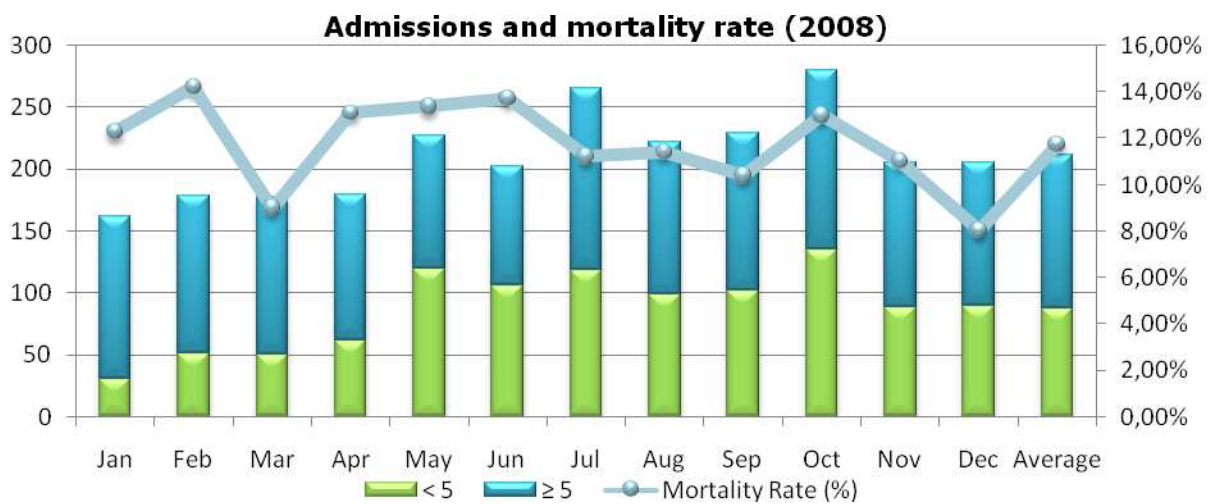
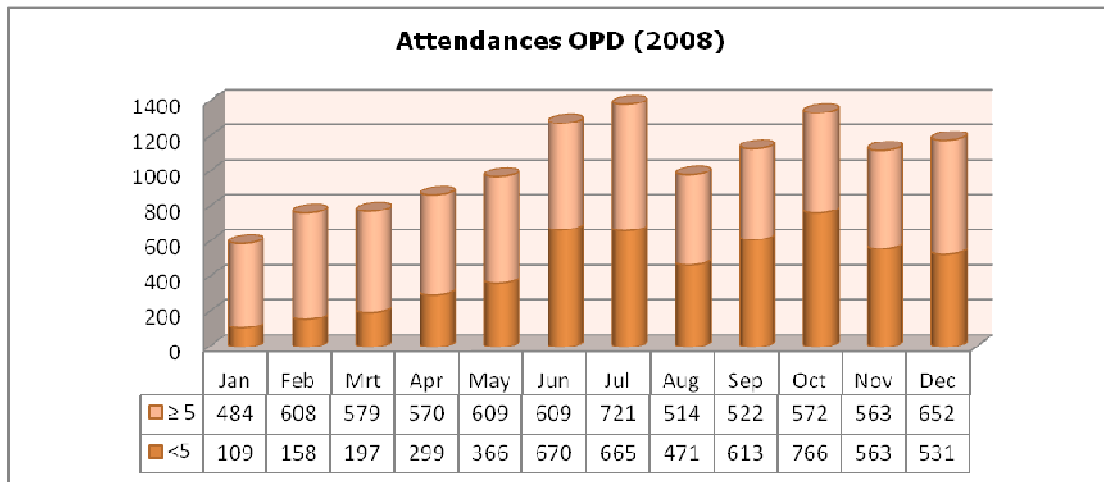
2008 also saw a number of students undertake their internships in Sierra Leone. The LHF policy is to cooperate with universities where such internships are recognised. Further forms of cooperation with medical universities are being investigated.

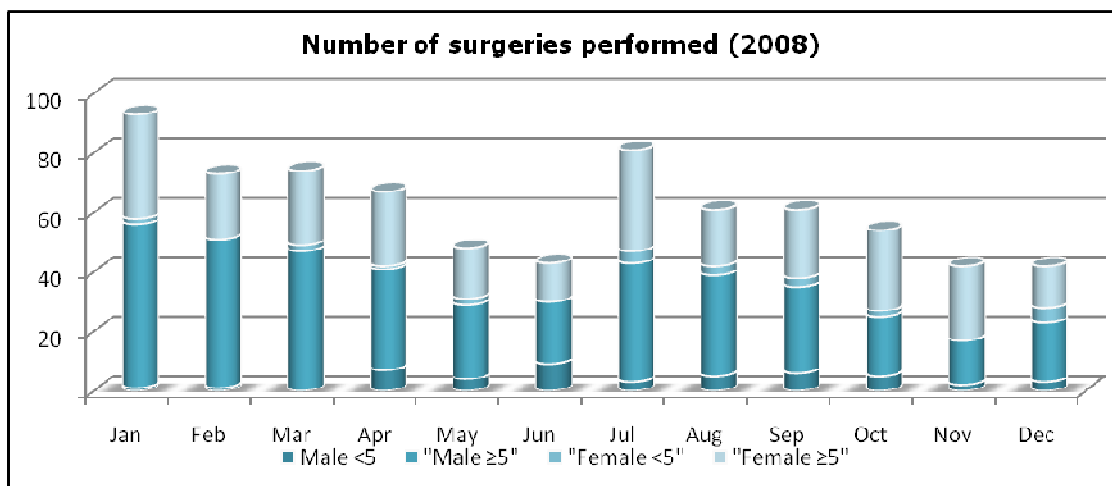
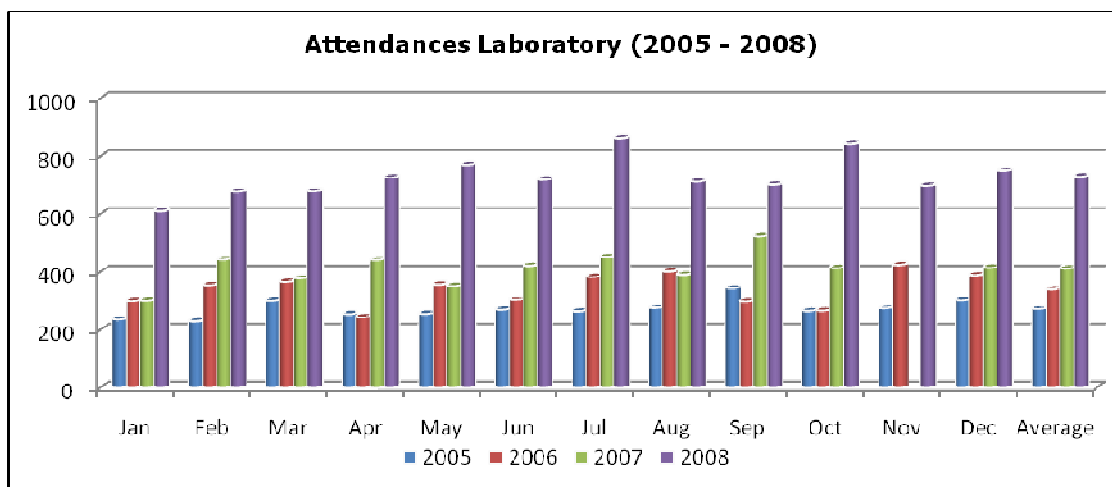
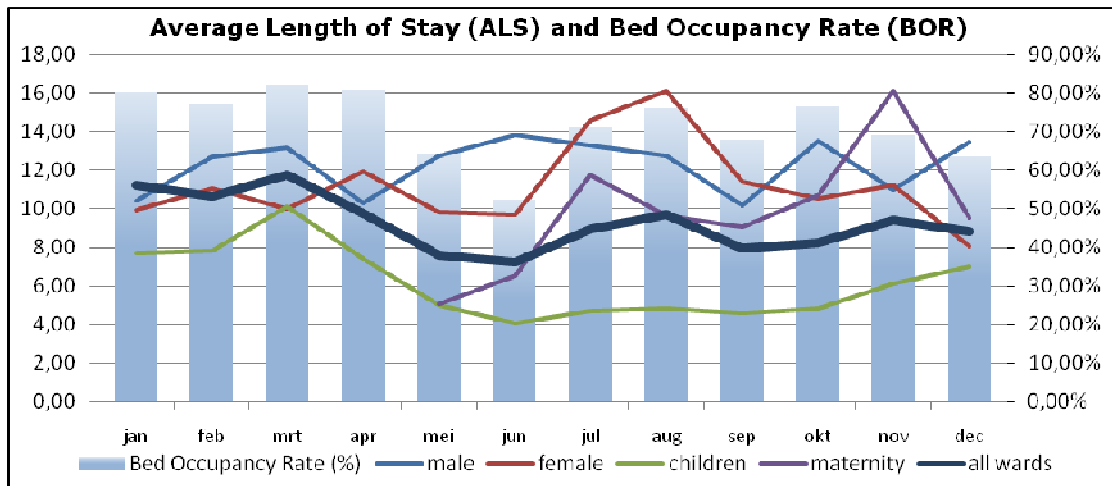
Meanwhile recruitment for medical teams to be sent out during 2009 is ongoing. The idea is to send out teams specialised in a particular field, such as urology, gynaecology and orthopaedics. The first team, consisting of a urologist and an anaesthetist, left in January 2009.

Succession plans for one of the tropical doctors are being drawn up, and particular attention will be given to candidates from Sierra Leone or another West-African country.

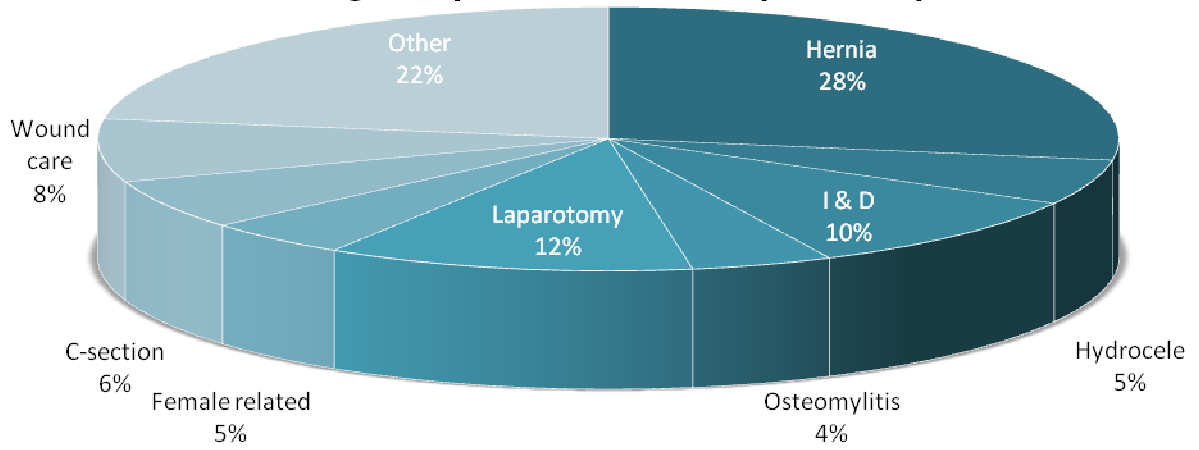


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### Surgeries performed in 2008 (total 739)



### Deliveries (apr - dec 2008)

