FINAL EVALUATION OF INTEGRATED EMERGENCY PROGRAMME IN YEMEN (2012-13)

Submitted to IERP Consortium through CARE International in Yemen

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Evaluation team:

Abhijit Bhattacharjee
Samira Handal, Chloe Day, Amal Saeed, Abdulmalek Alshalali, Adel Salah

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Evaluation team *28 April 2013*

Abbreviations

ADRA	Adventist Development and Relief Agency
ANC	Antenatal Care
CHW	Community Health Worker
CI	CARE International
CIUK	CARE International UK
CIY	CARE International in Yemen
CMAM	Community Management of Acute Malnutrition
CP	Consortium Partner
DAC	Development Assistance Committee (of the OECD)
DFID	Department for International Development
EPO	Emergency Programme Officer
FGD	Focus Group Discussion
GAM	Global Acute Malnutrition
HH	Household
HSNP	Humanitarian Safety Net Programme
IC	International Consultant
IDP	Internally Displaced Person
IERP	Integrated Emergency Response Programme
IGA	Income Generating Activity
INGO	International Non Government Organisation
IRY	Islamic Relief in Yemen
KII	Key Informant Interview
LEGS	Livestock Emergency Guidelines and Standards
M & E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MoPHP	Ministry of Public Health and Population
MOU	Memorandum of Understanding
MUAC	Mid Upper Arm Circumference
OCHA	Office for Coordination of Humanitarian Affairs
OECD	Organisation for Economic Cooperation and Development
OMS	Organisational Management and Support
ORS	Oral Rehydration Solution
OTP	Outpatients Therapeutic Programme
PHP	Public Health Promotion
PMU	Project Management Unit
PSC	Project Steering Committee
PSNP	Productive Safety Net Programme
SAM	Sever Acute Malnutrition
SCY	Save the Children in Yemen
SFP	Supplementary Feeding Programme
SGBV	Sexual and Gender Based Violence
SWF	Social Welfare Fund
ToR	Terms of Reference
ToT	Training of Trainers
U-5	Under-5 (children under five years age)
UNDP	United Nations Development Programme
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organisation
YHRP	Yemen Humanitarian Response Plan
YR	Yemeni Rial (US$ 1= YR 215)
YWU	Yemeni Women Union

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Executive Summary

Since 2010, the Department for International Development (DFID)/UKAid has supported a multi-sectoral programme through a consortium of five International Non-Governmental Organisations (INGOs)[1] in order to address the humanitarian needs arising from on-going conflict and displacement in the northern Governorates of Yemen. Initially aimed at addressing humanitarian needs of Internally Displaced Populations (IDP) and host communities affected by outbreak of armed hostilities in northern Yemen, in the last year (2012-13) of the programme, the project expanded to include vulnerable communities in another Governorate, Hodeidah,[2] where chronic poverty and malnutrition has veered close to a humanitarian crisis.

This report presents the findings of a terminal evaluation of the project covering the final year (phase III, 2012-13) of the grant which was made annually by DFID. The main objective of the evaluation was to assess the outputs, results and process of implementation of the project according to the OECD/DAC criteria for evaluating humanitarian assistance.

The evaluation was constrained by the fact that several key activities under the project were still being implemented or had recently been completed, and this made assessment of impact (and sometimes outcomes) problematic. Despite this limitation, the evaluation found sufficient evidence to conclude that the health programme targeting IDPs and vulnerable communities is bringing essential curative health services to communities who otherwise have no access to such services; and hygiene promotion work and nutritional interventions undertaken by the consortium partners (CPs) is creating awareness on breastfeeding, improved sanitation, hygiene and nutrition practices in villages.

In this phase, the key internal challenge was to transform the management of the consortium to make it more decisive, strategic and effective in providing oversight and leadership on programme delivery, monitoring and reporting which were found to be weak in previous phases. The functioning of the consortium improved significantly in phase III, although this was not sufficient to bring about programmatic integration among the five CPs, a weakness noted in a previous evaluation.[3]

Main Findings:

The overall conclusion of this independent evaluation is that the outcomes being realised through health clinics, hygiene and nutrition education, and community management of malnutrition have potential to contribute to improved mortality and morbidity. Although no official data on mortality or morbidity were available, the evaluation team met a sizeable number of individuals and families who have accessed life-saving interventions through the health and nutrition programme implemented by CPs. The hygiene/nutrition education programme is creating awareness on breastfeeding, improved sanitation, hygiene and nutrition practices in villages, and in medium to long term, this is likely to contribute to reducing mortality and morbidity, especially among infants and children. The livelihoods programme is producing mixed results, and is likely to have relatively less sustainable impact on recovery and resilience of communities than was intended.

At the level of consortium management, the functioning of the consortium improved significantly in phase III, although this was not sufficient to overcome some of the design

[1] The five INGOs are: ADRA, CARE International in Yemen (CIY), Islamic Relief Yemen (IRY), Oxfam and Save the Children in Yemen (SCY).
[2] In phase III, the programme has covered six governorates namely, Al-Jawf, Al-Hodeidah, Amran, Hajjahh, Sana'a and Sa'ada
[3] Natalie Hicks, Hussein Saleh Ali Saeed and Horia Aleryani. *Final Evaluation of the Integrated Emergency Response Project II in Yemen*, March – May 2012

problems associated with IERP through all phases.

Assessment Against Evaluation Criteria:

Relevance

Overall, the relevance of the IERP interventions was strong and the evaluation concluded that design of the programme took into account the context and needs of the vulnerable. However, as was noted in an external review[4] undertaken in early 2012, a high proportion of the humanitarian needs remain unmet by both the consortium and other agencies; and the sectoral reach of IERP remains limited, with IERP districts sometimes having only a single sector or agency operating in a geographic area.

Efficiency

The functioning of the consortium improved significantly in phase III, although this was not sufficient to overcome some of the design problems associated with IERP through all phases. Consortium approach, by its very nature, takes time and requires a substantial investment of management time and resources to get off the ground. The one-year (or even less) duration of programme made its operations costly in terms of management effort that went into it. Further, short-term funding of generally disparate activities spread over a wide geographical area made any integration unrealistic, and IERP thus failed to deliver economies of scale that could have been obtained through a cohesive joint programme in a compact area.

Effectiveness

The health programme targeting IDPs and vulnerable communities is bringing essential curative health services to communities who otherwise have no access to such services; and hygiene promotion work and nutritional interventions undertaken by the CPs is creating awareness on breastfeeding, improved sanitation, hygiene and nutrition practices in villages. The work on community management of malnutrition by one of the CPs utilising health centres has provided a good model for outreach programmes for nutritional surveillance and treatment, and in livelihoods, one of the CPs' approach to targeting some families with multiple inputs has potential to contribute significantly to transforming livelihoods of targeted families, although this needs to be verified in future through impact studies.

However, short period of implementation of several activities as well as long gaps between different phases of IERP funding limited the potential effects of some of the interventions in the areas of health and livelihoods, in particular.

Impact

The outcomes being realised through health clinics, hygiene and nutrition education, and community management of malnutrition are contributing to improved mortality and morbidity. The livelihoods programme is delivering mixed results and is likely to have relatively less impact on recovery and resilience of communities than was intended. The reason primarily lies in lack of a consistent and clear analysis of various options (livelihoods activities, unconditional cash transfers, cash-for-work) in the context of local economy, market and household economy. Livelihoods programme targeted at vulnerable communities requires continued support over a period of time, rather than one-off assistance, as was done in the IERP, and hence its impact is likely to be limited.

Sustainability

In areas where organisations have ongoing programmes, it is likely that some follow up

[4] Sharon Beatty. *Integrated Emergency Response Project II for Yemen 2011/2012 - External Review*, February 2012

support to sustain the outcomes will continue. ADRA's livelihoods programme which is based on repayable loans will enable it to continue supporting the livelihoods beneficiaries, if the loan portfolios are managed well. In the absence of any clear strategy on part of CPs and DFID for any follow up support to communities and/or local authorities as part of exit/phase out strategy, sustainability of many of the outcomes remain doubtful. The project design did not pay sufficient attention to a realistic phase out strategy.

Lessons:

There are several important lessons emerging from the project that need assimilation into future humanitarian and development programming in Yemen:

1. The low cost 'project management' model developed by SCY for its CMAM programme holds out significant promise for a country with a under-5 GAM rate of 15%[5] and u-5 mortality rate of 77 per thousand live birth. CMAM has shown that as staff capacity of health centres is limited, incentivising staff as well as employing additional staff and volunteers on short-term contracts through externally aided projects can make a rapid impact on the malnutrition scenario.

2. The homestead garden activity supported by Oxfam holds promise for improving household nutrition, besides providing education to communities and children about homestead gardening.

3. The low cost water filter distribution, combined with hygiene education, has been another activity with potential impact on morbidity. CIY's work with women's WASH committees in particular may provide important lessons for effective participation of communities in WASH programmes. An impact study on hygiene practices in the next 6-12 months in the project area could test and generate important evidence-based lessons for future policies in relation to two main approaches: (a) criticality of hygiene kits in adoption of hygiene practices; and (b) maintenance of water filters using own resources.

4. As a consortium, IERP has been weak in terms of systematising and disseminating lessons. As discussed earlier, a robust documentation and analysis of targeting data using SWF list could have provided valuable lessons for the government and entire aid community, but such opportunities were not made use of.

5. Capacity building of local institutions needs to be based on a clear medium to long-term strategy, and ad hoc one-off support in terms of provision of equipment and supplies may not have much effect.

6. Working through consortium involves substantial investment of time and energy at the formative stage before it starts to run efficiently, and short-term plans and funding undermine effectiveness of programmes.

Recommendations:

Consortium partners:

R1: CIY needs to work with its partner in Amran, YWU, and ensure that there is no disruption in funding for the specific legal aid and medical treatment cases taken up under the IERP III.

R2: SCY needs to urgently explore resources for extension of the CMAM programme during which it needs to actively work with health centres, MoPHP, UNICEF and other agencies specialising in nutrition toward a gradual hand over of the activities in the next 6-9 months.

[5] OCHA. *Yemen Humanitarian Dashboard*, 23 October 2012

R3: ADRA needs to build its management capacity to deal with loan portfolios using microfinance model.

DFID and CPs:

R4: To draw lessons on interventions aimed at improving food security and livelihoods status of vulnerable families, DFID /Oxfam needs to conduct systematic research and data analysis of contributions made through its cash transfer programme and livelihoods interventions. Such a study needs to draw on experiences emerging from similar initiatives in other similar contexts (Humanitarian Safety Net Programme, HSNP, in Kenya and Ethiopia's Productive Safety Net Programme, PSNP). This would be a valuable contribution to determining effective policy options for food security and anti-poverty programmes in the country.

R5: In order to draw lessons for future strategies, DFID needs to support Oxfam and CIY in undertaking impact studies in the next 6-12 months to examine the following aspects:

i. hygiene practices in post-project period – do the newly acquired practices continue, once direct inputs from the Agencies stopped, and which factors influenced choices made?
ii. water filters are currently being extensively used by families who received these; however, when the time comes for replacing the ceramic filters (which reportedly cost about $15 each) after nearly a year, what proportion of families would continue to use these filters and what factors influence their decisions?
iii. functioning of WASH committees – women's committees and mixed (men and women) committees.

DFID:

R6: Should DFID consider IERP-type consortium funding in future, it needs to factor in the need for longer time-frame that is needed to get consortium arrangements functioning effectively, as well as ensure that DFID's monitoring and oversight do not make excessive administrative and compliance demands at the cost of support on programmatic issues.

Section 1

Introduction, Purpose and Methodology of the Evaluation

1.1 Background to the Evaluation:

In order to address the humanitarian needs arising from on-going conflict and displacement in the northern Governorates of Yemen, the Department for International Development (DFID)/UKAid supported a multi-sectoral programme through consortium of five International Non-Governmental Organisations (INGOs) namely, ADRA, CARE International in Yemen (CIY), Islamic Relief Yemen (IRY), Oxfam and Save the Children in Yemen (SCY). The programme has been running since 2010, and was initially aimed at addressing the humanitarian needs of Internally Displaced Populations (IDP) and host communities affected by outbreak of armed hostilities in northern Yemen between the Government and the Al Houthi rebels. Over the course of last three years, humanitarian situation in the country has continued to deteriorate due to political turmoil and economic downturn leaving millions in need of assistance. In the last year (2012-13) of the programme, it has expanded to include vulnerable communities in another Governorate, Hodeidah,[6] where chronic poverty and malnutrition has veered close to a humanitarian crisis.

Funding for the programme by DFID has been awarded annually, with each annual cycle evaluated at the end of the programme period. Thus the programme has undergone two evaluations during 2011 and 2012, and this final evaluation covers the period 15 May 2012[7] to 31 March 2013, which marks the last year of DFID's funding.

This report presents findings and conclusions of the final evaluation undertaken between 7-29 March, 2013.

1.2 Purpose and Objectives of the Evaluation:

1.2.1 Purpose

As outlined in the terms of reference (ToR),[8] the core purpose of the summative evaluation was to assess overall performance of the Consortium's humanitarian response to the humanitarian crisis in the six governorates it has focused on, demonstrate the Consortium's accountability to stakeholders, and draw lessons and best practices for the Consortium members. As this is an end-of-the-project evaluation and continuation of the programme in current form is not envisaged, the main focus has been on drawing lessons for future programming in the project area.

[6] In phase III, the programme has covered six governorates namely, Al-Jawf, Al-Hodeidah, Amran, Hajjahh, Sana'a and Sa'ada
[7] Contract was signed in June and backdated to 15 May 2012. Effectively, implementation of the programme for most CPs started in September 2012 as funds were not received until then.
[8] Annex 1

1.2.2 Objectives and focus

Objectives of the evaluation and key questions

The main objectives of the evaluation were to assess the outputs, results and process of implementation of the project according to the OECD/DAC criteria for evaluating humanitarian assistance.[9] In specific terms, the evaluation addressed the following questions in order to draw conclusions against key evaluation criteria:

Relevance:
(a) Has the Consortium been able to help design the project within the context of humanitarian crisis and internationally coordinated response to the crisis as articulated in Yemen Humanitarian Response Plan?

(b) Were the implementation approaches, resources and scale of programming relevant to achieve intended outcome and output to enable vulnerable groups to recover from the shocks of conflict and socioeconomic crisis?

(c) Did the partners and beneficiaries consider that the interventions contributed to vulnerability reduction and protection of IDPs/ host communities and vulnerable communities in the targeted districts?

(d) Have interventions made through the IERP responded to the needs and priorities identified by communities and local authorities?

Effectiveness:
(a) Have the project's intended results been achieved and what were the supporting or impeding factors? What, if any, were the unintended results?

(b) Examine the extent to which needs of the vulnerable were taken into account in planning and implementation of the relief and recovery programme, and assess if the interventions were effective in addressing the needs of the most vulnerable. Does the project design and targeting take into account needs and vulnerability of women, disabled in particular, and are they involved in implementation of activities? Comment on the progress made in follow up on recommendations from previous evaluations in this respect.

(c) How effectively were the CPs able to undertake advocacy, communications and other upstream activities, especially on the vital issue of humanitarian need, humanitarian access, protection, and other key programmatic issues?

(d) To what extent the project has potential to contribute to addressing issues of equity and gender equality, beyond achieving the immediate objectives of the project?

(e) What measures were taken to ensure accountability to the beneficiaries?

Efficiency:
(a) How clear, coherent and effective were internal coordination mechanisms within the Consortium and decision-making processes at all levels? How well did the internal management and decision-making processes work together to support the various programmes to achieve results?

(b) To what extent were CPs' and PMU's human resources capacity, administrative, finance, and logistics/supply systems able to respond to the demands of the IERP project?

(c) Have resources for sectoral interventions been efficiently used to achieve relevant outputs? Have the interventions been implemented within intended deadlines and cost estimates?

[9] OECD/DAC. *Evaluating Humanitarian Assistance Programmes in Complex Emergencies*, 1998.

(d) Were implementation capacities of CPs adequate to deliver activities in a timely and efficient manner? What measures were taken to assure the quality of results and management practices, both in relation to process and products?

(e) What mechanism was in place to track performance of the overall response? Were issues that negatively affected operational response identified and dealt with in a timely and effective manner? What monitoring and evaluation (M & E) mechanisms were applied by PMU and CPs to ensure greater accountability?

(f) How did the consortium/CPs coordinate their work with rest of the international and national humanitarian system?

Impact:
(a) Will the outcomes that have been /are being realised, contribute to the impact as defined in the logframe's overall purpose, i.e., stabilising the mortality levels, resilience and recovery of people caught in humanitarian crisis in the Northern Governorates?

(b) Could the project have higher impact than is currently possible, had the project done things differently? If so, how?

(c) In the project areas, what would have been the situation now and in future had the project not been implemented?

(d) Are the activities and lessons emerging from the project scalable and likely to make wider impact in future? Are there innovative approaches emerging from this project? Which elements of the project are replicable and which are not, and why?

(e) How are the lessons from the project disseminated and are these being used to influence policies and practices nationally?

Sustainability:
(a) What mechanisms/ arrangements have been put in place to sustain the outcome of the programme in future? Is there an exit strategy? What will happen at the end of the project?

(b) To what extent local institutions, local government and communities have participated in the various activities of the project and taken ownership of activities? Examine the partnership strategy adopted by various agencies.

(c) What plans CP Agencies (individually) have for continued funding of the key initiatives under this programme?

1.2.3 Target audience

The primary audience of this evaluation is the IERP Project Management Unit (PMU) and Consortium partners – ADRA, CARE International, Islamic Relief, Save the Children and Oxfam – besides the Department for International Development (DFID). As secondary audience, other humanitarian agencies and donors may be interested in this evaluation as well, although the ToR did not specifically state this.

1.3 Organisation of the Evaluation:

The evaluation was commissioned by CARE International as the lead agency for the Consortium and managed by the Consortium Manager who oversaw the project. Through an international recruitment process, an independent consultant (IC) was selected and tasked to carry out the evaluation, with the help of five staff seconded by various CPs. The field visits for the evaluation took place during 10 to 29 March 2013. The consortium management team

provided support in arranging meetings and interviews, field visits and ensured that the evaluation team had access to necessary documents.

The evaluators and declaration of any bias:

Abhijit Bhattacharjee is an independent evaluation and strategy expert with over thirty years of senior management and consulting experience in international organisations in various parts of the world. With extensive experience in NGOs, the United Nations, Government aid agencies and Red Cross/Red Crescent Movement, he has in the past worked for Oxfam (1988-2000) which is one of the Consortium members, and carried out short-term consulting assignments for CARE International and Islamic Relief from time to time, but has never sought or occupied any full- or part-time staff position in any of the CP agencies in the past thirteen years, and has not worked in the past for the project under evaluation.

Samira Handal works for CARE International in Yemen as Grants and Information Officer.

Chloe Day works for CARE International UK as Emergency Programme Officer and has provided support to the Consortium, Project Management Unit (PMU) and CIY since mid-June 2012.

Amal Saeed works for Save the Children in Yemen as Monitoring and Evaluation Officer.

Abdulmalek Alshalali works for Islamic Relief in Yemen as Monitoring & Evaluation (M&E) Officer.

Adel Salah is Oxfam's Humanitarian Programme Officer in Yemen.

To ensure that data-gathering process minimised any possible bias and influence, the team leader (TL) took the following steps during interviews and focus group discussions (FGDs):

- While some selection of FGDs and key informant interviews (KII) were pre-arranged, attempt was made to hold a significant number of these extempore during site visits;
- It was ensured that staff members seconded into the evaluation team were not involved in any data-gathering process in their own organisations or from communities their respective organisation supported;
- During all FGDs and KIIs, participants were given an opportunity for at least 10-15 minutes to speak to the team leader without the presence of any other member of the team, should they so desired;
- The team met on a daily basis to compare notes and triangulate evidences gathered.

Following a series of initial briefings and meetings in Sana'a and prior to the commencement of fieldwork, the evaluation team produced an inception report[10] outlining key elements of the evaluation approach, framework and methodology which were agreed with the Project Management Unit (PMU) and CPs. In the fieldwork phase, the evaluators travelled to several districts to gather data from an extensive range of sources, including government/local authorities in governorates/districts, beneficiary communities and staff of CPs. A full itinerary of the evaluators is given at Annex 3. At the end of the field visit, an exit debrief was conducted in Sana'a with key stakeholders (CPs, PMU and officials from DFID in Yemen) where the team presented preliminary findings, following which draft reports were circulated for comments and further validation before the report was finalised.

1.4 Methodology:

1.4.1 Methodological approach

The overall methodology was based on both inductive and deductive approaches using qualitative data gathered through a mixed-method approach from a carefully selected range of sources as indicated below.

The data collection for this review was mainly done through purposively selected key informant interviews (KIIs), semi-structured discussions, documents research, case studies and carefully structured focus group discussions (FGDs) with local authorities and

[10] Attached as Annex 2.

communities in selected districts (Al Mina, Al Sukhna, Al Marawi'ah, Hais, Al Hawak, Al Hali districts in Hodeidah; Hairan, Haradh in Hajjah; Al Dhaher in Sa'ada; and Jabel Iyal Yazid, Eal Sourayh in Amran) which were visited during the evaluation. The evaluation also used data from documents made available by PMU and CPs.

1.4.2 Evaluation framework

Data obtained from desk research, KII, FGDs, beneficiary interviews, site visits and observations were analyzed to draw conclusions on the questions outlined in the inception report (based on OECD/DAC criteria), as well as assessed against accepted international humanitarian standards.

Key methods and sources of data

1. Semi-structured interviews, focus group discussions and site visits

The review conducted key informant interviews, semi-structured interviews (SSI) and focus group discussions (FGD) with the stakeholders – community members, beneficiary communities, women's groups, local authorities, CP staff and external stakeholders (like cluster leads, UNICEF, OCHA, UNDP etc). A summary of all interviews and FGDs conducted is provided in Table 1 below:

Table 1: Details of interviews and site visits conducted by the MTR team

Primary data sources	Sana'a	Districts/Governorates
CP staff	15	31
External stakeholders	7	1
Governorate officials	0	3
Local authorities	0	14
Volunteers/students	0	8
Partner NGOs	0	4
FGDs with groups (Beneficiaries/non-) Beneficiaries)	2 groups	19 groups in 13 locations
Individual beneficiary interviews	8	142

A full list of all interviewees and FGDs is provided at Annex 4.

2. Documents

Key documents were also used to supplement data gathered through case studies, KIIs and FGDs. Some of the vital documents which were examined by the evaluation are as follows:

1. IERP III Project proposal, logframe
2. Yemen Humanitarian Response Plans
3. IERP I and II Evaluation reports
4. IERP III Quarterly progress reports
5. Financial data showing breakdown of expenses on different activities/ interventions in the project

A detailed list of the key documents consulted is attached as Annex 5.

Triangulation of data

Triangulation is a core principle in mixed-method data collection as it ensures that the results are linked up into a coherent and credible evidence base. This evaluation mainly relied on:

- *Source triangulation*. The team compared information from different sources, i.e. at various management levels in different agencies – attempt was made to include

multiple key informants from different agencies;
- *Method triangulation.* The team compared information collected by different methods, e.g. interviews, focus group discussion, documents review.
- *Oral presentation* of preliminary findings and conclusions to PMU, CPs and DFID officials in the country as part of the validation process.

As a principle, the evaluation ensured that opinions, views and perspectives offered by each interviewee or key informant were tested against information obtained from other interviewees and documents. Any perspective or data offered by an individual that could not be validated against data obtained from other sources was considered 'unreliable evidence' for the evaluation and, hence, has not been included in the analysis.

1.5 Limitations:

The evaluation suffered from the following limitations:

1. Several programme activities were still in the process of implementation or were yet to be implemented at the time of field visits by the evaluation team. This limited the ability of evaluation team to assess outcome of these activities.

2. Data on activities undertaken through IERP III in Al Jawf were based on self-reported information, secondary reports and interviews with government health staff in Sana'a as evaluation team could not visit the area.

3. By and large, implementation[11] of activities – with the exception of some activities by Oxfam and SCY[12] – started in October 2012[13] owing to delays in approval by DFID as well as complicated funds transfer mechanism involving various entities within the Consortium Agencies, and this effectively reduced the project duration to six months. Impact of many of the activities will be realised after a reasonable lapse of time following implementation, and hence the evaluation could obtain very little data on impact.

4. Some of the questions outlined at the inception stage against the evaluation criteria have not been examined fully or in-depth during the evaluation, either due to (a) lack of sufficient time and readily available data, or (b) that data on these issues were being more appropriately gathered through other processes that were underway.[14] These questions are listed below:

i. Did the partners and beneficiaries consider that the interventions contributed to vulnerability reduction and protection (criteria - relevance)? - this evaluation has touched upon it, but a more systematic beneficiary survey which was underway during the evaluation would provide detailed insight;
ii. To what extent were CP's and PMU's human resources capacity, administrative, finance and logistics systems able to response to the demands (criteria – efficiency)? - the evaluation has examined these only in relation to the PMU as this was more appropriate and realistic within the time frame the evaluation had; and
iii. Have interventions been implemented within intended deadlines and cost estimates (criteria – relevance)? - the evaluation has examined timeliness, and it is expected that cost estimates will be available when the final project completion report is produced by PMU.

[11] This relates to delivery of the activities - although some preparatory work may have started earlier.
[12] These Agencies were able to start their implementation from June, almost as soon as formal approval of the project was communicated to them, as they have the capacity to pre-finance programme implementation through unrestricted funds.
[13] In case of Islamic Relief Yemen (IRY), most activities started in November-December 2012.
[14] With hindsight, as these questions were not central to the ToR, these need not have been included in the inception report.

1.6 Format of the Report:

The report is presented in five sections. Section 2 gives a brief introduction to the context of the IERP project, followed by presentation of key findings on sectoral interventions in section 3; in examining the work on each sector, the evaluation focused on the key outputs defined in the logframe of the project (Section 2, Table 3). Section 4 draws conclusions based on the criteria for evaluation as per the ToR and evaluation framework. In sections 3 and 4, wherever relevant, the report draws key conclusions at the end of each sub-section. In the final section (section 5), the report summarises the overall findings and lessons, and presents recommendations for future. Recommendations however are limited to areas that need following up on closure of the project.

Section 2

Introduction to IERP III – Context and Content

2.1 The Programme Context and Objectives:

2.1.1 Overview

The context within which this programme is being implemented is described in detail in the project document.[15] The 2013 Yemen Humanitarian Response Plan (YHRP) estimates that more than 13 million people (out of a total population of 24 million) continue to be in need of humanitarian assistance in Yemen.[16] IERP I and II (2010-12) significantly contributed among others to addressing the basic needs of conflict-affected population in five Northern Governorates in the country, although food insecurity and malnutrition continue to be serious issues in all five northern governorates, according to a study by the Consortium in late 2011.[17]

The year 2012 saw stepping down of the former President Saleh, as part of the Gulf Cooperation Council brokered initiative, with Abdu Rabbu Mansour Hadi being elected President in February 2012. Political uprisings across the region provided a context in which the Houthis could expand their control over Sa'ada and other parts of the country. The security situation in the country remains precarious. Al Houthis continued to control the Sa'ada governorate and had a strong presence in Al-Jawf governorate in the North, while parts of main towns like Sana'a or Taiz also came under attack. Simultaneously, the control of the Houthis in the North is being contested by tribal leaders and Salafists. The South remains a hotbed of military and political opposition.[18]

Continued unrest in the north has had a severe impact on all basic services, exacerbating already existing vulnerabilities in the population and especially contributing to the deterioration of food security and malnutrition. Violence, protection and particularly child

[15] *IERP Phase III – Main Narrative Proposal - Integrated Emergency Response Programme for Yemen Phase III (2012-13), 15 May 2012*
[16] UNOCHA. *Humanitarian Bulletin, Yemen* Issue 11, 28 December 2012– 28 January 2013
[17] ACAPS. *Summary Report: Joint Rapid Assessment of the Northern Governorates of Yemen*, November 2011
[18] ECHO. *HUMANITARIAN IMPLEMENTATION PLAN YEMEN* 2013

protection is a major concern, especially in Hajjah. Lack or delay of sufficient food assistance, incomplete targeting, rising food prices, and reduced purchasing power are increasing food insecurity in the northern governorates to an alarming extent (ACAPS/CARE 10/2011). Lack of access to health facilities and emergency levels of global acute malnutrition (GAM rate for children under 5 is 31.4% in Hajjah (UNICEF/MOPHP 07/2011) are major concerns with regard to both host communities and IDPs. Poor breastfeeding practices and care for children is identified as a key causal factor. Only one in five children were exclusively breastfed. The literacy level of mothers was found to be significantly associated with child malnutrition.[19] Children, IDPs and host communities are the most affected groups in the north. Humanitarian operations in the north continue to be challenged by the volatile security situation.

By late 2011 and early 2012 when planning for phase III began, in addition to the widespread conflict-driven displacement, the country was also facing a slow-onset crisis in food security, malnutrition and outbreak of communicable diseases. Approximately 750,000 under-5s were suffering from malnutrition and 500,000 were at risk of death unless urgent action was taken.[20] Malnutrition data indicated Global Acute Malnutrition (GAM) rates well above the emergency threshold. The situation was particularly acute in Hodeidah governorate, with the GAM and severe acute malnutrition (SAM) rates (31.7 percent and 9.9 percent respectively) at twice the WHO critical emergency threshold for immediate emergency interventions.[21]

Table 2: An overview of humanitarian situation in Yemen[22]

People without access to safe water and sanitation	13.1 million
Food insecure people	10.5 million
Population with spending power below US$ 2 /day	47%
People without access to healthcare	6.4 million
Acute malnourished children	998,000
Registered Internally Displaced Persons	385,000

In phase III, therefore, the CPs also added Hodeidah governorate in their response, in addition to the conflict-affected five governorates which were targeted during the previous phases. This was a major shift in the phase – the inclusion of most vulnerable communities along with a focus on the conflict-affected populations. Another shift in the project was in scaling down activities in Sa'ada governorate during phase III where CPs encountered severe challenges during programme delivery in phase II, with interference by the Houthis who controlled the area. Only Oxfam which had demonstrated successful programme delivery in the area continued to provide livelihoods and WASH support.

2.1.2 Phase II to Phase III – main challenges

Several lessons emerged from the previous phase which the project aimed to address during phase III. The key internal challenge was to transform the management of the consortium to make it more decisive,[23] strategic and effective in providing oversight and leadership to programme delivery, monitoring and reporting which were found to be weak in previous phases. An issue linked to this was also weak integration of CP activities on the ground which meant that potential synergies between different partner-activities were missed.[24] In phase III, the consortium was to create an integrated strategy around a common objective for the project and ensure that the Consortium management was streamlined to deliver effective and timely actions for smooth implementation of the project.

[19] ACAPS. *Secondary data review for Yemen*, February 2012
[20] UNOCHA, *Yemen Humanitarian Emergency, Situation Report No.14*, 13 February 2012.
[21] UNICEF, *Nutrition Survey among U5 Children in Al Hodeidah Governorate, Yemen*, 4 December 2011.
[22] Source: *Yemen Humanitarian Response Plan*, 2013.
[23] Sharon Beatty. *Integrated Emergency Response Project II for Yemen 2011/2012 - External Review*, February 2012
[24] Natalie Hicks, Hussein Saleh Ali Saeed and Horia Aleryani. *Final Evaluation of the Integrated Emergency Response Project II in Yemen*, March – May 2012

On the programmatic level, the project had several important lessons from the previous phases to work on. The key ones were as follows:[25]

1. *Livelihood interventions*: Livestock distribution was found to have limitations in terms of enhancing livelihoods of large section of target communities for various reasons including high cost of fodder and incidence of diseases. Some of the vocational training which was imparted as part of the programme had little demand in the local market. Hence the livelihoods programme needed to be reviewed and potential new opportunities like cash transfers and cash-for-work ought to be explored.[26]

2. *Weak community participation*: The phase II final evaluation noted weak participation by communities in needs assessment, besides need for greater clarity and transparency in beneficiary selection so as to minimise conflict between beneficiaries and non-beneficiaries.

3. *Delayed funds transfer*: Delayed delivery and rushed implementation in the final two months was also a consequence of delayed start up of phase II. Negotiations and requests for clarification in the original project proposal and receipt of funds by CPs took longer than expected.

2.1.3 IERP III Aims and outputs

The project aims at contributing to improving lives of vulnerable and conflict-affected people (IDP households, host families and vulnerable families) through six key outputs:

- Essential health services provided to vulnerable populations are improved;
- Vulnerable communities receive both preventive and curative nutrition services;
- Vulnerable families are supported with water, sanitation and hygiene inputs;
- Protection services provided to vulnerable conflict-affected people;
- School age children receive formal and informal education services;
- Vulnerable people in target areas are provided with livelihoods support.

As per the logframe of the project, the key output indicators targeted by the IERP III were as follows, and these form reference point for this evaluation while applying the evaluation criteria for this evaluation:

Table 3: Output indicators, IERP III

Sector/Output focus (Lead member)	Key indicators	Implementing partners	Target area
1. Health (ADRA)	1.1 No. of beneficiaries receiving primary and maternal healthcare, vaccination and medical referrals.	ADRA	Al Jawf, Hodeidah Sana'a
	1.2 No. of health facilities provided with equipment, supplies and staff capacity building.	ADRA & IRY (SCY from November)	Hodeidah
	1.3 No. of beneficiaries receiving health education messages, including patients treated by supported medical centres.	ADRA & IRY	Al Jawf, Hodeidah, Sana'a
Nutrition (SCY)	2.1 No. of beneficiaries receiving nutrition education.	SCY, ADRA & IRY	Amran, Sana'a, Al Jawf, Hajjah.

[25] Sources: Footnote 23, 24 and 26.
[26] DFID. *Project Completion Review: Integrated Emergency Response Programme for Yemen 2011/12 (IERP II),* November 2012

	2.2 No. of MAM and SAM cases treated.	SCY	Hodeidah & Hajjah
WASH (Oxfam)	3.1 No. of water facilities provided. 3.2 No. of HH trained on safe hygiene practices. 3.3 No. of HH provided hygiene material	CIY Oxfam	Amran Sa'ada & Hodeidah
Protection (CIY)	4.1 No. of women receive protection services and legal advice/counselling. 4.2 No. of community leaders and government aides that receive advocacy messages about protection needs of women and girls.	CIY	Amran
Education (SCY)	5.1 No. of teachers, school managers and school councils trained on planning, active learning and education in emergencies. 5.2 No. of learning spaces improved through physical rehabilitation. 5.3 No. of students receiving mine risk awareness training.	SCY	Amran, Hajjah & Sana'a
Early recovery (Oxfam)	6.1 No. of people that participate in vocational or business management training. 6.2 No. of HH receiving financial or non-financial productive inputs to develop an income generating activity.	Oxfam, ADRA & IRY Oxfam, ADRA & IRY	Sa'ada & Hodeidah Hodeidah & Sana'a

2.2 IERP III Budget and Expenses:[27]

Table 4: Agency-wise approved budget and expenses

	Revised Budget	**Cumulative expenditures up to 28 Feb 2013**	**Burn rate % total budget (as of 28 February 2013)**
CARE Amran	£913,653	£686,691	75%
PMU	£239,450	£152,302	64%
Oxfam	£1,276,934	£1,014,340	79%
IRY	£482,274	£339,265	70%
SCY	£1,125,807	£759,339	67%
ADRA	£967,740	£645,932	67%
CARE UK OMS	289,674	NA	NA
Total	**£5,292,532**	**£3,597,869**	**72%**

[27] Source: *Financial Analysis, IERP Consortium Performance*, February 2013

Table 5:Sector-wise/line item breakdown:

Sector/line items	Approved budget (£)	% of total budget
Health	603,591	11.4
Water & Sanitation	593,772	11.3
Livelihoods	755,173	14.3
Household /non-food items	196,518	3.7
Education	473,301	8.9
Other programmes	100,041	1.9
Logistics	327,792	6.2
Personnel and personnel support	1,717,296	32.4
Organisational Management Support	525,048	9.9
Total	**5,292,532**	**100**

Section 3

Evaluation Findings – Sectoral Performance

3.1 Health:

3.1.1 Overview

As per the project logframe, health activities were to deliver the following outputs: (a) beneficiaries receiving primary and maternal healthcare, vaccination and medical referrals; (b) health facilities provided with equipment, supplies and staff capacity building; and (c) beneficiaries receiving health education messages, including patients treated by supported medical centres.

Health services were provided mainly by two of the Consortium partners namely, ADRA and Islamic Relief in Yemen (IRY). ADRA's work was concentrated with IDPs in Sana'a, vulnerable communities in Al Jawf and Hodeidah governorates, while IRY's health work through the IERP III was concentrated in Hodeidah. In the second half of the project duration, SCY also undertook some work in this sector, specifically to provide equipment and nutrition drugs/supplies to health care facilities supported through another project[28] in Hodeidah and Hajjah. Security and access for humanitarian organisations continue to be difficult in Al Jawf, and ADRA is the only INGO which continues to provide healthcare to the communities in the Governorate.

[28] Funded by OFDA.

3.1.2 Key findings

ADRA:

ADRA's health programme in Al Jawf (six districts) has been going on for about ten years now and working through local staff who visit the area regularly, the organisation has acquired good understanding about the communities and established relationship with community leaders which helps it in accessing the communities directly, sometimes bypassing governorate authorities who tend to control and use aid for their own tribes and clan-groups. Access is an issue, including for Yemeni staff, but ADRA has tried to develop a strong monitoring system. The government doesn't really function in Al-Jawf, so there is no support from governmental structures, and health centres are ill-equipped and poorly staffed. ADRA has three field supervisors and 60 medical staff based in Al-Jawf, in addition to one Field Coordinator and one Field Assistant, based in Sana'a but frequently travelling to Al-Jawf. Targeting of individual-based activities is very difficult in the area as selection of individual beneficiaries tend to escalate conflict and hence ADRA focuses on community-based activities. Tribal disputes/feuds are extremely common. Employing people locally is also challenging as all forms of contract are perceived as providing life-long employment; ADRA therefore employs medical staff working in Al Jawf on daily wages.

ADRA provides periodic training to midwives and nurses of health centres – at the time of the evaluation, one such training was going on in Sana'a attended by 8-10 nurses/midwives from Al Jawf and several from Hodeidah and Sana'a.[29] Although most of them have been working for several years, participants found the training on emergency obstetric care, antenatal care (ANC) and nutritional assessment and surveillance particularly useful in their work and all the trainees interviewed rated the training highly. The training also covered nutrition education which they could pass on to communities in areas like breast-feeding, infant and child nutrition.

In Sana'a, ADRA runs a health clinic since 2010 for IDPs who came from Sa'ada. This clinic which was started during IERP I provide basic health care and referral services for the IDPs. Cases which cannot be treated in the clinic are referred to hospitals in Sana'a with which ADRA has prior arrangements for providing treatment to IDPs. All treatment-related expenses are paid for by ADRA from IERP funds.[30] FGDs during the evaluation indicated that for many families who had little income of their own, the clinic was their only lifeline for treatment of acute and chronic ailments. A government health centre catering for IDPs and poor in a deprived area (Jidr centre) of Sana's was also provided equipment and medicines, and a doctor seconded to work for two days a week through IERP III.

IDPs in Sana'a are trained in control of chronic ailments like diabetes and epilepsy, and IDPs have received group training on first aid, psychosocial issues, diabetes, nutrition and blood pressure awareness. There is however concern over cases requiring longer-term/repeated treatment e.g. chronic cases or patients with injuries requiring several surgeries, as IERP funding gaps (between phases) and uncertainties meant that the centres stopped providing services for a few months every year.

In Hais (Hodeidah), ADRA has a specialised clinic providing services in physiotherapy, and provides referrals for ENT (ear, nose and throat) and amputation cases to Hodeidah or Aden, besides basic healthcare. The centre has been long established and is funded through IERP since August 2012 (phase III). The centre caters to a large catchment area that includes both urban and rural population, and is considered having better capacity and services than a district hospital in Hais. During IERP III, the centre organised one eye camp with the help of Ministry of Health. ADRA in Hais works in partnership with Al Mustaqbal and Al Nousra Association as partners who mobilise communities and organise camps. Al Mustaqbal emerged out of ADRA's work some eight years ago and works closely with ADRA, building capacity of community based organisations and youth groups in conducting hygiene

[29] 5 training courses conducted for groups of 10-15 midwives each. Also training on neonatal care and nutrition in pregnancy (so each midwife undertakes 2-3 training sessions) was conducted by ADRA for Al Jawf health workers.
[30] ADRA receives discounted rates through negotiation of advance contracts with the hospitals.

education as well as monitoring work of local councils. ADRA also trained 180 students from 14 schools in first aid under the IERP III.

Islamic Relief:

IRY worked through health authorities in Hodeidah governorate and districts. Five health centres were selected in two districts for support through consultation with the authorities and they were provided necessary equipment, drugs and training. The centres were selected after conducting site assessments by IRY, and each centre was provided basic equipment (microscope, dentist's chair, tools etc) for US$ 18,000 each and essential drugs worth US$ 10,000. Additionally, ten staff from each centre were trained in health centre management. Interviews revealed that most of the support to health centres was provided from November onwards as it took IRY time to carry out needs assessment and procurement of supplies after they received funds in August. Although the support has been provided in close cooperation with health authorities, the evaluation team has not seen any clear capacity building strategy which is necessary if the one-off support is to be followed through as part of a continuous process.

IRY's health messages focused on hygiene education which is discussed in sub-section 3.4 below.

Conclusions:

1. Healthcare services provided through the IERP continue to meet critical needs of IDPs in Sana'a and vulnerable population in Al Jawf which in particular is deprived of all services due to difficult humanitarian access and poor government structures.

2. ADRA's ongoing health programme has contributed significantly to strengthening the capacity of frontline health staff in clinics and health centres catering to IDPs and deprived communities. IRY provided short-term support to selected health centres in Hodeidah in close cooperation with health authorities; however, in order to build strong capacities, these one-off support need to be followed through as part of a continuous process with clear capacity building strategy.

3. The long gaps between different phases of IERP when funding for ADRA's health clinics stopped set back progress made by patients requiring prolonged treatment for chronic illnesses and injuries.

4. Overall, the health component of IERP was delivering the outputs as intended in the logframe.

3.2 Nutrition:

3.2.1 Overview

Three IERP CPs – namely Save the Children Yemen (SCY), ADRA and IRY - have worked in the area of nutrition, with SCY providing a range of services including Community Management of Acute Malnutrition (CMAM), nutrition education and capacity building of health authorities in management of malnutrition, while ADRA and IRY have focused on nutritional education and awareness of communities through volunteers and health workers.

3.2.2 Key findings

Islamic Relief and ADRA:

In phase III, IRY selected 32 heath centre workers (midwives) and volunteers in Hodeidah Governorate[31] who were provided one week's Training of Trainers (ToT) programme which covered topics in breastfeeding, nutrition during pregnancy and after birth, infant nutrition, and basic personal hygiene. After training, these health workers went out to communities where they had sessions in schools, mosques, community centres, health centres and homes on

[31] During phase I and II, IRY worked in Amran and Sa'ada, and did not have any activity in Hodeidah.

various aspects of nutrition and personal hygiene targeting both women and men, often separately. Each session was attended by an educator (those who underwent training), a facilitator (responsible for recording attendees) and a coordinator to provide support on logistics. The volunteers took turns to cover different roles. At the end of each session they met to discuss how it went and put a report together. IRY mainly assisted them by liaising with the relevant authorities. Women interviewed in their homes reported using some of the lessons related to breastfeeding and infant nutrition in their daily lives, and some expressed desire to learn more.

ADRA targets nurses and midwives undergoing its Emergency Obstetrics Care (EmOC) for nutrition education as well. Apart from providing training on infant nutrition, feeding and weaning practices, it trains health staff in nutritional surveillance procedures (Mid-Upper Arm Circumference (MUAC) measurements, height-weight ratios). FGDs in Hais indicated that most women received key messages through community meetings or home visits by educators, and these were leading to changes in breast-feeding and infant feeding practices in the villages, as reported by FGD participants. Interviews with Al Jawf health staff showed that they found the nutritional assessment techniques particularly useful in their work with communities and were confident that this would help them save hundreds of lives in future.

Save the Children:

SCY's nutrition work through IERP III is focused in Hodeidah and Hajjah governorates, through government health centres. In Hodeidah, 91 community health workers (CHW) who were selected by the health centres in three districts were trained by SCY in nutritional surveillance and education. Besides the volunteer CHWs, SCY trained 20 health centre workers in CMAM and Infant and Young Child Feeding (IYCF) and therapeutic nutrition. The health workers were trained in diagnosis and treatment of severe acute malnutrition (SAM) and moderate acute malnutrition (MAM). Complicated cases are referred to hospitals.

SCY has good collaboration with UNICEF, WFP and health authorities for ensuring supply of plumpynut and supplementary food for outpatient therapeutic programme (OTP) which the health centres are trained to administer. The programme however was affected by occasional breakdown in supply chain for supplementary feeding programme which is managed by WFP.

The most significant intervention in the CMAM programme has been the creation of volunteer cadres who are attached to each health centre, working almost full-time as outreach workers. Volunteers were selected from the local area and were usually educated youths (mostly female in Hodeidah and mostly male in Hajjah) who showed an interest in undergoing intensive training. Each volunteer was paid a small stipend of US$ 100 per month to cover for their travel and transport. The volunteers go out to the communities and through community meetings and door-to-door visits provide nutritional and health awareness to people, besides identifying cases of malnutrition. Cases identified through the process are referred to the health centres. The regular visits by CHW ensured that all SAM and MAM cases received regular follow up support without which relapses could occur.

Box 1: Gholil health centre, Hodeidah governorate

SCY started working with the centre since early November 2012, and trained 17 volunteers on CMAM procedures and nutritional education. The centre had been supported by UNICEF since 2009, but their capacity was limited to dealing with only SAM cases which came to the centre. Although UNICEF had trained 20 volunteers, the outreach programme did not work as the focus was only on SAM and volunteers were not paid any stipend. Moreover, under the SCY support, the health centre has four staff who were recruited as project staff who devote full-time to the nutrition programme. Since December 2 when they started, the centre has treated 1,374 MAM cases.

In all health centres (2 in Hodeidah and 3 in Hajjah) visited by the evaluation team, the staff and volunteers attached to them were trained by SCY between October and November 2012. FGDs with communities /patients and interviews with governorate health officials revealed that as the health centres were not adequately staffed in the past (Al Sha'ab centre had only one staff) and had very little resource, these remained shut most of the time and people did not visit these centres. However, through the IERP III support, these centres now have a

minimum complement of staff (paid by the IERP project) and volunteers, and function regularly. Staff reported significant increases in patient attendance and treatment-seeking as a consequence.

All the health centres now have detailed record of all screening done since the CMAM programme started. Discussions with nutrition cluster coordinator and health authorities in Hodeidah confirmed SCY's significant role in CMAM programme in the governorate. Two critical elements of SCY's approach appear to have significant different to the CMAM programme: (a) a small stipend/travel allowance to the volunteers and dedicated project staff in the health centres; and (b) ensuring that besides SAM, the health centres also prioritised MAM – this enabled volunteers to educate people about infant nutrition and need to take early action, all of which also increased attendance at the health centres. It is understood from discussion with health officials that in the past when attention was paid to SAM only, the outreach programme did not work (Box 2).

Five health centres in Hodeidah and three in Hajjah were also provided with furniture and equipment (water cooler, TV, chair, generator, desks) and provision for sanitation. However, it was observed at least in one centre that the generator and TV provided by SCY were never used as the centre did not have budget to cover fuel and running costs of the generator.

Box 2: Volunteers at Al-Gholil Health Facility, Al Hawak

Two women volunteers (F1 & F2) received 3 days of training in November with 16 others (2 dropped out). They learnt about SAM, MAM, normal nutrition, breastfeeding, diarrhoea, MUAC and good nutrition practices. The 16 were divided into 4 groups and rotate between working in the centre and in the community. Undertake MUAC screening in the field and refer cases for treatment, do awareness activities in the community and teach people about use of PlumpyNut in the centre. They have seen the health of many children improve. People come from far away to the centre through word of mouth and after community awareness sessions. If after being registered as a case, a child doesn't present for 2 weeks, they follow up to find out why and submit a report. Often this is because when a child starts using PlumpyNut they vomit and parents think this is because the PlumpyNut is bad for them – CHWs provide counselling on this.

Overall the evaluation found strong evidences of awareness in the communities on breastfeeding and infant feeding practices which are reportedly changing, as revealed in FGDs and beneficiary interviews. SCY in particular has developed a model for CMAM which has enabled screening and treatment of thousands of children in five districts of Hodeidah and Hajjah. The staff capacity SCY's interventions have created in the health centres through which the CMAM programmes are implemented have shown results in a short time in terms of increased attendance/treatment at health centers and awareness of good nutritional practices. However, as the IERP III funding comes to an end now, the evaluation has not seen any alternative strategy for resourcing this important life-saving activity. SCY stated that their support through the fixed health facilities using the Ministry of Public Health and Population (MoPHP) was aimed at building the capacity of government staff, and there was an agreement made between the health centre staff and MoPHP Director General that the programme would continue even after SCY support ceased. However, key informant interviews by the evaluation team with all relevant MoPHP staff indicated that this was unlikely to happen unless some external donor came to their aid.

Conclusions:

1. The nutritional interventions have created strong awareness on breastfeeding and infant feeding practices in the communities, and this is reportedly leading to changes in practices in some communities.

2. The effective duration of nutrition education and CMAM programmes has been about five months as most activities undertaken by IRY and SCY started in November, 2012.

3. SCY's work on CMAM in collaboration with UNICEF and health authorities has proven to be a cost-effective model for dealing with malnutrition in some of the deprived areas of the country, although at this stage there is no realistic plan in place to sustain this at the end of IERP funding.

4. Overall, the nutrition component of IERP was delivering outputs as intended in the logframe.

3.3 Education:

3.3.1 Overview

SCY was the only CP which worked on education programme under this project. As per the logframe, education activities were to deliver the following outputs: (a) teachers, school managers and school councils trained on planning, active learning and education in emergencies; (b) learning spaces improved through physical rehabilitation; and (c) students receiving mine risk awareness training.

Several rounds of fighting in and around Sa'ada and in the northern governorates since 2004 has caused repeated and protracted large-scale internal displacement.[32] According to UNHCR, there were 323,992 Internally Displaced People (IDPs) as of 30 September 2012, in addition to an estimated 48,766 unregistered IDPs. Insecurity and tribal clashes hinder IDPs' return, and this has forced thousands of IDPs to continue to live in temporary homes/shelters/camps away from their original homes. Providing education to children in these circumstances becomes a humanitarian challenge as influx of the displaced overwhelms the capacity of normal schools in host communities, causing tensions between the two. Furthermore, the psychosocial trauma the twin factors of being victims of conflict and being uprooted from homes inflicted on IDP children needed to be addressed through support to their families and schools. SCY has focused on these issues in Hajjah and Amran governorates which have a high concentration of IDP children.

3.3.2 Key findings

SCY targeted 21 schools in Haradh and 21 in Amran districts which have hosted IDPs. Its interventions range from rehabilitation /reconstruction of classrooms, provision of school furniture, teaching aids and school bags for children, training of Ministry of Education staff (MoE) in minimum standards in education in emergencies and training of teachers on mine risk education, psychosocial support and active learning. FGDs with both teachers' groups and students in several communities revealed that the active learning component has brought about changes in methods of teaching in the schools. In some cases, school records showed that the number of students went up because there weren't enough teachers before and there wasn't enough space prior to IERP III. Children from IDP families found mine risk education useful as it gave them an awareness of safety measures they could undertake if they spotted mines. Teaching aids show what different types of mines look like and have storyboards showing how to react if one finds a mine. Psychosocial training enabled teachers to be sensitive to shock and displacement-related issues IDP children live through.

In all the schools assisted by SCY, student councils were formed to assist school management in maintenance of schools, organising school activities like morning assembly, study trips and creating a sense of leadership among students. This has changed attitudes among teachers and students, and school cleanliness has improved. The student councils have taken strong root and have the potential to sustain some awareness and educational activities after the completion of the project.[33]

Repairs and rehabilitation of schools by SCY appears to have made a significant difference in creating more space and capacity for increasing school enrolment – as evidenced by attendance and enrolment records seen by evaluators - besides improving learning environment. In some schools, SCY has also provided

Box 3: SCY and CIY collaboration in Amran

In Alshaheed Alhoudaimy School, Jebel Yazid District of Amran, SCY rehabilitated school toilets and CARE provided water tanks and taps. The school now has five toilets, two each for boys and girls, and one for staff. Staff reported that this has increased the overall attendance of girls in the school.

[32] UNHCR Yemen Fact-sheet, January 2013
[33] DFID. Project Completion Review: *Integrated Emergency Response Programme for Yemen 2011/12* (IERP II), November 2012

cleaning materials and hygiene kits[34] as well as water facilities. However, in most schools toilet facilities were common for both and girls, and this is attributed to be one of the reasons why number of girls drop out. Teachers in Haradh complained that while they were taught the minimum educational standards, basic facilities like adequate water and sanitation did not exist. In Amran, this aspect appears to have worked better as, working closely with CIY, SCY has tried to integrate WASH in its support to schools.

SCY had budget for distribution of uniforms to IDP children in Amran schools, but this caused problems as there were number of students from poor and marginalised families in host communities who needed support. Finally SCY had to include vulnerable children from host communities in the distribution. In some areas, in order to cover more children, SCY coordinated with other agencies (UNICEF and Al Saleh Foundation) which distributed uniforms and bags to children.

Conclusions:

1. SCY's education in emergencies programme is helping in increasing access to education for IDP and host community children, besides improving learning environment in schools through staff training and promotion of students' councils.

2. While SCY has attempted to cover a substantial number of schools in selected districts, its school rehabilitation work has in several instances failed to integrate minimum standards of sanitation provision.

3. Overall, the education component of IERP was delivering the outputs as intended in the logframe.

3.4 Water and Sanitation (WASH):

3.4.1 Overview

As per the logframe, the WASH activities were to deliver the following outputs: (a) provision of water facilities; (b) training of households on safe hygiene practices; and (c) provision of hygiene material to selected households.

CIY and Oxfam GB are two CPs which have a significant emphasis on WASH in their programme. Currently in the rural areas of Yemen, 43% of people do not have access to safe water.[35] Oxfam has focused on Hodeidah and Sa'ada governorates and CIY in Amran, all of which are affected by chronic poverty; the latter two are particularly vulnerable to incidence of conflict and IDPs on the one hand, and security and access issues limiting the presence of humanitarian organisations on the other. In line with priorities identified by the WASH cluster, both Agencies have prioritised the following objectives in their WASH programme:

(a) Restore, increase and sustain access to safe drinking water and domestic water from surface and ground water sources to emergency affected areas; and
(b) Restore, increase and sustain access to sanitation facilities to emergency affected areas and enhance personal and environmental hygiene standards.

3.4.2 Key findings

Oxfam:

In Shujaina village of Al Sukhna district, Oxfam trained five female WASH volunteers chosen by the village committee. The volunteers make home visits and educate women about six key hygiene messages which include preparation and use of oral rehydration solution (ORS) for treatment of diarrhoea, hand washing, personal hygiene, breastfeeding, boiling water to make

[34] In Amran schools, these were provided by CIY, with both SCY and CIY working together.
[35] WASH cluster, Yemen. *Strategic Operational Framework - Standard and guidelines of WASH cluster* – 2011

it safe and excreta disposal (one message for each household visit). School children take part in child-to-child learning project on 'healthy habits'. They teach their siblings what they have learnt - messages include: cutting nails, combing hair, washing hair and body, brushing teeth which now all children practise, as observed in schools and reported by students and teachers. All women in the FGDs received training in hand washing, excreta disposal (those who do not have a bathroom dig a hole and bury faeces), house cleaning, and importance of clean water. Women in FGDS reported that since their training, they washed hands properly after using toilets, before eating, and they kept their children cleaner and practised safer breastfeeding.

For distribution of hygiene kits, Oxfam targeted families with under-5 (u-5) children who received items like soap, washing powder, water container, jerry can, water storage container. Some women who have slightly older children only received soap – and most interviewees felt that it was unfair to differentiate between u-5 and 6-8 year children who were equally vulnerable. All women however asserted that since receiving WASH messages they kept their children and homes cleaner and tidier, and had better food hygiene. Water shortage continues to be a problem in Al Surad village of Hodeidah. Women have to walk for 30 minutes to the nearest well.

Box 4: Hygiene education in Al Surad

Two women in Al-Surad village of Hodeidah received WASH kits in November: water container, large bowl, small bowls, soap, washing powder. One of them rarely uses the water container. The large bowl given to her is useful. They also received white sheets like those used for "wrapping bodies in." She has not used these and does not know what they've been given to her for. The new idea they got from the training was how to make ORS to treat diarrhoea. All the women in the FGD attended a hygiene training session and learnt how to make ORS to treat diarrohea in children.

In Hais district, Oxfam trained 40 public health promotion (PHP) volunteers – each village had one man and one woman trained as PHP volunteer. Child-to-child activities through schools were also promoted to complement the work of PHP volunteers.

Oxfam is the only CP agency working in Sa'ada through IERP – its work is concentrated in four districts: Saqain and Sahar in the east, and Al-Dhaher and Sheda in the west Under WASH, Oxfam has undertaken construction /rehabilitation of wells, providing water pump and water points/ pipes for water distribution network. In the areas visited, Oxfam has rehabilitated 5 water wells, provided covers, apron and fencing, and educated people about water quality and hygiene. The response to hygiene education in the area has been mixed, possibly because water shortage is a big problem in Sa'ada villages. Oxfam staff said that although they have tried, it has not been always technically feasible to meet Sphere standards in terms of water quality and/or proximity to water points. In Al-Rozam village of Malaheedh district, water distribution is controlled by Al Houthis who charge YR 2500[36] per month from each family, making it unaffordable for many families to access sufficient water. In at least one FGD, several women were critical of the hygiene education programme as their first priority was to get enough quantity of water which Oxfam had not provided, although some of them appreciated having received soaps and cleaning materials which were useful.

Despite some criticism – which appeared to have come from villages where water shortages were acute and from families who may not have received hygiene kits or other direct benefits from the project – overall, there was a general agreement that awareness among children and villagers on hygiene and cleanliness had improved, and villages were kept cleaner than they were before. Evaluation team saw that most of the villages now have earmarked places for disposal of garbage which are overseen by village committees. Hygiene campaigns have been conducted by volunteers in number of villages.

In Al-Marbaz village in Sheda district, Oxfam rehabilitated a well and provided a pump. The water yield is good throughout the year and the pump now enables easy lifting of water and distribution from an overhead tank to the entire village of about 75 families.

[36] US$ 1= YR 215

CARE:

CARE's work in Amran is concentrated in seven districts where it carried out rehabilitation of water points and conducted hygiene promotion through community education, school committees and environmental clubs in schools. CARE's work through the IERP in all the three phases has focused on this governorate, and this helped develop an area-based approach in its WASH work whereby it seeks to maximise the impact in villages by working through communities, schools and volunteers. In several villages, CARE worked closely with SCY, with the former providing WASH facilities and hygiene kits in schools which were rehabilitated by SCY. CARE formed environmental clubs in schools with students and teachers who ensured that the school remained clean. Besides this, awareness committees involving 4-5 students and teachers each were formed whose job was to regularly visit communities and educate the latter on hygiene and use of hygiene kits.

Box 5: CARE's WASH work in Amran
12 water points were rehabilitated in 7 districts. Hygiene campaign was conducted in these districts, targeting 2500 households. 12000 hygiene bags were distributed in the 7 districts. Environmental clubs formed in 21 schools. Trained 50 volunteers and 12 committees.

Transect walks in the villages and FGDs with both school awareness committees and villagers showed that waste disposal habits have changed in communities and people do not litter everywhere. Number of families who have financial resources now see constructing toilets as an important priority, especially with awareness of women's particular needs; others started to dig holes for faeces disposal. CARE has also distributed household water filters in schools and houses which are extensively used. Each filter costs about US$ 30 and requires minimal maintenance, although the inner ceramic silver filter[37] needs replacing once a year at a cost of US$ 15. A woman health awareness volunteer makes home visits to educate people about sanitation, use of water filter, hand washing and waste management. There is also a man health promoter who conducts similar sessions with men in the village.

Question may be asked if people will continue to use the practices (like hand washing, use of water filters, safe disposal of garbage) they have learnt once the project ceases to supply materials like hygiene kits or water filters. While time alone will tell what proportion of people continue with the newly acquired habits, experiences elsewhere in similar programmes showed that if people were encouraged to use a practice for some length of time, they tend to stick with it even after the project comes to an end. This may be subject of an empirical study in coming months in the project area – to test whether families who use a water filter for a year or so, and families who get used to donated hygiene items for a few months, are likely to continue to use these into the future, utilising their own resources.

The water sources developed /renovated by CIY include berkeds,[38] plastic water tanks fitted with tap stands, installation of water lifting devices (pumps/motors) in existing village wells. In Almalaha village of Jabel Yazid district, CIY rehabilitated a well and provided a pump and tanks for water storage. A women's committee was formed to manage the water system; the committee is responsible for collecting water charges,[39] maintenance of the system and ensuring cleanliness and hygiene at the water source. This arrangement appears to be running smoothly, with all women actively participating. CIY staff stated that in several other villages (not visited by the evaluation team), similar women's committees have been functioning and participation in these has been strong. FGD and interviews revealed that a men's committee was also formed in this village to oversee all work, but this has remained inactive. In a neighbouring village, Al Sawadain, where CIY provided a water tank with tap stands during phase II, it was observed that all taps were continuously leaking. A brief unstructured discussion with a group of men and women present at the site indicated that this leakage has been going on for over two months, and the village committee which was put in

[37] Colloidal silver impregnated ceramic water filters placed inside a plastic casing.
[38] Berked (or berka) is a conventional rainwater harvesting structure which collects runoff from external ground catchments into an underground tank constructed for the purpose of storing water – very similar to structures found in Somalia and Ethiopia.
[39] Each of the 30 beneficiary families is required to pay YR 200 every two weeks to cover cost of running the pump.

place earlier by CIY was not doing anything about it. Some committee members interviewed complained that villagers[40] were not prepared to pay the cost of repairs which would come to about YR 4,000 (less than US$ 20) in total.

Conclusions:

1. The hygiene promotion work of both CIY and Oxfam is changing sanitation and personal hygiene practices in schools and villages, and this needs to continue through the cadre of volunteers that have been trained by the CPs.

2. In both Oxfam and CIY, staff were well aware of Sphere standards for WASH and have taken steps to ensure quality, though it may not have always been possible to adhere to minimum standards of water quantity for each family because of limited capacity of available water sources.

3. An impact study on hygiene practices in the next 6-12 months in the project area could test and generate important evidence-based lessons for future policies in relation to two main approaches: (a) criticality of hygiene kits in adoption of hygiene practices; and (b) maintenance of water filters using own resources.

4. Although the evaluation has not seen any work of CPs carried out during phase I or II to assess how sustainable the WASH/village committees that were set up have been, it was noted in Amran that women's WASH committees functioned better than men's, and this needs further research to test its validity as a strategy to make future WASH programmes sustainable.

5. Overall, the WASH component of IERP was delivering the outputs as intended in the logframe.

3.5 Early Recovery & Livelihoods:

3.5.1 Overview

Three CP Agencies, Oxfam, ADRA and IRY prioritised livelihoods programming – Oxfam in Hodeidah and Sa'ada governorates, IRY in Hodeidah, and ADRA in Sana'a and Hodeidah. The approach has been to provide a diversified range of livelihoods activities depending on individual skills and capacity as well as the carrying capacity of local economy. Key outputs defined in the logframe were: (a) people that participate in vocational or business management training; and (b) households receiving financial or non-financial productive inputs to develop an income generating activity.

The main causes of current food insecurity in Yemen include limited sources of income for the poor, fragile livelihood systems in rural areas, volatility of international food prices, and internal conflicts and displacement.[41] The causes are therefore chronic – due to marginal livelihoods system - as well as acute, owing to conflict related emergencies. The joint rapid assessment[42] conducted by IERP had concluded that employment generation and income-diversification activities (such as currently included under the IERP) might be an adequate tool to assist host communities/returnees, including provision of livestock/ agricultural inputs, vocational training, and skill training especially for women. For the vast majority of vulnerable households amongst IDPs, cash-programming (including cash-for-work and conditional/ unconditional cash grants) are considered favourable options for promoting small business initiatives, as well as to ensure better access to basic services. The study found that most difficulties in other sectors experienced by vulnerable groups were related to the lack of access to cash to pay for basic services, such as food, water, education and health.

3.5.2 Findings

ADRA:

[40] Interviews indicated that no less than about a hundred families use this tank to draw water for daily use.
[41] WFP. *WFP Yemen Food Security Monitoring System (FSMS) Bulletin*, February 2013
[42] ACAPS. *Joint Rapid Assessment of the Governorates of Northern Yemen*. October, 2011, p.7

ADRA's livelihoods work in Sana'a has targeted IDP communities. Selection of beneficiaries has been based on criteria such as:[43]

- Disabled / family includes a disabled member
- Female-headed households / low income women
- Display of a marketable skill (i.e. experience in tailoring).

Selected beneficiaries were provided livelihood support in the form of loans-in-kind (through purchase of inputs, raw materials or capital items) worth YR 65,000-165,000 which is required to be repaid in 10-15 equal installments. Beneficiaries were provided a week's training on basics of managing small businesses and income generating activities (IGA). In Sana'a, 61 people – mostly those who came from Sa'ada in 2010-11 - received loans, which are repaid at the rate of YR 8,000 to YR 20,000 per month. In a few cases met by the evaluation team, beneficiaries who had already been running some form of activity before taking the loan were making enough to be able to repay the loan, but in a large number of cases, families were already eating into the capital for meeting their family expenses. One grocery shop owner has to pay a rent of YR 20,000 per month (about YR 700/day) which means that out of his average daily net return of about YR 1,500, he needs to set aside YR 700 for rent, leaving only about YR 800 (US$ 4) for his family expenses and for repayment of loan. In one case, materials were purchased through the loan, but the beneficiary has not yet been able to start the business, as he has not found a place to operate from. In another instance, a woman was provided sheep which she was interested in, but as fodder has to be purchased throughout the year in Sana'a, this activity has become unviable.

In Hais where number of beneficiaries (both women and men) had received loans for IGA previously – some received 2-3 times in previous years through various projects – they have established their enterprises and are able to sustain themselves after repaying the loans. The loan repayment system has had both positive and negative effects on ADRA's interventions, as was evident in Hais. On the one hand, it encouraged serious commitment on part of beneficiaries to make their IGAs success and regular repayment gave them opportunity to seek repeat loans with which they could expand their business. On the other hand, ability to repay being a key consideration in selecting beneficiaries, targeting has included beneficiaries who can be considered some of the prosperous people in the community - educated youths whose parents were able to top up the loan amount with own capital; a flourishing family 'supermarket' which obtained loans to add a mobile SIM business to his ongoing business. It is understood that few better-off beneficiaries were supported by ADRA with the idea that expansion of their businesses would bring new services or make new items available within the neighborhood, and allow hiring of one or two workers to support the expanded business. The evaluators have not seen or heard of any example of additional employment being created as yet. Livestock loans (in cash, US$ 200 per family) were given to ten families in Hais for which beneficiaries selected were those who could produce a guarantor from Hais town (usually a trader) who was known to ADRA. The animals were purchased in local markets involving the loan recipient, guarantor, and a community member with breeding experience, although none of them knew if the animals purchased were vaccinated before distribution.

Box 6: Woman grocer of Hais

One woman received YR 30K in cash in January. Repayments are YR 5K per month – making sure she pays this back is the most important thing to her. She bought groceries to sell from her house (biscuits, cheese, kerosene, coal). She is the main money earner in the family. This is her third loan from ADRA – the other two she used for livestock (fodder was expensive) and then clothes to sell (income wasn't regular) and paid back. She had training on small business management (4 days) and was given a manual but she can't read. She had longer time to pay the previous loans off than the current loan.

The IERP III livelihoods activities started in September 2012 and as the effective project duration was only about six months, staff came under pressure to select beneficiaries in a short time. Beneficiaries also complained that in previous years, they were given longer time

[43] IERP Phase III – *Main Narrative Proposal - Integrated Emergency Response Programme for Yemen Phase III* (2012-13), 15 May 2012

to repay loans, but during this year, they were being asked to repay in 6-8 installments. While there are potential advantages of providing inputs through loans, this needs to be managed in a way that multiplies the capital and ensures repeat loans to beneficiaries over a period of time until they build a sustainable livelihood, as has been the experience of successful microfinance programmed worldwide. ADRA will need to build its expertise in beneficiary selection and choice of activities, as well in management of loan portfolios. Interviews with ADRA staff in both Sana'a and Hais brought out the need for better selection of IGA activities and skills in business planning and feasibility/viability studies, as well as acquiring livestock expertise for future programme.

IRY:

IRY's livelihoods interventions were concentrated in Hodeidah Governorate where it targeted 1,160 beneficiaries – 700 with livestock and 460 with IGAs. The selection of beneficiaries was made from the list of Social Welfare Fund (SWF) cash transfer beneficiaries through a detailed assessment of each beneficiary during door-to-door visits. For livestock support, each beneficiary received at least three animals (usually three or four) under 18 months old which were procured locally. Beneficiaries could choose their own combination of animals for fattening and reproduction.

Animals were distributed in January and onwards. Internal procurement policies required tendering which delayed livestock procurement. Animals had to be procured locally to be suitable to the environment and it was not possible to find one single supplier able to provide the number of animals needed. So IRY formed its own team to support the suppliers in procuring animals from local markets to speed up procurement. All animals were vaccinated before they were distributed to beneficiaries. The delay in the start-up of the project meant animals were distributed in winter when it was harder to feed them, especially in some of the peri-urban areas where sheep were distributed.

Box 7: Woman entrepreneur in Al Qataa

F1 is the sole breadwinner in her family, with four children and disabled husband. Lives in a rented house. All her children suffer from a genetic disorder, sickle cell anaemia, for which they need regular medication. She was provided YR 35,000 worth of good (household utensils) in early March which she vended through door-to-door sales. Although she received no training from IRY (at the time of the evaluation visit), she is confident that with her previous experience, she can now expand her business.

IRY's beneficiary selection process ensured that target households were either experienced in or were currently practising livelihood activities (i.e., livestock, vocational training, etc.) in order to ensure a level of sustainability. Beneficiaries of IGAs met had all been running their activities for some years, and the support from IRY appears to have helped them develop their activity. Beneficiaries met during the evaluation did not have alternative means of livelihood and appeared to be highly vulnerable, although the evaluation could not assess if other vulnerable families were left out. Unlike in other CP programmes, IRY did not provide training to livelihoods beneficiaries before providing the inputs, and this was provided at the end of March.

Oxfam:

Oxfam's livelihoods programme was implemented in Hodeidah and Sa'ada governorates. Livestock was distributed to 1,050 families and another 1,290 received IGA support. Livestock distribution took place in two batches, first in November and then in February, all procured locally. Each livestock beneficiary received two months of fodder supply. Oxfam used the SWF list for selecting beneficiaries for which it set up a small committee involving one member from local council and 2-3 villagers (usually 2 men, 1 woman). The latter reassessed the list based on eligibility criteria provided by Oxfam and made the final selection. FGDs with mixed groups beneficiaries and non-beneficiaries revealed that selection was made by Oxfam with the help of committees, with little involvement of the wider community which was not aware of the selection criteria. The committee members were the most vocal in all FGDs, and the men on the committees seem to have played a more central role in decision making than women.

Livestock beneficiaries met in Al Surad village of Hodeidah included women-headed households, disabled and families whose sole source of income was gathering firewood and selling these in local market. All livestock beneficiaries were given training in care of animals. Oxfam also trained 20 paravets in Hodeidah who were provided a small kit to provide veterinary care services to villagers, for a small fee. The paravet service is appreciated by villagers, although it was not clear how the kit will be replenished once the stocks run out.

Box 8: FGD with women in Al-Shujaina

18 women in the village are now doing sewing. 18 days of training on design, cutting, marketing received in December along with machine and material. They all had experience of sewing and some had machines but these were in bad condition. Now they make clothes and sell them in the village. Their lives have improved because now they can contribute to household expenses. Previously, they or their husbands could only make money from daily labour, if they found employment. Sometimes they face problems with transportation or have to borrow money to go to buy material from the markets. They would like to receive further training to learn advanced skills. Their selection was made by a committee with two Oxfam staff.

In Al Sukhna and Hais districts, Oxfam distributed sheep and goats to 850 families in phase III. After the first round of distribution (475 animals) took place in November, families reported the animals to be sick in five villages of Hais (32 families lost livestock which were replaced). Working closely with the animal health authorities, Oxfam undertook prompt screening and investigation which identified a new infectious disease in the animals, with the newly supplied animals being particularly vulnerable. Oxfam organised extensive vaccination campaigns in the affected villages with the help of local authorities, and the outbreak was contained.[44]

Oxfam's rationale for targeting (people with existing experience in a particular livelihood who have been hit by the recent crisis) seemed logical in terms of early recovery and their selection was generally good. In Hodeidah villages, a large number of livelihoods beneficiaries met were also recipients of unconditional cash transfer programme run by Oxfam which was funded through another DFID grant. Many of them received $200 Oxfam cash assistance in two installments, besides SWF payments of YR 12,000 every 3 months. The evaluation believes that often the poor require significant injection of cash and other forms of assistance over a period of time to create and/or rebuild sustainable livelihoods. For this reason, this evaluation thinks that supporting the same families with different forms of assistance (livelihoods support through IERP and cash transfers through another DFID humanitarian project, besides the fact that they were receiving a small cash support from SWF) was a good strategy, although this will require proper monitoring, follow up and data-gathering to determine how long such support needs to continue for each targeted family. Oxfam had earlier noted that complimentary cash transfer programmes will enhance local purchasing power and create the demand which otherwise would be stifled by the weakened purchasing power,[45] and this certainly is a valid argument.

In Sa'ada, for livelihoods Oxfam conducted house-to-house visits to understand people's needs and vulnerabilities. In addition, Houthis conducted their own assessments to make sure that Oxfam had chosen the most vulnerable people. A number of beneficiaries were provided intensive training in carpentry and masonry – the training lasted about three months – and, at the time of the evaluation visits, trainees were still waiting to receive their kits. It was reported that, as people begin to return to their homes in Sa'ada, there is big demand for these services.[46] In Sa'ada, 125 women have been given training in sewing and embroidery, and provided sewing machines in March. FGDs revealed that some women who have been involved in 'village tailoring' work in the past may find these training helpful and generate income, but for a large majority, the training will give them enough skill to meet their household requirements of sewing and tailoring.

One activity which Oxfam has assisted in large numbers in both Hodeidah and Sa'ada is bee-keeping. Number of families who were already into this trade in a small way were assisted

[44] 108 of 475 purchased animals died of the outbreak.
[45] CARE/PMU. *IERP Clarifications Interim Report*, September 2012
[46] In the IERP III, quarter 2 report, it was noted that there was limited demand for services in these areas, but this may have changed as people begin to return to their homes.

with three boxes of bees and this helped them make their ongoing activity more viable. It was noted that while bee-keeping is a high value activity, all bee-keepers met during the evaluation were highly vulnerable and some of them were engaged in daily labour or selling firewood to supplement their income. It is expected that the additional boxes and tools provided by Oxfam will help increase their income.

Conclusions:

1. ADRA's livelihoods intervention was based on providing loans; this has its advantages and potential if managed in a way that multiplies the capital and ensures repeat loans to beneficiaries over a period of time until they build a sustainable livelihood. ADRA will need to build its expertise in beneficiary selection and choice of activities, as well as in management of loan portfolios.

2. Both IRY and Oxfam have been able to ensure good targeting of vulnerable, although Oxfam's beneficiary selection process is seen less transparent by the communities as it involved a limited number of community leaders and Oxfam staff, and relatively low participation of women.

3. Oxfam's approach, in some villages, to targeting the same families with multiple inputs has potential to contribute significantly to transforming livelihoods of targeted families, provided the outcome is monitored regularly and the response adjusted based on empirical evidence over a period of time. This may also offer evidence-based lesson for the humanitarian sector in early recovery/livelihoods programme in Northern Yemen.

4. Overall, the livelihoods component of IERP was delivering the outputs as intended in the logframe.

3.6 Protection:

3.6.1 Overview

Protection is integral to all humanitarian response and humanitarian organisations have a duty to protect the lives and dignity of people of its concern. In Amran CARE has been working in partnership with Yemen Women's Union (YWU) to provide specific assistance in the area of legal aid, counselling, psychiatric care/treatment to women who are victims of domestic violence, sexual harassment, and family disputes. As per logframe of the project, the protection activities were to deliver two main outputs: (a) women receive protection services and legal advice/counselling; and (b) community leaders and government aides that receive advocacy messages about protection needs of women and girls.

3.6.2 Key findings

Sexual and Gender-Based Violence (SGBV) was common among IDP population and to deal with these, YWU worked with tribal leaders, local councils and the Governorate. The evaluation team met dozens of women and young girls who have been victims of physical and mental torture by male members of family, sexual abuse, alienation of property rights, forced marriages. Judicial committees involving judges and lawyers were formed to provide assistance in complicated cases. CARE support started in phase II and has continued in phase III, with some interruptions between April and June 2012 (time lag between phase II and III). YWU community mobilisers conduct regular advocacy sessions with community leaders, local councils, teachers, students and women to create awareness about the issues involved and make women aware of support they can obtain. Child marriage is very common among the tribes in Amran, and YWU has been working with tribal Sheikhs to educate them about tackling this issue. Community leaders, including some women, in the villages visited asserted that they were now actively discouraging child marriage.

Several cases of depression and schizophrenia arising from ill-treatment in the hands of male family members, physical and mental abuse and sexual assaults which remained untreated for long time were also taken up through the programme and referred to specialists. Some of these women met during the evaluation are reportedly already showing signs of improvement; however, families were worried that if the project funding stopped at the end of March, they

may have difficulty accessing the treatment. The same concern was noted for several legal cases which were pending in courts, as withdrawal of funding support for these may cause more harm to the cases.

CARE's support[47] to YWU has been, besides funding, toward building capacity of the latter's staff through training in legal protection, conflict resolution, international humanitarian law and presentation skills. Community mobilisers and advocates associated with YWU were trained in conflict resolution which they found particularly useful in mediation of family disputes. FGDs with village women in two locations indicated that an increasing number of women are now speaking out about the abuses they suffered for years at the hands of their family and relatives, and seeking support.

Conclusion:

1. CARE's support to YWU has been crucial in creating awareness about SGBV in Amran and an increasing number of women were coming out in various districts seeking legal assistance, counselling and medical support, and this work needs to continue, as any discontinuation of support mid-course may cause harm to the beneficiaries.

2. Overall, the health component of IERP was delivering the outputs as intended in the logframe.

Section 4

Evaluation Findings – Assessment Against OECD/DAC Criteria

4.1 Relevance:

Relevance is concerned with assessing whether projects are in line with local needs and priorities and refers to overall goal and purpose of a programme.

Yemen is caught in a complex emergency, with more than half of the population affected and a third targeted for humanitarian aid. Thirteen million people do not have access to safe water and sanitation, 10.5 million are food-insecure, 431,000 are displaced, and 90,000 children do not have access to education. Almost 1 million Yemeni girls and boys under-5 are suffering from acute malnutrition, of whom more than 250,000 have life-threatening severe acute malnutrition. Over the last two years, humanitarian programming has increased nearly threefold in scale and the funding received for the Yemen Humanitarian Response Plan (YHRP) has increased from US$121 million in 2010 to $329 million in 2012.[48] The IERP which began in response to the conflict in northern governorates has continued to address the central issues underpinning the interagency humanitarian plan. During phase III, the IERP expanded to include Hodeidah Governorate which was assessed as having some of the worst indicators of humanitarian need in its coverage.

[47] CARE has been supporting YWU since 2004
[48] OCHA. *Yemen Humanitarian Response Plan*, 2013

Although IERP funds were small in comparison with the overall need,[49] the CP members have played a key role in meeting core needs of some of the vulnerable communities. The nutrition interventions (nutrition education and CMAM), hygiene promotion and education in emergencies, in particular, have already been producing humanitarian outcomes for displaced, conflict-affected and vulnerable families in significant numbers in the districts where CPs are working.

The provision of water through development and rehabilitation of water sources in different districts is a critical need and two of the CPs (Oxfam and CARE) were focusing on this. The scale of the activities, however, in relation to extensive needs, remain small and scattered. This is undoubtedly a difficult area as availability of water resources, terrain and persistent under-investment in the sector by governments make any large-scale programming for developing and tapping water resources hugely resource-intensive. No single agency probably can solve the problem of water shortages in districts of Amran or Sa'ada, and this is where more coordinated and consolidated approach among multiple agencies will be required to draw up comprehensive plans and resourcing strategy.

The health interventions in Al Jawf and those in Sana'a targeted at the IDP communities fulfill major unmet needs of vulnerable communities. IERP has attempted to contribute to addressing chronic food insecurity arising out of structural causes as well as protracted emergency through livelihoods response. Oxfam in particular has, in some districts, combined livelihoods interventions with unconditional cash transfer to the most vulnerable which is highly relevant in the context as communities will require multiple assistance over a period of time in the form of cash and assets to create/rebuild sustainable livelihoods capability.

Overall the relevance of IERP remains strong and the evaluation concluded that design of the programme took into account the context and needs of the vulnerable. However, as was noted in the external review[50] undertaken in early 2012, a high proportion of the humanitarian needs remain unmet by both the consortium and other agencies; and the sectoral reach of IERP remains limited, with IERP districts sometimes having only a single sector or agency operating in a geographic area.

4.2 Efficiency:

Efficiency measures how economically inputs (funds, expertise, time) have been converted into outputs.

4.2.1 Management and coordination of Consortium

Taking lessons from previous phases, IERP III aimed at bringing about greater integration in programming by the CPs, with efficient management of the Consortium. The Consortium has introduced new management structures, with clearly defined authority for the Consortium Manager. A Project Management Unit (PMU) comprising a Consortium Manager, Assistant Manager, Finance Officer and M&E Officer, was established to oversee the project. In order to provide guidance to the PMU, a Project Steering Committee (PSC) which functioned as the decision-making body of the Consortium, and comprised the Consortium Manager of the PMU and a senior representative (Country Director, or Deputy or a designated staff member) from each of the Consortium partners, has been formed. The PMU is responsible for monitoring overall performance and has executive decision-making authority to reallocate funds and adjust project plans as a matter of last resort, if the PSC fails to take adequate action regarding performance or funds utilisation. The Project Steering Committee is also responsible for reviewing progress at regular intervals, bringing in a culture of collective responsibility.

[49] For the year 2012, the humanitarian needs were put at $585 million, as per the YHRP 2012.
[50] Sharon Beatty. *Integrated Emergency Response Project II for Yemen 2011/2012 - External Review*, February 2012

During phase III, CARE International UK began providing full-time support for the project from London to ensure timely liaison with DFID and to quality-assure reporting provided by the Consortium. CIUK appointed a full-time Emergency Programme Officer (EPO) who joined PSC meetings where possible, made regular visits to the country to work with the PMU (five visits during the project period) and maintained regular contact with the Consortium Manager and CIY senior staff to oversee the project from a contract management perspective.

Key informant interviews with all stakeholders provided a consensus view that setting up the PMU and PSC during phase III streamlined management and decision making, and CARE International UK's support improved quality of reporting on the project. CPs felt that this brought about better coordination among agencies, and members were better informed about the work of each other.

4.2.2 Timeliness

The project startup was delayed by 3-4 months due to three main factors:

a. delays in finalising the project agreement between DFID and CARE International UK (CIUK);[51]
b. gaps in Management capacity in CARE Yemen in the middle of 2012; and
c. delay in release of funds from Head Offices of CP-Agencies to their Yemen country offices.

The signing of agreement between CIUK and CARE Yemen (which involved approval by CARE US as the managing office for CARE Yemen) took at least five weeks after CIUK's signing of contract with DFID.[52] CIY (and CP members) was not made aware of the fact that DFID had backdated the start of the project to 15 May until end of June when it received the contract from CIUK. Likewise, signing of contract between CIY and CP-Agency Headquarters sometimes took several weeks as multiple offices[53] were involved in clearance of Memoranda of Understanding (MOU). Because of these, funds were received by CPs only in middle of August[54] which accounts for a delay of three months from the official start date of the project. It is to be noted that similar delays were observed in previous phases as well, as was noted in the external review of 2012,[55] indicating little improvement in this regard in phase III. The evaluation observed that in the case of some CPs, bulk of work on the ground started only in November 2013, as they needed to carry out assessments and do the groundwork for implementation after they received funds for the project. It is unclear to the evaluation team as to why necessary groundwork could not be carried out even while waiting for formal contract and funds transfer.

The project implementation was overburdened with compliance demands from DFID. DFID introduced a new requirement for quarterly requisition of funds which stipulated that unless 90% of the funds released in previous quarter was spent and accounted for, further funds would not be released. The contract between DFID and CIUK stated that any deviation in budget by more than 10% against a line item would require DFID's prior approval. However, in practice, even a less-than 10% readjustment of budget within different sectors within an agency budget required DFID's approval, and this took time. SCY wanted to move funds from underspent budget on salaries to purchase of medicines – an item not included in the original budget - and this took almost three weeks to obtain approval of DFID. All CPs reviewed their budgets in November and submissions for necessary revision were made to DFID which took three weeks for approval. CIY and Oxfam increased their physical target on water, keeping within the allocated budget, and even these changes needed approval by DFID. SCY's original proposal had put a figure of 60,000 children to be covered through its mine risk education, based on figures made available to it by local authorities at the time of preparing

[51] Contract signed on 28 June 2012.
[52] Signed on 3 August 2012
[53] In case one Agency, correspondence over wording of one clause in the MOU reportedly went on for several weeks.
[54] Funds were transferred by CIUK to CIY on 3 August, and CIY released funds to CPs on 15 August
[55] Sharon Beatty. *Integrated Emergency Response Project II for Yemen 2011/2012 - External Review*, February 2012

the proposal. On closer scrutiny during implementation, SCY discovered that this figure was wrong as the number of children in the target area was smaller, and hence wanted to revise the figure downwards; however, DFID insisted that SCY ought to stick to its original target.

DFID had confirmed willingness to receive a no-cost extension request following discussions between CIY and DFID in Sana'a in December. Following discussion in London, a formal request was submitted on 15 February 2013 which had to be revised and resubmitted[56] on 7 March. The approval of this request for no-cost extension came on 25 March 2013.

The evaluation noted the weaknesses and inefficiency the project implementation suffered during previous phases, and these may have been reasons for DFID taking on a hands-on approach in overseeing the project implementation, almost to the point of micro-managing the project's progress which certainly contributed to some of the delays in implementation during this phase.

4.2.3 Sectoral interventions and outputs

The evaluation's key findings on outputs in various sectors is presented in section 3. The evaluation has not seen detailed progress reports showing numbers and physical measure of outputs.[57] For a project which had an effective duration of 5-6 months for implementation, the sectoral performance has been along expected lines – the project has attempted to address several chronic issues arising out of structural causes as well as complex emergency through a short-term emergency response. Despite this, some of the interventions in the field of nutrition, health education and health services for IDPs, as examined in section 3, have generated demonstrable outcomes in a short time.

In Amran, both CIY and SCY have continued their operations from phase II, and in Sana'a IDP camps and Al Jawf, ADRA continued its health work from previous phases. Except for these, most of the other interventions have been in new geographical areas. The evaluation observed that the IERP operations were dispersed over a large area, in some areas covering only a few locations. For its modest budget, IERP might have had better economies of scale and synergy had members focused on a smaller geographical area and implemented their activities in the same areas throughout the duration of the project. The evaluation saw better cooperation and synergy between two CP members operating in Amran than elsewhere, probably because they have been working in the same area for several years and knew the communities well.

During planning for phase III, the project envisaged greater integration of programme among the CPs which did not materialise. In some sense, this was only expected. The Consortium was designed purely as a mechanism to access funds and created on the suggestion of DFID, and trying to thrust upon the members with varied competence and focus in multiple sectors and geographical areas an 'integrated' programme was unrealistic. At their best, such consortia can achieve a degree of coordination and mutual learning, which this project has attempted to do – though not always very successfully. It needs to be noted that consortium mode of programming is always time-consuming for everyone involved, and this becomes costly if the consortium is not built on a coherent joint programme with a limited set of shared objectives right from its inception. Some of the transaction costs associated with consortium processes could have been minimised had the programme had a longer time-frame that avoided a stop-start approach to project formulation and implementation.

[56] This was due to one of the CPs, Oxfam, changing its mind at a late stage – initially Oxfam did not show interest in no-cost extension, but in a PSC meeting on 20 February by which time the proposal was already submitted to DFID, it expressed its interest to be part of the 'extension' proposal.

[57] The evaluation was conducted in the last month of project implementation when activities were still being implemented. It was understood that a project completion report would be prepared by the project detailing out the physical measure of outputs achieved.

4.2.4 Coordination, learning and sharing

There has been some sharing of expertise between ADRA and IRY.[58] The Consortium held a learning workshop in February which was attended by all CPs. Coordination among CPs took place at national level. Sectoral meetings through working groups (WASH, Livelihoods, health, nutrition) took place in Sana'a which coordinated sectoral implementation as well as training and capacity building activities of members. At the field level, geographical coordination among the agencies was attempted in Hodeidah where at least four of the Consortium members were working, but this did not get traction to get going. Technical working groups with heads of sectors from CP member agencies was also initiated, but as the activities remained confined in Sana'a and communication did not trickle down from Sana'a to the field offices, the mechanism became dysfunctional.

CPs worked in partnership with local NGOs, some of who had better knowledge of the area. In Hais, ADRA used Al Mustaqbal and Noussra for community mobilisation; Oxfam used Al Mustaqbal and YWU as local partners and CARE's partnership with YWU in particular has been strategic in that YWU has been supported to take on full responsibility for implementation of activities under CARE's protection programme in Amran. The CMAM programme was implemented in partnership with UNICEF, WFP and local health authorities and the approach it has adopted through use of locally trained volunteers kept overall costs down.

Only in Amran did the evaluation find strong coordination between CIY and SCY - they have been holding two coordination meetings every month throughout all three phases of the project. Weak coordination at the field level created a particular problem in Hajjah and Hodeidah. Oxfam's cash transfer programme required[59] that in order to be eligible, families had to have a SAM case in the household and be registered with SCY/health centres. SCY CMAM volunteers and health staff came under pressure from community leaders to include names of children who may be only moderately malnourished. Both the organisations have discussed this at Hodeidah level, but the problem seems to continue in Hajjah.

KIIs with external stakeholders suggest that most of the CPs played a leading role in various clusters for humanitarian coordination, with the names of Oxfam and SCY being mentioned by most interlocutors without prompting.

4.2.5 Performance tracking and M & E

With strengthened mandate for the PMU, mechanisms were put in place for regular monitoring of sectoral outputs, and for reporting to the PMU to deal with forecasting, reporting and financial management issues. A dedicated M&E Officer was recruited for the project with the task of: (a) developing tools to monitor the quality of interventions provided under the project; (b) conducting an impact assessment of training and awareness-raising campaigns; (c) improving the timeliness and accuracy of reporting to DFID; and (d) developing a system that supports ongoing learning by partners. A monthly monitoring tool was developed which was used by CPs for providing consolidated data on progress to PMU. The PSC regularly reviewed progress. There have also been some peer monitoring visits by PMU and member-agency staff – for example, a joint monitoring visit by Oxfam, SCY and CIY was undertaken to learn from each other's WASH programme.

Weekly monitoring sheets were used by all CPs for gathering data on outputs, processes and beneficiary numbers across all sectors and for all partners. The PMU, consortium partner M&E focal points, and field staff were involved in this task. As well as the harmonised data sheets, each partner has an IERP activity log and a monthly tracker document (based on the format of the activity log).

[58] ADRA helped IRY in developing a list of medical supplies for the latter's health centres, besides allowing participation of two IRY staff in ADRA's health training.
[59] This appears to have been the case only in villages which were covered under SCY's nutrition interventions.

Conclusions:

1. The functioning of the consortium improved significantly in phase III, although this was not sufficient to overcome some of the design problems associated with IERP through all phases.

2. DFID's monitoring and oversight of the project was often counter-productive because of excessive administrative demands these placed on the project, instead of support on programmatic direction.

3. Short-term funding of generally disparate activities spread over a wide geographical area made any integration unrealistic, and IERP thus failed to deliver economies of scale that could have been obtained through a cohesive joint programme in a compact area.

4. Consortium approach, by its very nature, takes time and requires a substantial investment of management time and resources to get off the ground. The one-year (or even less) duration of programme made its operations costly in terms of management effort that went into it.

5. Delays in approval and funds transfer which affected previous phases showed no sign of improving in phase III.

4.3 Effectiveness:

Effectiveness measures the extent to which an activity achieves its purpose, or whether this can be expected to happen on the basis of the outputs.

4.3.1 Results

The health programme of ADRA is meeting critical needs for primary and maternal healthcare, including treatment of chronic diseases of IDPs and vulnerable communities in Al Jawf. ADRA's focus on training and capacity building is strengthening capacity of frontline health staff in clinics and health centres catering to IDPs and deprived communities. The hygiene promotion work and nutritional interventions have created strong awareness on breastfeeding and infant feeding practices in the communities, and this is reportedly leading to changes in practices in some communities. SCY's work on CMAM has proven to be a cost-effective model for dealing with malnutrition in some of the deprived areas of the country. SCY's use of trained full-time volunteers and CIY's awareness committees in schools were particularly effective tools in educating and changing hygiene and breastfeeding awareness.

Livelihoods activities by different agencies are showing mixed results. The amount of support being small (average US$ 300-350 per beneficiary), it has been generally effective in supporting people who had an ongoing and established trade or IGA like grocery, beekeeping, hawking, etc. Livestock (sheep) rearing has been a popular activity with limited potential to contribute to livelihoods for two main reasons: (a) with not much land available for browsing, people need to buy fodder for 4-6 months in a year which farmers are unable to afford; and (b) the herd size needs to be substantially large for sheep/goat rearing to make a significant contribution to family income.[60] Livestock programming could be effective if the approach was to help build the herd for each beneficiary-family over a period of time, with additional number of animals provided at least 3-4 times over a period of two years which would bring the herd size to about 40 in about three years.[61]

Short period of implementation of several activities as well as long gaps between different phases of IERP funding limited the potential effects of some of the interventions in the areas of health and livelihoods, in particular.

[60] Research conducted by the International Livestock Research Institute concluded that a pastoralist needs between 1000-1750 kg live-weight biomass in order to survive in dry areas (similar to Yemen). Roughly translated, this would mean 4-7 Tropical Livestock Unit (TLU) per capita or 2-5 camels, 4-7 cattle, or 25-77 shoats. In Yemen, the target groups are not pastoralists and do have other sources of income. Even assuming that livestock ought to contribute a third of family income, the minimum size of herd would be about 8-10 sheep for every member of family, or 40 for a family of five.

[61] Assuming animals were not hit by any fatal disease.

One activity Oxfam has promoted through its livelihoods programme is homestead gardening. Beneficiaries have been assisted with seeds and tools for growing vegetables on small plots (about 8-12 sq. mt). This has the potential to contribute to family's nutrition, if complemented with nutrition education.

The livelihoods, health and protection work in particular have attempted to target vulnerable women and disabled people. The protection work of CIY is helping raise issues like child marriage, inheritance and property rights for women and SGBV in communities which are core to the gender issues in Amran. SCY's education programme, by increasing access to school facilities, combined with the awareness work through students' councils, has the potential to encourage parents to send more girl children to schools, and thus contribute to addressing one the fundamental issues of lack of access for girls' education in the area.

Capacity building of local authorities has been an activity of some of the CPs. Besides training, this has also involved provision of tools, equipment and furniture. Where capacity building activities have been part of a longer-term strategy, these are more likely to be successful than instances where one-off support in the form of supply of equipment and materials have been provided. It was observed during the evaluation that some of the equipment (TV, generator) provided by SCY to schools in Hajjah remained unutilised due to lack of budget for running costs (fuel for generator). As is well known, this is a common problem most government departments face when they are donated any capital item requiring running and maintenance costs – unless the donated item is recorded in asset register of the government, no provision can be made for any maintenance budget.

The evaluation found no unintended results from the project.

4.3.2 Targeting

As discussed in section 3, all agencies have focused on IDPs and vulnerable communities in their programme. In selecting beneficiaries for livelihoods programme, both Oxfam and IRY started with SWF lists provided by the government, and then carried out assessments with the help of village committees. FGDs and beneficiary interviews showed that by and large, beneficiaries selected were some of the poorest and vulnerable – women-headed households, disabled, old people without family support, and families with little or no asset and regular income. CARE and SCY both targeted schools in areas with high concentration of IDPs.

Oxfam's livelihoods beneficiaries included a large number of families who were also recipients of unconditional cash transfer (through another DFID grant) and social welfare payments, and was in line with its livelihoods /recovery programme strategy for Yemen.[62] This approach of targeting the same families with multiple inputs, notionally, has the potential to contribute significantly to transforming livelihoods of targeted families.

CARE's selection of villages in Amran showed a roadside bias, and most of the villages are around Amran town. Discussions with CARE staff indicated that this was deliberate as, besides security considerations, access to village was a critical issue so that materials (for WASH programmes) could be transported easily. FGDs and interviews with local authorities revealed that the situation in villages away from the Amran town was desperate and not many organisations worked in those areas. ADRA's beneficiary selection in Hais in particular did include a number of non-poor (non-IDP) who got selected because of their ability to guarantee repayment of loans.

4.3.3 Community participation and accountability to beneficiaries

Participation of communities was actively facilitated in beneficiary selection for livelihoods and WASH programmes. Community mobilisers and volunteers selected from the communities were trained as hygiene promoters and worked with their respective communities. FGDs in all

[62] Oxfam Yemen. Yemen Recovery Strategy, 2012-15

locations showed that participation and community mobilisation were linked to implementation of ongoing activities and delivery of inputs by CPs. Given the short time-frame within which interactions with communities have taken place, community groups/committees are still in formative stage. The only exceptions seen were women's WASH committees in Amran which appear to be running on their own.

During phase III, CPs put emphasis on accountability to beneficiaries through feedback and complaints mechanism. IRY has put in place a formal complaints mechanism whereby all complaints are logged, formal response to each complaint provided, and a central database of all complaints maintained. Other organisations have informal mechanism which involve beneficiaries either sending their complaints through village committees or speaking to agency staff who provide oral responses. SCY used students' councils to share information and to receive feedback regularly for the education component. Most of the complaints generally related to exclusion issues – people complaining about not being provided direct benefits.

A complaints mechanism on its own does not ensure accountability. Participation, information sharing/transparency, adherence to various quality standards are all part of accountability to beneficiaries. Accountability also requires that women who have been promised legal aid continue to receive support until resolution of their cases, or that disruption in healthcare services for patients with chronic diseases does not take place. As discussed in section 3, CPs have attempted to adhere to Sphere standards in particular in their operations, though in some instances these may have been compromised due to resource constraints. In livestock distribution, key elements of Livestock Emergency Guidelines and Standards (LEGS) namely, procurement from local markets, vaccination of animals before distribution, have been followed. Although more could be done about information sharing, some of the beneficiaries were aware of what they were entitled to and broad selection criteria used by the Agencies. It is understandable that in the conflict-ridden and security context of Yemen, Agencies need to make their own judgment as to how much information about their plans they can share with communities.

A beneficiary satisfaction survey was underway at the time of the evaluation, findings of which were not available to the evaluation team.

4.3.4 Advocacy and communication

As was noted in the external review (Beatty, 2012), the presence of five CPs in the governorates in multiple sectors creates a potential for influencing humanitarian policy and practice through lobbying, and through developing common positions on key humanitarian issues. Not much progress had been made in this regard during phase III. The only instance of advocacy has been SCY's success in getting the Education Ministry to incorporate mine risk awareness as part of the national curriculum in schools.

One issue where CPs could have brought their collective experience to bear was in providing systematic feedback to SWF on its beneficiary list which some of the Agencies used, tested and validated. Had Oxfam, IRY and ADRA which undertook their own assessment for selecting beneficiaries for livelihoods programme documented their experience and presented their analysis of data to SWF, this would have a made significant contribution to discourse on vulnerability assessments and anti-poverty programmes in the country. Oxfam reported that in other programmes (not part of IERP), they have engaged with various parts government/SWF on poverty assessments and targeting.

Conclusions:

1. The health programme targeting IDPs and vulnerable communities is bringing essential curative health services to communities who otherwise have no access to such services; and hygiene promotion work and nutritional interventions undertaken by the CPs is creating awareness on breastfeeding improved sanitation, hygiene and nutrition practices in villages. SCY's use of trained full-time volunteers and CIY's awareness committees in schools were particularly effective tools in educating communities on hygiene/breastfeeding practices.

2. Agencies have largely targeted IDPs and the most vulnerable through the IERP III; while doing this, however, CARE has followed a conscious strategy of working in areas which were easily accessible and avoided remote communities for its WASH programme.

3. Capacity building of local institutions needed to be based on a clear medium to long-term strategy, and ad hoc one-off support in terms of provision of equipment and supplies may not have much effect.

4. Although CPs put substantial emphasis on beneficiary participation and accountability during phase III, the evaluation failed to conclude that these have made any radical difference (compared to the previous phase), largely because of the short time-frame (mostly 4-6 months) for implementation.

5. IERP contributed to SCY's advocacy on mine risk education in schools; this apart, the consortium may have missed opportunities for bringing collective voice to bear on humanitarian issues.

4.4 Impact:

Impact looks at the wider effects of the project - social, economic, technical, and environmental - on individuals, gender, communities and institutions.

The outcomes being realised through health clinics, hygiene and nutrition education, and community management of malnutrition are contributing to improved mortality and morbidity. Although no official data on mortality or morbidity were available, the evaluation team met a sizeable number of individuals and families who have accessed life-saving interventions through the health and nutrition programme. The hygiene education programme is bringing about behaviour changes in communities, and in medium to long term, this will contribute to reducing mortality and morbidity, especially among infants and children.

The livelihoods programme is showing mixed results and is likely to have relatively less impact on recovery and resilience of communities than was intended. The reason primarily lies in lack of a clear analysis of various options (livelihoods activities, unconditional cash transfers, cash-for-work) in the context of local economy, market and household economy. Livelihoods programme targeted at vulnerable communities requires consistent support over a period of time, rather than one-off assistance, as was generally done in the IERP – with the exception of support to some beneficiaries in Oxfam's programme - and hence its impact is likely to be limited.

There are several important lessons emerging from the project that need assimilation into future humanitarian and development programming in Yemen. The low cost 'project management' model developed by SCY for its CMAM programme holds out significant promise for a country with a under-5 GAM rate of 15%[63] and u-5 mortality rate of 77 per thousand live birth. CMAM has shown that as staff capacity of health centres is limited, incentivising staff as well as employing additional staff and volunteers on short-term contracts through externally aided projects can make a rapid impact on the treatment of malnutrition. The homestead garden activity supported by Oxfam holds promise for improving household nutrition, besides providing education to communities and children about homestead gardening. The low cost water filter distribution, combined with hygiene education, has been another activity with potential impact on morbidity. CIY's work with women's WASH committees in particular may provide important lessons for effective participation of communities in WASH programmes.

As a consortium, IERP has been weak in terms of systematising and disseminating lessons. As discussed earlier, a robust documentation and analysis of targeting data using SWF list could have provided valuable lessons for the government and entire aid community, but such opportunities were not made use of. Two particular aspects of hygiene promotion work could also offer important evidence-based lessons for future policies through impact studies in the next 6-12 months in the project area:

[63] OCHA. *Yemen Humanitarian Dashboard*, 23 October 2012

i. at the time of the evaluation visit, people were still receiving hygiene kits from the Agencies and were practicing key lessons provided through hygiene education programme – would these practices continue once direct inputs from the Agencies stopped?
ii. water filters were being extensively used by families who received these; however, when the time comes for replacing the ceramic filters (which reportedly cost about $15 each) after nearly a year, what proportion of families would continue to use these filters and what factors that will influence their decisions?

4.5 Sustainability:

Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn.

Sustainability remains a big question in this project. Although several activities have led to clear outcomes, these will require ongoing support in at least the medium term to be sustainable. As discussed in section 4.3, the local authorities or communities do not have the wherewithal and capacity to sustain many of the outcomes on their own. Village committees which have been formed are, by and large, still in formative stage, and would need to be accompanied for some time before these can begin to function on their own. Even where capacity development of local authorities/health centres was attempted through training and/or provision of supplies and equipment, these institutions did not have the resources to pay for the recurring expenses, at least in the near-term.

It is expected that in Amran and in ADRA health programmes, there may be some ongoing support to the activities that have been undertaken in the IERP because the organisations (and in case of CARE, its partner, YWU) have ongoing programmes in the same areas. ADRA's livelihoods programme which is based on repayable loans will enable it to continue supporting the livelihoods beneficiaries, if the loan portfolios are managed well. IRY stated that its UK Matching Fund Project will continue in Hodeida and further explore assisting governorate's health office in maintaining medical equipment purchased and delivered under the consortium project. Besides these, the evaluation team has not come across any exit/phase out strategy or clear indication by any of the agencies to continue supporting the programmes at the end of the current phase. This is a major weakness of using short-term emergency programmes lasting only a few months to address chronic issues which require support over a longer term. The project design did not build into it a realistic phase out strategy, especially for those activities that required consistent support and follow up over a relatively longer period.

Section 5

Overall Conclusions and Recommendations

Phase III marked the third year of implementation of the Integrated Emergency Response Programme launched in 2010 by the Consortium comprising ADRA, CIY, IRY, Oxfam and SCY. Launched initially in response to providing assistance in the conflict-affected northern governorates, during phase III, the project expanded to include Hodeidah governorate which – though not affected directly by conflict – had witnessed a slow-onset crisis in food security, malnutrition and outbreak of communicable diseases.

In this phase, the key internal challenge was to transform the management of the consortium to make it more decisive, strategic and effective in providing oversight and leadership on programme delivery, monitoring and reporting which were found to be weak in previous phases. An issue linked to this was also weak integration of consortium partners' activities on the ground which impeded creating potential synergies between different partner-activities.

Overall Findings:

The overall findings of the independent evaluation conclude that the outcomes being realised through health clinics, hygiene and nutrition education, and community management of malnutrition have potential to contribute to improved mortality and morbidity. Although no official data on mortality or morbidity were available, the evaluation team met a sizeable number of individuals and families who have accessed life-saving interventions through the health and nutrition programme implemented by CPs. The hygiene/nutrition education programme is creating awareness on breastfeeding, improved sanitation, hygiene and nutrition practices in villages, and in medium to long term, this is likely to contribute to reducing mortality and morbidity, especially among infants and children.

The livelihoods programme, with some exceptions, is likely to have relatively less impact on recovery and resilience of communities than was intended. The reason primarily lies in lack of a consistent and clear analysis of various options (livelihoods activities, unconditional cash transfers, cash-for-work) in the context of local economy, market and household economy.

At the level of consortium management, the functioning of the consortium improved significantly in phase III, although this was not sufficient to overcome some of the design problems associated with IERP through all phases.

Detailed Findings:

Consortium

1. The functioning of the consortium improved significantly in phase III, although this was not sufficient to overcome some of the design problems associated with IERP through all phases. Consortium approach, by its very nature, takes time and requires a substantial investment of management time and resources to get off the ground. The one-year (or even less) duration of programme made its operations costly in terms of transaction costs and management effort

that went into it.

2. DFID's monitoring and oversight of the project was often counter-productive because of excessive administrative demands, instead of support on programmatic direction, these placed on the project.

3. Short-term funding of generally disparate activities spread over a wide geographical area made any integration unrealistic, and IERP thus failed to deliver economies of scale that could have been obtained through a cohesive joint programme in a compact area.

4. Delays in approval and funds transfer which affected previous phases showed no sign of improvement in phase III.

Programme performance

Health:

1. Healthcare services provided through the IERP continue to meet critical needs of IDPs in Sana'a and vulnerable population in Al Jawf which in particular is deprived of all services due to difficult humanitarian access and poor government structures.

2. ADRA's ongoing health programme has contributed significantly to strengthening the capacity of frontline health staff in clinics and health centres catering to IDPs and deprived communities. IRY provided short-term support to selected health centres in Hodeidah in close cooperation with health authorities; however, in order to build strong capacities, these one-off support need to be followed through as part of a continuous process with clear capacity building strategy.

3. The long gaps between different phases of IERP when funding for ADRA's health clinics stopped set back progress made by patients requiring prolonged treatment for chronic illnesses and injuries.

Nutrition:

1. The effective duration of nutrition education and CMAM programmes has been about five months as most activities undertaken by IRY and SCY started in November, 2012.

2. The nutritional interventions have created strong awareness on breastfeeding and infant feeding practices in the communities, and this is reportedly leading to changes in practices in some communities.

3. SCY's work on CMAM in collaboration with UNICEF and health authorities has proven to be a cost-effective model for dealing with malnutrition in some of the deprived areas of the country, although at this stage there is no realistic plan in place to sustain this at the end of IERP funding.

Education:

1. SCY's education in emergencies programme is helping in increasing access to education for IDP and host community children, besides improving learning environment in schools through staff training and promotion of students' councils.

2. While SCY has attempted to cover a substantial number of schools in selected districts, its school rehabilitation work has in several instances failed to integrate minimum standards of sanitation provision.

WASH:

1. The hygiene promotion work of both CIY and Oxfam is changing sanitation and personal

hygiene practices in schools and villages, and this needs to continue through the cadre of volunteers that have been trained by the CPs.

2. In both Oxfam and CIY, staff were well aware of Sphere standards for WASH and have taken steps to ensure quality, though it may not have always been possible to adhere to minimum standards of water quantity for each family because of limited capacity of available water sources.

3. An impact study on hygiene practices in the next 6-12 months in the project area could test and generate important evidence-based lessons for future policies in relation to two main approaches: (a) criticality of hygiene kits in adoption of hygiene practices; and (b) maintenance of water filters using own resources.

4. Although the evaluation has not seen any work of CPs carried out during phase I or II to assess how sustainable the WASH/village committees that were set up have been, it was noted in Amran that women's WASH committees functioned better than men's, and this needs further research to test its validity as a strategy to make future WASH programmes sustainable.

Early recovery and livelihoods:

1. ADRA's livelihoods intervention was based on providing loans; this has its advantages and potential if managed in a way that multiplies the capital and ensures repeat loans to beneficiaries over a period of time until they build a sustainable livelihood. ADRA will need to build its expertise in beneficiary selection and choice of activities, as well as in management of loan portfolios.

2. Both IRY and Oxfam have been able to ensure good targeting of vulnerable, although Oxfam's beneficiary selection process is seen less transparent by the communities as it involved a limited number of community leaders and Oxfam staff, and relatively low participation of women.

3. Oxfam's approach, in some villages, to targeting the same families with multiple inputs has potential to contribute significantly to transforming livelihoods of targeted families, provided the outcome is monitored regularly and the response adjusted based on empirical evidence over a period of time. This may also offer evidence-based lesson for the humanitarian sector in early recovery/livelihoods programme in Northern Yemen.

Protection:

1. CARE's support to YWU has been crucial in creating awareness about SGBV in Amran and an increasing number of women were coming out in various districts seeking legal assistance, counselling and medical support, and this work needs to continue, as any discontinuation of support mid-course may cause harm to the beneficiaries.

Targeting, participation and accountability:

1. Agencies have largely targeted IDPs and the most vulnerable through the IERP III; while doing this, however, CARE has followed a conscious strategy of working in areas which were easily accessible and avoided remote communities for its WASH programme.

2. Both IRY and Oxfam have been able to ensure good targeting of vulnerable, although Oxfam's beneficiary selection process is seen less transparent by the communities as it involved a small number of community leaders and Oxfam staff.

3. Although the CPs put substantial emphasis on beneficiary participation and accountability during phase III, the evaluation is inconclusive on the question whether these have made any radical difference (compared to the previous phase), largely because of the short time-frame (mostly 4-6 months) for implementation.

Advocacy and scaling up:

1. IERP contributed to SCY's advocacy on mine risk education in schools; this apart, the consortium may have missed opportunities for bringing collective voice to bear on humanitarian issues.

Sustainability:

In areas where organisations have ongoing programmes, it is likely that some follow up support to sustain the outcomes will continue. ADRA's livelihoods programme which is based on repayable loans will enable it to continue supporting the livelihoods beneficiaries, if the loan portfolios are managed well. In the absence of any clear strategy on part of CPs and DFID for any follow up support to communities and/or local authorities as part of exit/phase out strategy, sustainability of many of the outcomes remain doubtful.

Lessons

There are several important lessons emerging from the project that need assimilation into future humanitarian and development programming in Yemen:

SCY/DFID/humanitarian agencies

1. The low cost 'project management' model developed by SCY for its CMAM programme holds out significant promise for a country with a under-5 GAM rate of 15%[64] and u-5 mortality rate of 77 per thousand live birth. CMAM has shown that as staff capacity of health centres is limited, incentivising staff as well as employing additional staff and volunteers on short-term contracts through externally aided projects can make a rapid impact on the malnutrition scenario.

Oxfam

2. The homestead garden activity supported by Oxfam holds promise for improving household nutrition, besides providing education to communities and children about homestead gardening.

CIY

3. The low cost water filter distribution, combined with hygiene education, has been another activity with potential impact on morbidity. CIY's work with women's WASH committees in particular may provide important lessons for effective participation of communities in WASH programmes. An impact study on hygiene practices in the next 6-12 months in the project area could test and generate important evidence-based lessons for future policies in relation to two main approaches: (a) criticality of hygiene kits in adoption of hygiene practices; and (b) maintenance of water filters using own resources.

PMU, Oxfam, IRY

4. As a consortium, IERP has been weak in terms of systematising and disseminating lessons. As discussed earlier, a robust documentation and analysis of targeting data using SWF list could have provided valuable lessons for the government and entire aid community, but such opportunities were not made use of.

CPs

5. Capacity building of local institutions needs to be based on a clear medium to long-term strategy, and ad hoc one-off support in terms of provision of equipment and supplies may not have much effect.

[64] OCHA. *Yemen Humanitarian Dashboard*, 23 October 2012

DFID

6. Working through consortium involves substantial investment of time and energy at the formative stage before it starts to run efficiently, and short-term plans and funding undermine effectiveness of programmes.

Recommendations:

R1: CIY needs to work with its partner in Amran, YWU, and ensure that there is no disruption in funding for the specific legal aid and medical treatment cases taken up under the IERP III.

R2: SCY needs to urgently explore resources for extension of CMAM programme during which it needs to actively work with health centres, MoPHP, UNICEF and other agencies specialising in nutrition toward a gradual hand over of the activities in the next 6-9 months.

R3: ADRA needs to build its management capacity to deal with loan portfolios using microfinance model.

R4: To draw lessons on interventions aimed at improving food security and livelihoods status of vulnerable families, DFID /Oxfam needs to conduct systematic research and data analysis of contributions made through its cash transfer programme and livelihoods interventions. Such a study needs to draw on experiences emerging from similar initiatives in other similar contexts (Humanitarian Safety Net Programme, HSNP, in Kenya and Ethiopia's Productive Safety Net Programme, PSNP). This would be a valuable contribution to determining effective policy options for food security and anti-poverty programmes in the country.

R5: In order to draw lessons for future strategies, DFID needs to support Oxfam and CIY in undertaking impact studies in the next 6-12 months to examine the following aspects:

i. hygiene practices in post-project period – do the newly acquired practices continue once direct inputs from the Agencies stopped, and which factors influenced choices made?
ii. water filters are currently being extensively used by families who received these; however, when the time comes for replacing the ceramic filters (which reportedly cost about $15 each) after nearly a year, what proportion of families would continue to use these filters and what factors influence their decisions?
iii. functioning of WASH committees – women's committees and mixed (men and women) committees.

R6: Should DFID consider IERP-type consortium funding in future, it needs to factor in the need for longer time-frame that is needed to get consortium arrangements functioning effectively, as well as ensure that DFID's monitoring and oversight do not make excessive administrative and compliance demands at the cost of support on programmatic issues.