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Evaluation to the Joint Appeal 'Cyclone Idai Mozambique - CHS Commitments 4 & 5

Final report

Prepared by Key Aid Consulting for Aktion Deutschland Hilft e.V.

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Cover photo credit: Eva Beyer, Aktion Deutschland Hilft

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Executive Summary

Tropical Cyclone Idai struck Sofala Province, Mozambique on 14 March 2019 and impacted three other provinces in the country (Manica, Tete, and Zambezia), as well as the countries of Malawi and Zimbabwe.[1] Cyclone Idai damaged 239,731 houses, caused a cholera outbreak, which sickened more than 6,500 people, destroyed classrooms and ruined agricultural land, and displaced at least 131,000 people.[2][3][4]

Aktion Deutschland Hilft e.V. (ADH), Germany's Relief Coalition, launched the joint appeal "Cyclone Idai Mozambique" five days after the storm made landfall in Beira. Over 12 million EUR were raised, and 10 member organisations (MOs) requested funding from the joint appeal for their response projects. The MO projects ranged from lifesaving assistance in the first six months of the response, to early recovery projects that were ongoing at the time of the evaluation. Seven MOs that had or were implementing projects with funds that were raised by ADH participated in this evaluation. Their activities were in the sectors of non-food items (NFIs); livelihoods support; water, sanitation and hygiene (WASH); education sector shelter and infrastructure and disaster risk reduction (DRR); and health. Project locations were in Sofala Province, in Beira District, Dondo District and in Nhamatanda District.

The general objective of this evaluation was to identify the extent to which MOs considered Core Humanitarian Standard on Quality and Accountability (CHS) commitments 4 ("Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them") and 5 ("Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints") in the design and implementation of their programmes. A mixed-methods approach was employed which combined key informant interviews (KIIs) and focus group discussions (FGDs) conducted in Mozambique and remotely, an online survey, and a desk review. Limitations of the evaluation include not being able to visit locations for two organisations due to insecurity and flooding and not having access to complaints records for most of the MOs.

The evaluation found that ADH MOs varied in the extent to which they had practical communication, participation, and complaints and feedback mechanism (CFM) policies and the extent to which they established CHS 4 and CHS 5 processes. Only two of the seven MOs submitted both a communication and participation policy and a complaint and feedback policy for review. At least two of the MOs were developing CHS 4 and CHS 5 policies at the time of the evaluation. While organisations with more policies tended to have more CHS 4 and CHS 5 processes, these processes were not always sufficient to ensure their actual implementation. Three factors were cited as reasons for partial implementation of policies: inadequate budgets for accountability processes (e.g. staff for CFMs, communications materials), lack of internal training and guidance, and the timing of the evaluation for the education projects, which had only started in January and February 2020, unlike the other ADH Cyclone Idai response activities.

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[1] Inter-Agency Standing Committee, "IASC Operational Peer Review: Mozambique: Cyclone Idai Response.," n.d.
[2] UNOCHA, "Mozambique: Cyclone Idai & Floods Situation Report No. 10," Situation Report, April 11, 2019, https://reliefweb.int/report/mozambique/mozambique-cyclone-idai-floods-situation-report-no-10-11-april-2019.
[3] Maria Moitinho de Almeida and Debarati Guha-Sapir, "Why Mozambique's Cyclones Tell Us Disaster Preparedness Needs Health at Its Core," The BMJ Opinion, May 10, 2019, https://blogs.bmj.com/bmj/2019/05/10/mozambiques-cyclones-disaster-preparedness-needs-health-core/.
[4] UNOCHA, "Mozambique: Cyclone Idai & Floods Situation Report No. 2 (as of 3 April 2019)," Situation report, April 3, 2019, https://reliefweb.int/report/mozambique/mozambique-cyclone-idai-floods-situation-report-no-2-3-april-2019.

Several methods of communication with crisis-affected people were used by MOs and partner organisations, depending on the type of response and the timing of project activities after Cyclone Idai. Community meetings and events and meetings with specific stakeholders (i.e. school directors, teachers, clinic staff, neighbourhood leaders) were the most common method of giving information to communities. These methods were also the most preferred methods cited by FGD participants to obtain information. While some communities visited were well-informed about the projects, in many cases, these methods did not sufficiently inform crisis-affected people about the projects/activities MOs were implementing. Reasons for this included late information to the community, not sharing information at all with the community, or community representatives (such as some school directors) not sharing the information with parents or teachers.

Similarly, crisis-affected people's level of participation was uneven across the projects and intervention sectors, due to the timing of the response, technical specifications of project activities, government considerations, and organisations offering few opportunities to participate in some projects. Activities such as disaster risk reduction (DRR) classroom rehabilitation had to follow guidelines set by the Mozambique government, and the selection of classrooms was done by the government.

The majority of FGD participants who knew of a CFM said that the CFMs were safe and accessible. Participants' preferred channel were complaints boxes and telephone hotlines (with the exception of clinic staff for the health projects, who prefer email addresses and in-person visits, in addition to phone numbers). However, awareness of MO's CFM was often limited: many FGD participants did not know of a CFM regardless of sectors and MOs. MOs for the health projects did not implement CFMs that were accessible for patients.

As only two MOs provided complaints records, the evaluation is limited in the assessment of the organisational response to complaints. It appears that sensitive and non-sensitive complaints were handled differently, in accordance with CHS 5 policies, but that not all staff are aware of separate procedures. Complaints submitted informally were not recorded for at least one organisation and possibly other organisations, which is problematic as this means that analysing complaints trends will be incomplete.

Monitoring of the progress in implementing the CHS 4 and CHS 5 policies appears to be a gap. Without this monitoring, MOs are unaware if their CFM and communication channels are inclusive, accessible, and relevant to communities in the communities, and whether different groups are able to participate in decision-making. Lacking internal monitoring of the implementation of CHS 4 and 5 also indicates that MOs do not have complete information to judge whether their existing policies are sufficient or whether they need to take further action, such as training more staff or adapting training materials. The evaluation did not find that organisations were specifically monitoring the communities' and beneficiaries' level of satisfaction with opportunities to influence the response. No monitoring tools were submitted that ask questions about this topic, nor were any satisfaction monitoring reports or data shared. Lack of monitoring for participation increases the likelihood that the avenues of participation are not the most practical for the target groups, as the MOs do not have the information to adapt these mechanisms in real-time.

This evaluation identified several challenges faced by MOs, which made it more difficult to fully meet the CHS 4 and 5 commitments: language differences between staff and communities, the emergency context immediately following Idai, and the technical requirements of certain projects Some organisations did not always have staff at community meetings who spoke local languages such as Sena and Ndau, and consultations and awareness raising activities are held in Portuguese.

The lack of information sharing in local languages inhibited awareness and understanding of the project and CFM among community members. Power dynamics and hierarchies also distorted the spread of information about projects and CFMs, particularly between teachers and school directors and to community members. The rehabilitation of classrooms and infection prevention control training activities had specific technical and legal requirements which made it more difficult for MOs to implement them with full community consultation. MOs without field offices and staff Mozambique did not know how to implement CFMs for their projects.

On the other hand, holding general community meetings and working with multiple stakeholders in the communities were best practices, as were relying on local knowledge and using focal points selected among community members to review the complaint boxes.

Conclusion

This evaluation found that MOs attempted to mainstream implement CHS commitments 4 and 5 in their programmes from the beginning of the response, with varying degree of success.

There are several areas for improvement for MOs to fully meet CHS Commitments 4 and 5 in the Cyclone Idai response, related to the design, implementation and monitoring of these commitments. Only two of the MOs had policies for both CHS 4 and CHS 5, although at least two organisations were developing policies at the time of the evaluation. Some of the MOs need to increase the resources and staff that they have for CHS 4 and 5 implementation, and all MOs would benefit from improving promotion of these policies internally and among partners. Community engagement and communication policies in particular need to be developed and staff trained on their use to ensure an appropriate level of community participation in the response, and MOs should start monitoring of the policy implementation and community satisfaction with opportunities to participate.

A number of recommendations followed from the evaluation:

Recommendation 1: Conduct a rapid power analysis and age, gender and diversity (AGD) at the assessment phase

Recommendation 2: Foster sharing on policies and experience at country-level among MOs.

Recommendation 3: Have one CFM system for all MOs in order to share expertise and costs.

Recommendation 4: Increase coordination with other humanitarian agencies and relevant institutions in project locations to harmonise CFMs and raise awareness about them.

Recommendation 5: Ensure minimum community participation in all sectors.

Recommendation 6: Have at least two channels available in every project location and ensure different methods of handling sensitive versus non-sensitive complaints while ensuring that complaints are not treated differently due to being submitted formally or informally.

Recommendation 7: Explore other types of CFMs for organisations that do not have a stable presence in the country.

Recommendation 8: Increase the use of community meetings as a means of communication and participation for communities, and do not rely solely on one focal point or institution for information sharing and decision-making during the response.

Recommendation 9: Have staff or community volunteers translate into local languages at community meetings and when raising awareness about CFMs.

Recommendation 10: Conduct more awareness raising internally and with beneficiary communities on opportunities to participate in the response and on how the CFM works.

Recommendation 11: Minimise the crisis-affected people's costs of accessing CFMs and of opportunities to participate in response decision-making.

Recommendation 12: Ensure disability mainstreaming is a part of CHS 4 and 5 policies.

Recommendation 13: Monitor both the communities' satisfaction with opportunities to participate in the response and the implementation of the CHS policies.

Recommendation 14: Ensure feedback data from all sources (including from daily interactions), is regularly and systematically analysed to inform programme design and implementation.

Sumário Executivo

O Ciclone Tropical Idai atingiu a Província de Sofala, Moçambique a 14 de Março de 2019 e se repercutiu em três outros distritos do país (Manica, Tete e Zambézia) assim como no Malawi e Zimbabwè. O Ciclone Idai destruiu 239731 casas, provocou a eclosão da cólera que afectou mais de 6500 pessoas, destruiu salas de aulas e arruinou terras agrícolas e deslocou ao menos mais 131,000 pessoas.

Aktion Deutschland Hilft e.V. (ADH), Germany's Relief Coalition lançaram um apelo conjunto "Ciclone Idai Moçambique" cinco dias depois da tempestade ter atingido a cidade da Beira. Acima de 12 milhões de Euros fora angariados, e 10 organizações membros (OM) solicitaram fundos ao apelo conjunto para os seus projectos de resposta. Os projectos das OM variaram entre a assistência ao salvamento de vidas nos primeiros seis meses da resposta, e projectos antecipados de recuperação que estavam sendo implementados no momento da avaliação. Participaram nesta avaliação sete OMs que tinham ou estavam implementando projectos com fundos angariados pela ADH. As suas actividades eram em sectores que não envolvem itens alimentares (NFIs)[5]; apoio em meios de subsistência; água, saneamento e higiene (WASH)[6]; sector de educação, abrigo e infraestrutura e redução do risco de desastre (DRR)[7]; e saúde. Os projectos estavam localizados na Província de Sofala, nos distritos da Beira, Dondo e Nhamantanda.

O objective geral desta avaliação era identificar até que ponto as OM consideram os Principais Padrões Humanitários para a Qualidade e Prestação de Contas (CHS) nos compromisso 4 ("Comunidades e pessoas afectadas conhecem os seus direitos e dever, tem acesso a informação e participam nas decisões que as afectam") e 5 (" Comunidades e pessoas afectadas pela crise têm acesso a mecanismos seguros e responsivos que tratam das reclamações") no desenho e implementação dos seus programas.

Para realizar a avaliação foi usado uma abordagem mista de métodos que combinou entrevistas aos informantes chaves (KIIs)[8] e grupos focais de discussão (FGDs)[9] conduzidos em Moçambique e remotamente, uma pesquisa online e revisão de literatura.

As limitações nesta avaliação incluem não ter sido possível visitar os locais onde duas organizações actuam devido a insegurança e inundações e, não ter tido acesso ao registo de reclamações na maioria das OMs.

A avaliação revelou que as OMs da ADH variam no sentido de que elas têm uma comunicação prática e participação, e Mecanismos de Reclamação e Retorno (CFM)[10] e no sentido em que elas estabeleceram os processos CHS 4 e CHS 5. Apenas duas das sete OMs submeteram uma política de comunicação e participação e de reclamação e retorno para revisão. Ao menos duas das OMs estavam desenvolvendo políticas de CHS 4 e CHS 5 no momento da avaliação. Embora organizações com mais políticas tendem a ter mais processos de CHS 4 e CHS 5, estes processos não eram sempre suficientes para garantir a sua implementação.

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[5] Sigla em ingles- para Non-food items
[6] Sigla em inglês - WASH - Water, Sanitation and Hygiene
[7] Sigla em inglês - DRR - Disaster Risk Reduction
[8] Sigla em inglês – KII – Key Informant Interviewee
[9] Sigla em inglês – FGD – Focus Group Discussion
[10] Sigla em inglês – CFM – Complaints and Feedback Mechanism

Três razões foram citadas para a implementação parcial das políticas: orçamentos inadequados para o processo de prestação de contas (ex: pessoal para Mecanismos de Reclamação e Retorno, materiais de comunicação), falta de formação interna e orientação, e a escolha de momento para a avaliação de projectos de educação, que começaram apenas em Janeiro e Fevereiro de 2020, ao contrário de outras actividades de resposta ao Ciclone Idai.

Foram usados vários métodos de comunicação com a população afectada pelas OMs e organizações parceiras, dependendo do tipo de resposta e do momento das actividades do projecto depois do Ciclone Idai. Os encontros comunitários e eventos comunitários e encontros com beneficiários específicos (directores e escola, professores, pessoal clínico, líderes comunitários) foram os métodos comuns de partilha de informação com as comunidades. Estes métodos eram os mais preferidos e mais citados para obter informações pelos participantes dos grupos focais (FGD). Embora algumas comunidades visitadas estivessem bem informadas acerca dos projectos, em muitos casos, estes métodos não informam de modo suficiente as pessoas afectadas sobre o projecto/actividades que estavam sendo implementadas pelas OM. Razões para isto incluem informação tardia à comunidade, a não partilha de informação de todo com a comunidade, ou os representantes da comunidade (tais como alguns directores de escola) não partilham a informação com os parentes dos alunos ou professores.

Similarmente, o nível de participação das pessoas afectadas era assimétrico ao longo dos projectos e dos sectores de intervenção, devido ao momento da resposta, as especificações d=técnicas das actividades dos projectos, considerações governamentais e as organizações proporcionam poucas oportunidades de participação em alguns projectos. Actividades como a redução de risco de desastre (DRR), reabilitação de salas de aulas tinham de seguir orientações estabelecidas pelo governo de Moçambique, e a seleção das salas foi feita pelo governo de Moçambique.

A maioria dos participantes dos grupos focais de discussão que sabiam dos Mecanismos de Reclamação e Retorno disseram que era seguro e acessível. Os canais preferidos pelos participantes eram as caixas de reclamação, linhas telefónicas SOS (com excepção do pessoal clínico dos projectos de saúde, que preferem usar emails e visitas pessoais, para além de números de telefone). Contudo, o conhecimento dos Mecanismos de Reclamação e Retorno nas OMs era limitado, muitos participantes dos grupos focais de discussão não sabiam dos Mecanismos de Reclamação e Retorno independentemente do sector ou OMs. OMs que implementam projectos de saúde não implementam Mecanismos de Reclamação e Retorno que são acessíveis para os pacientes.

Como apenas duas OMs providenciaram registo de reclamações, a avaliação está limitada a avaliação das respostas organizacionais as reclamações. Parece que as reclamações sensíveis e não sensíveis são tratadas diferentemente, de acordo com as políticas de CHS 5, mas não é todo o pessoal que está ciente destas diferenças de procedimentos. As reclamações submetidas informalmente não foram registadas por pelo menos uma organização e possivelmente outras organizações, o que é problemático porque significa que analisar as tendências das reclamações será imperfeito.

A monitoria do progresso da implementação das políticas do CHS 4 e CHS 5 parece uma falha. Sem esta monitoria, as OMs não estão cientes se os seus canais de comunicação e os Mecanismos de Reclamação e Retorno são inclusivos, acessíveis, e relevantes para as comunidades nas comunidades, e se diferentes grupos são capazes de participar na tomada de decisão. Falta da monitoria interna da implementação do CHS 4 e CHS 5 indica também que, as OMs não têm informação completa para avaliar se as suas políticas existentes são suficientes ou precisam de tomar outras medidas, tais como formar mais pessoal ou adaptar materiais de formação. A avaliação não encontrou organizações que estavam especificamente a monitorar o nível de satisfação das comunidades e dos beneficiários com as oportunidades de influenciar a resposta.

Nenhuma ferramenta de monitoria que responda a este tópico foi submetida, nem relatórios de monitoria de satisfação ou dados foram partilhados. A falta de monitoria da participação aumenta a probabilidade de que os meios de participação não são os mais adequados para o grupo alvo, visto que as OMs não têm informação para adequar estes mecanismos em tempo real.

Esta avaliação identificou vários desafios enfrentados pelas OMs, que tornam difícil o alcance total dos compromissos do CHS 4 e 5: diferença de linguagem entre o pessoal técnico das organizações e as comunidades, o contexto de emergência logo a seguir ao Idai, e os requisitos técnicos de certos projectos. Algumas organizações nem sempre nos encontros comunitários têm pessoal que fala as línguas locais como Sena e Ndau, e as consultas e actividades de sensibilização são feitas em português. A falta de partilha de informação em línguas locais restringe o conhecimento e a compreensão do projecto e dos Mecanismos de Reclamação e Retorno entre os membros da comunidade. As dinâmicas de poder e hierarquias também distorcem a disseminação de informação sobre os projectos e os Mecanismos de Reclamação e Retorno, particularmente entre professores, directores de escola e membros da comunidade. A reabilitação das salas de aulas e as actividades de formação em controlo e prevenção de infecções tinham requisitos legais e técnicos específicos que tornava mais difícil para as OMs implementarem por si mesmas todas as consultas comunitárias. OMs sem escritórios no campo e pessoal em Moçambique não sabem como implementar Mecanismos de Reclamação e Retorno nos seus projectos.

Por outro lado, organizar encontros comunitários gerais e trabalhar com vários beneficiários nas comunidades foram boas práticas, visto que era tomado em conta o conhecimento local e o uso de pontos focais seleccionados ao nível da comunidade para analisar as caixas de reclamação.

Conclusão

Esta avaliação verificou que desde o início da resposta, as OMs tentaram com variado grau de sucesso implementar de maneira regular os compromissos CHS 4 e 5 nos seus programas.

Existem muitas áreas por melhor da parte das OMs para alcançar plenamente os compromissos do CHS 4 e 5 na resposta do Ciclone Idai, áreas relacionadas com o desenho, implementação e monitoria desses compromissos. Apenas duas das organizações membros (OMs) têm política para os ambos os compromissos CHS 4 e CHS 5, embora ao menos duas organizações estivessem desenvolvendo políticas no momento da avaliação. Algumas das OMs precisam aumentar os seus recursos e pessoal para ter o CHS 4 e 5 sendo implementados, e todas as OMs beneficiariam pela promoção destas políticas quer internamente e entre as organizações parceiras. Políticas de comunicação e envolvimento comunitário em particular, precisam de ser desenvolvidas e o pessoal deve ser formado no seu uso para assegurar um nível apropriado da participação comunitária na resposta, e as OMs deviam começar a monitorar a política de implementação e a satisfação da comunidade com as oportunidades de participação.

Um conjunto de recomendações resultaram da avaliação:

Recomendação 1: Conduzir uma análise rápida de análise de poder, idade, género e diversidade (AGD) na fase de avaliação.

Recomendação 2: Encorajar a partilha de políticas e experiência ao nível do país entre as OMs.

Recomendação 3: Ter um Sistema de Mecanismos de Reclamação e Retorno para todas as OMs com vista a partilhar competências e custos.

Recomendação 4: Aumentar a coordenação com outras agências humanitárias e instituições relevantes nos locais do projecto para harmonizar os Mecanismos de Reclamação e Retorno e sensibilizar sobre eles.

Recomendação 5: Assegurar a participação comunitária mínima em todos os sectores.

Recomendação 6: Ter pelo menos dois canais disponíveis em cada local de projecto e assegurar diferentes métodos de lidar com reclamações sensíveis versus não sensíveis enquanto se assegura que, as reclamações não são tratadas diferentemente por terem sido submetidas formal ou informalmente.

Recomendação 7: Explorar outros tipos de Mecanismos de Reclamação e Retorno para organizações que não têm uma presença duradoura no país.

Recomendação 8: Aumentar o uso de encontros comunitários como meio de comunicação e participação para as comunidades, e não apenas ter em conta um ponto focal ou instituição para a partilha de informação e tomada de decisão durante a resposta.

Recomendação 9: Ter pessoal ou voluntários comunitários para traduzir para a língua local nos encontros comunitários e quando se realizam a sensibilização sobre os Mecanismos de Reclamação e Retorno.

Recomendação 10: Conduzir mais sensibilização ao nível organizacional e com os beneficiários da comunidade sobre as oportunidades de participação na resposta e de como o Mecanismos de Reclamação e Retorno funciona.

Recomendação 11: Minimizar os custos do acesso as oportunidades de participação na tomada de decisão da resposta e no Mecanismos de Reclamação e Retorno para as pessoas afectadas pela crise.

Recomendação 12: Assegurar a deficiência como parte regular das políticas do CHS 4 e CHS 5.

Recomendação 13: Monitorar a satisfação com as oportunidades de participação na resposta e a satisfação com a implementação das políticas de CHS.

Recomendação 14: Assegurar dados com retorno de todas as fontes (incluindo as provenientes da interação diária), é regularmente e sistematicamente analisada para informar à elaboração e implementação de programas.

Table of Contents

List of Acronyms

ADH	Aktion Deutschland Hilft e.V.
ADRA	Adventist Development and Relief Agency e.V.
AGD	Age, Gender and Diversity
ASADEC	Association for Community Development/Acçao Para o Desenvolvimento Communitario
ASB	Arbeiter-Samariter-Bund e.V.
AVSI	Association of Volunteers in International Service
CAFOD	Catholic Agency for Overseas Development
CHS	Core Humanitarian Standard on Quality and Accountability
CDC	United States Center for Disease Control and Prevention
CFM	Complaints and feedback mechanism
CP	Child Protection
CVA	Cash and Voucher Assistance
DPWV	Der Deutsche Paritaetische Wohlfahrtsverband e.V.
DRR	Disaster Risk Reduction
EPC	Escuela Primaria Completa (Complete Primary School)
FGD	Focus Group Discussion
GDPR	General Data Protection Regulation
HQ	Headquarters
IPC	Infection Prevention and Control
IR	Islamic Relief Deutschland e.V.
KAC	Key Aid Consulting
KEQ	Key Evaluation Question
KI	Key Informants
KII	Key Informant Interview
MO	Member organisation
NGO	Non-Governmental Organisation
NFI	Non-Food Item
OP	Older Persons
PSEA	Prevention of Sexual Exploitation and Abuse
PSS	Psychological Support Services
PWD	Persons with Disabilities

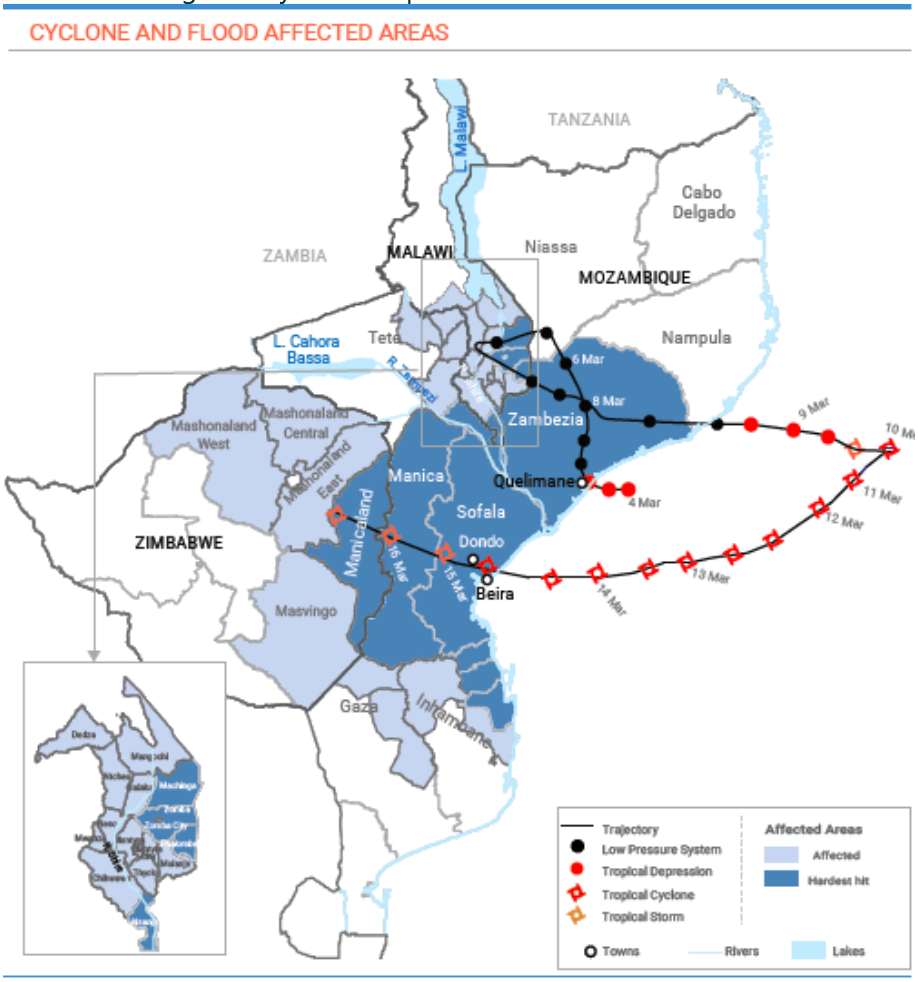
SODI	Solidarity Service International e.V.
SOP	Standard Operation Procedure
TLS	Temporary Learning Space
ToR	Terms of Reference
UCM	Catholic University of Mozambique
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme

I. Introduction

I.1. Cyclone Idai

Tropical Cyclone Idai struck Sofala Province, Mozambique on 14 March 2019. The storm caused flooding in Tete and Zambezia provinces prior to landfall, which affected 141,000 people. Between 14 and 15 March, the cyclone affected the district of Beira in Sofala: strong winds destroyed the roofs of buildings and heavy rains caused flooding in areas, particularly near Buzi and Lamegu where two dams broke. The storm affected four provinces in the country (Manica, Sofala, Tete, and Zambezia), before continuing on to Malawi and Zimbabwe. [11]

Figure 1: Cyclone Idai path and flood-affected areas[12]



The storm and its immediate aftermath killed 603 people, while a resulting cholera outbreak affected more than 6,500 people before being brought under control.[13] 239,731 houses were damaged, of

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[11] Inter-Agency Standing Committee, "IASC Operational Peer Review: Mozambique: Cyclone Idai Response.," n.d.
[12] UN Office for the Coordination of Humanitarian Affairs, *Southern Africa: Cyclone Idai Snapshot (as of 9 April 2019)*, April 9, 2019, April 9, 2019, https://reliefweb.int/report/mozambique/southern-africa-cyclone-idai-snapshot-9-april-2019.
[13] Maria Moitinho de Almeida and Debarati Guha-Sapir, "Why Mozambique's Cyclones Tell Us Disaster Preparedness Needs Health at Its Core," The BMJ Opinion, May 10, 2019, https://blogs.bmj.com/bmj/2019/05/10/mozambiques-cyclones-disaster-preparedness-needs-health-core/.

which 112,745 were completely destroyed.[14] At least 131,000 people were displaced during the month after the storm.[15] Thousands of classrooms were damaged, while countless teaching and learning materials were lost in floodwaters. Agricultural land was inundated and an infestation of fall army worm ruined farmers' crops in the first harvest after the cyclone.

Cyclone Idai was the not the only calamity to befall Mozambique in 2019. Tropical Cyclone Kenneth struck the country on 25 April 2019, an unprecedented occurrence (in recorded history) of two tropical cyclones making landfall in Mozambique in the same season.[16] While Cyclone Kenneth landed further north in Cabo Delgado Province, the occurrence of two natural disasters within a short timeframe further burdened the Government of Mozambique's and humanitarian agencies' capacity to respond effectively to Cyclone Idai.

I.2. Aktion Deutschland Hilft e.V.

Aktion Deutschland Hilft e.V. (ADH), Germany's Relief Coalition, was founded in 2001. ADH is currently comprised of 13 full members, one of which (Der Paritaetische Wohlfahrtsverband, or DPWV) is representing another 10 aid organisations towards ADH[17]. ADHs mandate are to jointly raise funds to support the work of its member organisations, to inform and increase awareness after large natural disasters or emergency situations and to promote education and vocational training especially in the area of acute disaster relief and preparation for possible emergency cases[18].

All member organisations have to prove the correct use of the funds towards ADH. ADH reviews the submitted proposals and budgets of its member organisations to ensure that they are in line with a particular appeal. The member organizations may only use the funds within the scope of the earmarking, deriving from the respective donation keyword[19].

Since its foundation, ADH has put focus on quality of the responses and identifying evidence of quality. To implement its commitment to quality assurance and to accessing project funds, they declare their willingness to grant unrestricted access to auditors with regard to the use of the project funds.

In line with its quality assurance scheme, ADH has established a permanent working group on quality assurance. This working group on quality assurance is facilitating events and discussions on programming quality topics, conducting evaluations, and promoting Sphere standards, along with building the capacity of Sphere trainers. One particular focus of the working group on quality assurance is – among others – the self-assessment process in regards to the Core Humanitarian Standard on Quality and Accountability (CHS).

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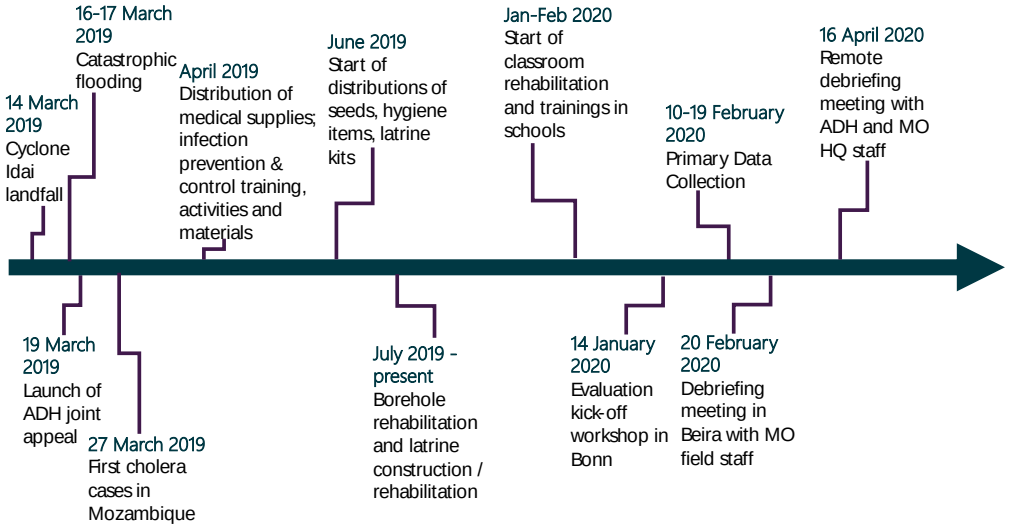
[14] UNOCHA, "Mozambique: Cyclone Idai & Floods Situation Report No. 10," Situation Report, April 11, 2019, https://reliefweb.int/report/mozambique/mozambique-cyclone-idai-floods-situation-report-no-10-11-april-2019.
[15] UNOCHA, "Mozambique: Cyclone Idai & Floods Situation Report No. 2 (as of 3 April 2019)," Situation report, April 3, 2019, https://reliefweb.int/report/mozambique/mozambique-cyclone-idai-floods-situation-report-no-2-3-april-2019.
[16] UNOCHA, "Mozambique Cyclones Idai and Kenneth," accessed March 3, 2020, https://www.unocha.org/southern-and-eastern-africa-rosea/mozambique.
[17] arche noVa e.V., Bundesverband der Rettungshunde e.V., SODI e.V., Freunde der Erziehungskunst e.V., Hammer Forum e.V., HelpAge Deutschland e.V., Handicap International Deutschland e.V. , Kinderhilfswerk Global Care e.V., Terra Tech e.V., and LandsAid e.V.
[18] Satzung Aktion Deutschland Hilft e.V. Bündnis deutscher Hilfsorganisationen
[19] Allgemeine Richtlinie für Aktion Deutschland Hilft e.V.

I.2.1. Joint appeal to Cyclone Idai

Five days after the storm made landfall in Beira, ADH launched the joint appeal "Cyclone Idai Mozambique." Over 12 million EUR were raised, and 10 MOs requested funding from the joint appeal for their response projects. Their projects ranged from lifesaving assistance in the first six months of the response, to early recovery projects that were ongoing at the time of the evaluation. Activities covered the areas of food and non-food items (NFIs); livelihoods support; water, sanitation and hygiene (WASH); education sector shelter and infrastructure and disaster risk reduction (DRR); and health. Project locations were in Sofala Province, in Beira District, Dondo District and in Nhamatanda District.

Figure 2: Timeline of Cyclone Idai and ADH response



I.2.1.1. Member organisations' projects

Ultimately, seven MOs that had or were implementing projects for the Cyclone Idai Mozambique response with funds that have been raised by ADH took part in this evaluation. These MOs are:

action medeor e.V.: In the ADH joint appeal, action medeor distributed medicines and medical equipment such as an ultrasound machine and otoscopes to the Catholic University of Mozambique (UCM) and its affiliated clinic, Sao Lucas, in Beira City. They also supplied mosquito nets to an orphanage in Beira District.

Adventist Development and Relief Agency (ADRA) Germany: ADRA Germany, via the ADRA Mozambique office, implemented livelihoods and WASH projects. The WASH activities aimed to repair boreholes and establish water management committees that were in charge of borehole maintenance, collecting money for such maintenance, and community cleaning. For the livelihoods component, ADRA distributed agricultural inputs such as seeds and tools.

Arbeiter-Samariter-Bund (ASB): ASB was present in the first weeks after Cyclone Idai to train health centre staff on infection prevention and control (IPC), and to improve health centres through installing water tanks, water pumps, water filters, fenced waste areas, tippy taps, and roofs for the patient waiting areas. ASB also distributed materials such as buckets, chlorine, gloves, alcohol hand sanitiser, aprons and rubber boots to the clinics, and it repaired some water lines at health centres. The organisation also conducted a training to a Mozambican organisation, Association for

Community Development (ASADEC), on the use of Sky Hydrants, a water filtration unit, and gave Sky Hydrants to them.

CARE Germany: CARE Germany is working with CARE Mozambique to rehabilitate 25 classrooms and temporary learning centres in three primary schools in Nhamatanda District. CARE also implemented hygiene promotion and distributed hygiene kits in Dondo and Beira districts.

Islamic Relief (IR) Germany: IR Germany is rehabilitating 18 classrooms in six primary schools, and is also training teachers and students on Disaster Risk Reduction (DRR), child protection (CP), prevention of sexual exploitation and abuse (PSEA), and psychological support services (PSS). As IR does not have a presence in Mozambique, it partnered with an international NGO, Catholic Agency for Overseas Development (CAFOD), which implemented project activities through an Italian NGO, AVSI Foundation. CAFOD coordinated the work of AVSI and provided technical assistance while AVSI staff directly implemented activities.

World Vision Germany: World Vision Germany has worked with World Vision Mozambique in rehabilitating school latrines, repairing boreholes, distributing latrine kits to individual households, and conducting hygiene promotion and awareness in schools in Nhamatanda and Buzi districts.

Solidarity Service International (SODI): SODI, a member of the DPWV, does not have a permanent presence in Mozambique. As a result, it worked through a local organisation, Kubatsirana, in Macorococho village of Nhamatanda District. Kubatsirana distributed agricultural inputs (seeds) and hygiene kits to 200 households (an estimated 1,400 individuals) that had been affected by the cyclone.

II. Evaluation Purpose and Objectives

One key component of ADH's quality assurance focus is to conduct external evaluations of its joint appeals. Members of ADH's permanent working group on quality assurance regularly meet to decide the focus and research questions for each evaluation. The working group chose to focus the evaluation for the joint appeal "Cyclone Idai Mozambique," on the CHS, specifically CHS commitments 4 (humanitarian response is based on communication, participation and feedback) and 5 (complaints are welcomed and addressed).

The general objective of the evaluation is to identify the extent to which MOs considered CHS Commitments 4 and 5 in the design and implementation of their programmes. The evaluators used the Evaluation Criteria from the Organization for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC), specifically the criteria of relevance to look at the relevance and appropriateness of CHS 4 and CHS 5-related processes.

Specifically, the evaluation was commissioned to:

- Assess the introduction and implementation of CHS 4 for communication, participation and feedback, and CHS 5 for complaints about MOs' relief activities in Mozambique;
- Draw recommendations to better support the planning of future programmes and projects.

The following four key evaluation questions (KEQ) were developed to meet the evaluation objectives:

1. What CHS 4 (humanitarian response is based on communication, participation and feedback) and CHS 5 (complaints are welcomed and addressed) programmes, policies and processes were used during the humanitarian response?
2. CHS 4 – To what extent was humanitarian response designed and implemented by ADH MOs is based on communication, participation and feedback?

3. CHS 5 – To what extent do ADH MOs welcome and address complaints?
4. What were the main challenges faced by and best practices identified by MOs with CHS 4 (humanitarian response is based on communication, participation and feedback) and CHS 5 (complaints are welcomed and addressed)?

CHS guidance notes and indicators were used to develop working questions and indicators to judge how the questions would be answered.

II.1. Core Humanitarian Standard Commitment 4

Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them.

CHS Commitment 4[20] "emphasises the need for the inclusive participation of crisis-affected people."[21] Inclusive participation has several factors: communities and community members affected by the crisis, including marginalised and vulnerable groups, have the opportunity to participate, know how to participate, are informed of the humanitarian response, and are satisfied with the opportunities to participate. They are also able to provide feedback on the response, and humanitarian agencies can obtain formal feedback through assessments or post-distribution monitoring and informal feedback through daily interactions.

There are three performance indicators associated with CHS 4:

- Communities and people affected by crisis (including the most vulnerable) are aware of their rights and entitlements;
- Communities and people affected by crisis consider that they have timely access to relevant and clear information;
- Communities and people affected by crisis are satisfied with the opportunities they have to influence the response.

According to the guidance note for CHS 4, "Feedback mechanisms…should be seen as separate from complaint mechanisms for serious infringements of practice or behaviour (see Commitment 5) although in practice there is usually an overlap in the type of feedback and complaints received."[22] For the organisations that participated in this evaluation, complaints and feedback were not separated by mechanism; the same mechanisms that receive feedback also receive complaints.

However, this does not mean that the organisations' responses to "serious infringements of practice or behaviour" and to feedback are the same, which is explored in the findings section. In this report, the authors use the term "complaints and feedback mechanisms" (CFM), and questions about the effectiveness of these CFMs will primarily be discussed in relation to the KEQ on CHS Commitment 5.

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[20] Referred to as "CHS 4" throughout the rest of this report.
[21] "CHS Guidance Notes and Indicators" (CHS Alliance; The Sphere Project; Group URD, 2015).
[22] IOM, "Mozambique Disaster Risk Assessment," DTM Report, January 2020, https://reliefweb.int/sites/reliefweb.int/files/resources/Mozambique%20-%20Disaster%20Risk%20Assessment%20%28January%202020%29.pdf.

II.2. Core Humanitarian Standard Commitment 5

Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.

CHS Commitment 5[23] describes how humanitarian agencies must ensure crisis-affected people's right to submit complaints and to receive "an appropriate and timely response."[24] Complaint mechanisms allow humanitarian agencies to uncover and respond to incidents of fraud, malpractice, or exploitation, while empowering the crisis-affected people to initiate the response by making the complaint.

There are three performance indicators associated with CHS 5:

- Communities and people affected by crisis, including the vulnerable and marginalised groups, are aware of complaint mechanisms established for their use;
- Communities and people affected by crisis, consider the complaint mechanisms accessible, effective, confidential and safe;
- Complaints are investigated resolved and results fed back to the complainant within the stated timeframe.

Complaint mechanisms can take a variety of forms, including (but not limited to): email addresses, hotlines or SMS services, static complaint and suggestion boxes, help desks, in-person office visits, staff or complaint focal points, and surveys. Humanitarian agencies working in Mozambique have the option of either creating their own organisational hotline for beneficiaries and crisis-affected communities to call, or of using the Linha Verde, the "green line" (or to have both their own hotline and use Linha Verde). Linha Verde was set up by World Food Programme (WFP) to be a multi-agency CFM for agencies implementing responses to cyclones Idai and Kenneth. It went "live" on 16 May 2019. In terms of its use, WFP and NGOs raise awareness of the hotline in the areas where they work, and beneficiaries call the call centre if they have a complaint. WFP call operators then forward the complaint and contact information (if given) to the humanitarian agency that was the focus of the complaint.

II.3. Scope of projects in the evaluation

The evaluation did not review all project activities implemented by the MOs under the ADH joint appeal. The findings are specific only to the sectoral activities that the evaluation team was able to visit. MO's activities which were not included in the scope of this evaluation were:

- CARE's hygiene promotion and hygiene kit distribution – The evaluation team visited schools where CARE is implementing education activities and not the communities where CARE distributed hygiene kits and conducted hygiene promotion, and therefore the findings of this evaluation only apply to CHS 4 and CHS 5 implementation related to the education programming.
- World Vision's borehole repair, latrine kit distribution, and hygiene promotion – The evaluation team was unable to visit project locations except for the Metuchira Nharuchonga community where World Vision only implemented latrine rehabilitation at a school.

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[23] Referred to as "CHS 5" throughout the rest of this report.
[24] "CHS Guidance Notes and Indicators."

- Action medeor's distribution of mosquito nets to an orphanage – The evaluation team visited the clinic and university that were recipients of medical supplies from action medeor but not the orphanage that received mosquito nets.

III. Methodology

Key Aid Consulting employed a mixed-methods approach for this evaluation. Primary data was collected in Sofala Province, Mozambique, in the districts of Nhamatanda, Dondo and Beira, in addition to remote interviews with key informants in Germany and Chimoio District of Manica Province. The methodology is summarised in the figure below:

Figure 3: Summary of the methodology

Inception phase & desk review	Inception report	Desk review
	Briefing with ADH consultancy managers (18 December 2019) Workshop in Bonn (14 January 2020)	Comprehensive and structured review of 58 documents (code of conducts, PSEA/CFM/accountability policies, contextual information, project budgets, reports, CFM data)
Data collection	In-country and online survey	
	04 – 21 Feb: 11 online survey respondents from 9 organisations (MOs and partners)	10 Feb – 03 March: 26 FGDs and 21 KIIs conducted remotely or in Beira and Nhamatanda districts with community members, parents of schoolchildren, teachers, clinic staff, university administrators, community leaders, and project staff
	20 February 2020: Debriefing workshop in Beira with 13 participants from 5 organisations	16 April 2020: Remote Debriefing workshop
	Total of 176 individuals consulted	
Final report	Data coding and analysis.	First draft: 16 March 2020. Final draft:.
Review limits	Beneficiaries of SODI project were not able to be interviewed; beneficiaries of action medeor were not able to be interviewed and only one project location of World Vision was visited.	Most member organisations did not share records of complaints and feedback received

IV. Findings

IV.1. CHS 4 and CHS 5 policies and processes used

This section discusses the CHS 4 and CHS 5 programmes, policies and processes that are in place (either as documented or undocumented policies and processes related to meeting CHS 4 and CHS 5), how affected people were aware of and used these polices, how they were implemented by the MOs, and evaluates the extent to which they were context sensitive.

IV.1.1. Policies documented and in place within MOs

The primary and secondary data collected suggests that there is wide variation among MOs and implementing partners' policies related to CHS 4 and CHS 5.

Four out seven MOs had a complaints response policy (CHS 5) and another MO had an SOP for patient complaints and grievances; two of those with a complaints response policy also had a specific policies related to communication with and participation of communities in the response (CHS 4). Two organisations had no formal policies for either CHS 4 or 5. Other CHS 4 and 5-related documents shared by MOs included separate policies for safeguarding, gender justice, whistleblowing and accountability, as well as codes of conduct, guides to managing complaints, awareness raising material on PSEA, and a presentation on humanitarian principals and mandate. Additionally, two partner organisations submitted CHS 4 and 5 and other policies.

At the time of writing this report, three MOs were developing or looking to develop CHS policies that were specific to the type of response they had implemented. The SOP for patient complaints and grievances was not considered a full complaints response policy as it did not include complaint forms or templates (to record the complaints), and so was considered to be incomplete. Even among full complaints response policies, it would appear that not all of them offer the necessary level of detail, such as a time commitment to close the feedback/complaint loop and provide the complainant with a reply from the organisation.

For CHS 4, only three of the MO survey respondents (out of 8 MO survey respondents) said that their organisation had a specific policy for communication with communities and communities' participation in the humanitarian response; of the other MO survey respondents, two were unsure, one did not answer, and one said there was no specific policy. Of the three that said there was a policy, only one belonged to an MO that submitted a CHS 4 policy to the evaluators. It is possible that the other two MOs have a CHS 4 policy, but as they were not shared during the evaluation, the consultants could not include them in the analysis. The evaluators only considered a document as a policy if it detailed specific actions to take in implementing communication and participation processes.

The presence of designated CHS-specific focal points within MOs and partners is correlated with the presence of CHS-specific policies. Organisations with CHS-specific policies were more likely to have a focal point or focal points. They were frequently monitoring and evaluation (M&E) staff, but sometimes a programme staff member or, in one case, part of the accountability staff.

Sharing CHS policies and SOPs between MOs and local partners, in order to ensure partners implemented CHS 4 and 5 processes, was not observed in the evaluation. The reason for this was that these MOs did not have formalised complaints response policies at the time of the evaluation. In the case of one MO which implements through an international partner (which has CHS certification), the partner and its own implementing partner already possessed, or had developed, their own CHS policies and SOPs, which the MO considered sufficient.

The lack of formal written policies in some organisations does not mean that those organisations are not implementing CHS 4 or CHS 5 measures. Particularly for local organisations and other partners such as clinics, which may be unfamiliar with international humanitarian standards, written policies on CFM or communication were missing but key processes nevertheless appear to occur. For example, a local organisation told the evaluation team that they do not have formalised policies or guidelines for either CHS 4 or 5. Yet they collect complaints and feedback at their distribution desks, and have regular consultations with the communities they work in, in addition to using community activists, involving local leaders and government in consultations, and making phone numbers of the field staff available to the community. Similarly, three of the clinics visited mentioned having weekly or daily meetings with the communities or patients that they serve; the focus of these meetings is on disease prevention, but there is at least one case where community members can publicly give complaints, and clinic directors are also in contact with community leaders for information sharing purposes.

IV.1.2. Extent to which these policies are known, being implemented and being followed

MOs set up a variety of mechanisms to receive and respond to complaints: community meetings, suggestion boxes, complaint desks at distributions, and hotlines (Linha Verde and organisation-specific hotlines) are the main channels of CFMs. Other informal channels are also used, such as staff (both M&E and project staff) speaking in-person with different community members or beneficiaries when visiting project locations, and some MOs and partner staff making their personal phone numbers available to communities to call in case of complaints or questions. In addition, M&E activities and systems are also utilised to gather feedback and complaints through assessments such as post-distribution monitoring and evaluations.

Staff knowledge of the complaints and feedback policies appears to be incomplete. Out of the seven MOs, only two submitted presentations that are meant for training or promoting their policies internally.[25] Among the MOs, none of the non-M&E field staff KIs had been trained on CFMs, communication or participation, while all of the M&E staff KIs and nine of the 11 survey respondents (a mix of programme, M&E and accountability staff) had been trained on at least one of those topics. As for the two local partner organisations, each had at least one staff who had been trained or mentored on complaint mechanisms, but not by the ADH MOs and not under this appeal. The two international partner organisations' key informants had also been trained on CHS 4 and CHS 5. It is worth mentioning that only four of the nine online survey respondents who had received training on CHS 4 or CHS 5 topics felt very confident that they had enough knowledge to put the training principles into practice. The other five were only partially confident, and most chose "community engagement" as a topic on which they need more information.

Despite gaps in knowledge about the policies, a positive finding is that most of the staff interviewed were able to describe their responsibilities in meeting the CHS commitments, even those that are not CHS focal points in their organisations. M&E staff and in some cases programme staff either implement the CFM directly by checking and responding to the complaints submitted (through complaint boxes or at distribution complaints desks), or they oversee their organisations' implementation of CFM systems and support other staff and community activists. For two organisations that do not have hotlines, at least one member of their staff give their contact information to community members for them to call with complaints, questions or feedback. Another example given by a non-M&E programme staff was that he/she drafted the organisation's CHS policy and assisted in training community activists on it. Many of the key informants facilitate or attend community meetings as part of communication processes. However, there were a couple MO staff who did not know their role in implementing CHS 4 and 5. This, linked with the findings about organisational training and promotion of the CHS, shows that there could be more work to be done in these organisations to ensure the staff's understanding of CHS 5 policies and CHS 4 activities.

Yet, it appears that the implementation of most MOs' policies is incomplete. Only six of the 11 survey respondents thought that their organisation's CFM policy was fully used or implemented. The other five respondents said that their CFM policies were partially implemented. Of those five respondents who noted there was a CHS 4 policy, only one said it was implemented fully, and the other four said it was partially implemented, though no reasons for this were given. In addition, the consultants consider the implementation of policies to be incomplete due to the inconsistent recording of

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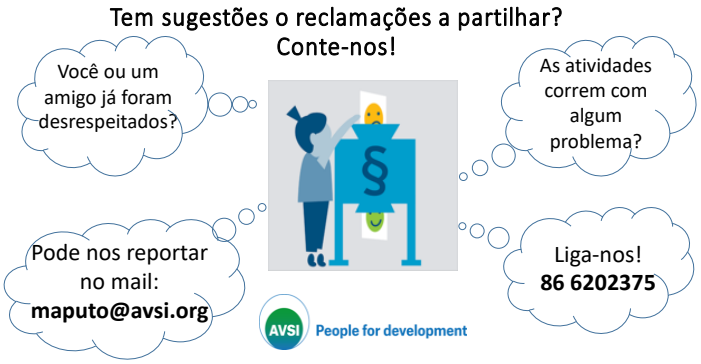
[25] World Vision and CARE; Islamic Relief has checklists for different staff as part of the 'Beneficiary Communication Participation and Feedback Guidance Pack' but not training materials.

complaints and feedback, the insufficient promotion of the CFMs among crisis-affected communities, and the lack of monitoring CHS policy implementation.

Logging of complaints and feedback appears to be inconsistent for some of the organisations, although there is not enough data to provide a clear answer to know for each organisation with complaints mechanisms. Only one MO provided a database of complaints for the project, while another MO provided the October monthly report of complaints and suggestions received. Another MO provided a database that did not have any complaints in it yet. For both the monthly report and the database, the complaints logged were only submitted through complaint and suggestion boxes and helpdesks. For one organisation, the evaluators were told that verbal complaints were addressed but not recorded. For the other organisations, it is unclear if complaints were not submitted through other channels for their projects (the report says no complaints were logged for text messages, calls, office visits or other channels), or if in-person complaints are also not logged. For the other MOs, no records of complaints were submitted.

There was evidence collected through KIs, although with limited detail, of two MOs promoting the CHS commitments. One KI spoke of how they were able to "sell" the suggestion box to communities by explaining it to them during assessments and taking advantage of trainings such as for WASH committees to also include an explanation and discussion of the suggestion boxes. They also started using the boxes as a pilot and later expanded to other communities. Some of the other KIs also discussed having community meetings or trainings with students or teachers on the CFMs and topics such as safeguarding. Two organisations mentioned promoting Linha Verde by sharing posters with the community. Another organisation's CFM posters were observed when conducting FGDs at a school (A poster explaining the different CFMs used by AVSI is shown below). However, many of the FGD participants did not mention having attended a training or meeting in which CFMs were explained. This appears to be a problem as several of them specifically said they had not been informed of the complaint and suggestion boxes or hotlines that were implemented in their communities, and they did not know how to use those CFMs.

Photo 1: Poster for AVSI CFM



While most of the MOs appear to be monitoring their projects, the evaluators did not come across specific examples of MOs monitoring of their own progress in implementing CHS 4 and 5 commitment policies and processes (e.g. satisfaction with the available CFMs, effectiveness of communication channels), as this was neither observed by the team nor mentioned by key informants. Without such monitoring, organisations lack valuable information about whether the CFMs are accessible to the communities and inclusive of different groups; whether opportunities to participate in decision-making are accessible, inclusive, and relevant to the communities; and whether communication about the response is understood by the target beneficiaries. Furthermore, if the MOs are not monitoring the implementation of CHS 4 and 5 internally, they do not have

complete information to judge whether their existing measures are sufficient or whether they need to take further action, such as training more staff or adapting training materials.

The existence of formal policies does not systematically correlate with more effective implementation of CHS 4 and 5. Even the two organisations with both CHS 4 and CHS 5 policies did not show evidence of conducting monitoring of the policies and had beneficiaries who were unaware of their CFMs and/or project activities. On the other hand, one local partner organisation does not have CHS policies but implements a helpdesk at distributions, and uses local language and community activists for better communication with the crisis-affected people.

Data from the survey and KIIs suggests that there were three main reasons behind this partial implementation. First, for the education projects, the implementation of the projects had only started in January and February 2020, unlike other activities implemented under the ADH Cyclone Idai response. The education organisations could not start the rehabilitation of classrooms without approval from the government, and they were also delayed by the procurement of construction companies. Implementation of activities for CHS 4 and CHS 5 were beginning as well, meaning that communication, especially on the CFMs, was ongoing.

Second, the lack of full-time or part-time staff to design and implement policies is a reason for partial implementation for some of the MOs and partner organisations. KIs noted that the time and resources that CHS-focal points have for CHS activities and processes is often insufficient, particularly to meet Commitment 5. As noted by two different KIs, the M&E staff have other responsibilities, and that these positions are not always fully funded by a project. Several staff interviewed said that they needed more resources to implement the CHS commitments. One KI spoke of the lack of budget lines for CHS activities, such as a dedicated staff for the CFMs and enough resources for communication. Another partner KI mentioned that his/her participation in this particular evaluation was limited because he/she was unable to get enough funding for evaluation activities such as attending meetings held in locations where the MO does not have a presence.

Third, most KIs reported a lack of internal capacity to fully implement CHS 4 and 5 processes, which was further exacerbated by the lack of guidance from HQ on the topic. The interviews and survey responses show that more training is needed for staff on CHS 4 and 5, particularly in communication with communities and recording complaints. Monitoring CHS implementation is another area in which awareness among staff reportedly needs to be increased, particularly on CHS 4 processes, and monitoring of CFMs, if organisations are not tracking complaints and the follow-up that they make to the complaints.

IV.1.3. Context appropriateness of policies used

There are different contextual factors that can affect the success of CHS 4 and CHS 5 processes, and the data suggests that the MOs' CHS 4 and CHS 5 policies could be improved to be more appropriate to the local context.

The political context and history of war in Mozambique leads to difficulties for all community members to participate in decision-making and give feedback and complaints. Mozambique has had one main ruling party since its independence and has a history of civil war and insurgency movements. In Sofala Province, an opposition party is in power, putting it at odds with the national government. Community members who support or supported different parties or leaders may not enjoy the same level of participation or access to information that other community members have.

FGD participants were asked about culturally appropriate methods of communication and complaints and feedback for their communities, as well as whether existing CFMs were safe and accessible for them. **Responses varied widely: there was no one method of communication that was**

favoured by all, but a few were more popular than others. Meetings was the most commonly cited method; these could be community-wide meetings, meetings between parents and school directors, meetings between teachers and project staff, or meetings between community members and the *Secretário do bairrio*.[26] Certain groups preferred different meetings. For instance during one FGD in Beira District, the mothers of schoolchildren said they were not informed of community meetings and that the "real meetings" were in the church, not with the community leaders.

In addition to meetings, FGD participants cited phones and suggestion boxes most frequently as preferred CFMs. Other methods that were also mentioned included going to the *Secretário do bairrio* to then go to the organisation, or speaking directly with the school director. For clinic staff and university administration staff who received support from health projects, they mentioned email, Skype calls, in-person office visits and phone numbers as the best methods of communicating complaints or feedback to MOs. A clinic KI noted email was better for having a formal record of the complaint, but that in-person visits were necessary as well. One Catholic University administrator described how another health project with the United States Centers for Disease Control and Prevention (CDC) used monthly teleconferencing meetings on Skype, which allowed for regular and strong communication throughout the project. The ADH-funded project for the university was much shorter, so the monthly meetings may not be relevant for this type of project. However this could still be a method to consider for future programmes, particularly for MOs that do not have a presence in Mozambique during part or all of the project.

FGD participants did not offer many suggestions of alternative methods of communication for more vulnerable groups such persons with disabilities (PWD), older persons (OP), children or people who speak minority languages. They thought the same channels could be used, but with help from other community members. Examples include having parents or group members travel to the houses of PWD or OP, or having another community member bring them on a bike to meetings, or having schoolchildren bring messages to their OP or PWD relatives. One FGD participant provided the suggestion of using the people who bring the Basic Social Security Subsidy grants to OP to also talk to them and get their complaints and feedback at these same meetings. Several FGD participants noted that children are already used to submit complaints to complaint boxes by community members who either feel shy about doing so themselves or do not know how to write.

For FGD participants who knew of the CFMs, most of them felt they were safe and accessible, with the exception of one group of parents that wondered whether the school director looked at the complaints, and another group of teachers that said they do not want to be seen complaining. They noted that being seen leaving a complaint can lead to being marked as a troublemaker by the school director who usually has links with the ruling party and ultimately the authorities. Related to this, some community members may perceive the suggestion boxes to be insecure. One key informant mentioned that there had been an incident (in a different project) where the complaint box was stolen by a community leader that was unhappy with the number of complaints. This perceived or real lack of security can discourage community members from using the boxes.

Furthermore, while many organisations have an email address for people to use to submit a complaint, it appears to be inaccessible[27] for most of the crisis-affected people these projects cover. The data suggests that the email address is more relevant for intermediaries, such as clinic staff, than actual beneficiaries.

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[26] Official government official for the neighbourhood.

[27] This is primarily because beneficiaries have no/low computer literacy and fewer of them have access to smartphones with internet capabilities.

There were two formal assessments that were shared with the consulting team that specifically look at community power relationships and dynamics, information sharing and access between different groups, and how decisions are made and by whom in the communities. This included a gender assessment that CARE conducted to assess decision-making and access to information in communities, and an accountability assessment conducted by World Vision that looked at participation, consultation, complaints, and languages spoken in the communities and among different groups. Other MOs did not submit such kind of assessments for the document review, so it is unclear to what extent they tried to assess the power dynamics of different groups. Furthermore, it does not appear that the gender assessment's recommendations for community-driven response and inclusive community engagement have been used in the CHS policy; while it mentions the inclusion of certain groups, there are no specific measures to address their power differences in the policy (such as what should be done differently for these groups). The evaluators also did not direct observe the findings from the accountability assessment being incorporated into the World Vision CHS policies reviewed, but there was evidence from a KI that the accountability assessment had been used to determine which CFMs to implement and how to communicate with communities.

Although some of the KIs noted the different challenges in community dynamics and the importance of the response to be inclusive and to adapt to the local context, they did not all discuss community power differences or how their MOs' communication and participation strategies and CFMs were inclusive for these different groups.

> *"It's an advantage of our strategy to work with local partners. Local partners are mostly founded by common interest, sometimes a NGO or women's group or church group. They have direct contact with the target group, directly in field. They have to describe them to us, are mostly sensitized to local structure. So we have good experience in this sense, who has to be included in project, who has power and how it can be used for positive targets for project."* – KI

Overall, the MOs did attempt to make the CFM designs appropriate to the local context, but many of the CHS policies and processes, particularly for CHS 4, were not entirely appropriate for those communities.

Both organisations with CHS 4 policies and those without had communication and participation processes that could or did exclude certain groups. Some projects were designed to only involve certain stakeholders in information sharing and decision making. It is likely that these stakeholders (school directors, clinic staff, government authorities, *Secretários do bairrio*) are less representative of certain vulnerable groups, such as older persons. In addition, for some MO's projects' community meetings, Portuguese was used with people who only speak local languages, and written materials (in both Portuguese and local languages) to explain hotlines and other CFMs may have been ineffective for people who are illiterate. KI staff did not mention their established measures to ensure that marginalised groups can participate safely and effectively in making decisions about the response, nor if crisis-affected people who live far from meeting areas are able to participate in making decisions, so it is possible that they are not able to do so.

The reviewed policies do not offer specific methods for addressing political factors that can affect CFMs, such as choosing a community focal point to keep the complaint boxes or ensuring that hotlines are accessible to people who are afraid to be seen using the complaint boxes. Some MOs do not have CFMs that are accessible to different groups affected by their projects. For instance, there are people who are not able to write complaints or do not have phones to use hotlines or SMS services. For the health projects, email addresses to submit complaints are not accessible for patients or other crisis-affected people who have an issue with the response (whether a complaint about staff or problem with the infection prevention treatment), as the patients are not given

information about those email addresses. As noted in Section IV.1.3, the promotion of the CFMs in communities appears to be incomplete. CFMs are not appropriate for the communities if the community is not adequately sensitised on how to use them. In addition, the evaluation team did not receive information about whether CFMs are able to respond to complaints left in local languages (especially through the hotlines), but it appears that organisations without local language staff would not be able to respond to complaints which are not in Portuguese.

Although power differences between MOs and partner organisations do exist, the evaluation did not amass information on how these differences affect the implementation of CHS 4 and CHS 5. The two MOs that work with local implementing partners were aware of disparities in power between their organisations, but only one mentioned specific steps to try to address this. No specific challenges in power differences were noted by local or international partners, but this was a limitation of the interview questions, as they did not ask partner organisation KIs if differences in power between local partners and the MO was a challenge.

> *"We are on at the same level [as local partners] but we know reality is not this. So [we] try to include in projects other measures such as capacity building to strengthen [local] partners, and the target group. [I] see power differences in very different issues. E.g. language. We communicate with other Mozambican partners, so we have volunteers to translate into Portuguese, have skype meeting translated into Portuguese [instead of English]." – KI*

IV.2. Implementation of CHS 4

This section discusses communication channels and the types of participation that were chosen, and to what extent such communication channels allowed a flow of information between the community, partners and MOs.

It also evaluates how each organisation sought to ensure their response was participatory and encouraged affected people's ownership. Lastly, it covers the methods and mechanisms in place to monitor and provide feedback on the level of satisfaction with opportunities to influence the response.

IV.2.1. Information from/to crisis-affected people

MOs and partners used several methods of communication with crisis-affected people, depending on the type of response and the timing of project activities after the cyclone. However, in many cases, these methods did not sufficiently inform crisis-affected people about the projects/activities MOs were implementing.

Overall, information to crisis-affected people was insufficient, although there were marked differences between projects and locations, with some area communities having more information about the projects there. However, in others it was provided late or was completely absent according to some FGD participants, or it had not been adequately shared from community or school representatives to other members of the community. Differences were observed across the sectors, especially between secondary health projects and the other sector projects.

The main communication channels KIs identified were community meetings, FGDs, assessments, community committees, and CFMs, as well as meetings with school directors or clinic staff.

Perceptions of quality[28] and timeliness of information from partners and MOs ranged widely, but generally, all of the projects appear to have at least some gaps in information flow. These ranged the timeliness to the quality of information given. Some FGDs had no criticism of either the timeliness or quality of information, but more often than not, participants reported that information about the project was late or did not occur at all. The evaluation also uncovered a couple examples of beneficiaries having inaccurate information.

Education sector projects all relied primarily on school directors for communication, according to the Mozambique Ministry of Education guidelines in which the school director must be first contacted separately by the organisation before any other information sharing can take place. Those MOs that were engaged in education met with school directors prior to the start of activities. Other ways in which they shared information was to hold community meetings or events to raise awareness on the activities with parents or parents group representatives, children, community leaders, teachers and school directors; to give information to children through peer clubs at the school; to distribute brochures in Sena and Portuguese at meetings or events; and to have project staff visit schools on a regular basis. However, a project staff admitted that these community meetings or events were less useful for communicating about "soft" activities, such as trainings for teachers and students, compared to "hard" activities like classroom rehabilitation, since the community was more interested in hearing about infrastructure activities than DRR training for students. For these projects, teachers were especially likely to report to have not received information about classroom rehabilitation or school latrine rehabilitation activities or having not received it on time, a finding that is not limited to a particular MO or location. Several stated that information had been provided during the holiday period in December and January, when they were not at the school. Some teacher and parent FGD participants were not aware that classroom rehabilitation was going to occur until they saw the construction companies at the school. At one school, parents asked the evaluators when the temporary learning spaces (TLS) were going to be installed. TLS are not an activity that is part of this particular project; although they may have been considered at one point, this was not discussed with the community. Yet somehow the parents at this school believed that TLS were an activity that were going to be implemented. Only one of the parents in this particular FGD had been to a community meeting for the project, and they were less informed about the project. This rumour may have been entirely unrelated to the organisation, but it indicated that the spread of information from meeting attendees to other parents had not been complete or accurate. Many of the parents and teachers interviewed were dissatisfied with the information they currently have on the projects, and requested that they be included in information-sharing before the start of activities.

At least one of the organisations will be installing signboards with information on the cost of the classroom rehabilitation, but those signboards had not yet been installed at the time of the evaluation due to a lengthy process of agreement with the construction company that is in charge of the rehabilitation activities.

"It's not clear. For example, the organisations don't tell us how much money are they using on the construction. We must know how much was spent to know if the classrooms are worth the money spent or not." – Mixed parents and teachers FGD

"When the schoolchildren['s] parents ask what is happening, I feel like a stranger in my own school. I don't know what is going on." – School teacher in FGD of Muhavi 1 EPC

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[28] Quality in this evaluation refers to the accuracy, completeness and relevance of information.

On the other hand, for health sector projects, nearly all clinic staff said that they had information on time and that there were no issues with its quality. In only one clinic was information sharing mentioned as a problem, which was related to internal administrative communication. In this same clinic, the KI was lacking information on which organisation was supposed to provide a medical supply that had not been delivered and so did not know who to contact to follow-up.

For the borehole construction and rehabilitation, the FGD participants described having complained in the past about needing a water point but not receiving an answer. The FGD also noted complaints about not understanding some of the roles of the different committees set up. These issues however are intertwined with the actual management of the committees and payments for the maintenance of water points[29], so it may be less about communities not having information and more an issue of dissatisfaction with the actual project.

Photo 2: Borehole rehabilitated by ADRA

The evaluation was only able to interview two livelihoods beneficiaries; one described getting information from the *Secretário do bairrio* while the other said he/she was not consulted at all. This beneficiary also requested that meetings be in local languages instead of Portuguese, which may mean that there were consultations, but that they were not accessible for non-Portuguese speakers.

It seems that information that the MOs receive from the communities is fairly accurate, but occasionally there are problems with incorrect or missing information.

KIs views of the information received from communities varies as well. Most said that the information was accurate and timely, and they were able to directly determine the communities' needs. Two KIs mentioned receiving incorrect information, but this was from community leaders or school directors. Project or M&E staff reported using monitoring to verify information and cross-check beneficiary selection. MO staff did not mention any issues concerning information coming from the clinics, although in most cases they were able to observe the clinic's needs directly. However, the evaluation uncovered two examples of information gaps from clinics to MOs. For one project, two of the clinics visited mentioned not having the space to build a separate waiting area for patients, which was part

[29] Communities pay a small fee to a water committee for the maintenance of the water points.

of the training they had received on IPC. This problem of space had not been communicated to the MO staff during the training. In the other case, one of the medicines provided to a clinic was not a type normally used in Mozambique, but it is unclear if this information was forwarded on to the MO.

IV.2.2. Participation in the response

Crisis-affected people's level of participation was uneven across the projects and intervention sectors, due to the timing of the response, technical specifications, government considerations, and organisations offering few opportunities to participate in some projects.

Beneficiaries' and communities' participation in decision-making about the project activities was difficult to compare between the projects. Projects that started more than six months after the cyclone obviously had more opportunities and fewer barriers to participation than projects implemented in the first weeks after the natural disaster. Additionally, the type of activity and the type of beneficiary have implications for the level of participation and who is able to participate; activities that have very technical specifications (e.g. engineering and healthcare) necessarily limit the decisions that laypeople can take, while certain WASH and livelihoods projects may present more choices.

> *"[You] don't sit with [the] community to decide what to rehabilitate, that's on the government to say which schools and [which] technical guidelines [of] engineering."* – KI
>
> *"We are trying to not have the director [for the person interviewed about infection control], but ask the director if the identified person responsible for hygiene, like a nurse…Close communication with clinics is a core aspect. Close communication at all times."* – KI

The health sector projects had the least direct participation of beneficiaries. The ultimate beneficiaries of health centre projects – the patients – were not part of a process of selecting activities for their clinics, but clinic directors and staff had been consulted for most health centres the evaluators visited. The KIs from health organisations discussed how their projects were not designed in a participatory manner due to the urgent need of the response. However, one KI noted they had the backing of the health ministry and also took time to have meetings with the clinic directors to make them aware of the reasons for implementing IPC training. For ASB, the clinic directors and staff participated by selecting the staff to attend the IPC training and by talking to the ASB staff during the assessment of the health centre facilities. They did not choose the training topics, although the interviewed staff said that the training had been informative and necessary for them. For action medeor, the university administration sent a list of medicines to the organisation, and the clinic director told the university administrators what medical equipment was needed which was then forwarded on to action medeor.

For the education projects, the Ministry of Education selected the schools or classrooms for rehabilitation, rather than the communities. The KIs from education projects were clear in stating that the projects were not intended to be participatory, e.g. that did not plan for communities to select the classrooms or methods of rehabilitation. The government also mandated the type of rehabilitation, which caused problems in some locations where communities wanted to rebuild classrooms as quickly as possible but did not have classrooms which could be rehabilitated with the conventional materials and DRR technical guidelines which were used on the project.[30] In some

[30] Unconventional material classrooms, which are the majority of classrooms in Nhamatanda, are made out of clay and mud brick, whereas conventional classrooms have concrete walls. Only the conventional classrooms can support the weight of the type of DRR roof which was used in the MO projects.

locations, the communities rebuilt the unconventional classrooms and were upset to not be selected by the government. Some KIs noted that the government's selection of schools did not always adequately reflect the needs of the communities; political considerations were mentioned as having an influence, which suggests a need for creating an avenue for communities to participate in these types of decisions.

For two organisations that implement WASH and/or livelihoods projects, the KIs said that they hold community-wide consultations that are open to all. The other organisation that conducts WASH and/or livelihoods projects only has meetings with government officials, community leaders, and community committees. Notably, this organisation's beneficiaries were less satisfied with their opportunities to influence the response and also with the CFMs.

For WASH projects, FGD participants mentioned having given their opinion during community meetings or having shown the organisation the boreholes that needed to be rehabilitated. This was triangulated by a report from ADRA that noted the decision to not rehabilitate certain boreholes was taken after the community reported not liking the salinity of water from them.

For the two livelihoods beneficiaries interviewed for this evaluation, only one said that he/she gave an opinion on the type of seeds to be distributed. For Kubatsirana, staff said they distributed different seeds in various areas due to communities' preferences, and they also revised their project by removing food distribution as an activity after the community told them they already received food from WFP.

IV.2.3. Satisfaction with opportunities to influence the response

It was not feasible to evaluate crisis-affected people's satisfaction with opportunities to influence the response, as the MOs do not systematically collect feedback on this topic.

There is little evidence that organisations are specifically monitoring the communities' and beneficiaries' level of satisfaction with opportunities to influence the response, and no monitoring tools were submitted that ask questions about this topic. Only one MO staff mentioned collecting information on this particular subject, asking beneficiaries, "Are you involved now and are you happy to be involved?" Many other KIs said that they do monitoring in the communities, but they did not specify whether they asked about beneficiaries' satisfaction with opportunities to influence the response. In some projects, that is likely due to beneficiaries not having had opportunities to influence the response in the first place. For other projects however, it is unclear why this monitoring is not done. One possible reason is that staff were unaware that this should be a question to include in their monitoring.

The lack of monitoring for this question increases the likelihood that avenues of participation were not the most practical for crisis-affected people, as the MOs do not have the information to adapt these mechanisms in real-time. Monitoring the satisfaction with participation opportunities would have alerted MOs prior to this evaluation that in some communities, they needed to modify the implementation, either by changing the avenues for participation (such as location or time of community meetings, or groups consulted) or altering how they provide information about such opportunities to participate (e.g. how to participate, who can participate, method of communication, etc.).

The one MO KI that said they do monitor satisfaction noted that the results of the monitoring are not routinely shared with communities. Without sharing these results, there are missed opportunities for further information gathering (community members may be able to provide more explanation

or alternative opinions), and crisis-affected people do not get to see how the information they provide is being considered. If the implementation is changed, they will not understand why this occurred.

IV.3. Implementation of CHS 5

This section covers communities' aware of the existing complaints and feedback mechanisms offered by the MOs and partners, and how complaints are being handled and dealt with by MOs/partners.

IV.3.1. Community awareness of CFMs

Similar to the knowledge of project activities, community awareness of CFMs differed greatly between projects and locations.

For all projects except one, the evaluators found some beneficiaries that did not know about the CFM or how to use it. The one exception was SODI's project, as the evaluation team could not travel to Macorococho to meet beneficiaries and verify their awareness of CFMs, due a recent attack[31] and ongoing insecurity at the time of fieldwork, as well as flooding. However, the community leader from Macorococho who was interviewed did say that he was able to give feedback to Kubatsirana.

The lack of awareness among FGD participants of the other projects was not surprising, as some CFMs were relatively new, and in other cases they are not fully operational or designed for the crisis-affected population (such as email addresses).

In other cases, the lack of awareness did indicate a problem with information sharing about the CFM, either in terms of outreach or the quality of the explanation. FGD participants in one location of Dondo were unaware of the safety of the complaint boxes and thought that the school director goes through the complaints and removes any that are negative about the school or himself. In another group in Nhamatanda, participants complained that the boxes are only brought to the community when there is a visitor or some kind of assessment. This could be be a problem with information sharing (i.e. communities have not been informed of how the complaints boxes work and so misunderstand who has access to the keys and where the complaints boxes are located when the organisation's staff is not coming to the community to check the box), or a problem with misuse of the complaints boxes (i.e. the school director actually is accessing the complaints inside and the other organisation's complaints box is only available during visits).[32] As both of these FGDs did not have participants (with the exception of one participant in the Dondo FGD) who had received awareness raising on the CFMs and how to use them, information sharing about the complaints boxes needs to be improved. The FGD with participants complaining about the school director is also in a location where the CFM is new and other FGDs for this project had participants who were unaware of the CFMs, making it more likely that this issue is related to low awareness about which people have access to the complaints boxes. With the Nhamatanda FGD, the CFM is not new but project beneficiaries in other FGDs were unaware of the complaints mechanism. As the finding was apparent in different locations and with various projects across sectors, it appears that all of the MOs need to increase awareness of the CFMs and ensure they are accessible to all groups in the communities.

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[31] "Mozambique: Sofala Health Centre Attacked and Burnt Down," *Agencia de Informacao de Mocambique*, January 22, 2020, https://allafrica.com/stories/202001220772.html.

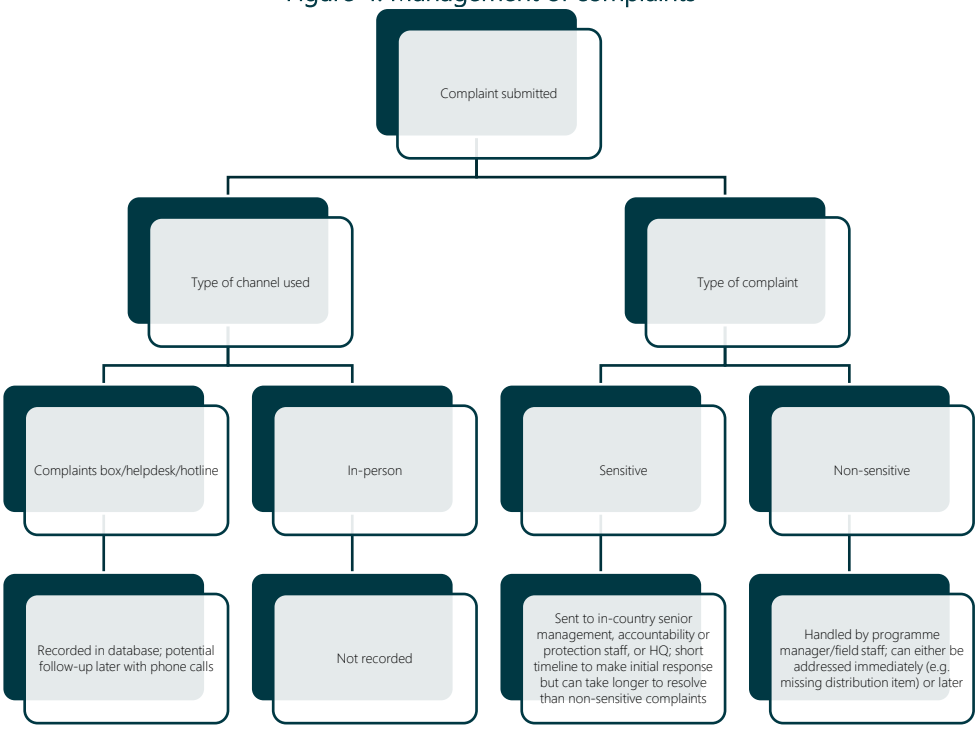
[32] For the possibility of misuse of the complaints boxes, the relevant MOs will be informed by the evaluation team in order to look into these problems further.

Photo 3: Complaint and suggestion box for AVSI Foundation at Metuchira Nharuchonga EPC (Complete Primary School)

IV.3.2. Management of complaints on different topics and through different channels

The treatment of complaints can vary by the channel in which it was submitted and by the nature of the complaint, as shown below:

Figure 4: Management of complaints



Based on the data collected, it remains unclear whether complaints are managed differently according to the sensitivity of the topic. On the one hand, M&E and coordination staff who are involved in the implementation of CFMs were more likely to say that there are different ways of handling complaints based on the nature of the complaint. Complaints about sexual abuse or exploitation was the most common example given of a complaint that should be fast-tracked or sent

directly to the country office in Maputo or to a specific protection focal point, compared to complaints about not receiving items or infrastructure issues. Furthermore, in the complaints policies reviewed, there are descriptions of how sensitive complaints should be treated differently. On the other hand, there were a few KIs who did not seem to know whether complaints were treated differently or who misunderstood the question, which may indicate the need to increase staff's awareness on the different ways to handle and respond to more serious complaints. In addition, the lack of access to CFM databases prevented the evaluation team to further explore the topic. It is also unclear if complaints about discrimination are treated more seriously or the same as complaints about not being selected for distribution.

Complaints do not appear to be handled in the same way whether they are submitted through informal or formal channels. Despite KIs noting that the complaints were handled in the same way, the data collected suggested this was not the case. As noted in Section IV.1.2, only two complaint databases were submitted, one of which did not have any complaints registered yet. For formal channels, these two MOs use Excel databases that record the type of complaint, whether it is sensitive or not, contact information for the person making the complaint, date it was made, and how it was followed up. Verbal complaints[33] that were given directly to staff are not being recorded and monitored in the same manner as complaints submitted by hotlines or complaint and suggestion boxes. One interviewee explained that they had not been recording those complaints because they were addressed and dealt with on the spot, but both CFM best practices and the organisation's own policy state that verbal complaints should be recorded and tracked. Information was not given on how complaints submitted through FGDs or community meetings are treated, but it is likely that they are not always tracked the way that hotline, complaint box, and helpdesk complaints are.

Complaints submitted through Linha Verde could not always be handled the same as complaints submitted through other formal channels, due to the organisation not receiving information about the complaint. Different organisations had very different experiences with Linha Verde. Some do not use it at all, particularly the organisations that implemented their activities before Linha Verde was set up and those that do not have a continuous presence on the ground in Mozambique. Other organisations are not responding to Linha Verde calls in the same manner as complaints submitted through other channels because they don't get enough information from Linha Verde to respond, such as contact information for the complainant, or even a notification that a complaint was made about their organisation. The MO staff who say that they received complaints via Linha Verde noted that it was initially more difficult. One MO staff mentioned that it improved once a focal point was provided for the hotline, and another stated that he/she had encouraged the WFP staff to ask complainants for more information in order for them to properly respond to the complaint. In other cases, MOs incorrectly received complaints from the Linha Verde focal point about activities that they do not implement.

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[33] According to two KIs and the desk review also suggests that verbal complaints are not recorded in the same way as there were no complaints in the databases seen which were marked as being submitted verbally to staff except at helpdesks. It seems unlikely that no verbal complaints were given at all and more likely that these verbal complaints are not recorded.

IV.3.3. Complaints received in the ADH response and how they were addressed

The primary and secondary data[34] collected were insufficient to answer how the MOs handled complaints.

The consultants mostly relied on online survey data for information about types of complaints received via CFMs, in addition to one complaints database and one complaints report. Based on the sources provided (the database for one MO, one MO's complaints report for October, and the online survey responses), and triangulated with information from KIIs and FGDs, the types of complaints relate to three main problems: missing items (from a distribution), beneficiary selection (especially wanting to be selected, but also requesting for a vulnerable person to be included) and infrastructure problems (frequently noted in the FGDs by participants who want to see classrooms built to protect their children from the sun and rain while sitting in class). There were also requests for new activities (such as building roads), as well as positive feedback that was submitted through the CFM, namely gratitude for the activities.

As most FGDs did not have someone who had given a complaint to the MO or partner organisation (or who did not want to self-identify/discuss it during the FGD), information on this question is limited. In one FGD, parents of schoolchildren said that the MO added classroom construction after they had complained that about the project only constructing latrines. In other FGDs in one community, the community members said that they had requested seeds and another borehole to be built but that the MO had not responded to these requests. According to one FGD participant, one non-sensitive complaint that they submitted through email to a MO was acknowledged but no response was made.

The database with recorded complaints provided incomplete information on how complaints are responded to. For instance, it just says "resolved" or "pending;" descriptions of how complaints were resolved were only available for some complaints, which noted that another organisation provided the service or that water had been provided to address the problem. 39 of 59 complaints in the database were resolved at the time it was submitted to the evaluation team. The report provided by the other MO only mentioned that complaints about missing items were resolved immediately by replacing the items if they were submitted during the distribution, but did not give information on how other types of complaints were addressed. 46 of the 75 complaints received were classified as resolved.

There was not enough evidence to evaluate the MO's response time to complaints. The online survey data is limited; four respondents did not know how long it takes for their organisation to respond to complaints or they said the question was not applicable to them; two respondents said it takes two to seven days, one said it was one day or less, and two said it is more than two weeks. The October report noted that there were delays in responding to complaints, but did not specify the length of time it took to respond to them. Instead, it only mentioned that some complaints were about a distribution in May. The database with complaints has dates for when complaints are received and when they are resolved, but in some cases, the dates were clearly incorrect (e.g. date resolved was earlier than date received) so the time to resolve them is not known.

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[34] To be able to fully answer the question, the consultants would have needed access to complaints and feedback databases from MOs.

IV.4. Challenges and best practices

This section answers the fourth KEQ on the main challenges MOs faced in implementing CHS 4 and CHS 5; and the best practices identified by MOs in CHS 4 and CHS 5.

IV.4.1. Main challenges

MOs implementing CHS 4 and CHS 5 systems and activities face challenges related to project design, the context where they operate, the sector of the response, and the language.

KIs and FGD participants highlighted different factors that make or made implementing CHS processes difficult. Several of the challenges are related to implementing the CHS commitments in general for all organisations, while others are specific to the type of response. One general challenge is the lack of contact information to follow-up with a complainant. When sensitive complaints are left in the boxes, there is no way to get more information to investigate.[35]

Project design challenges:

Project budgets did not always include lines for CFM activities, namely staff to monitor complaints and feedback, which limited the CHS implementation. It was unclear why this was a challenge, as ADH funding is flexible and encourages activities to meet the CHS commitments. More information is needed to determine whether this is due to a lack of awareness among staff who develop the proposals, or if there is pressure to not budget over a certain amount for M&E and accountability staff.

Contextual:

Emergency contexts can preclude consulting with crisis-affected people and instead only allow for limited consultation with representatives. After Cyclone Idai, there were immediate needs that had to be met, and not enough time or staff available to consult the communities about their priorities or to set up formal complaint and feedback measures. According to the guidance note for CHS 4, in the immediate aftermath of an emergency, it is acceptable to only consult a limited number of stakeholders. However, consultation with government and other community representatives may be insufficient to understand the communities' needs and priorities, and such lack of consultation means the communities themselves are often unaware of the response. It also increases the possibility that political considerations rather than crisis-affected people's needs and rights will be used to prioritise relief.

Raising awareness among crisis-affected people on CFMs or other CHS measures is difficult if the intended targets of information want to be paid to attend meetings or trainings (e.g. parents, teachers, committee members). One organisation mentioned having challenges holding trainings with teachers from one area because they were less motivated to come to unpaid meetings or trainings.[36] During the preliminary findings presentation in Beira, participants confirmed that there are differences between humanitarian agencies in payment policies (e.g. whether participants are paid transport reimbursements for trainings or meetings, whether refreshments are provided, etc.).

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[35] For complaints that do not have contact information for the complainant and specific details of the incident, such who is involved and location.

[36] It was noted by project staff that some of the bigger international organizations pay attendees to come to their trainings.

The consultants did not obtain information on organisational policies or practices for meeting payments and refreshments, so a comparison of different policies or practices was not done in this evaluation.

Security issues in some locations prevent organisations from returning to collect feedback if complaint and suggestion boxes are used. It was also noted in the one CFM report shared with the consultants that delays in returning to open the complaint and suggestion boxes led to delays in responding to complaints in a timely manner.

Finally, one contextual challenge is related to the humanitarian context in general. There are numerous different humanitarian agencies operating in Mozambique. Each agency has its own approach and policies, and those that have CFMs do not all use the same mechanisms. This can create confusion among the communities, especially if crisis-affected people are not aware of which organisation is doing which activity, as well leading to issues of coordination. The most obvious example is Linha Verde, but there are also others. In one location visited, two MOs are implementing activities at the same school. One MO had a complaint and suggestion box there, but it is unclear whether complaints about the other MOs submitted through the box would be forwarded to them. Referral processes were not part of the scope of this evaluation, but that is an important question to consider for CFMs.

Sectoral challenges:

There are CHS challenges that are only applicable to specific sectors or activities.

Communities may not be able to participate in decisions on activities that are very technical such as choosing how to rehabilitate classrooms or choosing which IPC measures to put in place at a clinic, and it can be a challenge for organisations to explain why certain classrooms are rehabilitated in a certain manner instead of being done more quickly with local materials or why an organisation is giving gloves and buckets instead of medicines to a clinic. This is also a challenge of community needs versus priorities (e.g. ensuring DRR or protection versus having classrooms as soon as possible). These interventions may require organisations to spend more time in explaining decisions with communities and to use different methods of communicating the reasons for specific activities.

Health sector interventions, such as distributing medical supplies through non-humanitarian partners or projects that send emergency medical staff for a limited period of time to the affected areas, are not in direct contact with the beneficiaries, the patients, and sometimes not even the clinic staff. For action medeor's project, the MO was in contact with the UCM administration and German-Mozambican Association only, not the Sao Lucas Clinic that received items, and it did not have a country presence. For ASB's project, the field team were in contact with the clinics' staff and ASADEC (a national NGO) during the response and were available by email after they left the country. Neither MO had direct communication with the patients that used those clinics (e.g. about the email address CFM), and even so, most patients would have been unlikely to be able to use email address CFMs. Even if those MOs had had complaints boxes or hotlines for patients, they would have needed someone present on the ground to receive and address the complaints.

CFMs for secondary healthcare projects may also be less likely to be used because of the unique status of the beneficiaries. People who are sick may be are afraid to complain as they are more vulnerable and fear not being treated properly if they do so. They may also be unable to complain at the health centre because they are too sick to do so.

Language:

Language differences between international and Mozambican staff, as well as between Mozambican staff from other regions and community members in Beira, Dondo and Nhamatanda, present difficulties for implementing CHS 5, and especially CHS 4. At the beginning of the Cyclone Idai response, coordination meetings were held in English rather than Portuguese. This prevented local organisations from participating at the cluster level, meaning that they received less information on the response than other agencies. One KI cited this as a reason that their local partner was not using Linha Verde; they had had no connection to WFP and so were not in a position to promote or use the hotline as a CFM.

As previously noted, **another language challenge for some organisations was ensuring that staff were present at CHS activities who speak the local languages**. In these locations, many crisis-affected people do not speak Portuguese. The community meetings that were held in Portuguese were not accessible to community members. This dilutes and distorts the information that is shared, and also creates power imbalances in favour of the few Portuguese speakers in the community, who can control information sharing.

IV.4.2. Best practices

A few best practices were noted by KIs and communities.

- **Holding community meetings with different members of the affected population, not just school directors or community leaders, is more likely to be successful for information sharing**. Bilateral meetings with school directors or community leaders should still occur, but organisations that also include general meetings open to all of the affected people are more likely to meet their CHS 4 commitment on information sharing.
- **Having government, local leaders, staff, and community activists/volunteers all present at distributions was cited as a way to improve both communication and the helpdesks, as there is more transparency and accountability with different representatives present.** Furthermore, using local volunteers and local knowledge was mentioned as a best practice to communicate with the community and design appropriate CFMs; the CFMs would then be more relevant and appropriate to the context, and information would be better disseminated. One organisation uses community focal points the community selected to open the complaint and suggestion boxes. This was said to improve community trust in the CFM.
- **A best practice related to the handling of complaints was to ensure sensitive complaints are treated urgently and go directly to director or head of the country mission (or to HQ offices), instead of through normal processes or channels.** This is the structure for many CFMs, but it is an important reminder for organisations that are still developing their CFMs. It is also essential that all organisations ensure that their staff know how to address sensitive complaints, e.g. about sexual abuse or exploitation, fraud, corruption, etc. Sensitisation on such topic for staff and also community members, such as parents of schoolchildren, is integral to this process as well.
- Ongoing awareness raising on the CFMs to get people to feel more comfortable with using them, and to ensure they know how to submit different types of complaints.

V. Conclusion

This evaluation clearly demonstrates that MOs tried to mainstream CHS 4 and 5 in their programme, with varying degree of success. It also found several areas for improvement for MOs to meet CHS Commitments 4 and 5 in the Cyclone Idai response.

While many organisations have a policy that discusses complaints, only two organisations had policies that addressed CHS 4 and CHS 5. Some organisations are still developing their policies however. Resources and staff for CHS 4 and 5 need to be increased in some MOs. Understanding of the CHS policies is insufficient among some field staff, showing the need for more promotion of the commitments, even within organisations that have policies. Community engagement and communication policies in particular need to be developed to ensure the appropriate community participation in the response.

Community awareness of organisations' CFMs and of opportunities to participate in the response varied. In several locations, there was no awareness. In others, FGD participants knew of complaint boxes and/or phone hotlines, and they attended community meetings.

Several factors such as language differences between staff and communities, the emergency context immediately after a storm, and the technical requirements of certain projects increase the difficulty of fully meeting the CHS 4 and 5 commitments. Even now, organisations do not always have staff available who speak the local languages such as Sena and Ndau, and instead hold consultations and awareness raising activities in Portuguese. However, this lack of information sharing in local languages means that awareness and understanding is limited among communities. Power dynamics and hierarchies affect the spread of information and use of CFMs, whether it is between teachers and school directors or in general among community members. Some types of projects that have specific technical requirements (such as resilient rehabilitation of classrooms, or IPC training) may be more difficult to implement with full community consultation. In other cases, the lack of field staff in Mozambique made it difficult for organisations to implement CFMs.

Holding general community meetings and working with multiple stakeholders in the communities were seen as best practices, as were relying on local knowledge and using focal points selected among community members to review the complaint boxes.

VI. Recommendations

On the basis of the findings above, suggestions and recommendations for ADH members to further strengthen their progress on meeting CHS 4 and CHS 5 include:

Design of CHS 4 and CHS 5 policies and processes

Recommendation 1: Conduct a rapid power analysis and age, gender and diversity (AGD) at the assessment phase.

Undertake studies such as age, gender and diversity (AGD) analyses or power analysis to understand vulnerability characteristics, needs and preferences of particular groups (including women, older people, and people with disabilities) would allow MOs to choose appropriate channels for CHS 4 and 5. Also aim to include relevant information on other community dynamics which may impact

information sharing, decision-making, or complaints mechanisms, such as whether people feel safe to be seen using a complaints box, if people feel comfortable participating in decisions and disagreeing in public forums, and if there are any political considerations to take into account.

The data for such studies could be collected during a multi-purpose need assessment at the beginning of the response, and could be obtained via a few KIs, FGDs and a desk review.

Recommendation 2: Foster sharing on policies and experience at country-level among MOs.

ADH and member organisations with more experience in CHS should support MOs with less experience to design projects with adequate budget lines and activities for CHS, such as for staff and assessments.

As some of the MOs have less experience in setting up CFMs and/or developing communication and participation policies, ADH and the more experienced MOs can provide them with guidance on which resources and activities to budget for, and can even share policies as well as trainings. ADH's permanent working group on quality assurance would likely be the best place for this information sharing to take place, and organisations still developing or looking to improve their policies could reach out to other MOs.

Recommendation 3: Have one CFM system for all MOs in order to share expertise and costs.

One CFM system for all ADH MOs would allow for better coordination and consistency in handling complaints (including referrals), reduce costs associated with managing CFMs, and allow organisations with less experience of setting up and running CFMs to learn from those with more experience. However, in order to be viable and avoid the problems Linha Verde currently faces, MOs will need to have a data sharing agreement and mechanisms to pass on complainants' contact information, with said complainant's permission. ADH's permanent working group on quality assurance should start the discussion of this and Recommendation 4 between MOs.

Recommendation 4: Increase coordination with other humanitarian agencies and relevant institutions in project locations to harmonise CFMs and raise awareness about them.

Duplicate or overlapping CFMs may confuse crisis-affected people, or create gaps. Better coordination is necessary to improve referrals between organisations and ensure that complaints are received by the correct organisation.

Recommendation 5: Ensure minimum community participation in all sectors.

Although the level of community participation will necessarily be affected by the timing of the response and type of activity, there are opportunities for some MO projects to increase community participation. With agricultural inputs, beneficiaries should be able to participate in the decisions on the types of inputs to be distributed. The availability of inputs and technical guidance from the government or the organisation are necessary but not sufficient to make the decision, as it is also important to hear from potential beneficiaries about what types of crops or tools they need and are able to use. For WASH projects, a community's preference for the placement of boreholes and latrines should be taken into consideration. Communities should also be part of the discussions about the organisation and management of WASH committees to avoid creating tensions about the collection and use of water point fees. In education projects when it is not feasible to ask

communities to select the schools, MOs could include, for instance, conduct an assessment to ensure that the schools the government selects are indeed the most in need of assistance, to avoid perceptions of political influence. As for health projects, MOs should try to consult both clinic directors and other relevant staff about project activities.

The lack of information (or use of information) on power dynamics and relationships in communities can prevent MOs from having CHS policies and processes that are appropriate and inclusive. This would include having consultations with people of different power and positions separately (e.g. having one meeting with a school director and one meeting with the schoolteachers, having meetings with the community separate from meetings with the *Secretário do bairrio* or having separate FGDs with some community members).

Recommendation 6: Have at least two channels available in every project location and ensure different methods of handling sensitive versus non-sensitive complaints while ensuring that complaints are not treated differently due to being submitted formally or informally.

No one method will be accessible, comfortable, and safe for every crisis-affected person in a given location. As such, MOs should always have at least two options, and try to ensure all community members have access to at least one of the mechanisms. Handling the complaints should be the same across mechanisms, e.g. those that are submitted via the hotline or complaint box should be handled the same as those submitted verbally to an organisation's staff member. The treatment of the complaint should only differ based on the nature of the complaint (i.e. sensitive versus non-sensitive), not on how it was submitted. Training on CFM should include training on handling complaints submitted informally.

Recommendation 7: Explore other types of CFMs for organisations that do not have a stable presence in the country.

For instance, have a dedicated number on an app that can be used by people who would otherwise be unable to email or call an international number. The selected app will need to be in compliance with the EU General Data Protection Regulation (GDPR), such as Signal.

Should recommendation 3 be adopted, this recommendation becomes redundant.

Implementation of CHS 4 and CHS 5 processes

Recommendation 8: Increase the use of community meetings as a means of communication and participation for communities, and do not rely solely on one focal point or institution for information sharing and decision-making during the response.

In many communities visited during the evaluation, information did not cascade down from school directors to parents and teachers. Although school directors are critical to meet when starting projects in schools, organisations should have community-wide meetings in these locations or at least meetings that include teachers and parents. While meetings with school directors are needed to be held first in order to respect local norms, the projects should also require the involvement of teachers and parents in consultations. Try to include all of the teachers of a school in at least one awareness-raising session, as it appears that teachers were less satisfied if they were not informed or consulted directly by the organisation. When it is not feasible to have as many meetings, organisations can use the school councils to send out information and represent parents of students. In communities where organisations are aware of misinformation or mistrust in the community of

some focal points (such as with specific school directors), they should take prioritise additional consultations and awareness-raising. Similarly for health interventions, MOs should make sure to meet with at least one representative of every institution that will have project activities. When activities are too technical for community members to choose their design, consider holding joint consultations with the community and government where the rationale for the selected activities (e.g. resilient rehabilitation of classrooms, IPC training) is explained.

Recommendation 9: Have staff or community volunteers translate into local languages at community meetings and when raising awareness about CFMs.

To increase community awareness of project activities, rights and entitlements, and organisations, MOs should prioritise having at least one community activist or staff member to translate at community meetings and other consultations, if they are not already doing so.

Recommendation 10: Conduct more awareness raising internally and with beneficiary communities on opportunities to participate in the response and on how the CFM works.

Not enough staff are aware about CHS policies and processes, which indicates the need to increase trainings and create easy-to-understand materials for MO and partner staff. MOs should also consider using additional sources of communication, for instance radio or television to increase awareness on organisation's responses and CFMs. In locations near Beira, television is a popular medium, whereas in Nhamatanda, radio has a bigger reach. MOs could use such methods, tailored to the local context, to increase communities' knowledge of their activities and CFMs.

Recommendation 11: Minimise the crisis-affected people's costs of accessing CFMs and of opportunities to participate in response decision-making.

Hotline or text message CFMs should ideally be toll-free for beneficiaries to use.

Organisations should aim to have meetings in different locations to reach community members who may be unable to attend meetings held far from their homes. Trainings or awareness raising with key groups on the CFMs should attempt to minimise costs and time spent away from jobs or livelihoods by adapting to the needs of participants.

Recommendation 12: Ensure disability mainstreaming is a part of CHS 4 and 5 policies.

MOs should update their policies or project-specific CHS process guidance to have concrete measures to make communication, participation, and complaints mechanism activities inclusive to people with disabilities. A first step is to use the work on Washington Group on Disability[37] to collect information and perspectives from people with disabilities during assessments and as part of monitoring for the CHS 4 and 5 activities. Other guidance specific to people with disabilities could serve a reference to MOs.[38]

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[37] http://www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/

[38] Here is one document that is particularly comprehensive and short: Working with persons with disabilities in forced displacement (UNHCR, IRC, HI, Working Under the Same Sun). There is other guidance available on the topic.

Monitoring of CHS 4 and CHS 5 implementation

Recommendation 13: Monitor both the communities' satisfaction with opportunities to participate in the response and the implementation of the CHS policies.

Questions about community satisfaction with participation opportunities can be added to post-distribution and post-construction monitoring. At community meetings, MOs can also instruct attendees to leave feedback through the CFMs about whether they feel comfortable with the opportunities to participate. Implementation of the CHS policies can also be monitored through staff surveys or focus groups and tracking CHS 4 activities (recording feedback at community consultations, and the level of participation in these forums, looking at who participates). MOs should provide training participants with evaluation forms after trainings to give feedback on the training.

Recommendation 14: Ensure feedback data from all sources (including from daily interactions), is regularly and systematically analysed to inform programme design and implementation.

Feedback and complaints that are provided informally (e.g. to programme staff) should also be recorded in the same manner as feedback and complaints given through other channels. Tracking the complaints and feedback allows for a better understanding of the project's implementation and allows MOs to change their implementation and design of projects to better suit the crisis-affected people and locations.

VII. Annex 1. List of Agencies and Others Interviewed or Consulted

The evaluation used a mixed-methods approach and followed a four-step process. It began with a briefing call with representatives from ADH and Key Aid Consulting (KAC) in December 2019 and lasted until April 2020. During the review period in February/March 2020, the Evaluation Team interviewed or consulted one or more representatives from the following organization or institutions:

ADH Member Organisation/Partner Representatives in Germany

- action medeor
- ADRA
- ASB
- CARE
- Islamic Relief
- SODI e.V:
- World Vision

ADH Member Organisation/Partner Representatives in Mozambique

- action medeor
- ADRA Mozambique
- ASB
- ASADEC (Association for Community Development)
- AVSI Foundation
- CARE Mozambique
- CAFOD (Catholic Agency for Overseas Development)
- Kubatsirana
- SODI e.V:
- World Vision Mozambique

In addition to the interviews and focus-group discussions with the key informants listed in this table, the evaluation team also consulted with a range of beneficiaries and key stakeholders in Mozambique.

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IX. Annex 3. Evaluation Terms of Reference

Terms of Reference (ToR)

Independent Evaluation of the Aktion Deutschland Hilft (ADH) joint appeal to "Cyclone Idai Mozambique"

1. Introduction

Aktion Deutschland Hilft (ADH) – Germany's Relief Coalition is an alliance of 13 renowned German aid organisations founded in 2001. Together they provide humanitarian aid in the case of large catastrophes and emergency situations.

The ADH Bonn office is commissioning an independent evaluation of ADH's joint appeal "Cyclone Idai Mozambique" to

a) assess the introduction and implementation of Core Humanitarian Standard on Quality and Accountability[39] (CHS) 4 on communication, participation and feedback and CHS 5 on complaints in its relief activities in Mozambique, and
b) draw recommendations to better support the planning of future programmes and projects.

2. Background

On 14 March 2019, the tropical cyclone Idai made landfall at speeds of up to 195 kilometres per hour near Beira city, Mozambique. Less than six weeks later, on April 25, 2019, cyclone Kenneth dealt a hard blow to northern Mozambique about 600 miles north of Idai's impact zone.

Its heavy rains and strong winds led to flash flooding that affected around 3 million people in Mozambique, Zimbabwe, and Malawi. Idai and Kenneth were two of the top five worst storms to ever hit Mozambique. It caused hundreds of deaths and left 1.8 million people in need for direct assistance after massive destruction of property and crops.

On 19 March 2019 Aktion Deutschland Hilft (ADH) launched a joint appeal to support the affected population. The appeal raised over 12 million EUR from which 10 organisations party to ADH requested funds for their emergency responses.

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[39] Sphere Association. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, fourth edition, Geneva, Switzerland, 2018 [https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf]

During the first phase of the emergency the respective member organisations (MOs) assisted survivors with lifesaving, humanitarian assistance such as food, clean water, shelter, emergency latrines, and non-food items.

As of today, the organisations continued providing humanitarian assistance, while supporting disease control and prevention measurements, food security activities or distributing essential drugs to health care centres.

For more information refer to: https://www.aktion-deutschland-hilft.de/de/hilfseinsaetze/zyklon-idai-mosambik-spenden-sie-jetzt/ (German only).

3. Purpose, key evaluation questions and general aims of the evaluation

ADH aims to ensure quality in its work and thus builds on a strong culture of lessons learnt. As such, ADH is committed to review its joint appeals through external evaluations. ADH intends to commission an external evaluation of its joint appeal "Cyclone Idai Mozambique".

3.1. Purpose of the evaluation

All people affected by crisis have a right to receive protection and assistance. This right ensures the basic conditions for life with dignity. Common elements and ways of working are useful for promoting an effective humanitarian response. Without a common approach, outcomes may be inconsistent and unpredictable. The Core Humanitarian Standard on Quality and Accountability (CHS) sets out nine commitments that should be used to improve the quality and effectiveness of humanitarian response. Humanitarian agencies should implement and carry out their assistance according to the CHS. It is, however, recognised that the extent and the degree to which humanitarian organisations are able to include the CHS within their activities may vary according to the context they are working in.

The objective of the present evaluation is to identify to what extent the two standards CHS 4 and CHS 5 have been considered by the organizations in the design and implementation of assistance provided to the survivors of the cyclones in Mozambique.

The aspect of learning is of particular importance for this evaluation.

3.2. Main questions / relevant aspects to cover

The evaluation will address three Key Evaluation Questions (KEQs). All KEQs should be queried independently from each other. Following sub-questions are conceivable but not exclusive:

KEQ 1: Existing policies, programmes and processes for CHS 4 and CHS 5:

- Which policies, programmes and processes related to CHS 4 and CHS 5 are documented and in place within the organisations and their partners?
- What are the organisational commitments towards participation, ownership and complaints (CHS 4 and CHS 5)?
- To which extent are these commitments promoted and followed up within the organisations and their partners?
- In which way are organisational responsibilities regarding CHS 4 and CHS 5 actually implemented within the organisations and their partners?

- In which way is staff encouraged to implement and to put into action existing policies (i.e. through trainings, guidelines, open commitment)?
- To what extent is „cultural appropriateness" taken into consideration?
- In which way are power dynamics assessed and taken into account?
- What are best practices and main challenges?

KEQ 2: CHS 4 - Humanitarian response is based on communication, participation and feedback

- Which communication channels and which types of participation were chosen
- Describe the different methods at different levels and phases of the activities both from the point of view of the community but also of the organisations/partners.
- Is there a flow of information from communities to organizations/partners and from partners to organizations? If yes, in what ways (systematic and non-systematic)?
- What methods and mechanisms are in place to monitor and to provide feedback regarding the level of satisfaction (with special regard to gender, age, and diversity)?

KEQ 3: CHS 5 – Complaints are welcomed and addressed

- How are complaints and feedback defined within the organisations and partners?
- Are complaints weighted differently in regard to their topic in the organisations (complaints regarding activities versus protection, abuse and discrimination)?
- What are the organisation's formal complaints handling procedures (i.e. in regard of priorities and response timeframe)?
- Are communities, staff and partners aware of the existing complaints handling procedures?
- Are formal complaints handling procedures and informal/unstructured complaints treated in different ways? If yes, in what ways (examples, good practices)?
- Which kind of complaints and feedback was received during the current intervention? How it was handled?

The KEQs should be addressed with special, but not exclusive, consideration of the OECD/DAC criteria of appropriateness, relevance and sustainability. As a reference CHS 4 and CHS 5 in the 2018 Sphere Handbook should be taken in to account.

The KEQs listed above are to be considered as guiding questions only and the evaluation team is not limited to them. The refining and further elaboration of the questions should be done by the evaluation team, which will propose a matrix of detailed evaluation questions. The final evaluation questions will be discussed and agreed upon through consultation with the ADH Bonn office and the organisations participating in the evaluation.

3.3. General aims of the evaluation

The aims of this evaluation are to:

- better understand the implementation of CHS 4 and CHS 5 within the projects
- identify good practices
- identify gaps and areas of unmet needs both in activities and from a cross-cutting perspective

- provide "lessons learnt" for future projects in order to improve the work of ADH and its organisations
- formulate individual recommendations for organisations participating in the evaluation.

4. Evaluation approach and methodology

The evaluation team must adopt a consultative and participative approach to triangulate data.

This will include:

- Briefing by the ADH Bonn office, kick-off workshop and inception report
- Secondary information analysis
    - Desk review of relevant programme and project documents and reports such as proposals, assessments, project budgets, monitoring and assessment reports, organisations' own evaluations, accountability policies, standards and guidelines for Sphere and CHS
- Direct information analysis
    - Interviews with ADH Bonn office and in the participating organisations' headquarters in Germany
    - Field visits to selected sites in Mozambique (selection done together with the ADH Bonn office); interviews, focus group discussions and/or questionnaires with country/regional offices, local partners, beneficiaries, governmental authorities and other stakeholders (balanced mix of quantitative and qualitative methods required)
- Debriefing workshop at the end of the field visit in Mozambique with evaluated organisations led by the evaluation team to
    - present the draft findings of the field visit
    - discuss possible recommendations and substantive issues emerging from the draft findings of the field visit
- Debriefing workshop with ADH Bonn office and the evaluated organisations led by the international/lead evaluator to
    - present the draft findings of the draft evaluation report
    - discuss substantive issues emerging from the draft report
    - gather feedback on the findings and on recommendation
- Submission of a draft evaluation report to ADH Bonn office and the evaluated organisations for comments and feedback
- Submission of final evaluation report
- Submission of individual recommendations for all participating organisations

The evaluation should combine evaluation tools based on international standards and guidelines like the Code of Conduct of the Red Cross/Red Crescent societies, the adapted ALNAP and OECD/DAC criteria, the Core Humanitarian Standard on Quality and Accountability and the Sphere Minimum Standards in Humanitarian Response and Grand Bargain commitments.

5. Deliverables and deadlines

5.1. Proposal outlining methodology and work plan (max. 4 pages)

The proposal outlines the methodology of the planned evaluation and its work plan. It is part of the documents to participate in the second stage of the tender (refer to Chapter 9). The proposal will be used as the basis for the inception report.

Deadline: 4 December 2019, only after invitation by ADH

5.2. Inception report (max. 10 pages)

The inception report sets out the planned approach to meeting the consultancy objectives, methodologies to be used and questions to be answered through reviews and planned interviews. It provides a description on how data will be collected and suggests possible data collection tools such as questionnaires and interview guidelines.

Deadline: 3 days after the kick-off workshop.
The inception report needs the approval of ADH Bonn office and the permanent working group on quality assurance prior to the start of the evaluation.

5.3. Draft evaluation report (for the structure, refer to point 5.4. Final evaluation report)

Deadline: End of February / beginning of March 2020

5.4. Final evaluation report including a summary (max. 35 pages excluding annexes)

The report should include (but is not limited to) the following:

- Executive summary (max. 2-3 pages)
- Evaluation purpose, objectives, and scope
- Methodology (reflection and linking to the TOR and possible constraints leading to deviations from the TOR)
- Findings (related to the objectives of the TOR)
- Conclusions
- Recommendations
- Lessons learnt
- Appendices (including TOR, maps, questionnaires, list of interviewees, and bibliography)

  Deadline: Will be agreed at the debriefing workshop

5.5. Individual recommendations for all participating organisations (max. 1 page per organisation)

Around 8 organisations will participate in the evaluation.

Deadline: Will be agreed at the debriefing workshop

Language

All documents should be written in English.
The executive summary of the final evaluation report should be written in English and Portuguese.

The evaluation team will directly report to ADH Bonn office.

They will be bound by ADH rules of confidentiality. All material collected during the evaluation process will be handed over to ADH prior to termination of the contract. The evaluation report and all background documentation will become property of ADH and will be published according to ADH rules and regulations.

The evaluation team will not be allowed to present any of the analytical results as its own work or to make use of the evaluation results for private publication purposes.

6. Expected timeframe

Activities	Deadlines
Call for CVs, references and work samples of at least one report that was completed for a recent evaluation of a humanitarian programme	19 November 2019
Closing date for applications (only short-listed candidates)	4 December 2019
Recruitment of evaluation team	11 December 2019
Kick-off workshop in Germany	8 or 14 January 2020 (1 day)
Inception report	3 days after the kick-off workshop
Evaluation phase including draft evaluation report	End of February / beginning of March 2020
Debriefing workshop in Germany	Beginning of March 2020 (1 day); will be agreed at the kick-off workshop
Finalisation and submission of evaluation report	Will be agreed at the debriefing workshop

The evaluation team lead is requested to immediately inform ADH Bonn office if serious problems or delays are encountered. Any significant changes to the evaluation timetable must be approved by the ADH Bonn office.

7. Budget

Offers should include a proposed budget for the complete evaluation, covering all consultancy fees, visa, transport, accommodation and subsistence costs. The budget should present consultancy fees according to the number of expected working days over the entire period.

It is anticipated that the evaluation will last 45 working days (around 31 for the international and 14 for the national evaluator).

The evaluation team is responsible for its own travel arrangements, including related visas and insurance. ADH Bonn office and/or the organisations will provide all contact persons (addresses etc.).

8. Qualification of evaluation team

The team should consist of minimum two evaluators, one international and one from Mozambique, and be appropriately gender balanced. The international evaluator is leading the team and is responsible to select an adequate local evaluator in order to complete the evaluation team.

As a team the evaluators should have the following skills and experiences:

- Very good understanding of the Core Humanitarian Standard on Quality and Accountability, the Sphere Minimum Standards in Humanitarian Response, and the adapted ALNAP and OECD/DAC criteria, as well as an appreciation of key challenges and constraints to their application in the relevant context.
- Strong analytical skills and ability to clearly synthesize and present findings, draw practical conclusions, make recommendations and prepare well-written reports in a timely manner.
- Longstanding experience in evaluating humanitarian programmes targeting natural catastrophes.
- Knowledge of multi-methodological approaches (qualitative and quantitative methods) in humanitarian evaluation (as evidenced by recent publications).
- A sound knowledge of the context in Mozambique.
- Experience in collecting data from vulnerable groups.
- Demonstrated capacity to work both independently and as a team.
- Excellent oral and written communication skills.
- Demonstrated cross-cultural skills.
- Knowledge and experience working with ADH is a plus.
- For the international evaluator:
    - Knowledge and prior experience of working in Southern Africa, preferably in Mozambique.
    - Excellent writing and presentation skills in English.
    - Considerable knowledge of German.
    - Knowledge of Portuguese is a plus.
- For the national evaluator:
    - Fluent in English and Portuguese.

9. Tender

Tenders will be accepted by consultants as well as from commercial companies, NGOs or academics.

ADH has a 2-stage recruitment process:

- First stage: Call for up to date CVs, at least two references for all evaluators involved and work samples of at least one report that was completed for a recent evaluation of a humanitarian programme.
- Second stage: Short-listed evaluation teams will be invited by ADH to submit a complete offer.
    - This offer must include the following:
        - Covering letter explaining interest and suitability for this position
        - Proposal outlining methodology and work plan (max. 4 pages)
        - Comments and suggestions on this TOR
        - Proposed evaluation budget

The final decision on tenders will be taken by ADH, following short-listing and possible interviews. Only short listed candidates will be invited to submit a complete offer and will be contacted for the next step in the application process.

Deadline for CVs, references and work samples:

Forward CVs, references and work samples electronically to Markus Moke (moke@aktion-deutschland-hilft.de) and Sibylle Gerstl (sgerstl@aol.com) by 19 November 2019.

Deadline for complete offers (after invitation by ADH only):

Forward offers electronically to Markus Moke (moke@aktion-deutschland-hilft.de) and Sibylle Gerstl (sgerstl@aol.com) by 4 December 2019.

Postal address:

Aktion Deutschland Hilft e.V.

Department of Quality Assurance

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53113 Bonn

Germany

KEY AID

CONSULTING