Islamic Relief Worldwide

Disasters Emergency Committee Evaluation of Phases 1 and 2 of the East Africa Crisis Appeal, Somalia, 2017

Evaluation Report

Islamic Relief Worldwide (IRW)

Disasters Emergency Committee (DEC) Evaluation of Phases 1 and 2 of the East Africa Crisis Appeal, Somalia, 2017

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Field Work completed by Smart Vision

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1. Acknowledgements

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2. Abbreviations

3W	Who, What, Where
ADCAP	Age and Disability Capacity Programme
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
ARI	Acute Respiratory Infection
AWD	Acute Watery Diarrhoea
CCCM	Camp Coordination and Camp Management
CHS	Core Humanitarian Standards
CLTS	Community Lead Total Sanitation
CO	Country Office
CRM	Complaints and Response Mechanism
DAC	Development Assistance Committee
DEC	Disasters Emergency Committee
DNH	Do No Harm
EHA	Evaluation of Humanitarian Action
FGD	Focus Group Discussion
FSL	Food Security and Livelihoods
FSNAU	UN Food Security and Nutrition Analysis Unit
HMIS	Health Management Information System
IDI	In-depth Interview
IDP	Internally Displaced Person
IEC	Information Education and Communication
INGO	International Non-Governmental Organisation
IPC	Integrated Phase Classification
IRS	Islamic Relief Somalia
IRW	Islamic Relief Worldwide
KII	Key Informant Interview
LNGO	Local Non-Governmental Organisation
MOH	Ministry of Health
NFI	Non-food Item
NGO	Non-governmental Organisation
OECD	Organization for Economic Cooperation Development
ODK	Open Data Kit
OP	The Operations Partnership
PDM	Post Distribution Monitoring
PLWD	People Living with Disabilities
RO	Regional Office
SGBV	Sexual Gender Based Violence
SMART	Specific, Measurable, Achievable, Realistic and Time Bound
SME	Small-medium Enterprises
SPSS	Statistical Package for the Social Sciences
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WMC	Water Management Committees

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3. Executive Summary

The evaluation found that overall project has been delivered in a timely way and all activities were delivered as per the project plan. Output data available demonstrates that the project has either met or exceeded all output targets planned in the project proposal. Targets for beneficiaries supported with food, latrines, and water facilities were exceeded. The table below provides a score for each CHS standard, using the CHS Member Self-Assessment scoring system.

Core Humanitarian Standards (CHS) Criteria	CHS Member Self-Assessment Scoring System
Quality Criterion 1: Humanitarian response is appropriate and relevant.	**3 – Fully meets Requirement**
Quality Criterion 2: Humanitarian response is effective and timely.	3
Quality Criterion 3: Humanitarian response strengthens local capacities and avoids negative effects.	**2 – Meets intent of requirement**
Quality Criterion 4: Humanitarian response is based on communication, participation and feedback.	3
Quality Criterion 5: Complaints are welcomed and addressed.	3
Quality Criterion 6: Humanitarian response is coordinated and complementary.	3
Quality Criterion 7: Humanitarian actors continuously learn and improve. Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection.	2
Quality Criterion 8: Staff are supported to do their job effectively and are treated fairly and equitably.	3
Quality Criterion 9: Resources are managed and used responsibly for their intended purpose.	3

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Overall, the project design and delivery were relevant and appropriate for the needs of the beneficiaries. It was based on initial needs assessments, beneficiary consultations, as well as coordination with local authorities, relevant clusters and other INGOs operating in the area. The project was able to adapt effectively to the changing context and meet emerging needs of additional IDPs. Examples of how the project was adapted are described in the body of the report and include expanding the reach of the food interventions and building additional latrines.

However, there is no evidence that comprehensive advanced planning was conducted to anticipate changes in the context and emerging needs, but rather that it was approached in a reactive way. In addition, inclusion, protection and gender were not systematically considered throughout the project design and implementation. The specific constraints faced by vulnerable groups were not assessed in a through way. It was assumed that the availability of services automatically resulted in vulnerable groups having access, without thorough assessment of the barriers that might prevent access, or specific examples of how activities had been adapted to address these challenges. For example, although latrines were gender segregated, the latrines were only set one meter apart, and some beneficiaries perceived this as potentially unsafe for women and girls. The project would have benefitted from dedicated and consistent engagement of technical experts. This would have ensured a more strategic

approach to design and implementation, as well as consideration and analysis of alternative approaches such as cash-based approaches and exit strategy planning. All deliverables were completed within the planned timeframe. Minor delays were reported but the project commenced on time and activities were delivered as expected. In summary, it was found that the project objectives were effectively met.

Capacity building measures have been implemented throughout the project activities. Some best practices were found, which demonstrated how the project strengthened local capacities and resilience, including active engagement of local stakeholders and development of skills. However, improvements were needed to sufficiently meet this criterion. There was an insufficient focus on early recovery and resilience, considering the context and the protracted nature of the crisis. Activities were focused on meeting initial emergency needs of the IDP population. The potential longer-term evolution of the context was not comprehensively considered in planning and implementation. It was also suggested by a number of key informants, that there was insufficient in-depth analysis of beneficiary needs and capacities that could have contributed to the inclusion of early recovery approaches. While needs assessments took place, the project would have benefitted from a more in-depth needs analysis and consideration of the evolution of the context over the two-year time frame.

The mechanism established to ensure beneficiary participation and feedback throughout the project were found to be effective overall. Information was effectively and appropriately shared, received and considered satisfactory. This is supported by a number of examples of beneficiary participation. An average of 82% and 73% of respondents across both districts felt they participated in assessment and implementation. Participation in monitoring and planning averaged 50% across the two districts and could be improved. In particular, in Baidoa and Mogadishu, 63% and 51% respectively reported that they were not sufficiently involved in monitoring and planning.

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Some areas to consider for future interventions are that information sharing with beneficiaries regarding project components and implementation should be more consistent across the project cycle, rather than for specific activities. Communities supported by the project were found to have access to safe and responsive mechanisms to handle complaints. Awareness of the complaints mechanisms across beneficiary communities was generally high, averaging 80% across the two districts. However, this awareness did not translate into use of the mechanism, as very few complaints were logged. The limited number and complexity of complaints could indicate generally high satisfaction with the project design and delivery. However, it may also indicate barriers to use and reluctance in logging complaints. When complaints were received, they were not complex and overall solutions to the complaints made were found to be satisfactory by the evaluation team.

Overall coordination was evaluated as effective. There were examples of good collaboration with local authorities and line ministries, especially Ministry of Health (MOH) and Ministry of Water regarding health worker training. Coordination through 3Ws (Who, what, where) and mapping of other NGO activities was conducted to avoid duplication. Cluster meetings were well attended for all sectors and took place at Mogadishu and Baidoa levels. Coordination meetings were held with other DEC implementers and assistance was shifted if it was covered by other organisations.

There was insufficient evidence gathered regarding how lessons were continually fed back into the project cycle management to improve delivery. Overall it will be important for IRW to document and incorporate learning from previous evaluations in a more comprehensive and systematic way, as well as document how it is used to inform project design and delivery in future projects.

All evidence collected in the evaluation indicates that communities and people affected by

the crisis received the assistance they required from competent and well-managed staff and volunteers. The Code of Conduct, Whistle-blowing Policy, Child Safeguarding Policy and Fraud Policy were all reported to be in place and included in staff inductions. However, insufficient evidence was collected to more comprehensively review and evaluate this criterion. Modalities and mechanisms of implementation were found to be cost-effective and efficient. Adequate human and financial resources were applied to delivering the project outputs and outcomes. Risks were found to be managed effectively.

Learning and Recommendations

1. **Long term planning:**

Key Learning: Despite being a two-year project, the project was designed with an emergency mind-set, focusing on meeting emergency needs, without sufficient consideration of a longer-term approach. Early recovery and rehabilitation were not comprehensively addressed in project design and implementation. There was some scope to include recovery-focused approaches, given the context and the two-year timeframe.

Recommendation: Future projects would benefit from a detailed assessment into longer-term needs and capacities alongside emergency relief activities, for example at the 3-month stage, when initial needs had been met. A more comprehensive approach to planning for multi-year projects should be developed.

2. **Contingency planning:**

Key Learning: Some of the contextual changes could have been anticipated in advance and planned for in a more systematic and comprehensive way. For example, there was no contingency planning for an influx of IDPs, or analysis of the potential vulnerabilities or capacities of additional IDPs, or specific scenario or preparedness planning. Although the project demonstrated a good ability to adapt to the changing context, this was managed in a reactive and ad hoc way and should be improved in future projects.

Recommendation: Consider comprehensive contingency planning at project design stage. Establishing a rapid response mechanism could also enhance the project design and enable more streamlined response to new arrivals, disease outbreaks, or other emergencies.

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3. **Recovery and resilience:**

Key Learning: There were some positive examples of how the project enhanced local capacities, but the project was short term and emergency focused, prioritising delivery and distributions.

Recommendation: Consider a more comprehensive approach to early recovery and resilience in future projects. Strengthening the involvement of local resources and local capacity building would support resilience and empowerment, and ultimately a longer-term impact. The feasibility of income generating activities such as kitchen gardens are options to assess for future projects, as well as involvement of IDPs to identify solutions and early recovery ideas. Future projects would also benefit from a more deliberate focus on host communities, as well as IDPs.

4. **Communication, participation and feedback:**

Key Learning: Communication and participation were found to be high during assessment and implementation. However, results were lower for planning and monitoring. It was also found that understanding of particular activities was potentially low, for example why and how to treat water and vector control.

Recommendation: For future projects, ensure sustained project communication throughout the life-cycle of the project. Ensure complicated messages are communicated using appropriate methods. Consider more targeted communications methods, for example, geographical variations. Include more training for staff, and follow-up sessions in communities.

5. **Complaints mechanisms:**

Key Learning: Ongoing monitoring of the new CRM that has been established is recommended, with comprehensive documentation to evaluate its effectiveness and capture useful learning. Whilst awareness of CRM system is high, the understanding of how to use the system remains an impediment to access and ensuring feedback and complaints are received. In Baidoa District, for example 66% of the respondents reported that the lack of information about the CRM was the major challenge in accessing it. The main reason identified by 48% of respondents in Mogadishu was the lack of a proper channel of communication. It is clear that high awareness of CRM systems does not necessarily translate into high use of the systems. Trust and understanding how to use the systems create significant barriers, especially in communities where illiteracy is high.

Recommendation: Ongoing monitoring of the new system is recommended, with comprehensive documentation to evaluate its effectiveness and capture useful learning. In the Somalia context, it will be important to invest in further work to ensure that beneficiaries know how to use, and are comfortable accessing the mechanisms established, and that they are adequately adapted to ensure relevance for rural and remote areas, where beneficiaries are likely to be less familiar with them.

6. **Inclusion, protection and gender:**

Key Learning: Inclusion, protection and gender were not systematically considered throughout the project design and implementation. The specific constraints faced by vulnerable groups were not assessed in a thorough way. It was assumed that the availability of services automatically resulted in vulnerable groups having access, without thorough assessment of the barriers that might prevent access, or specific examples of how activities had been adapted to address these challenges. Although latrines were gender segregated, the latrines were only set one meter apart, and some beneficiaries perceived this as potentially unsafe for women and girls. Space was a major constraint, but this should be considered in future projects, with women included in identifying alternative solutions in the design process.

Recommendation: Gender and Disability and Age Inclusion Advisors should be involved in future projects to ensure these aspects are comprehensively addressed in future design, implementation, monitoring and evaluation, including ensuring that feedback on gender, protection and inclusion issues are recorded and addressed in project design and adaptation.

7. **Technical approaches:**

Key Learnings and Recommendations: Technical approaches were limited to emergency approaches and would benefit from consideration of rehabilitation and recovery to ensure more sustainability.

- Use of cash: use of cash-based approaches could have been assessed more comprehensively.
- Shelter: The insufficient quality of shelter materials and possibility of providing semi-permanent designs for shelter should be considered for future projects, as well as seeking advice from, and coordination with, the Shelter Cluster and feeding in lessons learned.
- Health exit strategy: Increased planning and coordination around health facilities could have increased sustainability. When supporting a fixed health facility, give preferential support to an existing one. Aim to obtain land from government or donated by the local community for additional facilities. If it is on private land it is almost impossible to pursue a successful exit strategy and for the MOH to take it over. This has been a considerable issue for health actors in the past. Assess if the facility meets WHO criteria, for example catchment population. This will improve the potential to incorporate the facility into the existing health system. If possible ensure MOH can provide staff even if they require incentives. More in-depth engagement with local authorities, WHO and other heath actors is recommended.
- Latrines: With the additional influx of IDPs to the camps, the risk of latrines becoming overburdened is a concern for the project team. Before the end of the project period, the project team should prioritise exploring options for further emergency funding for

additional latrines. They should also discuss this with the WASH cluster and UNICEF to identify other partners with resources.

- As the camps were built on private land, the ability to prevent congestion was limited, and agencies are subject to the conditions set out by the landlords. This meant that the role of NGOs is more challenging as they had to negotiate with the landlords and support the IDPs in advocating for themselves – rather than a dedicated camp management agency. Furthermore, construction and town development continued, which reduced space for IDP settlements, and meant IDPs could face demolition, or forced evictions if the landlord decided to use the land for another purpose.

8. **Technical support:**

Key Learning: The project would have benefitted from dedicated and consistent engagement of technical experts thereby contributing to a more strategic approach to design and implementation. Specifically, there were gaps in the expertise of shelter, food and WASH Advisors.

Recommendation: For future projects, IRW is recommended to identify a technical advisor for each sector. If they are not available globally consider adding them as part of the response team at RO or project level, depending on the size of the response.

9. **Learning:**

Key Learning: This is an area that was consistently highlighted as weak at an organisational level and the evaluation data collected showed a lack of in-depth consideration of learning from previous DEC evaluations and limited systematic synthetisation of lessons learned and incorporated into project design and delivery.

Recommendation: A more comprehensive approach to learning could be embedded ensuring lessons are captured and documented into a learning log. These should be readily accessible to inform future DEC responses. Evaluation reports should be shared with future response teams.

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10. **Coordination with DEC Members:**

Key Learning: IRW should continue ongoing and comprehensive collaboration with other organisations in the DEC and maximise information sharing to ensure interventions are coordinated.

Recommendation: Collaborative feedback to DEC on funding and implementation issues would also be advantageous. Important current challenges where a collective approach with other DEC Members could be advantageous, are embedding safeguarding practices into programming, ensuring the necessary checks and controls are in place, reflecting localisation in programming, ensuring beneficiary engagement and capacity development, and the design of multi-year projects.

4. Introduction

The **purpose** of the evaluation of Phases 1 and 2 of the 'East Africa Crisis Appeal, Somalia, 2017', commissioned by IRW was to conduct "a systematic and impartial examination of humanitarian action intended to draw lessons to improve policy and practice and enhance accountability." (ALNAP EHA Guide, 2005). It included comprehensive operational and technical assessment of IRW's response, with the intention of providing analysis and recommendations to inform change and development where necessary, as well as demonstrate transparency and accountability to beneficiaries and other stakeholders.

The **specific objectives** of the evaluation were to:

- Assess the extent to which both Phases 1 and 2 of the DEC project have delivered the anticipated objectives indicated in the log frame, with specific attention to outputs, outcomes and goals.
- Search for evidence of the goals of this project having been met in terms of the positive and negative, intended and unintended, and the primary and secondary effects of the project, alongside direct or indirect contributions to any systemic change.
- Evaluate the extent to which the outcomes and outputs have been/are being met in line with the agreed project objectives.
- Assess the key innovations used in the project that improved or worsened delivery of project goals, outcomes, outputs, and deliverables, and how learning was used in improving project performance.
- Analyse and comment on the sustainability of the project outcomes/impacts and suggest measures to maintain long term sustainability.
- Provide a judgment of the quality and accountability of the intervention, using the Core Humanitarian Standards as a framework.
- Document lessons learned and develop clear and actionable recommendations for adoption and integration into any similar future development related projects within the region and elsewhere.

Scope of work: Geographically, the evaluation was conducted among the communities where the response, part of the DEC's *East Africa Crisis Appeal, Somalia, 2017*, was implemented. These are Tredish Internally Displaced Persons (IDP) camp in Mogadishu and ADC, Towfiq and Hanaano IDP camps in Baidoa. Primary data was collected directly from the field through visits by the evaluation team. The thematic scope covered Emergency Response, Water, Sanitation and Hygiene (WASH), Shelter and Health. To enhance utilization of lessons learnt for the purpose of advocacy, the team will share the evaluation findings with key stakeholders with an emphasis on lessons learned and best practices.

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Approach: OP has taken the following approach to deliver the evaluation:
1. Inception
2. Data collection and analysis (field data collection, key informant interviews and literature review)
3. Report drafting and feedback
4. Expert peer review and quality control
5. Final evaluation report

OP provided overall management, technical review and development of the evaluation methodology and report. Data collection in Somalia was led by OP's partner Smart Vision. Details of the evaluation team and roles and responsibilities can be found in Annexes I and J.

5. Methodology

5.1.   General Approach
OP's main principles during independent monitoring and evaluations are objectivity and honesty, as we believe this is the only way to enhance project quality and eventual impact. These principles underpinned this evaluation to produce information and make recommendations that are sufficiently valid and reliable. They are based on the field data collected and analysed. The evaluation process was guided by CHS and principles of the surveillance and monitoring for Evaluation of Development Programmes provided by the Organization for Economic Cooperation and Development's Development Assistance Committee (OECD-DAC).

5.2.   Data Collection Methods and Tools

Information for the evaluation was collected using primary and secondary data collection methods, including both quantitative and qualitative techniques. Tools were developed by OP and Smart Vision in consultation with IRW and with consideration of objectives of the evaluation as well as verifiable indicators contained in the project Monitoring and Evaluation (M&E) plan and guided by CHS. These were expanded into variables utilising a comprehensive evaluation matrix that allowed for full assessment of the project's relevance, efficiency, effectiveness, impact, targeting and sustainability. Specifically, the following methods and instruments were used for data collection:

Desk Review: The evaluation team reviewed core project documents available including project proposal/plans and budgets, needs assessment reports, data breakdowns of beneficiaries, camps and services per camp, IRW project reports, project monitoring data including mobile clinic data, nutrition data and referral data, complaints mechanism documents (Headquarters (HQ)) and data to review existing feedback from beneficiaries on the project (global and Somalia specific), learning from DEC evaluations for East Africa, Yemen and Nepal, as well as CHS and the Sphere Project.

Quantitative Data Collection Methods: Quantitative data was collected through:
  ➢ **Individual household interviews** using structured questionnaires (Annex D: Household Questionnaire). The aim of this component of the evaluation was to collect end-line data that allowed evidence-based impact assessment of the project's goal when compared with baseline information.

Sample Size and Sampling Procedure: In order to generate statistically acceptable representative data, we have calculated appropriate sample size using a modified version of Krejcie and Morgan (1970) table of sample determination. This calculation is defined by the formula below:

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$$\text{Sample Size(SS) } n = \frac{Z^2 * (p) * (1-p)}{C^2} \times N/n + N-1$$

Where: n= calculated sample size, Z = Z value (95% confidence level), p = percentage expressed as decimal, (0.5 used for sample size needed), c = confidence interval, expressed as a decimal, N= the population size.

The maximum number of direct beneficiaries of any project activity was 15,000. Computing the sample size at 95% confidence level and margin of error of 0.1 based on this population gave a sample size of 96 households in Baidoa. Doing the same for Mogadishu with a similar population suggested a sample of 96. However, the actual samples collected were 94 and 107, respectively. To avoid any bias associated with non-random sampling, individual households were selected using simple random sampling from a list of beneficiaries, using random numbers generated by Excel computer software. The sampling ensured that gender, vulnerabilities (age, disability, ethnicity etc), and minority communities, were represented.

Qualitative Data Collection Methods: For deeper understanding of the variables under investigation as well as triangulation of information obtained, the evaluation also employed qualitative methods to collect information from various interest groups. The data was collected through the following methods:

  ➢ **Focus Group Discussions (FGDs):** The FGD groups were purposively selected to ensure inclusion of all segments of the population considering gender, age, disability and minority groups. There was also a separate FGD by trained enumerators with boys and girls. The information collected was used to verify against individual household (HH) interviews. See Annex E: FGD Template

> **Key Informant Interviews (KII):** These were conducted with community leaders, officials from local authorities and officials from other actors who have activities within the same sectors and areas as IRW. It was not possible to interview officials from government line ministries. See Annex F: KII Interview Template for Field Interviews
> **Health Facility Checklist and Observations**: This was collected using a semi-structured checklist that allowed for recording of hospital data and variables that defined indicators of interest for this evaluation. It also involved records of direct observation of infrastructure, equipment and supplies at one Health Facility. See Annex G: Health Facility Checklist
> **In-Depth Interviews (IDI) with IRW staff:** The evaluation team conducted in-depth interviews with key project staff, regional and global staff members to get all necessary information on project implementation, achievement of project results and efficiency. Project budget, utilization of funds, accountability and monitoring and evaluation processes were also explored, as were intended and unintended outcomes of the livelihood support project. Of special interest were key expectations, understanding of CHS, understanding of DEC, key successes and project challenges, changes in project design and implementation, innovations, sustainability plans, complaints and feedback mechanisms and resource gaps. See Annex H: In-depth KII Interviews Template for IRW Staff. The selection of interviewees followed initial purposive sampling (based on relevance of role to the DEC project) with snowball sampling thereafter and where applicable.

5.3. Data Collection and target population:

Following development of the tools, the evaluation team created a training plan and recruited the data collection team. Enumerators were experienced and had previously worked with the selected field assessment service provider, Smart Vision. Enumerator training workshops were organised in Mogadishu and Baidoa, focusing on the data collection tools and methodology, as well as data cleaning and entry. Tools were pre-tested and relevant adjustments made before the final copies were programmed in the Open Data Kit (ODK) platform for use in the field. The data collection was conducted between 28th April - 4th May 2018, following a pre-defined schedule at target sites in Mogadishu and Baidoa. The two teams were led by Smart Vision experts Abdurahman Shimoy, and Sadik Ahmed respectively and were supported by IRW. KI Interviews with IRW staff were conducted following the field data collection, 4-9th May 2018. All identified informants were interviewed, with the exception of the Humanitarian Director and Area Manager, who were engaged in field visits.

Using the data collection tools developed in Annex D-H, the following data was collected, as planned.

S/No	Interviews	Achieved		Total number of participants attending the FGD
		Mogadishu	**Baidoa**	
1	Household respondents	94	107	201
2	FGD with men	1	3	33
3	FGD with women	1	3	22
4	FGD with children	1	3	24
5	KII with community leaders	1	1	2
6	KII with officials from Line Ministries	0	0	It was not possible to interview officials.
7	In-depth interviews with IRW	12		12
8	Health Facility check list	1	0	1

5.4.   Profile of target population

Individual Household Interviews: A total of 201 households were interviewed. 107 from Baidoa and 94 from Mogadishu Districts in Somali. 85% of those interviewed were women. In Baidoa District, 83 respondents were female while 24 were male. In Mogadishu, there were 88 women and 6 men interviewed, as shown in the adjacent chart. The minimum and maximum age of the respondents was 16 and 80 years. In Baidoa the respondents' average age was 40 years. In Mogadishu, the average was lower at 34 years. 72% of those interviewed in Baidoa district were married, 3% were single, 7% were divorced and 18% were widowed. 84% of those interviewed in Mogadishu district were married, 2% were single, 4% were divorced and 10% were widowed. The average number of household members was 8 in Baidoa District and 7 in Mogadishu District. The total number of household members by gender and age groups (i.e. 0-4, 5-17, 18-59, 60-79 and 80+ years) were distributed as shown in the chart below. Age group 5-17 had the highest frequency in both Districts. 80 years and above had the lowest frequency in both districts and for both male and female categories.
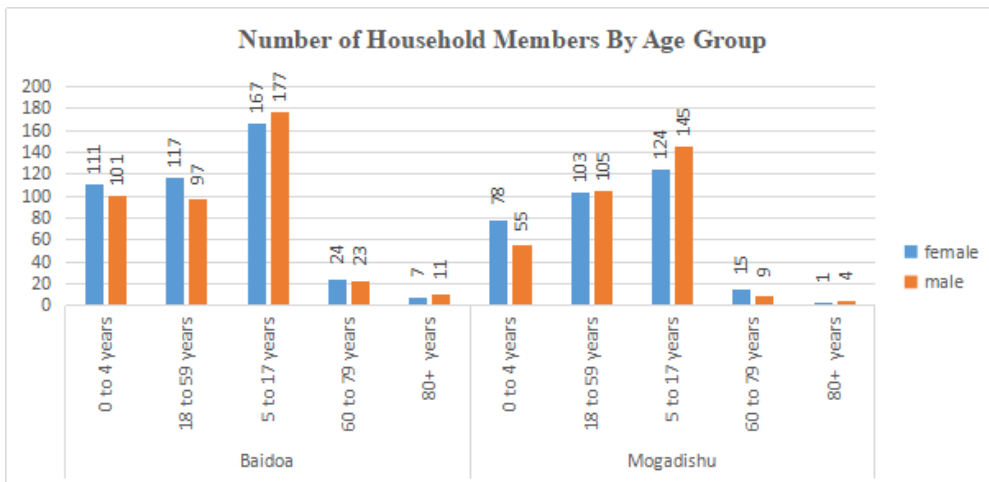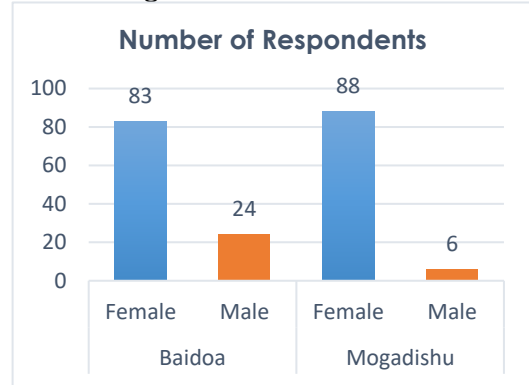
The average number of households with a vulnerable member in Baidoa was less than one. The maximum number of vulnerable members in a household was 3 in Baidoa and 2 in Mogadishu. The maximum number of vulnerable men was 3 in Mogadishu and 2 in Baidoa.

The criteria for vulnerable and vulnerable women were:
- ➢ Households with more than 6 children and acknowledged to be poor.
- ➢ Households with severe acute malnourished children under the age of 5 years.
- ➢ Households with members who are living with severe disability.
- ➢ Households with chronically ill adult members, especially the household head.
- ➢ Female Headed Households.
- ➢ Child Headed Households (with a child aged 16 or older).
- ➢ Pregnant and lactating women who are acknowledged to be poor.

The mean length of time that the households have stayed in the camp was 21 months in Baidoa and 12 in Mogadishu Districts.

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FGDs: A total of 12 focus group discussions were held, 9 in Baidoa and 3 in Mogadishu. The FGDs were attended by 79 respondents in total. 42% were male, 28% were female and 30% were children. The chart to the right shows the distribution of male, female and child respondents across the two districts.

FGD Respondents
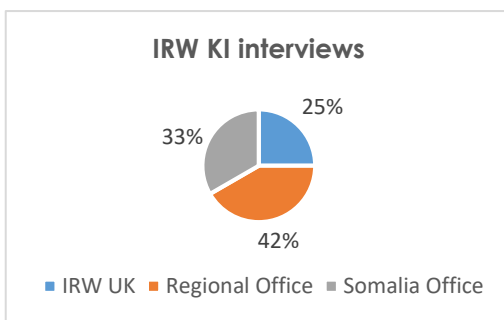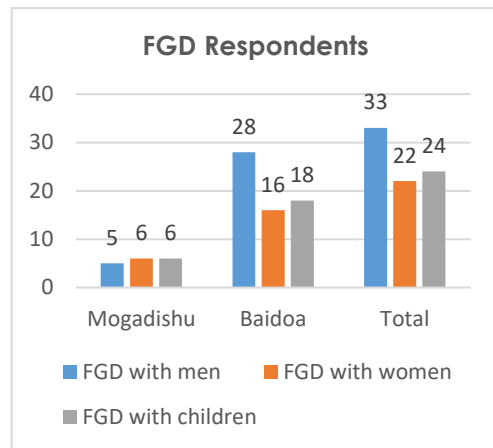
IRW KI interviews

KI Interviews:

In depth interviews with IRW staff: A total of 12 KI Interviews were conducted with IRW staff, at different levels of the organisation, to gain as wide a perspective as possible. The interviewees all worked closely on the project or had relevant insight and experience on specific aspects of the evaluation, such as accountability or CHS standards. The interview list can be found in Annex C. The breakdown of respondents is in the chart.

KI Interviews with community leaders: Two interviews were conducted, in Tredish IDP camp in Mogadishu and Towfiq and Hanaano in Baidoa, in order to get the perspective of community members involved in the project design and delivery. This provided another source of information to verify data collected in KI interviews, FGDs and HH surveys.

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Health Facility Observations: One health facility observation and checklist was completed for Deynile Health Facility. This was used to verify information provided in KI Interviews, FGDs and HH surveys.

5.5.   Data Entry and Analysis

Electronic forms were used to collect quantitative data using the ODK platform. The forms were transferred to a central system coordinated by the evaluation team at the end of each day of data collection. The files were continuously verified and checked for errors as they came in before being encoded and transferred to SPSS data analysis software. The data was analysed and presented in the form of tables and graphs to make interpretation and comparison easier. Qualitative data was analysed by sifting and coding into themes using an Analytical Framework, before inferences were drawn. Results within and across different groups of people interviewed and from various methods were collated and triangulated. The integrated information was compiled for this evaluation report.

6. Context Analysis

6.1.   Overview of context

Somalia is the most fragile state in the Horn of Africa due to continuous conflict and recurring natural disasters. In recent years, consecutive seasons of poor rainfall have led to severe drought and a high prevalence of food insecurity. The influx of displaced populations to urban population centres in Somalia had already overwhelmed the limited services, and as the drought intensified in most parts of Somalia, many families struggled to meet basic needs.

At the time of the DEC appeal in March 2017, the UN Food Security and Nutrition Analysis Unit (FSNAU) reported that more than 3.2 million people in Somalia were continuing to experience Crisis (Integrated Phase Classification (IPC)) Phase 3) levels of acute food insecurity, with 700,000 of these experiencing it at Emergency (IPC Phase 4) levels. The conflict and economic hardship have led to mass displacement of people who generally end up in informal settlements close to urban centres as Internally Displaced Persons (IDPs).

6.2. Needs overview

Within Banadir Region, Mogadishu and Baidoa town are epicentres of displacement, as a result of armed hostilities and unpredictable climatic conditions. This worsened the production capacities of farming families and resulted in periods of acute food and seed insecurity due to loss of harvest and failure to plant, as well as the loss of livestock. The number of IDPs within Mogadishu has increased significantly over 2017-2018. Baidoa is home to an estimated 273 IDP settlements, most of them in the far corners of the town. Approximately 20,000 households have moved there since March 2017, resulting in loss of assets and sources of livelihood, including livestock and land. In the settlements IDPs have little access to stable employment, while food insecurity and water shortages continue to exacerbate the situation. Limited access to basic household utilities is made worse by the continuous influx of IDPs and puts more strain on their adaptability and capacity to cope. Most of the IDPs who erected makeshift structures along the major entrance road to the town of Baidoa were seen to lack essential livelihood support and their numbers continued to increase on daily basis. It was expected that the number people moving to both Baidoa and Mogadishu would gradually increase. Additionally, previous surveys among the IDPs settlements also indicated that most of them did not plan to go back to their original land due to limited access to household necessities.

Most affected groups are small scale farmers, youth, and women. According to Inter-agency cluster reports in October 2017, there was a growing danger of food and nutrition crisis with approximately 6,000 children at risk of acute malnutrition. The situation of many people in the IDP camps required urgent attention with sustained and integrated lifesaving humanitarian assistance and livelihood protection support in order to prevent further food security deterioration. The hygiene and sanitation conditions in the settlements were generally poor with insufficient sanitation facilities leading to open defecation. At the time of the DEC appeal and IRW's assessment, several water points in certain camps were dysfunctional due to over-use, forcing IDPs to buy water at prohibitive costs. Additional emergency latrines and garbage disposal pits in camps also needed to be built and there was a need to continuously de-sludge existing pit latrines. With the expected rainfall season imminent, rehabilitation of WASH facilities (water points and latrines) remained critical. The facilities required reinforcement to avoid breakages that would lead to water contamination in flood prone areas and an upsurge of AWD/Cholera cases.

6.3. Project locations

In this context IRW initiated an integrated emergency response project in Tredish IDP camp in Mogadishu and Towfiq and Hanaano in Baidoa with funding from DEC in July 2017. The goal of the project was to increase access to safe water, improve sanitation facilities, increase access to health services and provide lifesaving support through distribution of food, NFIs and Shelter to IDPs.

7. Project Summary

7.1. Outcomes and activities as stated in the project proposal

Phase 1 Outcomes

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- **Outcome A:** Improved nutritional status amongst drought affected communities through addressing the immediate gaps in household food requirements;
- **Outcome B:** Improved culturally appropriate and dignified WASH practices being adopted amongst targeted drought-affected households leading to a decrease in water and sanitation related morbidities and mortalities e.g. AWD;
- **Outcome C:** Reduced vulnerability and improved protection amongst drought affected communities;
- **Outcome D:** Improved dignity of vulnerable IDPs in targeted intervention areas;
- **Outcome E:** Affected communities and people have access to safe and responsive complaints handling mechanism.

Phase 2 Outcomes
- **Outcome A:** Improved nutritional status amongst drought affected communities through addressing the immediate gaps in household food requirement;
- **Outcome B:** Improved culturally appropriate and dignified WASH practices being adopted amongst targeted drought affected households leading to a decrease in water and sanitation related morbidities and mortalities e.g. AWD;
- **Outcome C:** Improved access to emergency primary health care services for IDPs in Mogadishu;
- **Outcome D:** Effective beneficiary accountability mechanisms in South Central Somalia.

Activities
- **Distribution of Food and Non-Food Items (NFIs):** In Phase 1 of the project, this activity involved distribution of food packs and NFIs to 1200 households in Mogadishu and 800 households in Baidoa. In Phase 2, food packs consisting of 25kg rice, 25kg white flour, 10 kg sugar, 3 litre cooking oil, 4 kg porridge, 2 kg dates and 900g milk powder were to be provided to 900 newly arrived IDP households specifically those with children, lactating and pregnant women and people with disabilities.
- **Development of Water Supply Infrastructure:** This activity involved piping water from private boreholes to water taps in the targeted IDP camps in Mogadishu and Baidoa. The project targeted 12 water distribution points in the camp with each distribution site receiving 20,000 litres of water per day for a period of 6 months. Twelve portable water tanks were to be provided at each of the water distribution sites, situated where women and girls could easily access them without safety implications. A total of 15,000 IDP households were expected to benefit from this activity.
- **Environmental Health:** This activity involved solid waste management, cleaning of drainages and vector control in the IDP camps. A total of 1,200 households were to directly benefit.
- **Hygiene Promotion Education:** This activity involved dissemination of hygiene promotion messages and awareness campaigns aimed at improving knowledge, attitude and practice to decrease water and sanitation related morbidities and mortalities. It was intended to benefit 1,200 households in Mogadishu and 800 households in Baidoa.
- **Shelter:** This activity involved distribution of emergency/transitional shelters. In Mogadishu, 500 households received tents and another 700 households were provided with plastic sheets for emergency shelter. In Baidoa, 800 households were provided with plastic sheets for shelter.
- **Health Support:** This activity, implemented in Phase 2 of the project, involved establishment and operational facilitation of a health post and 2 mobile clinics in the target areas. The health facilities are expected to reach 8,400 individuals (1,500 children, 1440 men, 5460 women). Mobile clinics services were expected to be functional for both phases of project implementation and accessible for the most vulnerable IDPs (children and women), who otherwise cannot reach the fixed structure due to their weak condition. Equipment for the mobile clinics was to be purchased and installed in vehicles to meet minimum standards for emergency intervention.

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- **Accountability:** This activity involved sensitization of beneficiaries to ensure that they had good information about IRW's CRM, and understood how to give their views about delivery of services, distributions and IRW staff, as well as how they would receive feedback on any complaints they raised. It also aimed to ensure IDPs and other stakeholders could utilize the CRM should there be violations by IRW staff of the Code of Conduct and Child Protection Policy. Through the feedback gathered from beneficiaries, IRW also aimed to assess the ongoing relevance and appropriateness of the response and ensure community leaders and the target population were actively involved in project evaluations.

8. Findings

8.1. Overall project achievements

This section provides detailed findings on the **effectiveness** of the intervention including any under-achievement issues with reasons, as measured against the stated goals, outcomes, and outputs of the project. Examples are provided throughout the section to illustrate the findings.

Achievement against planned outputs and outcomes
The project focused on immediate emergency needs, as required by the context. Therefore, the primary focus was on achieving the output targets, and assumptions were made that the achievement of outputs would contribute to the desired changed and outcomes.

Output data available demonstrates that the project has either met or exceeded all output targets as they were planned in the project design. All key informants reported that the project had exceeded its targets in terms of food distribution and shelter support, due to effective and efficient procurement processes. Key informants reported that the project regularly adapted to the continuous influx of new IDPs to the project area and was able to use resources effectively to reach additional beneficiaries.

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The outcomes as stated in the project design do not always meet the criteria of being specific, measurable, achievable, realistic and time bound (SMART), and are therefore challenging to measure objectively. IRW Somalia did not develop and systematically monitor outcome indicators. However, achievement against outcomes has been assessed by the evaluation team through looking at the relevant output monitoring data, as well as through FGDs and HH surveys. Evidence and examples to demonstrate where outcomes have been met or are likely to be met by the end of the project period, are detailed below.

Phase 2 Outcomes	On track	Evidence outcome has been met
A. Improved nutritional status amongst drought affected communities through addressing the immediate gaps in household food requirement.	Exceeded	**Output A1: Food Packs distributed to 900 new arrivals in Baidoa IDP camps** 1042 HHs food packs were distributed in January against the planned target of 900 HHs. This increase in the number of beneficiaries is a result of the competitive bidding process conducted during the tendering process. The food component was reported to improve dietary intake in FGDs.

B. Improved culturally appropriate and dignified WASH practices being adopted amongst targeted drought affected households leading to a decrease in water and sanitation related morbidities and mortalities e.g. AWD.	Met	**Output 2.1: Water piping system from private borehole is installed to Tredish IDP Camp to serve at least 4500 HHs** The installation of water piping system from private borehole to the garget IDP camps has been successfully completed. The IDPs are accessing safe and clean water from this water system, through the construction of an elevated water tank with capacity of 20m^3 and 6 water distribution kiosks serving 7,500 households. The targeted beneficiaries previously trekked for more than five kilometres to fetch and pay for their water from private boreholes. IR Somalia (IRS) was able to reach more beneficiaries as it increased the number of water kiosks from 6 to 8. IRS was able to construct more water distribution kiosks as the result of the competitive bidding process during the tendering process. Sanitation facilities, waste management and hygiene promotion supported improved hygiene knowledge and practices, and beneficiaries reported cleaner environments and a decrease in open defecation. This contributed to improved health, as reported by IDPs. FGDs confirmed the hygiene promotion activities were culturally appropriate. It is not possible to conclude a decrease in water and sanitation related morbidities and mortalities as a direct result of this project. As direct attribution is almost impossible, this outcome should measure contribution to a reduction instead.
	Exceeded	**Output B 2.2: Water piping system from private boreholes installed to Baidoa IDP Camp to serve at least 4,500 HHs** 9,672 HHs are receiving daily 40m^3 of water in 80 IDPs in Baidoa, two elevated tanks were constructed. All pipelines have been installed and all kiosks have been completed. Water facilities provide 15 litres/person/day which is in accordance with Sphere standards. Water Quality testing and treatment was conducted by the suppliers. The boreholes are regularly chlorinated, and water quality analysis carried in collaboration with the WASH cluster and the Ministry of Energy and Water Resources to ensure that supplied water is safe for human consumption.
	Met	**Output 2.3 WASH committee trainings to manage water points in Tredish and Baidoa serving 9000 HHs**

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		In IDP camps where Water Management Committees (WMCs) already existed, IRS worked with them in selection process of the water tank and communal water kiosks installation Upon completion of the water sources pipeline extensions (from the private Boreholes to the IDPs kiosks). IRS revitalized WMCs to take over management of the water points (IDP communities getting the water supply). The WMC were also trained on sustainable operation and maintenance and realistic cost recovery options that were suitable for each community. The WMC was trained to monitor efficient use of the water piping put in place by IRS and take preventive measures to avoid breakdowns. The WMCs formed part of IRS's exit strategy to ensure sustainability of the infrastructure provided under this project. The WMCs and hygiene promotion volunteers were elected by the community democratically using acceptable social norms, but participation of both women and men was encouraged. Two committees comprising of 66 people were established in each community where water points where installed (Mogadishu and Baidoa). WMC members were trained on water kiosk and tank management and maintenance, including how to trouble shoot and fix simple faults during breakdowns. WMCs are responsible for conducting monthly inspections of all water points to identify any needs for further repair or maintenance.
	Met	**Output 2.4 120 Pit latrines constructed in Baidoa IDP camps to improve sanitation for at-least 480 HHs** All 120 emergency pit latrines planned for IDP camps in Baidoa have been successfully completed (480 HHs (2,880 ppl) i.e. average 24ppl/latrine.) However, the number of people in the IDP camps has since increased from 38,126 HHs to 41,325 HHs, according to CCCM Cluster. This is a potential gap in the project and a concern which has been flagged by the project team. This should be followed up by IRW with relevant clusters and coordination mechanisms.
	Met	**Output 2.5 & 2.6 Improved knowledge of vulnerable IDP beneficiaries about sanitation and personal hygiene**

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| | | IRS undertook intensive community-based hygiene promotion in target locations/IDPs targeting 2,196 HHs using different approaches.

The key approach used included messages given at public gatherings and house-to-house campaigns. IRS used culturally accepted IEC materials written in the local language developed by the Somalia WASH cluster.

The messages at public gatherings and on IEC materials focused on good personal hygiene practices, treatment of drinking water at Point-of-Use (POU), safe handling of water for consumption, good use/maintenance of latrines (with the aim to end open defecation), and hand washing using soap or ashes.

In total 11,901 HHs benefitted from Hygiene and Sanitation Education activities carried out in Mogadishu and Baidoa, including promoting essential preventative behaviours to prevent the spread of cholera/AWD in IDP settings. |
|---|---|---|
| C: Improved access to emergency primary health care services for IDPs in Mogadishu | Met | **Output 3.1: IDP women and children have access to mobile health intervention in Mogadishu.**

IRS established primary health care centres in Bondhere and Daynile to provide primary health services.

Medical devices, drugs and equipment are provided, and water and electricity supplies covered at both centres.

These facilities treat around 200 patients per day which is equivalent to 4,000 per month. |
| | Exceeded | **Output 3.2: 12 medical project staff have their skills in HMIS improved through training**

Training for HMIS was successfully conducted for three days facilitated by the Ministry of Health of the Federal Government of Somalia. A total of 17 IRS health staff from three health facilities were trained to improve their knowledge and skills on HMIS and reporting. The three days training was conducted on 18 - 20 February 2018. The budget allowed further staff to benefit from this training, including three laboratory technicians and two community health workers. |
| D. Effective beneficiary accountability mechanisms in South Central Somalia | Met | **IDPs said they felt empowered to voice their concerns through the established Complaint-Response mechanism**

141 project beneficiaries have utilized the IRS CRM. |

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		More than 50% of the 141 feedback messages were received through telephone calls by the beneficiaries both in Baidoa and Mogadishu. Out of the 141 beneficiaries who have used the system, 62 had inquiries about the dates of relief items distributions, 58 were appreciation messages, 19 had complained about the loss of their distribution cards while 2 beneficiaries had concerns about the quantity of the food items. If the feedback was a complaint being raised, the beneficiaries received a response within 7 working days.

8.2. Project Management

Local context, risks, hazards and vulnerabilities: The project was designed by IRW based on an analysis of relevant risks and hazards. Each IRW Country Office, including Somalia, has a disaster preparedness plan, which is regularly reviewed by the Country Director. It was not possible for the evaluation team to verify whether this is up to date, relevant and of good quality. However, it appears some of the contextual changes could have been anticipated in advance and planned for in a more systematic and comprehensive way. See section on contingency planning below for more details.

Local contextual characteristics include drought, economic hardship, chronic vulnerability, presence of proscribed groups and protracted conflict. Specific vulnerabilities include significant proportions of women, children, disabled and older people in the IDP population, risk of negative coping mechanisms, risk of enrolment of young boys and men into Al Shabab.

Risk Management:
KIs reported that risks were effectively identified, analysed and managed throughout the project with no major issues found. This was done through a risk register, reviewed bi-weekly to highlight risks, challenges and improvements. The risk register was reviewed by the project team and found to be of good quality and regularly maintained throughout the project. Only two risks identified had a net risk rating of medium. All other risks had a net risk rating of low. Adequate and effective controls and mitigation measures were reported to be in place. However, these were not evaluated in detail by the evaluation team as this was not the focus of the evaluation. The main risks and mitigation measures highlighted in KIIs with IRW staff are outlined below.

Risks identified	Mitigation Measures
Volatile and changing context	Used local networks to ensure good information and continued access.
Security	Good communication with clusters, UN agencies and government. Recruited staff from local community, delivered supplies directly into camps, and established a WhatsApp group to alert staff to incidents and at times of heightened risk.
Presence of proscribed groups	Established and maintained good relationships with local government and community networks to receive/exchange information. Designated security focal points in place, training for staff and regularly updated movement plans.
Influx of additional IDPs	The project budget (through efficient procurement processes) enabled some flexibility to cover some of the additional influx of IDPs, as IRS was able to

	negotiate effectively on cost of food, without jeopardizing its quality, as per Sphere standards. However, it was not possible for later IDPs and this had a significant impact on meeting Sphere standards in relation to water and sanitation particularly the number of people per latrine (see below for further details on sanitation facilities).
Inflation	Use of U.S. Dollar currency (USD) helped to mitigate price hikes when using the local currency, so changes in the local economy had limited impact on this project.
Delays to project activities	Collaborated closely with the Ministries of Health and Water to ensure the project was on schedule and to train the health teams and outreach staff.
Insufficient sanitation facilities	Followed Sphere minimum guidelines of 20 people per latrine initially. However, with the increase in number of IDPs, and a lack of contingency funding, the 120 latrines were used for 480 HHs (2,880ppl) i.e. average 24ppl/latrine, which is above the Sphere minimum standard of 20 per latrine, (not taking into account HH size variation). After additional arrivals of IDPs, 8,181 HHs (49,086 persons) were served by only 120 latrines (an average of 409ppl). This is inadequate and raises critical concerns on whether the 120 latrines are able to bear the sewage load particularly if this is not a temporary measure and IDPs remain longer. It will significantly increase the challenges faced by WMCs in managing effluent, waste, hygiene and maintenance of the toilets.
Lack of sustainability	Water trucking was initially provided to respond to immediate needs and access to water supply. To make this more sustainable, the project moved to using private boreholes, which it had initially assumed may not be possible. However, the team were able to negotiate well with the private borehole owners.

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Changes to project plan: 100% of key informants reported that there were no major changes to the project plan, and this is supported by the project documentation and progress reports. All deliverables were implemented as per the project design, based on the initial needs assessment.

Challenges to project implementation: Based on DEC responses to reports, the project fulfilled the terms and compliance requirements of the grant. According to IRWs feedback log and KI interviews with IR Somalia, no major issues or concerns were raised by DEC regarding the project implementation. However, in follow up with head office staff to verify this, it was reported that in a meeting with DEC in January 2018, DEC raised the issue of quality of data in the output reports, the quality of the reports and the timeliness of reports which were submitted by the East Africa office. Head Office staff reported the need to edit and improve reports and output tables. DEC also raised the issue of slow implementation of the response during Phase 2. Phase 2 had started on October 2017 but IRW response in all three countries hadn't commenced until January 2018. DEC feedback highlighted issues in data quality, quality of reporting and timeliness of reporting. Future projects should consider additional training and

oversight on data collection and data management, reporting, DEC requirements and output monitoring.

Other challenges raised in KIIs are outlined below:

- **Contextual changes:** One of the biggest challenges identified by the evaluation team was the constantly changing and deteriorating humanitarian context in the project areas. The influx of IDPs and changing conditions and needs meant that the project required adaptations. In Baidoa especially, many new IDPs arrived over the project period, and it was difficult for IRW to address the needs of everyone, given the resources available.
- **Security:** Security was a challenge throughout the project implementation, especially regarding distributions. This was mitigated by information gathering from local networks and support from local leadership with clan leaders and community elders being cited in FGDs as playing a particularly vital role, as well as through robust coordination with local authorities. Furthermore, a bomb blast near to the IRS Mogadishu office, in October 2017, caused a minor delay to project implementation. In response, a communications tree and mapped routes were established, and staff were provided with support if needed, indicating a good duty of care to staff.
- **Limited resources compared with needs:** A challenge consistently cited by KIs was that the vulnerability and number of beneficiaries exceeded the limited resources available from the project. The target locations of Mogadishu and Baidoa had more than 261 IDP camps, but finite project resources had to be prioritised. However, due to effective procurement processes, resulting in a reduction in cost, the project was able to address some needs of the additional IDPs. It was suggested by KIs that a contingency component to account for new IDPs (rapid response mechanism), should have been factored in to the project design.
- **Participation of beneficiaries:** KIs highlighted that full engagement of beneficiaries is challenging in a disaster zone due to time constraints, displacement, trauma and capacity of beneficiaries. It was suggested that participation can become a formality and tokenistic, rather than substantive, and the process could be improved. For example, participation in monitoring and planning was found to be low (50% or lower).
- **Oversight:** Head Office staff interviewed suggested that information flows and the project design process between country and Head Office could be improved, especially at proposal stage. Regional Office (RO) staff reported that the decentralisation in East Africa was more advanced than other regions, which may have had an impact on the information flow. Reporting from the Country Office to the RO had increased since January 2018 with regular weekly reports and updates. This has helped improve oversight and understanding of potential contextual changes e.g. influx of IDPs. It was suggested that there is a tendency to prioritise rapid response, to the detriment of longer term planning, thinking and robust challenging of assumptions and information.

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Contingency planning: IRW KIs reported that the Somalia contingency plan had the facility to reallocate project resources or change sectors, but it was not considered necessary as the focus of the project was on responding to the emergency needs of the IDPs. Initially the project was able to adjust to meet the needs of further IDPs through cost savings. However, without a contingency fund, the project's ability to respond to further influxes of IDPs was limited. It was unable to adequately address the increased needs particularly in relation to sanitation (number of latrines) later in the project. This has not been verified by the consultants as details were not shared. It was also reported that there was support and oversight for project implementation, including regional weekly monitoring reports, and support from Mogadishu office.

It appears some of the contextual changes could have been anticipated in advance and planned for in a more systematic and comprehensive way. For example, there was no contingency planning for a possible influx of IDPs, analysis of the potential vulnerabilities or capacities of additional IDPs, or specific scenario planning or preparedness planning. No rapid response mechanism was set up to respond to new arrivals, outbreaks or health emergencies. Although the project demonstrated good ability to adapt to the changing context, this was managed in a reactive and not in a systematic way. For example:

- It used available pre-positioned and buffer stocks of health supplies from a previous project, to cover gaps.
- Gaps in staff were covered by volunteers, for example health workers.
- Water bladders leftover from 2012 in the warehouse were utilized during the first phase of the project.

8.3.   Evaluation of project against Core Humanitarian Standards (CHS) Standards

This section provides analysis and conclusions regarding the accountability of the intervention to the affected-groups against the CHS. All data collected was analysed using an analysis matrix. An overall rating was given to each quality criteria, based on the evidence provided and against the scale below.

Rating	Scale
Recurrent Failure	0
Not systematically implemented	1
Meets the intent but not sufficient quality assurance	2
Meets requirement	3
Exemplary implementation and high quality	4
Exceeds Requirements	5

All data was compared and triangulated across the multiple data sources. Examples for each of the nine commitments are detailed below.

Quality Criterion1: Humanitarian response is appropriate and relevant.

Core question: Did IRW provide assistance appropriately and relevantly address priority needs of the affected communities?
Key Indicator: Extent to which the project met the needs of the assisted communities (in % or rating)

Overall Rating:	3

Relevance to context and needs

The project design was based on an initial needs assessment, beneficiary consultation, coordination with local authorities, relevant clusters and other INGOs operating in the area, and mapping of needs with objectives. An additional assessment was conducted in January 2018. IRW had worked in the target locations previously and therefore understood the context and had developed relationships with the communities. Cluster meetings and 3Ws (Who, What, Where), were used to identify gaps and meet needs in areas where IRW was already operating.

The project was implemented during a period of crisis including drought, perpetual conflict and continuing movement of IDPs. It was designed and implemented to meet the immediate basic needs of the large numbers of people moved to the outskirts of Mogadishu and Baidoa. IDPs faced a lack of water, food and shelter, many had travelled between 40-200 miles without any possessions. The project focused solely on meeting these emergency needs. IRW KIs reported that the project design was based on previous work with the target communities, as well as needs assessments conducted in 2017 and 2018. Adaptations were made based on emerging or changing needs, for example increased latrine construction from phase 1 to phase 2. However, in phase 2 only the 120 planned latrines were constructed as further IDP influxes were not considered in the plans. Therefore, as previously mentioned, the number of latrines per person is inadequate raising the critical concerns that sanitation needs are not being adequately met.

There was a variation in perspective as to the appropriate scope and focus of the project. RO KIs reported that during the project design process, the scope was considered overly ambitious for the budget and activities were subsequently cut. However, other KIs suggested that the scope of the project and the insight into beneficiary needs was too limited considering the protracted nature of the context in the target locations. Overall, the project can be seen as relevant and appropriate in its response to spikes in displacement and meeting basic emergency needs, however it perhaps did not consider the wider context sufficiently.

Relevance and appropriateness of beneficiary selection criteria

IRW used an inclusive and transparent beneficiary selection process and criteria, as follows:

- IDP households which were displaced and had lost livelihood assets back at home of origin.
- Households which had limited or no source of regular income i.e. no jobs or business income and earning almost nothing or less than the poverty line value of USD 1.25 per day.
- Households which were community-acknowledged poor with a defined community definition of being poor amongst the poorest.
- Internally displaced families whose livelihoods and sources of income had been distorted by the displacement.
- In addition, priority was given to the following vulnerable groups:
  - Households with more than 6 children and acknowledged to be poor.
  - Households with severe acute malnourished children under the age of 5 years.
  - Households with members who are living with severe disability.
  - Households with chronically ill adult members, especially the household head.
  - Female Headed Households.
  - Child Headed Households (with a child aged 16 or older).
  - Pregnant and lactating women who are acknowledged to be poor.

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According to household interviews, 76% of the respondents in Baidoa rated the beneficiary selection process as "very fair" and 61% in Mogadishu rated the process as "fair". Only 2% in Baidoa and 1% in Mogadishu rated the process as "not fair". The adjacent chart shows more details of the rating. When asked why assistance was not fair, no substantial reasons were given.

Rating the beneficiary selection process

Baidoa: Fair 22%, Not fair 2%, Very fair 76%
Mogadishu: Fair 61%, Not fair 1%, Very fair 38%
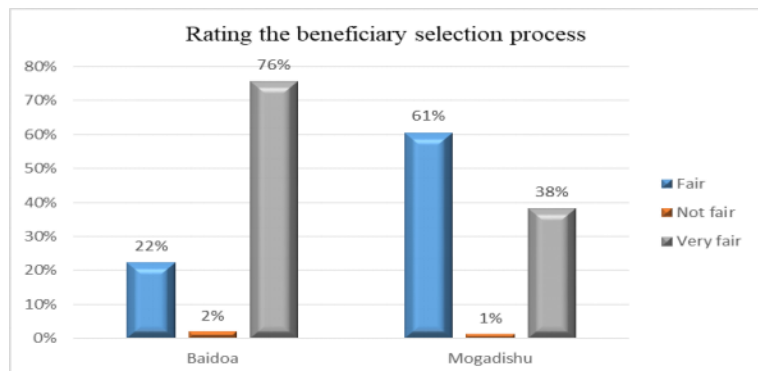
The whole population in the camps are in need but the resources available are limited, which can cause perceived unfairness.

Beneficiary selection criteria were decided in collaboration with camp committees, following consultation with the targeted communities. According to FGDs, the beneficiaries were provided with explanations of the selection process. They understood this and agreed with the selection criteria. FGDs confirmed that communities were involved in identification of vulnerable groups.

Relevance and appropriateness for vulnerable groups
FGD participants reported they felt that the project responded effectively to the needs of vulnerable groups. Some examples cited were:
- Elderly and disabled headed households now have sufficient access to water. Distances travelled before and after the intervention were not disaggregated for elderly and disabled people but those interviewed indicated a reduction. Please refer to the overall reduction in distances travelled to collect water below on pg31-32.
- Pregnant mothers and children have improved and safer access to clean water.
- Children and women have increased knowledge to support safe and healthy practices. Children and mothers were sensitized on handwashing and use of mosquito net by the committees. This is demonstrated in their knowledge and practices on hygiene such as hand washing.
- Pregnant women have access to ante-natal care.

IRW staff reported that all activities factored in vulnerable groups and actively addressed their concerns, for example in food distribution, they are seen first and given special consideration. Answers given in FGDs supported this.

IRW staff reported that targeting of the most vulnerable was done in coordination with local authorities and there was a good knowledge of new IDPs coming to the area. The answers given and details in project documents were often generic and do not necessarily reflect the thorough analysis of the constraints of vulnerable groups and how their specific challenges are being met. The examples above suggest the activities have benefitted vulnerable groups but do not provide insight into how any activities were adapted to specific needs to overcome any barriers to access. The project report states that inclusive processes are applied in implementation and that the most vulnerable and marginalized members of the community such as People Living with Disabilities (PLWD) were specifically engaged through their respective leaders in camp zones to ensure that they are all present at the project discussion meetings with the communities. It further states that the most vulnerable and marginalized members of the community are involved in random one to one discussions to ensure their full understanding of the project activities and provide further support for their inclusion on the project business undertakings in their respective IDPs camps. Similar reports were given in KI interviews, but more specific examples or evidence were not provided.

Response to emerging needs
As mentioned above, there were no major changes to the project, i.e. changes that required donor approval or major changes to the budget. However, some adaptations were made to the project, based on the changing context, emerging needs in the IDP camps and/or beneficiary feedback, including onsite distribution monitoring, Post Distribution Monitoring (PDM) and Complaints and Response Mechanism (CRM). Changes were made based on needs identified in ongoing assessments, and gaps identified in cluster meetings and 3Ws. Examples cited are as follows:

- The influx of IDPs to the project areas, was greater than anticipated due to the continuous drought. To accommodate the additional beneficiaries and ensure DNH,

the number of latrines was increased in phase 2, although there was no scope within the plans to accommodate further influxes of IDPs during phase 2. Contingency planning should have been better incorporated at planning stage.

- The context, needs and beneficiary preferences were different in the Baidoa camps compared with Mogadishu. Larger wooden structures were erected with bigger shelter sheets to accommodate the larger family sizes in Baidoa.
- Water trucking was implemented in phase 1. In phase 2, pipelining was implemented to ensure improved sustainability.
- The number of water outlets was increased to meet the needs of the increased number of beneficiaries.

As mentioned above, there is no evidence that comprehensive advanced planning was done to anticipate changes in the context and emerging needs, but rather that it was approached in a reactive way.

Relevance and appropriateness of technical design

Technical support: A Food Security and Livelihoods (FSL) Advisor provided technical support to the project. However, there were no other technical advisors assigned to support the project, and therefore there were gaps in oversight on design and implementation. It was reported that Dr Saydul Alom, Country Director, Somalia provided oversight and technical input on the health component of the project, but as CD it is likely that his time would have been limited. The lack of technical input on the project is a potential gap that should be addressed in future projects.

Meeting technical standards: Key informants reported that the design of all project infrastructure and activities considered relevant standards such as Sphere and Age and Disability Capacity Programme (ADCAP) as well as national healthcare standards. There was no Age and Disability Inclusion Advisor assigned to this project, so verification is limited. Some examples are outlined below:

- Health: training was provided by the MOH for healthcare staff, drugs were procured according to World Health Organisation (WHO) guidelines for pharmaceuticals.
- Sanitation: Latrine construction was 4 to 24 people per latrines, not always meeting Sphere standards. Evidence has not been provided as to whether there was technical sign-off of the infrastructure by the relevant authorities.
- Water: The amount of water used by all households was between 40 to 120 litres per day which is an equivalent of 2 to 6 jerry cans per day. At the upper end, this exceeds the Sphere standard of at least 15 litres per person per day.
- Disability: IRW's global partnership with HelpAge on the ADCAP project ensured that disability standards were considered in the design of sanitation facilities. No Age and Disability Inclusion Advisor was assigned to this project, which should be considered for future projects.

Challenges experienced receiving assistance: Most of the FGDs indicated that they did not experience major challenges receiving assistance. The issues consistently raised in FGDs were:

Food/NFIs

- The food ration was insufficient. This was because there was only one distribution and food needs were unmet. No issues regarding the quality were reported.
- The first food distribution point was located far from the camp and therefore the beneficiaries had to pay for transport to retrieve it. This also made it more challenging for vulnerable groups to access their assistance.
- The distribution point was highly congested.

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- Persons with disabilities had challenges with long queues and waiting times, although they were mostly prioritised by the distribution teams.
- Long waiting times at distribution points. (30 to 40 minutes reported). An alternative distribution method could be to identify the beneficiaries and assign distribution to a third party, e.g. store owners where the ration is from.
- Female FGD participants expressed concern that armed people should stay away from the point of distribution points. This was followed up with the evaluation team. It is a common practice for soldiers to go to places where there is a crowd due to security concern. However, they can also use this as excuse to attempt to receive commodities from the distribution. No assistance was provided to armed personnel and they did not disrupt the distributions. However, this is a challenge that is difficult to overcome for the distribution teams.

Shelter
- The plastic sheets were not of sufficient quality when exposed to harsh condition such as hot weather, wind and heavy rainfall.
- Shelter did not provide adequate privacy, as only plastic sheets were provided. This is a function of the limited budget and emergency nature of the assistance. Semi-permanent shelter assistance should have been considered as IDPs were likely to stay some time.
- Shelter was easily damaged by harsh weather conditions such as wind and harsh sun.

Sanitation facilities
- Site field visits confirm that latrines were segregated but due to space constraints, they were only one meter apart, which appears not to have been appropriate for some of the beneficiaries. Further consideration of the design is needed, as well as involvement of women and girls in this.

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Advantages and disadvantages of sector approaches and suggestions for improvement:
Distributions: FGD respondents suggested that disabled persons, pregnant mothers, elderly persons and people who are unhealthy should be categorized and allocated different days for distributions.

Shelter: FGD participants repeatedly suggested that semi-permanent or permanent shelter should be considered in future and that mosquito nets should have been more widely provided; mosquito nets were provided to 800 HH, but all target beneficiaries were not sufficiently considered in the project design.

Early recovery: There was insufficient consideration of rehabilitation and early recovery within the project design, considering the timeframe and context. Some IRW KIs expressed the view that the project reinforced what was described as a 'camp culture' and a dependency on aid and should have focused on contributing to a rehabilitation and relocation approach, as well as an increased emphasis on protection. Participants of FGDs suggested that after addressing emergency strategies, it is worthwhile to introduce resilience project activities where IDPs are trained on business management skills and provided with some financial packages for them to establish Small and Medium Enterprises (SMEs) to generate livelihoods and income rather than depending on food supply and other non-food items.

Provision of water: The project adapted from water trucking to putting in piping from existing boreholes. Agreements were made with owners of boreholes to provide water at a subsidized rate. These options were not adequately considered at the outset of the project.

Food versus cash: It was reported by IRW KIs that IRW often distributes cash in similar projects and that cash was being used by other agencies and markets were functioning. It is unclear why there was no further analysis and assessment of the benefits of providing cash-based

assistance. It will be important to consider a mixed approach for future projects (context, security and market dependent).

Health: Health posts within camps were not possible as the camps were too congested, therefore outreach was considered the best option. Patients with medical complications were referred to the main hospital. Pre-positioned stock meant that insecurity did not delay or disrupt the provision of health services. IRS works in close collaboration with MOH in coordination of health service delivery and there is information sharing during implementation and closure of health facilities. The MOH oversees and formulate policies in health sector with help of WHO. However, MOH does not manage any health facilities, or have land for a structure and neither does it have human resources (medical staff) except the administrative staff based in the Ministry. The need for an exit strategy without abandoning the community was discussed extensively. In conclusion, it was accepted among the health staff and the IRS management that there was a need to continue providing the free healthcare services after the project ends, even without the receipt of further funding on the premise that IRS will provide medical and administrative support and the staff would provide their services on a voluntary basis. Despite funding challenges, IRS is reluctant to withdraw this much-needed service. In addition, health education and information for beneficiaries was incorporated in health services offered by health workers, with counselling provided for every pregnant and lactating woman and child carers. The health providers are expected to give morning health education sessions to all patients and provide individualised health education to patients in their consultation rooms. Furthermore, it has not been possible to plan an exit strategy with MoH as ongoing land issues make identifying community land which could be donated for a health facility challenging.

Quality Criterion 2: Humanitarian response is effective and timely.

Core questions:
1. To what extent did the project meet its stated project objectives in a timely way?
2. Were selected mechanisms of implementation effective in achieving project objectives?

Key Indicators:
1. Overall rating how the project met its stated project objectives
2. Rating of effectiveness of project approaches

Overall Rating:	3

Timeliness
All deliverables were completed within the planned timeframe. IRW KIs reported some delays due to insecurity and transportation of supplies. This was verified by FGDs, which confirmed that the project had commenced on time and activities had been delivered to the expected timeframe.

In Baidoa District, 93% confirmed that they received information on the quantity of food/NFIs they were to receive under this project, in Mogadishu 53% received the information. 96% in Baidoa said they received their entitlement in good time. In Mogadishu 67% received assistance in good time. 94% in Baidoa and 72% in Mogadishu said they received the correct amount of food or NFIs. When probed further, there was no evidence that the 28% of respondents in Mogadishu had not received the correct assistance, but rather refers to the fact that beneficiaries had ongoing needs not covered by the project.

63% of respondents in Baidoa rated the distribution process as "very effective" and 52% in Mogadishu rated it as "effective" (see adjacent chart). However, 12% of the total respondents in Baidoa felt that the process was "not effective". The main reason for this is that there were still needs after the project period.
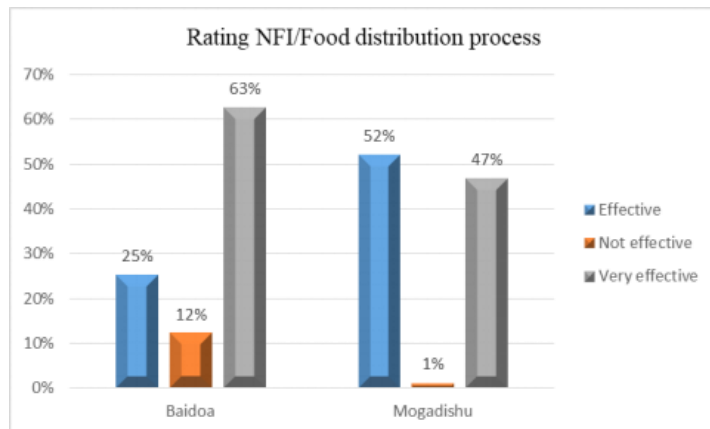
99% and 96% in Baidoa and Mogadishu Districts respectively, felt there were no incorrect practices by IRW staff during the

implementation process. Those who witnessed poor performance or poor practise stated that the community leaders, village support group or IRW staff were responsible, however none of them reported the poor performance or poor practices either due to concern about the possible effect on their assistance or that they did not know who to report to. This is in spite of the high awareness of complaints mechanisms, indicating gaps in encouraging use of the complaints mechanisms and/or barriers to using it, the most prevalent being illiteracy. Please refer to the below section on pg48-49 for more details. The poor practices that they witnessed were delayed distribution of food and information. In Baidoa, the 1% who witnessed incorrect practices felt that the village support groups provided food to people not eligible for assistance on their own authority.

Effectiveness and impact

FOOD AND NFIs

The impact of distribution of food was measured by the number of times that the children and adults ate daily before and after the project. Paired t-tests were conducted using Statistical Package for the Social Sciences (SPSS) to compare the difference between the means of frequency of eating each before and after the project for children and adults. The table below shows the results:

Paired T-test of means of daily eating frequency

N=201			
	Mean of daily eating frequency		
Category	Before	After	t
Children	2.0199	2.5423	-10.572***
Women	1.9154	2.4677	-10.669***
Men	1.8856	2.4328	-10.875***
*** Significant at 1%			

The results showed that the difference in means before and after the project were significant at 1%. This means that the distribution of food to the beneficiaries had a positive impact on the number of times that each household ate daily, for both children and adults. The IRW project increased the daily eating frequency for children by an average of 0.52239, for women by an average of 0.55224 and men 0.54726. A further analysis was done in STATA, to assess the impact at the District level. The results showed that there was a significant increase at 1% significant level of the daily eating frequency in both Mogadishu and Baidoa district for all categories. The table below gives the results of each category by District.

A paired T -test of means of daily eating frequency before and after IRW project by District

Mogadishu N=94, Baidoa N=107		Mean of Daily Eating Frequency		
Category	Location	Before	After	T
Children	Mogadishu	2.1017	2.6170	-7.4167***
	Baidoa	2.0280	2.4766	-7.7026***
Women	Mogadishu	1.9574	2.5419	-6.9940***
	Baidoa	1.8785	2.4112	-8.1350***
Men	Mogadishu	1.8936	2.4362	-7.2266***
	Baidoa	1.8785	2.4299	-8.1072***
*** Significant at 1%				

Food

Food lasted an average of 0.972 months in Baidoa and 0.979 in Mogadishu. 100% in Baidoa stated that the IRW project was important in their settlement. 72% of respondents in Mogadishu also agreed of the project's importance. The reasons given for this are as follows:
- IRW assistance came when it was needed the most.
- The project improved the living standards of the beneficiaries.
- Food, water, medicine and shelter were provided.
- Vulnerable communities were specifically included (widowed, elderly, disabled, pregnant women and children).

Those respondents in Mogadishu who stated that the IRW project was not important gave the following reasons:
- Respondents are not currently receiving any assistance. The main issue was related to family size, as the same amounts were provided regardless of family size.
- The project did not have the desired long-term impact. It provided important initial emergency assistance but no longer-term support, to help sustain food security.
- Not all their needs were met, for example livelihood support.

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WATER SUPPLY INFRASTRUCTURE

An assessment was conducted to evaluate the impact of the provision of water supply infrastructure by IRW. It was done by:
- Comparing the changes in frequencies of the number of households that used a certain type of water source before and after the project.
- Comparing the time taken to get to the water source before and after the project.
- Comparing the length of time taken waiting in line for water before and after the IRW project.

Source of water

The number of respondents using piped water after the IRW project increased significantly from 30 to 70 in Baidoa district and 59 to 82 in Mogadishu District. The number using protected wells also increased in both districts. The number using unprotected wells however reduced from 59 to 12 in Baidoa and 5 to none in Mogadishu. It was reported that there are protected wells available in the camps and unprotected wells are used for cleaning purposes. The number using Boreholes remained relatively the same in Baidoa district. Further details on the frequency with which respondents used various water sources before and after the IRW project are shown in the adjacent chart.

Frequency of respondents using the water source before and after IRW project
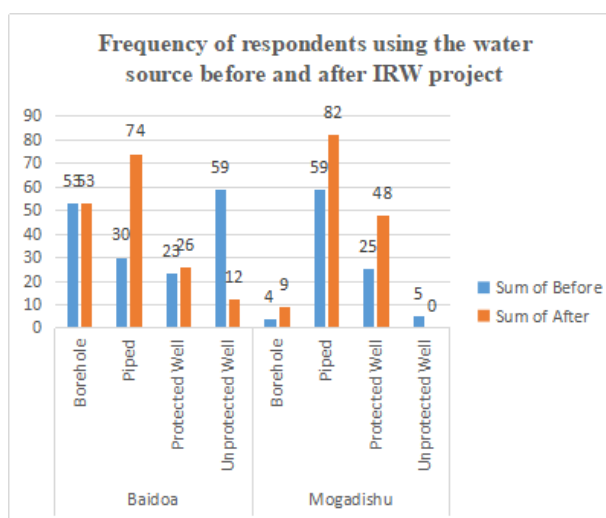
Distance to access water source

The table below shows the number and percentage of households walking certain distance intervals measured in metres before and after the IRW project on water infrastructure. The percentage of households walking less than 100 metres to access water in Baidoa District, increased from 22% to 61%. Those walking for more than a kilometre, reduced from 24 to 8%. This was due to people previously being in a camp with a closer water point. In Mogadishu, the case was similar with the number walking less than 100 metres increased from 56 to 73% and those walking more than a kilometre reduced from 10% to none.

District	Distance	Number of households		% households	
		Now	Before	Now	Before
Baidoa	Less than 100 metres	65	23	60.75	21.5
Baidoa	100-200	2	5	1.87	4.67
Baidoa	200-300	2	3	1.87	2.8
Baidoa	300-400	15	15	14.02	14.02
Baidoa	400-500	7	11	6.54	10.28
Baidoa	500-1000	7	24	6.54	22.43
Baidoa	Above 1 Km	9	26	8.41	24.3
Total		**107**	**107**	**100%**	**100%**
Mogadishu	Less than 100 metres	69	53	73.4	56.38
Mogadishu	100-200	6	20	6.38	21.28
Mogadishu	200-300	3	8	3.19	8.51
Mogadishu	300-400	0	9	0	0
Mogadishu	400-500	0	0	17.02	3.19
Mogadishu	500-1000	0	1	0	1.06
Mogadishu	Above 1 Km	16	3	0	9.57
Total		**94**	**94**	**100%**	**100%**

Time waiting in line for water

Time spent waiting in line for water before the project reduced notably after the IRW project as shown in Table below. Those waiting for less than 30 minutes increased to 69% from 31% before the project in Baidoa. In Mogadishu District, they increased from 60% to 67%. Today, there are no households in either location waiting more than 2 hours in line for water. The figures suggest that waiting time reduced for all targeted beneficiaries.

District	Time	Number of households		% of Households	
		Before	After	Before	After
Baidoa	Less than 30 mins	33	74	31%	69%
Baidoa	30 mins – 1 hour	59	32	55%	30%
Baidoa	1 hour – 2 hours	2	1	2%	1%
Baidoa	More than 2 hours	13	0	12%	0
Total		**107**	**107**	**100%**	**100%**
Mogadishu	Less than 30 minutes	56	64	60%	68%
Mogadishu	30 mins – 1 hour	20	25	21%	27%
Mogadishu	1 hour – 2 hours	10	5	11%	5%
Mogadishu	More than 2 hours	8	0	8%	0%

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Total		94	94	100%	100%

Other measures of water infrastructure impact

The adjacent table shows 90% of households in Baidoa and 98% in Mogadishu stated that the water taste was good. 6% and 11% in Baidoa and Mogadishu respectively participated in maintenance of water sources. 98% and 100% in Baidoa and Mogadishu respectively did not pay for water maintenance. The participation in maintenance was

Baidoa N=107, Mogadishu N=94
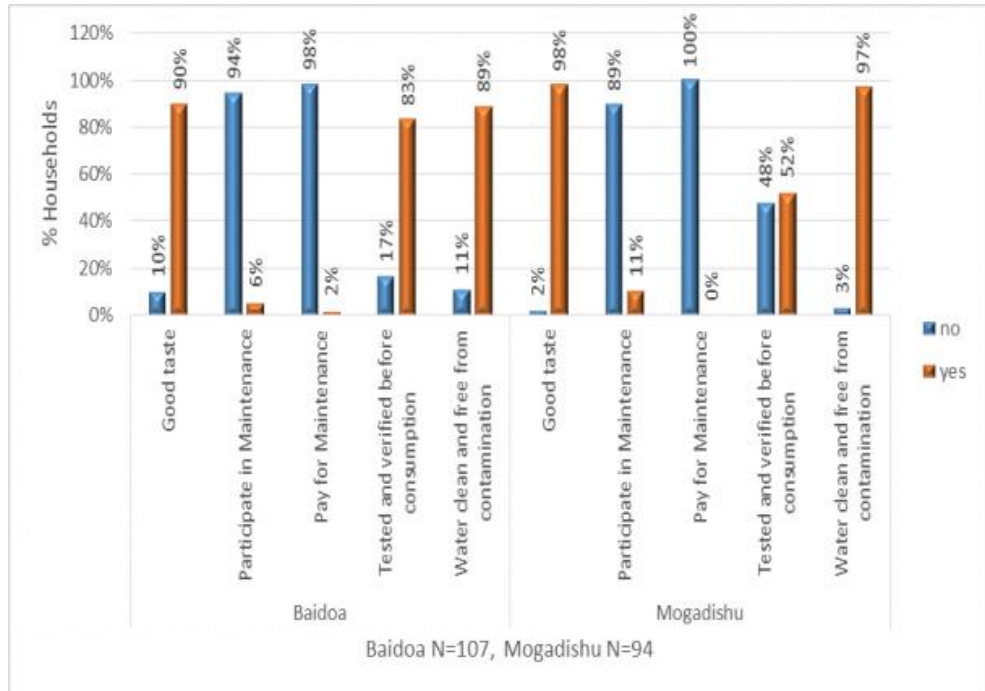
related to ensuring that the water sources were not contaminated and cleaning the areas near water sources shared by the community. 83% in Baidoa and 52% of respondents in Mogadishu said that the water was tested and verified suitable for drinking before consumption. 89 and 97% in Baidoa and Mogadishu District were confident that the water was clean. The 11% who were not confident the water had been tested could be because of the high rate of illiteracy among respondents, who do not necessarily know or understand what water testing is, and they think it is not tested. The field team confirmed the water was tested by the agent and it is potable. A potential learning is to do more awareness raising and information sessions regarding water testing and when it has been done.

Water quantity

The amount of water used by all households was between 40 to 120 litres per day which is an equivalent of 2 to 6 jerry cans per day. At the upper end, this exceeds the Sphere standard of at least 15 litres per person per day. As shown in the table adjacent, the amount of water used increases with household size.
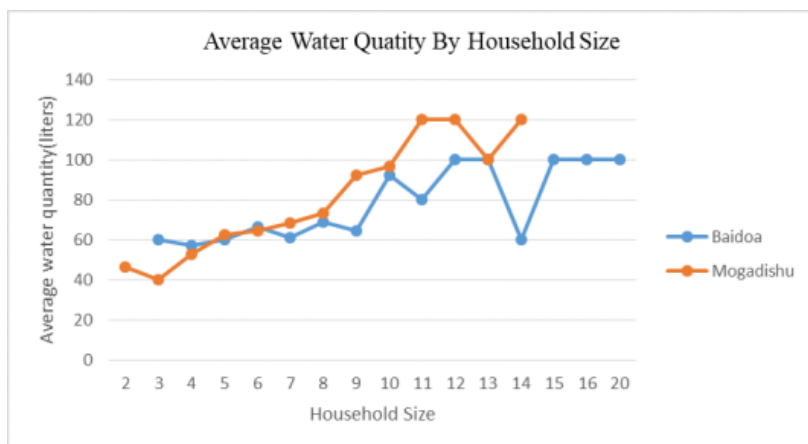
ENVIROMENTAL HEALTH

Waste disposal

The table below shows how the community in Baidoa and Mogadishu disposed of waste before and after the IRW project. Leaving waste anywhere in the compound was reduced by 31% in Baidoa and by 6% in Mogadishu Districts. Disposing of the waste in pits increased in both districts as a result of the IRW project. Other methods listed were throwing solid waste away into bushes, or giving it to farmers as manure.

District	Method of disposal	Before	After
Baidoa	Burn it	65%	76%
Baidoa	Waste pit	2%	7%
Baidoa	Bury	2%	17%
Baidoa	Leave anywhere in the compound	31%	0%
Total		**100%**	**100%**
Mogadishu	Burn it	56%	43%
Mogadishu	Waste pit	13%	32%
Mogadishu	Bury	11%	16%
Mogadishu	Leave anywhere in the compound	13%	6%
Mogadishu	other specify	7%	3%
Total		**100%**	**100%**

The evaluation also measured the use of clearing of drains and vector control exercises, and whether these were conducted in the last six months to improve environmental health in Baidoa and Mogadishu. The ratings are shown in the tables below:

Clearing of drains in the last 6 months

Row Labels	No	Yes	Total
Baidoa	54%	46%	100%
Mogadishu	59%	41%	100%

Vector control exercise in the last 6 months

Row Labels	No	Yes	Total
Baidoa	98.13%	1.87%	100.00%
Mogadishu	78.72%	21.28%	100.00%

The yes responses are low due to a very low level of awareness on whether vector control exercise had taken place. As with water testing, it is important to provide adequate and accessible information on these activities.

Hygiene practices

43% of households in Baidoa and 20% in Mogadishu were involved in hygiene promotion activities (see table below) under this project. 98% and 63% in Baidoa and Mogadishu Districts respectively put this knowledge into use in the following ways:
- Washing hands after toilet use.
- Cleaning own house and surroundings.
- Creating hygiene awareness.
- Importance of good hygiene.

Hygiene promotion activities and using the knowledge acquired

District	Item	No	Yes	Total
Baidoa	Involvement in hygiene promotion activities	57%	43%	100%
Mogadishu	Involvement in hygiene promotion activities	80%	20%	100%

| Baidoa | Put knowledge into use | 2% | 98% | 100% |
| Mogadishu | Put knowledge into use | 37% | 63% | 100% |

68 respondents in Mogadishu and 106 in Baidoa reported that they regularly washed their hands. The table below shows what was used for hand washing by District. The most popular item was soap and water in both districts. 86% in Baidoa and 88% in Mogadishu stated that the type of hand washing chosen was a result of the IRW training.

Item used for hand washing

Row Labels	Baidoa N=106	Mogadishu N=68
i) Soap and water	58%	84%
ii) Ash and Water	20%	9%
iii) Plain water	23%	6%
iv) Others	0%	1%
Grand Total	**100.00%**	**100.00%**

64% of respondents in Baidoa and 79% in Mogadishu reported that they treated their water. The most popular water treatment method was boiling in Baidoa and use of aqua tabs (Chlorine) in Mogadishu. 97% of those who did not treat their water in Baidoa was because they believed their water was from a safe source. 55% in Mogadishu stated that they did not see the importance of treating water and 30% did not know how to do it (see tables below).

Water treatment method

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Row Labels	Baidoa N=69	Mogadishu N=74
i) Boiling	72%	19%
ii) Filter with cloth	1%	3%
iii) Use of aqua tab (Chlorine)	26%	78%
Grand Total	**100.00%**	**100.00%**

Reasons for not treating water

Row Labels	Baidoa N=38	Mogadishu N=20
i) My water is from safe source	97%	15%
ii) I don't see the importance	3%	55%
iii) I don't know how to do that	0%	30%
Grand Total	**100%**	**100%**

SHELTER

In Mogadishu, 100% of the beneficiaries in the target locations had plastic sheets provided by IRW. In Baidoa, 23% were provided assorted polythene and 74% were provided with plastic sheets (see adjacent chart).

Shelter Provided by IRW (Baidoa N=87, Mogadishu N=93)

Living Conditions After Project
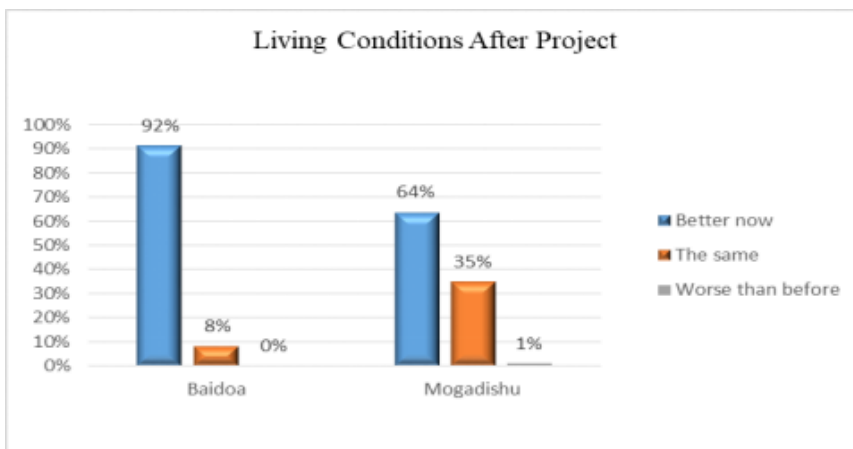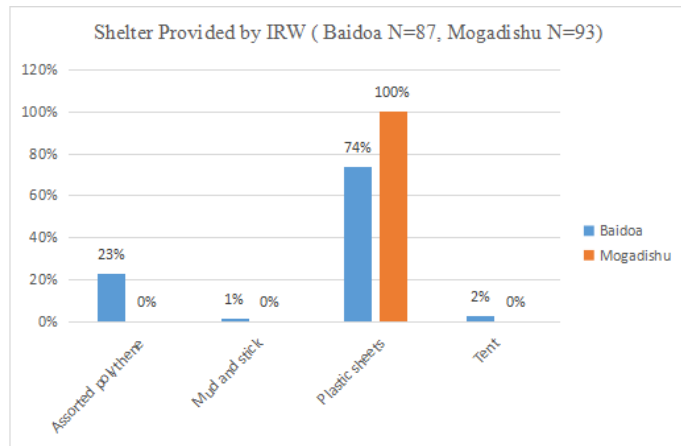
Living conditions

92% in Baidoa, said their living conditions were better after the IRW project compared to 8% who felt that they remained the same. In Mogadishu, 64% felt their living conditions were better but 35% felt that they remained the same. There was a small group of 1% in Mogadishu who felt their living conditions were worse now than before the implementation of the project (see chart above).

The reasons given for why they felt that the IRW project improved their living conditions are:

- Basic needs of food, water, health and shelter were met.
- The project has improved both their human dignity and livelihoods.
- Food was provided during the Ramadhan period.

Dignity/ self-esteem

75% of respondents in Baidoa indicated that their dignity or self-esteem is better now due to the IRW project compared to 25% who say it remained the same. The variation was different in Mogadishu with 54% saying the situation is better now and 44% saying it remained the same (see adjacent chart).

Dignity/self-esteem situation comparison before and after IRW project
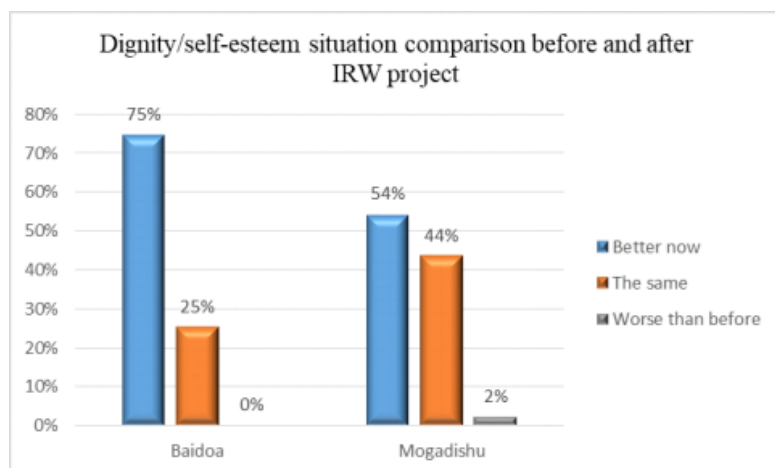
The reasons given for why dignity or self-esteem has improved as a direct consequence of the project included:

- They no longer beg their neighbours for food.

- They now eat three times a day.
- They are less mentally stressed.
- They worry less about food.
- They have a place to sleep.
- They have clean drinking water.

HEALTH SUPPORT

The IRW project on health support was only provided to the Mogadishu community. An impact assessment on health support was done by a paired t-test on the mean health facilities that the community has access to and the time taken to get to those facilities before and after the project. The type of health facilities that were used before the IRW project were also evaluated. The results are as shown below.

Before IRW intervention on health in Mogadishu, the most popular way of seeking medical attention was buying medicine from pharmacies (see table below). 9% of the respondents visited traditional healers. Private clinics and other distance medical facilities were used by 24% and 21% of the respondents.

Health facilities attended before the IRW Project in Mogadishu District. (N=94)

Health Facility	% of who those who attended the facility before IRW project
Bought medicine directly from drug shops/pharmacies	35%
Medical facilities in another distant area	21%
Other	24%
Private clinics	24%
Visited traditional healers	9%

NB: A household can use more than one health facility.

T test of means analysis was done in STATA to compare the difference of the number of facilities within reach of respondents and the time taken to reach a facility before and after the IRW project. The results are shown in the table below.

Paired T test of means before and after the IRW project

	Before	After	T
Facilities within reach	0.4149	0.8404	-10.595***
Time taken to reach facility	138.5857	10.18	-12***

*** Significant at 1%, N=94

The mean number of health facilities that were within reach before the IRW intervention were 0.415 and after the intervention they were 0.84. The difference is significant at 1%. Time taken to reach the facilities reduced significantly at 1% from an average of 138 minutes to 10 minutes. The three tables below provide a further breakdown of the facilities within reach before and after the project and the time taken to reach those facilities.

Within reach Before the IRW project in Mogadishu District (N=94)

Number of facilities	Number of households	Percentage households
0	56	60%
1	37	39%
2	1	1%

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Within reach after the IRW project in Mogadishu District (N=94)

Number of facilities	Number of households	Percentage households
1	89	95%
2	5	5%

Time needed to reach health facilities before and after IRW

Time	No of households before the project	No of households after the project
5 minutes and less	2	62
6-10 Minutes	1	11
11-30 Minutes	10	23
31-60 Minutes	26	7
61-120 Minutes	14	0
Above 120 Minutes	42	0

The IRW health facility was the nearest one for 99% of the respondents. Of those who attended the IRW health facility, 69% went for vaccination of their children, 65% went for postnatal care, 53% went for consultancy from a professional or visited the clinic and 41% went to give birth (see table below).

Activities in health facilities

Activity in health facility	% yes	% no
Has visited Professional/ clinic	53%	47%
Given Birth	41%	59%
Post-natal care	65%	35%
Child vaccination	69%	31%

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Age (in months) of youngest children brought to the facility
The age range of youngest children brought to the health was less than one month to 18 months (see table below).
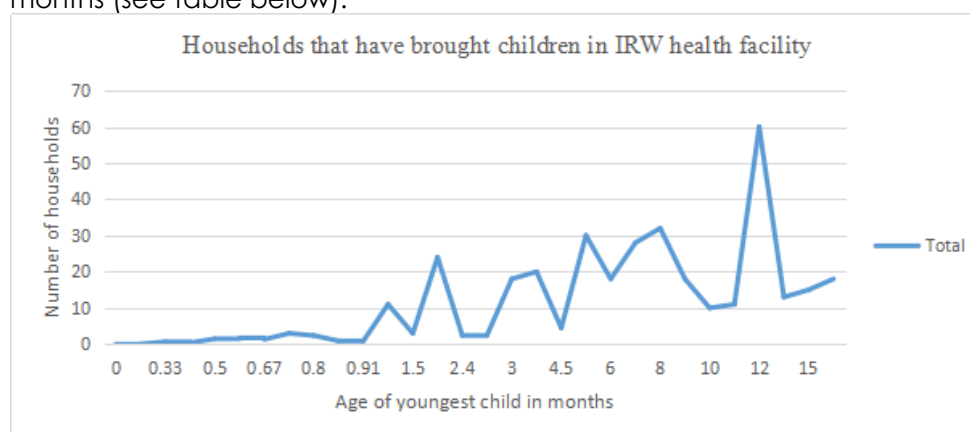
Diseases affecting children

Of all households surveyed, acute respiratory diseases were the most commonly reported health problem among girls and measles among boys, with 25 and 22 cases respectively taken to the health facility – see table below. Diarrhoea and malaria were also commonly reported health problems.

91% of the respondents received the prescribed medicine in the health facility. 49% rated the services received in the health facility as "very good", 50% rated as "good" compared to 1% who rated it as "poor". The reasons for rating the services very good were that they got the required medicine and the children were treated effectively at health facility. 84% of the respondents said that the IRW project on health support had a positive impact on the assisted community.
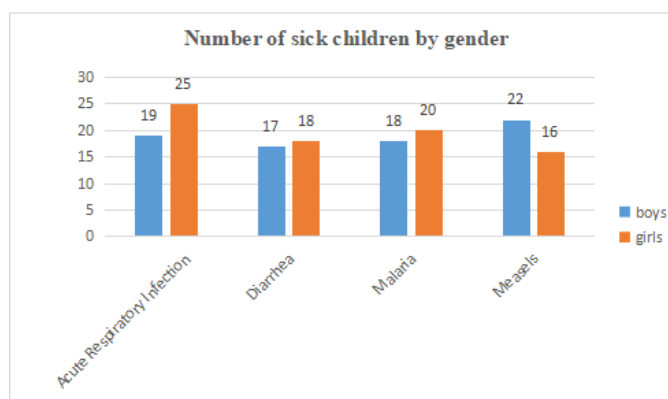
HEALTH FACILITIES
- One health facility (Deynile) was evaluated in Mogadishu. During the time of monitoring, there were 3 nurses and 1 midwife present. The health facility offers the following services:
- Medical consultation and referrals
- Medical commodities
- Antenatal care
- Post-natal care
- Reproductive health services (family planning).

In the last 3 months, a total of 3,591 patients were treated in the health facility. The table below shows the number of females and males treated in each age group.

Number of people treated in Daryeel health facility in the last 3 months:

Row Labels	Female	Male	Grand Total
0-24 months	250	296	546
25-60 months	342	322	664
6-14 years	372	170	542
15-49 years	1167	217	1384
50-60 years	159	44	203
Above 60	167	85	252
Grand Total	2457	1134	3591

No deaths were reported in the health facility from acute respiratory infection (ARI), diarrhoea, malaria, measles or suspected TB in the last 3 months. ARI had the highest number of cases for both male and female between 0-60 months and above 5 years. There were no measles or suspected TB cases, for 0-60 months treated in the last 3 months.

Cases treated/died in the last six months by disease:

Row Labels	Deaths	Female	Male	Total
0-60 months Cases treated & fatalities in the last 6 months	**0**	**390**	**413**	**803**
ARI	0	278	288	**566**
Diarrhoea	0	106	121	**227**

Malaria	0	6	4	**10**
Measles	0	0	0	**0**
Suspect TB	0	0	0	**0**
Above 5 years Cases treated & fatalities in the last 6 months	**0**	**247**	**197**	**444**
ARI	0	217	184	**401**
Diarrhoea	0	15	4	**19**
Malaria	0	7	5	**12**
Measles	0	0	0	**0**
Suspect TB	0	8	4	**12**
Grand Total	**0**	**637**	**610**	**1,247**

Under this project, IRS provided primary health care services in two ways. Firstly, through a static health facility owned by IRS where vaccination services are provided to the targeted beneficiaries. Secondly through primary health care services provided through a mobile clinic in the IDP camps. This facility is not equipped to provide services such as vaccinations but refers the patients who require them to the static health care facility near the IDP camps. The facility assessed did not administer vaccinations for any disease including BCG, polio, PENTA, OPV, IPV or measles to children or TT vaccination to pregnant women. 84 women attended the antenatal care clinic in the last 3 months. 178 women have given birth in the health facility in the last 3 months, and no complications were reported during this time.

Intended or positive effects of the project

IRW KIs reported the following positive effects of the project. The examples most highlighted and which were supported by feedback from FGD respondents are outlined below:

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- ▪ **WASH:** Water and sanitation infrastructure has led to better health and hygiene through provision of clean and safe water. Despite the emergency nature of the intervention, the water supply solutions were sustainable including hygiene sessions, water management committees and water infrastructure (piping, water tanks). The change from water trucking to boreholes and piping will contribute to a more sustained impact. This was felt to promote community empowerment and ownership. Waste management activities have created a safer and cleaner environment, minimising open defecation and increasing the use of latrines.
- ▪ **Health:** Support of a permanent health facility is considered positive, as IDPs have continued to stay in the target locations and there have been limited reports of people returning home. Hygiene promotion had a significant impact on community knowledge and practices, including reports of increased use of latrines and hand washing.
- ▪ **Resilience:** Beneficiaries reported that their resilience improved in the camp settings. They were able to transition from a survival phase and develop their capacity to increase household income. It was also reported that health and hygiene components supported resilience, due to support and counselling provided to beneficiaries experiencing trauma.
- ▪ **Conflict sensitive approach:** Piping water has meant it can be accessed by IDPs and host communities separately thereby reducing risks of tension.
- ▪ **Protection and gender:** IRW staff reported that the design of latrines contributed to increased protection for women and girls, gender sensitivity and inclusion of disabled people. However, contradictory information was collected from FGD and HH, which reported that latrines were not sufficiently segregated. Site visits confirmed that the segregation was only one meter apart. Space was a major constraint, but the learning is that this needs to be better considered in future projects with more emphasis on

inclusion of women in the design process to find alternative solutions. The water facilities also contributed to improved and safer access for women and young girls who were often responsible for collecting water for their families. Distance and time to collect water has been reduced.

Unintended or negative consequences of the project

IRW KIs reported the following negative or unintended effects of the project. These were supported by feedback from FGD respondents:

- **Aid dependency:** Some IRW KIs reported that the project reinforced camp culture in Somalia, thereby increasing aid dependency. This is partly due to IDPs escaping the pressure of recruitment into armed groups, as well as to get support. Other IRW KIs contradicted this, reporting that IDPs have become more resilient and have established positive coping mechanisms as a result of the assistance provided. This is a systemic issue in Somalia and given the remittances from diaspora communities contributing substantially to the local income, it is unlikely to be something one agency can resolve. However, considering approaches that foster resilience such as the example of water piping as opposed to short term solutions such as water trucking are positive.
- **Target population:** The target population was exclusively IDPs, which was reported to be unlike other IRW projects in other parts of Somalia. However, health and water facilities are also accessible to host communities. Additional engagement with villages and host communities should be considered for future projects, in line with DNH principles.
- **Health promotion**: Community Led Total Sanitation (CLTS) was not used as an approach in this current project, but the project utilised the existing Information, Education and Communication (IEC) materials. The health teams are better trained as a result of this project.
- **Integration of IDPs:** There was little evidence of integration of IDPs within the wider community or a strategy to maximise IDP capacity and manage limited resources within the camps.
- **Congestion in IDP camps:** As the camps were built on private land, the ability to prevent congestion was limited, and agencies are subject to the conditions set out by the landlords. This meant that the role of NGOs is more challenging as they had to negotiate with the landlords and support the IDPs in advocating for themselves – rather than a dedicated camp management agency. Furthermore, construction and town development continued, which reduced space for IDP settlements, and meant IDPs could face demolition, or forced evictions if the landlord decided to use the land for another purpose.

Unintended consequences or effects of the projects do not appear to have been documented or measured in any specific way. Future projects would benefit from a more systematic approach to documenting learning, particularly where the events are cyclical in nature such as repeated poor rains and resulting drought.

Quality Criterion 3: Humanitarian response strengthens local capacities and avoids negative effects

Core Question: To what extent did the project strengthen local capacities, which supports resilience?
Key Indicator: Rating on extent of and quality of capacity building?

Overall Rating:	2

Supporting local capacities

Capacity building components have been incorporated throughout the project activities. Several examples of active engagement of local stakeholders and development of skills were highlighted in KIs with IRW staff. These were corroborated against FGD discussions with community members.

Community members: FGDs with community members reported that they developed skills and knowledge through taking part in the selection process and identifying vulnerable groups. They met with IRW to address the challenges faced during the project. They closely worked with IRW in disseminating information on health promotion education throughout the project. They increased their knowledge through participation in community education on hygiene and sanitation. This included the importance of proper hygiene and sanitation, proper disposal of solid waste, washing hands after visiting the toilet and before and after eating meals, as well as handling baby excreta with care by disposing of it in the latrines. It also covered how to overcome the diseases that arise as a result of poor hygiene and sanitation in and around the homestead, and solid waste management strategies. In addition, they participated in the monitoring and evaluation exercises undertaken by the project staff of IRW.

Water Committees: WASH committees have been trained and had the responsibility to oversee WASH activities and manage water to the communities. Negotiation and planning skills have been built through experience of working with private contractors, and involvement in project implementation and they have been linked to further private contractors for ongoing contacts and work. Hygiene and sanitation awareness has contributed to improvement in attitudes and practices across the target communities, as detailed in the section above, and has gone a long way to overcoming the practice of open defecation.

Ministry of Health: The project trained health workers in project health facilities and outreach workers.

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Camp Committees (CCs): All key informants highlighted the strong organisation and engagement of camp committees. They were actively engaged in meetings to select beneficiaries and able to build strong leadership. These meetings became the forum within which to make decisions about how to manage their camps and how to present their needs to other organizations. Key informants highlighted that CCs especially played a role in identifying vulnerable groups, identifying the additional needs in the community, and minimising community tensions. The CCs demonstrated their ability to disseminate and reinforce hygiene messages throughout the project, including handwashing sessions, and safe practices. For example, in Mogadishu, regular sessions were conducted on safety, hygiene, engaging with all stakeholders, including soldiers, local authorities and LNGOs. It was noted that there was no representation from children, but that they were indirectly involved through activities such as hygiene promotion, which were tailored to support their knowledge and skills levels.

Community leaders: The project has contributed to increased empowerment felt by community leaders. Leadership and coordination skills have been developed through bringing people together for discussion and planning, contributing to beneficiary selection, informing local authorities, as well as mobilising the community in the project and engaging beneficiaries in meetings.

IRW staff: IRW staff were trained on CHS.

Engagement with local leaders and authorities

All key informants reported that engaging and coordinating with local authorities in the areas of implementation was crucial to the success of the project. The majority of IRW key informants staff reported positive engagement with all stakeholders.

Local Authorities: IRW project staff reported that local authorities were engaged and actively participating in local coordination bodies and the cluster body at Mogadishu level. It was reported that IRW has a good relationship with the local authorities, and well-established lines of communication. They cited consultation at design stage and throughout the project implementation, engagement in project kick-off meetings, consultation on target locations and beneficiary selection, DNH approach and a needs-based approach, as examples of this. In Baidoa, the coordination system was reported to be weak in the initial phase especially with the Ministry of Planning but through increased engagement by IRW, this improved in phase 2 and they became more proactive and empowered as the project continued.

KIs highlighted that the local authorities provided invaluable information and support on security issues, especially during distributions where they maintained a boundary around the distribution point to prevent overcrowding, and supported verification of beneficiaries. However, a minority of key informants suggested that the approach with stakeholders required improvement, citing major challenges including tensions between UN system, local government and NGOs regarding coordination. It was also highlighted that more could have been done to engage and obtain an understanding of longer term needs, recovery planning and in contributing to reducing dependency. Longer term relationships have emerged from this response, with KIs highlighting collaboration on identification of needs, training, and participation in design. It was not possible for the evaluation team to conduct interviews with the local authorities and therefore this information remains unverified.

Local Leaders: Engagement was reported as positive with clan leaders and community elders highlighted as playing a vital role in community consultation and targeting in the camps. KIs cited their engagement in inception meetings, identification of vulnerable people, support with distribution planning and security, as important contributions.

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Gatekeepers: It was reported that there was an increased need during the project implementation to monitor the influence of the gatekeepers, who owned the land. Additional checks were required as they have significant influence on resource management and use of land within the camp.

Alignment with Government plans: KIs reported that the project was aligned with the National Development Plan for Somalia, including the specific section on emergency response and durable solutions. Coordination included a meeting with the Ministry overseeing Humanitarian Response in 2017, at federal level, as well as ongoing meetings and coordination with South Central region departments, due to the localised nature of the Somali government structure. One KI cited that the local authority plans focused on integrating IDPs into the community and stimulating income generation. For example, as a result of project assistance, some heads of households were relieved of supporting immediate needs such as food and water and were able to engage in income generating activities such as firewood and burning of charcoal. This aligned with the goal of the local authority to support the IDPs community in income generating activities.

Resilience building and early recovery
The majority of KIs reported that the project was focused on meeting emergency needs and that early recovery was not a priority. The project engaged proactively with target beneficiaries and local governance structure to empower the community and support resilience. It aimed to involve the beneficiaries in decision-making and develop a sense of ownership in future planning. Durability was incorporated in activities where possible and relevant, for example the water and sanitation infrastructure.

The approaches that KIIs and FGDs identified as resilience building were:
  ▪ Water facilities placement: through raising awareness of hygiene, beneficiaries found

their own ways to manage water overflow and ensure facilities were kept in good condition. For example, to solve the issue of stagnant water, the community mobilised to collect stones to stop water overflow. This indicates good collective ownership of the facilities.

- Communities were mobilised and provided with sanitation tools such as wheelbarrows and spades and they used them to maintain a clean environment. They also were able to use the tools to develop livelihoods, for example planting seeds and selling wood.
- The project provided counselling during the hygiene sessions to supported beneficiaries experiencing trauma. This was not originally planned but was incorporated into the project to support resilience building.
- Construction of latrines – hand washing facilities attached to the side of latrines encouraged good practise and made the intervention more sustainable.
- As a result of direct benefit from the project some of the household heads (mostly men) were relieved of providing basic family needs such as food and therefore were able to engage in own income generating activities such as firewood and burning of charcoal to support their households. This has partly contributed to the goal of the local authority to support the IDPs community in involving themselves in activities that generate income to take care of their household rather than depending on aid.

Some examples of activities that will support early recovery were highlighted by interviewed KIs:

- WASH infrastructures were durable and will support recovery. For example, construction of boreholes and piping provides a more durable and sustainable water solution, which can also be used by the IDP and host communities in the future.
- Construction of water tanks and ongoing maintenance by water committees helped prevent water run-off.
- There is no clear way forward for handover of IRW Health facilities to the Ministry of Health. Previous exit plans have not been successful to date. A recommended first step would be to see if they can be recognised by the MoH in consultation with WHO. Transfer will be challenging where the facilities are built on private rather than government land. This should be investigated further.

Some KIs believed that the project lacked focus on early recovery and longer-term planning, which was necessary considering the context and the protracted nature of the crisis. Activities were focused on meeting initial emergency needs, with most of activities implemented early in the project. It was highlighted that in the South Sudan DEC project, an early recovery approach was more advanced. There were suggestions that microfinance might have been geared to activities such as irrigation, kitchen gardens and repatriation of IDPs. The feasibility of such options was not assessed in detail, but it would have been advantageous to conduct in-depth analysis of beneficiary needs and capacities that could have contributed to early recovery approaches, as well as ensuring IDPs could identify solutions and early recovery ideas. Moreover, some KIs felt that the distribution focus of the project could contribute to dependency on aid at the expense of building resilience and early recovery.

Quality Criterion 4: Humanitarian response is based on communication, participation and feedback

Core Question: Were established mechanisms effective in ensuring beneficiary participation and feedback?
Key Indicator: Rating of the effectiveness of participation and feedback mechanisms

Overall Rating:	3

Organisational approach to beneficiary feedback: Beneficiary accountability and communication guidelines have been introduced to all Country Offices (COs). A systematic roll-out has started to ensure clear communication channels. It is evident that there is broad knowledge across the organisation regarding the overall accountability framework. Prior to these changes, it was reported that feedback mechanisms are often delegated to officer level positions and there is a lack of global central oversight or comprehensive approach at IRW organisational level. It was also highlighted in KI interviews with Head Office staff that understanding, and follow-up has varied hugely at country office level. Where complaints are received, and documented they are followed up. The previous inconsistent approach to documenting and managing complaints has now been addressed through the new field office complaints policy. There was little evidence or examples provided as to how beneficiary feedback was used and fed back into project implementation and design, the beneficiary accountability guide and requirements of beneficiary communication plan at the start of a project is designed to address these issues more systematically and comprehensively.

To address these issues, a new field office complaints policy has been agreed at board level, which has been circulated to COs with follow-up actions. A more standardized approach to complaint management is being developed and implemented, including a complaint focal person, standard register, standard phone-number and email. Focal points will be trained and have responsibility to raise awareness of main complaints and establish clear timelines and tracking for follow-up. The current status was described as a transition period from individual officers managing feedback mechanisms in an ad hoc way, to a comprehensive and systematic mechanism that is properly managed.

Baidoa N= 107, Mogadishu N=94
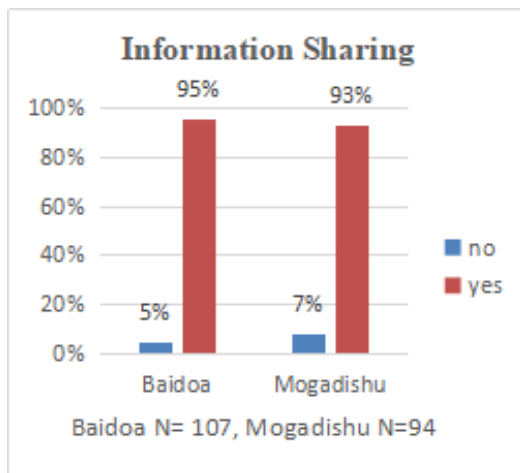
Information Sharing: The monitoring team assessed whether the community was aware of the IRW project at the beginning of the implementation, using the household survey. 95% and 93% of the participants in Baidoa and Mogadishu Districts respectively, felt that they were informed (see adjacent chart).

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Proportion of respondents that received information by method

86% of those who received information in Baidoa District heard about it through community leaders, 62% of those heard during community meetings while 38% received information through IRW staff. In Mogadishu, of those who knew about the project, 38% received this information through IRW staff while 29% heard through meetings and 24%
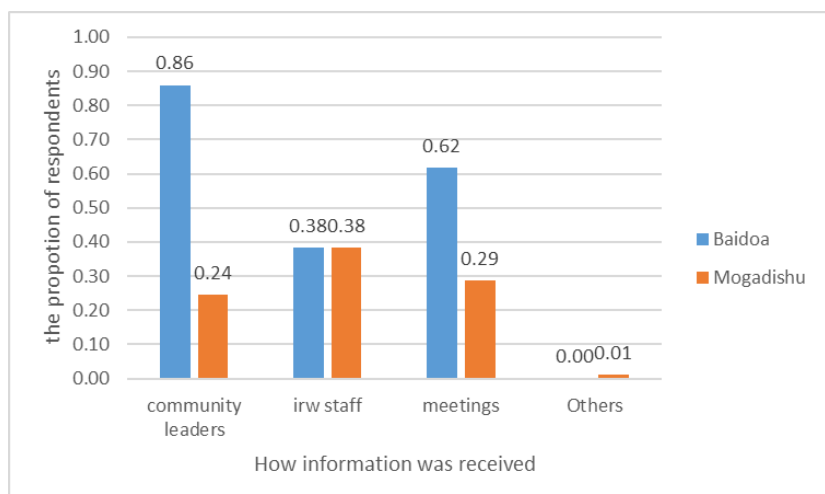
through the community leader. Please note that respondents received information from multiple sources. The above chart shows this in detail.

Type of information shared with the community by District (Baidoa N=102, Mogadishu N=87)

Type of Information Received
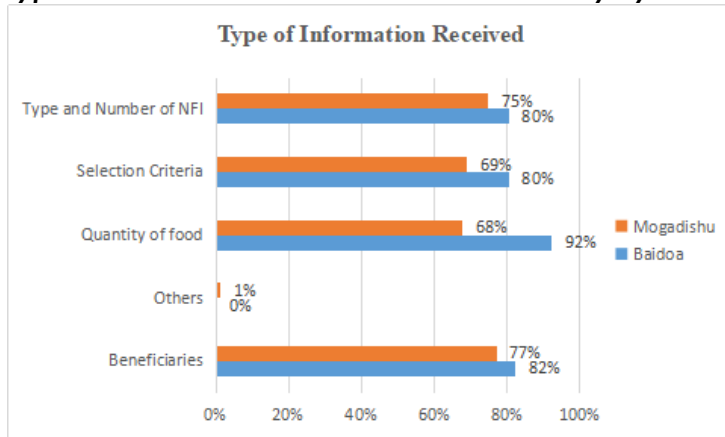
The chart to the left shows the percentage of respondents who received information on type and number of NFIs, selection criteria, beneficiaries and quantity of food to be issued prior to the commencement of the project. 92% and 68% in Baidoa and Mogadishu district respectively stated that they had received information about the quantity of food to be received. In Baidoa, 80% said they had information about the selection criteria and type and number of NFIs before these phases were implemented. The type and number of NFIs was the least shared information in Mogadishu District with 75% of the 87 respondents receiving the information while in Baidoa the quantity of food to be received was reported to be the least shared information.

**Participation:** Analysis of the data from Baidoa and Mogadishu gave the results shown in the chart below. A total of 65 and 64 of all respondents in Baidoa and Mogadishu districts respectively participated in the assessment, implementation, monitoring and planning. 68% of those in Mogadishu and 61% in Baidoa felt that they participated in the implementation. In Mogadishu district, 92% were involved in the implementation stage and 94% in Baidoa were involved in the assessment stage. The lowest involvement was in the monitoring stage, at only 37% in both Baidoa and Mogadishu.

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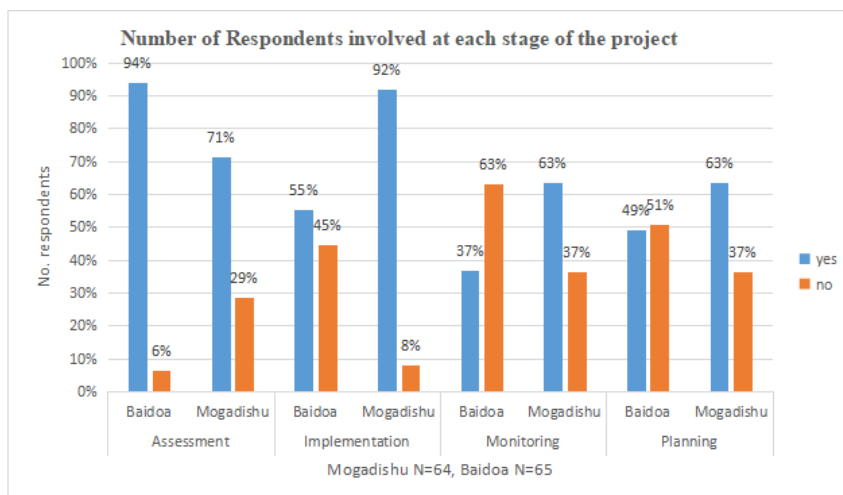
Beneficiary feedback: The CRM included the following components:
▪ Dedicated telephone line and email address.
▪ Complaints boxes provided in each area of implementation, so beneficiaries could voice concerns.
▪ Visible and transparent communication with communities.
▪ On-site monitoring, daily and weekly.
▪ During assessments, beneficiary selection, implementation, monitoring and feedback

was elicited from camp committees such as the beneficiary selection committee, health committee, and water committee.

- During distribution, three types of monitoring were utilised including phone, help desk and complaint box
- Information boards were used to explain entitlements and criteria e.g. food basket.
- Feedback was collected weekly and analysed. Feedback was also provided via community meetings
- In phase 2, a complaints tracker was introduced, logging the complaints and follow up.
- Ongoing awareness raising on feedback channels.

Challenges and potential improvements highlighted by KIs and FGDs were:

- Information sharing should be more consistent rather than a one-time activity.
- Information was flowing but could have been improved.
- Distributions were conducted close to camps but not inside. There was good communication on the distribution plan and collection points but some concerns that more could have been done to make sure people didn't need to pay to get to distribution points. In response to this issue, the IRW team has a robust selection criteria for distribution sites and therefore it may be difficult to overcome the challenge identified. The criteria are as follows
  - ➢ Availability of distribution space in the camp to accommodate smooth distribution exercise. Most of the camps are congested and getting a big space around the camp is usually a problem;
  - ➢ Security. Vast number of IDPs camps are located at the outskirts of the town. The distribution of food or non-food items in the camp could cause security challenges.

47 appears in right margin
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Quality Criterion 5: Complaints are welcomed and addressed. Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.

Core Question:
1. Did beneficiaries have access to safe and responsive mechanisms to handle complaints?
2. Were the most effective solutions applied in addressing different complaints?

Key Indicator: Rating of the effectiveness of complaint mechanisms

Overall Rating:	3

Overall approach to complaints and response mechanism
The components of the new mechanism were reported as:

- Confidential complaint channels had been established: Suggestion/complaints boxes were provided, and contents were collected and analysed. Feedback was provided via meetings. Information boards displayed contact details informing people how they can call, text-message or email a staff member outside the project area (e.g. Mogadishu), who was not involved in the distribution.
- Complaint logging and tracking was done using a central database. An independent complaints focal person responds to complaints.
- Response procedures established: Complaints are processed and responded to by M&E Coordinator at country level within 7 days. If they involve a high-level risk such as a protection issue, they would be flagged to HQ and responded to within 15 days.

- Provision of training to field staff to sensitize and mobilise the community to provide feedback.

Awareness of complaints and response mechanisms: 70% of the respondents in Baidoa District and 89% in Mogadishu were aware of CRMs. Approaching the office desk was the most popular method in both districts (97% in Baidoa and 60% in Mogadishu). In Baidoa, only 3% were aware that they could use the complaints box whereas in Mogadishu only 2% were aware of the Hotline. This is due to the high illiteracy levels throughout. 12% of those who are aware of the CRMs have used them in Baidoa District while 7% of those who are aware in Mogadishu have used them. In Baidoa, 50% of those who forwarded complaints reported that they received a response in a timely manner and the other 50% were resolved. 100% of those who forwarded complaints in Mogadishu reported they received a response in a timely manner and the issues were resolved.

Feedback and complaints reported: The main feedback and complaints reported by IRW staff and in FGDs were:

- Beneficiaries lost ration cards
- Feedback on quantities and quality of food received
- Request for more information on what would come in 6 months/1 year
- Questions about the project timeline, dates of distributions, etc.
- Provision of health care
- Food shortage
- Request for permanent shelter rather than temporary
- Income generating activities
- Education for children
- Protection.

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Handling of complaints: Feedback that was not high risk or complex was quickly responded to and resolved. Staff reported that no serious or complex feedback or complaints were received. This was verified by FGD participants, who reported that complaints were listened to, considered and answered in a timely and appropriate way with clear explanations. FGDs confirmed that complaints were handled confidentially. This has not been verified by project documentation.

Reasons for not using CRM: The reasons why beneficiaries failed to use the CRMs when needed in Mogadishu, were; i) lack of confidentiality, ii) lack of the understanding them or iii) lack of comfort in using them. This was due to Illiteracy, lack of phone or difficulty in reaching the office. Future projects could consider more awareness raising is needed to ensure beneficiaries know the CRM is confidential and they can trust the system.

The respondents acknowledged that there were challenges experienced in accessing the CRMs. In Baidoa District, 66% of the respondents reported that the lack of knowledge about how to use the CRM was the major challenge in accessing the CRM. The main reason identified by 48% of respondents in Mogadishu was the lack of a proper channel of communication. Other reasons identified were complaints without genuine reasons, lack of commitment from IRW staff, and lack of clear feedback mechanisms.
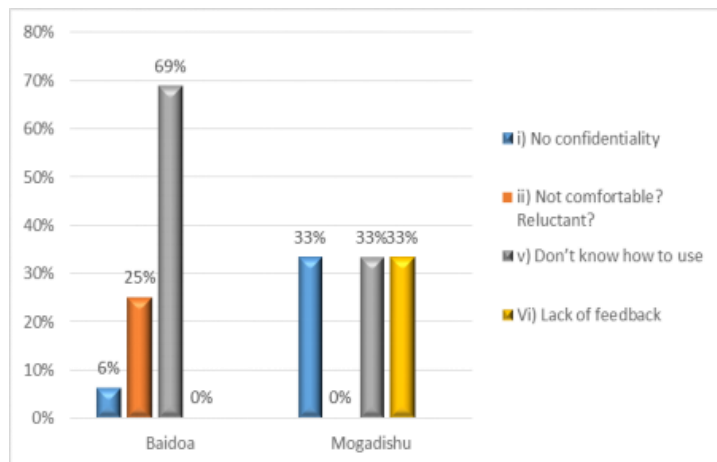
Challenges to achieving an effective CRM: 66% of respondents in Baidoa felt there was a lack of good information about the CRM whilst 48% in Mogadishu thought there was no proper channel of communication (see chart below).

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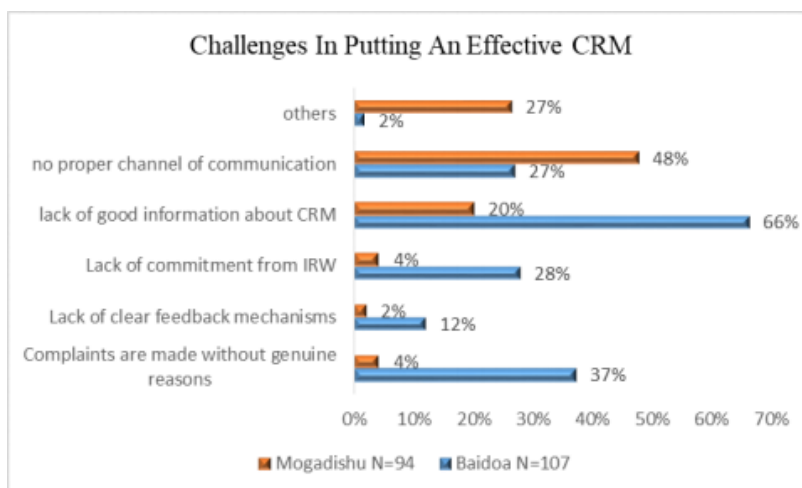
KI interviews and FGDs cited the following challenges to delivering an effective CRM:

- A phone number was not an effective channel for feedback because beneficiaries did not always have access to a phone or want to use one to communicate.
- There were very few complaints or feedback, indicating that awareness raising was not necessarily effective.
- High levels of vulnerability and therefore the possibility that beneficiaries may perceive that aid would be stopped if they made a complaint.

Suggested improvements: The table below shows the suggestions given by the respondents of how the CRMs and feedback to the community can be further improved:

The suggested areas of improvement in % of total respondents Baidoa N=107, Mogadishu N=94

Type of improvement	Baidoa	Mogadishu
Handling the complaints with high level confidentiality	59%	43%
More information sharing on CRM	32%	32%
Timely feedback to the community	69%	21%

Use of multiple channels	18%	10%
Other	0%	19%

Improvements needed that were highlighted in FGDs and KI interviews:

- Further disseminate information on CRM
- Increase number of visits to each box to ensure ongoing sensitisation and consistent follow-up and response times
- Focal person should be independent of project implementation otherwise their focus is on delivery and they won't look into it further. This is now the M&E Coordinator.

Quality Criterion 6: Humanitarian response is coordinated and complementary.

Core Questions:
1. What level of complementarity and coordination did this project have with other projects?
2. Were beneficiary selection and verification process effective in ensuring that assistance reaches the most vulnerable families among affected population?

Key Indicators:
1. Rating of complementarity and coordination performed by the program with other initiatives
2. Rating of effectiveness of beneficiary selection and verification

Overall Rating:	3

Approach to Coordination: Overall coordination was viewed as a success and that IRW was highly visible and well known in the areas of implementation. Coordination through 3W and mapping of other NGO activities was conducted to avoid duplication. Cluster meetings were well attended for all sectors and took place at Mogadishu and Baidoa levels. Coordination meetings were held with other DEC implementers and assistance was shifted if they were covered by other organisations. Regular health reports were compiled and submitted to MOH and WHO. Coordination on security was consistently reported as a success, including coordination with local authorities and other agencies, as well as a good understanding of local context. Coordination in Baidoa was considered weaker, but improved throughout the project due to engagement with other agencies working in the area and with clusters to fill gaps in assistance. In addition, the project effectively collaborated with the MOH to provide training to healthcare staff.

Quality Criterion 7: Humanitarian actors continuously learn and improve. Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection.

Overall Rating:	2

Lessons learned
Key learning from three other DEC evaluations in South Sudan, Ethiopia and Somalia were incorporated into the project in the following ways:
- Lesson: Better targeting and focus to improve response programming. In the previous DEC response, wide geographic coverage was difficult to manage effectively. Response: Coverage was considered to be appropriate and achievable in this project.

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- Lesson: Increase engagement with the community during the first phase and work with all stakeholders, beneficiaries and government for better informed responses. Response: Worked more with the Ministries at all levels and with local authorities. Used beneficiary input to inform the design of Phase 2.
- Lesson: Insufficient monitoring. Response: Increased frequency of monitoring, to include weekly updates (since Jan 2018).
- Lesson: Lack of follow up to complaints. Response: tracking sheet in place and a complaint is now tracked until it has been resolved.

There was insufficient evidence gathered regarding how lessons were continually fed back into the project cycle management to improve delivery. Overall it will be important for IRW to document learning and incorporate learning from previous evaluations in a more comprehensive and systematic way, as well as document how learning has been used in future work.

Quality Criterion 8: Staff are supported to do their job effectively and are treated fairly and equitably.

Core Question: Did communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers?
Key Indicator: Rating of competence and management of staff and volunteers

Overall Rating:	3

All staff working on the project were required to sign a Code of Conduct before signing their employment contracts. All staff received inductions on the Code of Conduct. Complaints and grievance procedures are in place, as well as a Whistle-blowing policy. The policies have been received and verified by the evaluation team.

Insufficient evidence was collected to comprehensively review and evaluate this criterion.

Quality Criterion 9: Resources are managed and used responsibly for their intended purpose.

Core Questions:
1. Were the modalities and mechanisms of implementation cost-effective and efficient?
2. Were adequate human and financial resources applied to deliver the project outputs and outcomes?
3. Were risks managed effectively?

Key Indicators:
1. Rating of the cost-effectiveness of the voucher project and food kits project
2. Rating of efficiency in the allocation of human and financial resources
3. Rating of effectiveness of risk management

Overall Rating:	3

KI interviewees cited a number of factors that contributed to the project outputs being delivered to the highest quality at the lowest costs. These were the timely implementation of projects activities, suppliers delivering directly into the camps (a common practice in Somalia

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that helps reduce delays), effective procurement processes, availability of food, and the ability to negotiate lower prices. Key themes identified are elaborated below:

Resources gaps: No major resources gaps were identified by any key informants. Some challenges identified were distances between implementation areas, numbers of staff and overhead costs not sufficient for the size and scope of the project, limited resources compared with the needs of the population and the increase of IDPs to the project areas.

Personnel costs: DEC feedback suggested that personnel costs were the highest for projects in Somalia, 9% higher than the average across all members. This was because IRW implemented the project directly in both Mogadishu and Baidoa, and 24 new emergency staff were recruited to ensure smooth and timely implementation of activities. It is recommended to highlight the number of healthcare related staff directly engaged in the project in future DEC project submissions. Additionally, MEAL Coordinator, Security and media team members were % charged as per their expected contribution to the project. Staff from the surge capacity roster were deployed to support scaling up of the emergency response. This included an Emergency Project Manager and Emergency Field Coordinator. Regional staff based in Nairobi were involved in providing support to the Somalia team. The Regional Humanitarian Manager, Regional Media and Communication Coordinator, Regional Desk Coordinator, Regional HR Manager and Regional Finance Manager all provided ongoing support through regular visits and follow up. For future projects, it should be noted that it is becoming more challenging to fund response related positions not located in Somalia. This should be factored into future budgeting.

Procurement: Procurement was reported as highly effective by regional and country KIs, however it was not possible validate procurement processes, through a review procurement documentation KIs highlighted that the project team were able to attain very competitive prices and managed to lower estimates and reach more beneficiaries as a result. KIs said that this was possible, because the procurement committee had a database of previous suppliers and performance, suppliers were selected based on previous experience, and good relationships made negotiation possible. Distributions processes were also streamlined and timely because suppliers delivered directly into the camps, a familiar practice in Somalia. No issues or delays were reported regarding the procurement of medicines, and they were in full compliance with WHO.

Contractors recruited were requested and encouraged, where possible, to hire local labour including from IDP communities, e.g. for digging latrines. There was no warehousing in the camps, so contractors used IDPs for unloading etc., which contributed to beneficiary capacity building and income generation. The community contribution was voluntary, e.g. spreading gravel for water drainage and around water points, etc.

9. Conclusions, Learning and Recommendations

9.1. Conclusions

Overall project achievements:
The evaluation found that overall project has been delivered in a timely way and all activities were delivered as per the project plan. Output data available demonstrates that the project has either met or exceeded all output targets, planned in the project proposal. Targets for beneficiaries supported with food, latrines and water facilities were exceeded. However, insufficient evidence has been provided regarding monitoring and achievement of project outcomes.

Evaluation against CHS Criteria:

Quality Criterion1: Humanitarian response is appropriate and relevant.

Overall Rating:	3

Overall, the project design and delivery were relevant and appropriate for the needs of the beneficiaries. The project design was based on initial needs assessments, beneficiary consultations, as well as coordination with local authorities, relevant clusters and other INGOs operating in the area. An additional assessment was conducted in January 2018. IRW had worked in the target locations previously and therefore had an understanding of the context and had developed good relationships with the communities. Cluster meetings and 3Ws were used to identify gaps and meet needs in areas where IRW was already operating. Beneficiary selection criteria were appropriate and relevant. The project was able to adapt effectively to the changing context and meet emerging needs of additional IDPs. However, there is no evidence that comprehensive advanced planning was conducted to anticipate changes in the context and emerging needs, but rather that it was approached in a reactive way.

Quality Criterion 2: Humanitarian response is effective and timely.

Overall Rating:	3

All deliverables were completed within the planned timeframe. Some slight delays were reported but the project commenced on time and activities were delivered as expected. The project approaches were found to be effective in meeting its objectives.

Quality Criterion 3: Humanitarian response strengthens local capacities and avoids negative effects.

Overall Rating:	2

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Capacity building components have been incorporated throughout the project activities. Some good examples were found of how the project strengthened local capacities, and resilience including active engagement of local stakeholders and development of skills. However, improvements were needed to sufficiently meet this criterion.

There was an insufficient focus on early recovery and resilience, considering the context and the protracted nature of the crisis. Activities were focused on meeting initial emergency needs of the IDP population. The potential longer-term evolution of the context was not comprehensively considered in planning and implementation. The distribution focus of the project could contribute to dependency on aid at the expense of building resilience and early recovery. Approaches more focused towards early recovery such as irrigation, kitchen gardens and repatriation of IDPs, could have also been considered. It was also suggested that there was insufficient in-depth analysis of beneficiary needs and capacities that could have contributed to early recovery approaches. The project would have benefitted from more in-depth needs analysis and consideration of the evolution of the context over the two-year time frame.

Quality Criterion 4: Humanitarian response is based on communication, participation and feedback.

Overall Rating:	3

The mechanisms established to ensure beneficiary participation and feedback throughout the project were found to be effective overall. Information was effectively and appropriately

shared, received and considered satisfactory and there were significant examples of beneficiary participation. Some areas to consider for future project are that information sharing should be more consistent rather than a one-time activity.

Quality Criterion 5: Complaints are welcomed and addressed.

Overall Rating:	3

Communities supported by the project were found to have access to safe and responsive mechanisms to handle complaints. Awareness of the complaints mechanisms across beneficiary communities was generally high but few complaints were logged. No complex complaints were received and overall solutions to complaints made, were found to be satisfactory and timely. This could indicate high satisfaction with the project design and delivery, or that beneficiaries were reluctant to log complaints. Reasons for not using the CRM (lack of confidentiality, lack of the understanding them or lack of comfort in using them, due to Illiteracy, lack of phone or difficulty in reaching the office), should be explored in future projects. Alternative methods of collecting complaints could be sought, such as at meetings, involve beneficiaries in design of awareness raising and communications materials to ensure they are appropriate to literacy levels and ensure beneficiaries know the CRM is confidential and they can trust the system.

Quality Criterion 6: Humanitarian response is coordinated and complementary.

Overall Rating:	3

Overall coordination was evaluated as effective. There were examples of good collaboration with local authorities and Line Ministries, especially MOH and Ministry of Water in the area of training. Coordination through 3Ws and mapping of other NGO activities was conducted to avoid duplication. Cluster meetings were well attended for all sectors and took place at Mogadishu and Baidoa levels. Coordination meetings were held with other DEC implementers and assistance was shifted if it was covered by other organisations.

Quality Criterion 7: Humanitarian actors continuously learn and improve. Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection.

Overall Rating:	2

There was insufficient evidence gathered regarding how lessons were continually fed back into the project cycle management to improve delivery. Overall it will be important for IRW to document learning and incorporate learning from previous evaluations in a more comprehensive and systematic way, as well as document how learning has been used in future work.

Quality Criterion 8: Staff are supported to do their job effectively, and are treated fairly and equitably.

Overall Rating:	3

All evidence collected in the evaluation indicates that communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers. The Code of Conduct, Whistle-blowing Policy, Child Safeguarding Policy and Fraud Policy were all reported to be in place and included in inductions. However, insufficient evidence was collected to more comprehensively review and evaluate this criterion.

DEC feedback highlighted issues in data quality, quality of reporting and timeliness of reporting. Future projects should consider additional training and oversight on data collection and data management, reporting, DEC requirements and output monitoring.

Quality Criterion 9: Resources are managed and used responsibly for their intended purpose.

Overall Rating:	3

Modalities and mechanisms of implementation were found to be cost-effective and efficient. Adequate human and financial resources were applied to delivering the project outputs and outcomes. Risks were found to be managed effectively.

9.2. Learning and Recommendations

11. **Long term planning:**

Key Learning: Despite being a two-year project, the project was designed with an emergency mind-set, focusing on meeting emergency needs, without sufficient consideration of a longer-term approach. Early recovery and rehabilitation were not comprehensively addressed in project design and implementation. There was some scope to include recovery-focused approaches, given the context and the two-year timeframe.

Recommendation: Future projects would benefit from a detailed assessment into longer-term needs and capacities alongside emergency relief activities, for example at the 3-month stage, when initial needs had been met. A more comprehensive approach to planning for multi-year projects should be developed.

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12. **Contingency planning:**

Key Learning: Some of the contextual changes could have been anticipated in advance and planned for in a more systematic and comprehensive way. For example, there was no contingency planning for an influx of IDPs, or analysis of the potential vulnerabilities or capacities of additional IDPs, or specific scenario or preparedness planning. Although the project demonstrated good ability to adapt to the changing context, this was managed in a reactive and ad hoc way and should be improved in future projects.

Recommendation: Consider comprehensive contingency planning at project design stage. Establishing a rapid response mechanism could also enhance the project design and enable more streamlined response to new arrivals, disease outbreaks, or other emergencies.

13. **Recovery and resilience:**

Key Learning: There were some positive examples of how the project enhanced local capacities, but the project was short term and emergency focused, prioritising delivery and distributions.

Recommendation: Consider a more comprehensive approach to early recovery and resilience in future projects. Strengthening the involvement of local resources and local capacity building would support resilience and empowerment, and ultimately a longer-term impact. The feasibility of income generating activities such as kitchen gardens are options to assess for future projects, as well as involvement of IDPs to identify solutions and early recovery ideas. Future projects would also benefit from a more deliberate focus on host communities, as well as IDPs.

14. **Communication, participation and feedback:**

Key Learning: Communication and participation were found to be high during assessment and implementation. However, results were lower for planning and monitoring. It was also found

that understanding of particular activities was potentially low, for example why and how to treat water and vector control.

Recommendation: For future projects, ensure sustained project communication throughout the life-cycle of the project. Ensure complicated messages are communicated using appropriate methods. Consider more targeted communications methods, for example, geographical variations. Include more training for staff, and follow-up sessions in communities.

15. **Complaints mechanisms:**

Key Learning: Ongoing monitoring of the new CRM that has been established is recommended, with comprehensive documentation to evaluate its effectiveness and capture useful learning. Whilst awareness of CRM system is high, the understanding of how to use the system remains an impediment to access and ensuring feedback and complaints are received. In Baidoa District, for example 66% of the respondents reported that the lack of information about the CRM was the major challenge in accessing it. The main reason identified by 48% of respondents in Mogadishu was the lack of a proper channel of communication. IT is clear that high awareness of CRM systems does not necessarily translate into high use of the systems. Trust and understanding how to use the systems create significant barriers, especially in communities where illiteracy is high.

Recommendation: Ongoing monitoring of the new system is recommended, with comprehensive documentation to evaluate its effectiveness and capture useful learning. In the Somalia context, it will be important to invest in further work to ensure that beneficiaries know how to use, and are comfortable accessing the mechanisms established, and that they are adequately adapted to ensure relevance for rural and remote areas, where beneficiaries are likely to be less familiar with them.

16. **Inclusion, protection and gender:**

Key Learning: Inclusion, protection and gender were not systematically considered throughout the project design and implementation. The specific constraints faced by vulnerable groups were not assessed in a through way. It was assumed that the availability of services automatically resulted in vulnerable groups having access, without thorough assessment of the barriers that might prevent access, or specific examples of how activities had been adapted to address these challenges. Although latrines were gender segregated, the latrines were only set one meter apart, and beneficiaries perceived this as potentially unsafe for women and girls. Space was a major constraint, but this should be considered in future projects, with women included in identifying alternative solutions in the design process.

Recommendation: Gender and Disability and Age Inclusion Advisors should be involved in future projects to ensure these aspects are comprehensively addressed in future design, implementation, monitoring and evaluation, including ensuring that feedback on gender, protection and inclusion issues are recorded and addressed in project design and adaptation.

17. **Technical approaches:**

Key Learnings and Recommendations: Technical approaches were limited to emergency approaches and would benefit from consideration of rehabilitation and recovery to ensure more sustainability.

- Use of cash: use of cash-based approaches could have been assessed more comprehensively.
- Shelter: The insufficient quality of shelter materials and possibility of providing semi-permanent designs for shelter should be considered for future projects, as well as seeking advice from, and coordination with, the Shelter Cluster and feeding in lessons learned.
- Health exit strategy: Increased planning and coordination around health facilities could have increased sustainability. When supporting a fixed health facility, give preferential support to an existing one. Aim to obtain land from government or donated by the local community for additional facilities. If it is on private land it is almost

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impossible to pursue a successful exit strategy and for the MOH to take it over. This has been a considerable issue for health actors in the past. Assess if the facility meets WHO criteria, for example catchment population. This will improve the potential to incorporate the facility into the existing health system. If possible ensure MOH can provide staff even if they require incentives. More in-depth engagement with local authorities, WHO and other heath actors is recommended.

- Latrines: With the additional influx of IDPs to the camps, the risk of latrines becoming overburdened is a concern for the project team. Before the end of the project period, the project team should prioritise exploring options for further emergency funding for additional latrines. They should also discuss this with the WASH cluster and UNICEF to identify other partners with resources.
- As the camps were built on private land, the ability to prevent congestion was limited, and agencies are subject to the conditions set out by the landlords. This meant that the role of NGOs is more challenging as they had to negotiate with the landlords and support the IDPs in advocating for themselves – rather than a dedicated camp management agency. Furthermore, construction and town development continued, which reduced space for IDP settlements, and meant IDPs could face demolition, or forced evictions if the landlord decided to use the land for another purpose.

18. **Technical support:**

Key Learning: The project would have benefitted from dedicated and consistent engagement of technical experts thereby contributing to a more strategic approach to design and implementation. Specifically, there were gaps in the expertise of shelter, food and WASH Advisors.

Recommendation: For future projects, IRW is recommended to identify a technical advisor for each sector. If they are not available globally consider adding them as part of the response team at RO or project level, depending on the size of the response.

19. **Learning:**

Key Learning: This is an area that was consistently highlighted as weak at an organisational level and the evaluation data collected showed a lack of in-depth consideration of learning from previous DEC evaluations and limited systematic synthetisation of lessons learned and incorporated into project design and delivery.

Recommendation: A more comprehensive approach to learning could be embedded ensuring lessons are captured and documented into a learning log. These should be readily accessible to inform future DEC responses. Evaluation reports should be shared with future response teams.

20. **Coordination with DEC Members:**

Key Learning: IRW should continue ongoing and comprehensive collaboration with other organisations in the DEC and maximise information sharing to ensure interventions are coordinated.

Recommendation: Collaborative feedback to DEC on funding and implementation issues would also be advantageous. Important current challenges where a collective approach with other DEC Members could be advantageous, are embedding safeguarding practices into programming, ensuring the necessary checks and controls are in place, reflecting localisation in programming, ensuring beneficiary engagement and capacity development, and the design of multi-year projects.

10. Data quality

The BOND principles were used to assess the quality of evidence collected against a checklist. A score is included below for each category:

Principle	Criteria	1	2	3	4	N/A	Comments/ Evidence
1. Voice and Inclusion We present beneficiaries views on the effects of the intervention, and identify who has been affected and how	1a. Are the perspectives of the beneficiaries included in the evidence				X		
	1b. Are the perspectives of the most excluded and marginalized groups included in the evidence			X			Attempts were made to have FGDs that were representative of all groups, but full details and numbers of vulnerable groups were not available/collected.
	1c. Are the findings disaggregated according to sex, disability and other relevant social differences			X			Where possible numbers were disaggregated although not all social differences were captured
	1d. Do beneficiaries play an active role in the assessment process			X			Beneficiaries were engaged in data collection via focus groups and KIIs, however they were not involved in the design of the tools. due to time constraints.
	Score for Voice and Inclusion						13/16

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Principle	Criteria	1	2	3	4	N/A	Comments/ Evidence
2. Appropriate-ness We use methods that are justifiable given the nature of the intervention and purpose of the assessment	2a. Are the data collection methods relevant to the purpose of the assessment and do they generate reliable data				X		
	2b. Is the size and composition of the sample in proportion to the conclusions sought by the assessment				X		
	2c. Does the team have the skills and characteristics to deliver high quality data collection and analysis				X		
	2d. Do the methods for analysis unpack the data in a systematic way and produce convincing conclusions				X		
	Score for Appropriateness						16/16

Principle	Criteria	1	2	3	4	N/A	Comments/ Evidence
3. Triangulation	3a. Are different data collection methodologies used and different types of the data collection?				X		

		1	2	3	4	N/A	
We make conclusions about the intervention's effects by using a mix of methods, data sources and perspectives	3b. Are the perspectives of the different stakeholders compared and analysed in establishing if and how change has occurred?			X			Lack of local authority input.
	3c. Are conflicting findings and divergent perspectives presented and explained in the analysis and conclusions?			X			Where possible this has been reflected in the evaluation, although this was not exhaustive.
	3d. Are the findings and conclusions of the assessment shared with and validated by a range of key stakeholders (e.g. beneficiaries, partners and peers)?			X			Findings were validated where possible through triangulation and sharing of the report, but this was not possible to achieve on all levels.
	Score for Triangulation						13/16

Principle	Criteria	1	2	3	4	N/A	Comments/ Evidence
4. Contribution We can show how the change happened and explained how we contributed to this	4a. Is a point of comparison used to show that change has happened (e.g. a baseline, counterfactual, comparison with similar group?)			X			This was reflected in the report where possible, however it was not always possible due to a lack of baseline information to do this across all areas and no comparison with similar groups.
	4b. Is the explanation of how the intervention contributes to change explored?			X			This was explored; however, the response is ongoing and not all interventions have been completed. In addition, indicators were predominantly at output not outcome level.
	4c. Are alternative factors (e.g. the contribution of other actors) explored to explain the observed result alongside an intervention's contribution?			X			We were able to assess some elements, e.g. in discussions with RO about agencies running other camps but verification was limited
	4d. Are unintended and unexpected changes (positive or negative) identified and explained?				X		

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	Score for Contribution						11/16

Principle	Criteria	1	2	3	4	N/A	Comments/ Evidence
5. **Transparency** We are open about the data sources and methods used, the results achieved and the strengths and limitations of the evidence	5a. Is the size and composition of the group from which data is collected explained and justified				X		
	5b. Are the methods used to collect and analyse data and any limitations of the quality of the data collection methodology explained and justified?				X		
	5c. Is it clear who has collected and analysed the data and is any potential bias they may have explained and justified?				X		
	5d. Is there a clear logical link between the conclusions presented and the data collected				X		
	Score for Transparency						16/16

11. Annexes

Annex A: Terms of Reference for the evaluation
Annex B: Documents consulted during the evaluation
Annex C: List of KI Interviewees
Annex D: HH Questionnaire
Annex E: FGD Template
Annex F: KII Interview Template for Field Interviews
Annex G: Health Facility Checklist
Annex H: In-depth KII Interviews Template for IRW Staff
Annex I: Organisation details
Annex J: Evaluation team composition
Annex K: Evaluation schedule

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![The Operations Partnership logo]

Islamic Relief Worldwide Management Response to DEC Somalia Response Program Phase 1 and 2 Evaluation (July 2018).

Overview

Islamic Relief Worldwide (IRW) is committed to improving the quality and accountability of its humanitarian programmes. As part of its accountability to the DEC, IRW conducted an external evaluation of its Phase 1 and 2 DEC funded Emergency programme in East Africa. The purpose of this evaluation was to:

- Assess the extent to which the programme objectives were achieved.
- Facilitate self-analysis of overarching lessons learned.
- Make recommendations that will influence future interventions of Islamic Relief Worldwide, our partners in Somalia as well as other countries, and also to guide future humanitarian strategy.

This was an external evaluation that went through a competitive bidding process. The intended users of this evaluation are: IRW, IRW's Somalia Country Office, the DEC, and the Humanitarian community.

IRW implemented this project through its own country office in Somalia. The evaluation lasted for a period of thirty days and included travel to project areas.

Overall response

The evaluation assesses the overall performance of the project, but also provided useful recommendations which goes beyond the project. Islamic Relief positively received the findings and will adopt the recommendations.

Details of how IRW will action the recommendations can be found in the table below.

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
		Long-term funding is quite scarce and very competitive. Currently there are three main consortiums who work on resilience programme with funding from DFID, USAID and EU. Unfortunately IR is not part of those set ups. There are					62
Future projects would benefit from a detailed assessment into longer-term needs and capacities alongside emergency relief activities, for example at the 3-month stage, when initial needs had been met. A more comprehensive approach to planning for multi-year projects should be developed.	Partially accept	no other multi-year funding instruments at present. However, we will work on		Seek partnerships with NGOs involved in cash transfer programming	Country Director	Country Director	November 2018

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Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
		teaming up with other agencies so we can secure funds for recovery and development					
Contingency Planning		.					
							63
Consider comprehensive contingency planning at project design stage. Establishing a rapid response mechanism could also enhance the project design and enable more streamlined response to new arrivals, disease outbreaks, or other emergencies.		IRW has established Rapid Response Fund from which countries office can draw funds for immediate response		Revise the Country Disaster Preparedness plan including the contingency planning	Country Director	Regional Director	October 2018
Recovery & Resilience							

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
Consider a more comprehensive approach to early recovery and resilience in future projects. Strengthening the involvement of local resources and local capacity building would support resilience and empowerment, and ultimately a longer-term impact. The feasibility of income generating activities such as kitchen gardens are options to assess for future projects, as well as involvement of IDPs to identify solutions and early recovery ideas. Future projects would also benefit from a more deliberate focus on host communities, as well as IDPs.	accept	The resilience programming is central part of IR Somalia 2017-2021 strategy	High	Ensure that the design of new projects is aligned with the country strategy	HoP	Country Director	64 Continuous
Communication, Participation, and Feedback							

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
For future projects, ensure sustained project communication throughout the life-cycle of the project. Ensure complicated messages are communicated using appropriate methods. Consider more targeted communications methods, for example, geographical variations. Include more training for staff, and follow-up sessions in communities. Accept	Accept		High	We will develop communication messages in local languages	Communications Officer	Country Director	Continuous
Complaints Mechanism							65
Ongoing monitoring of the new system is recommended, with comprehensive documentation to evaluate its effectiveness and capture useful learning. In the Somalia context, it will be important to invest in further work to ensure that beneficiaries know how to use, and are comfortable accessing the mechanisms established, and that they are adequately adapted to ensure relevance for rural and remote areas, where beneficiaries are likely to be less familiar with them.	Accept	We have communicated entitlements to the beneficiaries in both local and English languages, provided complaint response mechanisms such boxes, telephone	High	Further strengthen the system. Raise awareness on the importance of complaints and feedback mechanisms.	HoP	Country director	Continuous

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
		numbers and contact person					66
Inclusion, Protection, and Gender							

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
Gender and Disability and Age Inclusion Advisors should be involved in future projects to ensure these aspects are comprehensively addressed in future design, implementation, monitoring and evaluation, including ensuring that feedback on gender, protection and inclusion issues are recorded and addressed in project design and adaptation.	Accept		High	Protection and Inclusion is part of the initial needs analysis Provision is budgeted for appropriately Training and sensitisation provided by Global advisors to identified countries	Global operations	PQ	67 Continuous
Technical Approaches							
Use of cash: use of cash-based approaches could have been assessed more comprehensively.	Accept	IR did not have prior experience in Cash-based programming in Somalia. In May 2018, we developed a cash-based programming	High	Establish a system for cash-based programming; train staff on its use and roll	IRW to approve the guidelines Regional FSL and regional FM to train staff	Country Director	November 2018

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
		guidelines for East Africa region. We also take part in the CALP in Nairobi.					
Shelter: The insufficient quality of shelter materials and possibility of providing semi-permanent designs for shelter should be considered for future projects, as well as seeking advice from, and coordination with, the Shelter Cluster and feeding in lessons learned.							68

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
Health exit strategy: Increased planning and coordination around health facilities could have increased sustainability. When supporting a fixed health facility, give preferential support to an existing one. Aim to obtain land from government or donated by the local community for additional facilities. If it is on private land it is almost impossible to pursue a successful exit strategy and for the MOH to take it over. This has been a considerable issue for health actors in the past. Assess if the facility meets WHO criteria, for example catchment population. This will improve the potential to incorporate the facility into the existing health system. If possible ensure MOH can provide staff even if they require incentives. More in-depth engagement with local authorities, WHO and other heath actors is recommended.	Partially Accept	Over the past five years, we tried to handover two health facilities to the ministry of health. Unfortunately, the MoH could not take over the facilities due to lack of funds to continue the services.	High	Continue the dialogue with MoH in order to pave the way for staggered handover of the facilities.	HoP	Country Director	69 Mid 2019

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
Latrines: With the additional influx of IDPs to the camps, the risk of latrines becoming overburdened is a concern for the project team. Before the end of the project period, the project team should prioritise exploring options for further emergency funding for additional latrines. They should also discuss this with the WASH cluster and UNICEF to identify other partners with resources.	Partially accept	The new influx overwhelming the latrines were not foreseen during the project design. Secondly many donors do not often provide funds for activities that are contingent upon future developments.	Medium	IR will make more efforts to ensure future response interventions consider changing scenarios.	Emergency Programme Manager	Country Director	70 Continuous

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
As the camps were built on private land, the ability to prevent congestion was limited, and agencies are subject to the conditions set out by the landlords. This meant that the role of NGOs is more challenging as they had to negotiate with the landlords and support the IDPs in advocating for themselves – rather than a dedicated camp management agency. Furthermore, construction and town development continued, which reduced space for IDP settlements, and meant IDPs could face demolition, or forced evictions if the landlord decided to use the land for another purpose.	Accept	This is happening as powerful landlords and gatekeepers have grabbed large swath of land during the years of chaos in Somalia. The government does not still have the power and means to bring them under control.	High	We will continue to work with the ongoing advocacy by the NGO forum and the UN on the protection of IDPs from evictions	Country Director	Regional Director	71 Continuous
Technical Support							

Evaluation recommendations	Do we accept, partially accept or reject the recommendation?	Reasons for response	Priority level	Actions to be taken	Who is responsible for doing it	Who is accountable for ensuring action takes place	Timeframe
Long Term Planning							
For future projects, IRW is recommended to identify a technical advisor for each sector. If they are not available globally consider adding them as part of the response team at RO or project level, depending on the size of the response.	Accept		High	Recruit more technical sector specialists	IRW	IPD Director	Dec 2019
Learning							
A more comprehensive approach to learning could be embedded ensuring lessons are captured and documented into a learning log. These should be readily accessible to inform future DEC responses. Evaluation reports should be shared with future response teams.	Accept	Our progress reports, evaluation report capture lessons learned from project.	High	IRW Programme Quality Department will lead on establishing knowledge management system	IRW	PILM	72 June 2019