YEMEN CRISIS DEC APPEAL PHASE II
FINAL EXTERNAL EVALUATION REPORT

Save the Children
Yemen Country Office

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Save the Children

The Republic of Yemen
Ministry of Public Health
& Population

Leading Yemen to Better Health Safety and Well Being

Yemen Crisis DEC Appeal Phase II: Final Evaluation Report

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Project Title:	Lifesaving health, nutrition and wash for conflict-affected children in Lahj and Taiz governorates in Yemen"
Project Location:	Lahj and Taiz Governorates - Yemen
Implementation Period:	1st of July 2017 –31st of August 2018
Project funded by:	Disaster Emergency Committee (DEC)

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Project Summary

Title	Final Evaluation report
Date of report	10th December 2018
Author	Ahmed Tammam
Name of the project	"YEM Yemen Crisis DEC Appeal Phase II"
Project Start and End dates	1st of July 2017 –31st of August 2018
Project duration	(14 months)
Project locations:	Lahj and Taiz governorates
Thematic areas	Health & Nutrition
Sub themes	Humanitarian health & nutrition Maternal, infant and young child nutrition Water, sanitation and hygiene (WASH)
Total budget	Total: 2,210,161 Funding office: 144,590 (SCUK expenditure forecast) Implementing office: 2,065,571 (Yemen CO expenditure forecast)
Donor	Disaster Emergency Committee (DEC)
Estimated beneficiaries	Planned net reach by sector: WASH 139,240 Health 135,291 Nutrition 31,234 Total net individual: 305,765
Overall objectives:	• Vulnerable populations, including IDP, returnee and host communities have access to quality, integrated, primary health care. • To contribute to a reduction in morbidity and mortality related to acute malnutrition amongst children under 5 years of age and pregnant and lactating women. • Children and their families have access to safe water, improved sanitation facilities and the knowledge and attitude towards practicing good hygiene behavior

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List of Acronyms

CHS	Core Humanitarian Standards
CHV	Community Health Volunteer
CRM	Complaint Response Mechanism
DEC	Disaster Emergency Committee
DFID	Department for International Development
FGDs	Focus Group Discussions
FSL	Food Security and Livelihoods
GAM	Global Acute Malnutrition
HCs	Health Centers
HNO	Humanitarian Needs Overview
IDPs	Internally Displaced Populations
IPTT	Indicators Performance Tracking Table
IYCF	Infant and Young Child Feeding
KIIs	Key Informant Interviews
MAM	Moderate Acute Malnutrition
MEAL	Monitoring, Evaluation, Accountability and Learning
MoPHP	Ministry of Public Health and Population
MoU	Memo of Understanding
MTMSGs	Mother to mother support groups
OFDA	Office of Foreign Disaster Assistance
PLWs	Pregnant and lactating women
PMs	Project managers
RH	Reproductive Health
SAM	Severe Acute Malnutrition
SC (I)	Save the Children (International)
TAs	Technical Advisers
USD	United States Dollar
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization
WMC	Water Management Committee

Executive Summary

Since mid-March 2015, the conflict in Yemen has spread to 21 of 22 governorates, prompting a large-scale protection crisis and aggravating an already dire humanitarian situation in the poorest country in the Middle East. Conflict, displacement, and economic decline are placing compounding pressure on essential basic services and accelerating the collapse of the institutions that provide them. In December 2016, SC received financial support from the Disaster Emergency Committee (DEC) to respond to the humanitarian needs in Lahj and Taiz governorates. The humanitarian response by SC under the DEC support was implemented in two phases. The first phase of the response ran from December 2016 to June 2017 (six months). Funding was extended into DEC phase two from July 2017 to end of August 2018 (14 months). During Phase 1, SC supported health facilities with emergency medical supplies (that included supplies for the cholera response), general medical supplies for health & nutrition, distributed mosquito nets & hygiene kits and rehabilitated latrines & water schemes in all supported Health Facilities. All activities under the project were conducted in coordination with the Ministry of Public Health & Population (MoPHP). For Phase 2 SC has been focusing on the cholera response, conducting awareness sessions on cholera prevention, rehabilitating community water schemes to provide clean water, building latrines at community level and continuing the provision of medical supplies to HFs. SC has also been conducting measles vaccinations in its area of intervention and continued to work in coordination with the MoPHP.

In September 2018, Save the Children (SC) Yemen country office hired an experienced consultant to carry out a final evaluation for DEC phase 2 project, with the purpose to:

- Assess the project's performance and achievements vis-à-vis the project's overall objectives, the project indicators in the logical framework;
- Assess the effectiveness and the efficiency of the methodologies used throughout the project;
- Generate lessons learned from the implementation of activities and the outcomes achieved; and
- Develop specific recommendations to guide future programme management and design.

In addition, the evaluation questions sought to assess the programme against the nine Core Humanitarian Standards (CHS). The methodology employed a combined qualitative and quantitative data approach, triangulating primary and secondary data to ensure findings as comprehensive, credible and clear findings as possible, taking into account access limitations due to the ongoing conflict. Key project stakeholders were identified through the review of secondary documents and confirmed through consultations with the evaluation focal point at SC.

The project's health component was highly relevant to the context given the lack of quality of health services in the conflict-affected communities reached, due to a lack of trained health personnel and medication. The nutrition component and water, sanitation and hygiene (WASH) components were relevant to the chronic malnutrition situation in Yemen. The intervention was also in line with the priorities of Yemen Humanitarian Needs Overview (HNO) as well as the SC Yemen Country Office 2016-2018 country strategy plan. There was consensus among respondents that the project had responded to the priority health and nutrition needs of both IDP and host communities and the capacity needs of the MoPHP and health centre personnel. Effective preparatory activities meant that the project was able to start on time, but it did encounter delays due to complex Human Resources and procurement procedures. During implementation the project successfully remained relevant and effective in the face of a fluctuating context by identifying successful mitigation measures and adapting its activities to changing needs. Project indicators remained on track even when significant additional activities (such as a cholera response) were included. The project's integrated and community-based both were reported by both community and MoPHP respondents as also enabling a more effective project and increasing the added-value of SC's intervention. It was also found to be a more cost-effective operational approach. However, it should be noted that whilst the WASH component of the project was seen as appropriately gender-sensitive, this was not the case for the health centres which, for example, did not have sex disaggregated toilets, and were also not accessible for persons with disabilities.

The project targeted health centres based on needs identified using health indicators and district-level vulnerability data which was analysed in collaboration with the MoPHP and the health and nutrition clusters. To ensure a degree of sustainability after the end of the project, various measures were put in place such as, implementing the project activities in line with the existing government or traditional systems and protocols, using the local services and suppliers as much as possible, and employing local community mobilizers to increase coverage and act the link between communities and

SC. However, it was noted that local structures and health personnel will struggle to fully maintain activities without external support; in particular, the availability of medicines and activities related to nutrition. On the other hand, respondents felt that the project had helped raise awareness amongst community of their rights to health and nutrition services. Nevertheless, the lack of an appropriate exit strategy is a notable weakness.

Engagement with community member and beneficiaries was ensured throughout the programme cycle at regular intervals. One of the key success of this project is the well-established monitoring, evaluation, accountability and learning (MEAL) system, the SC indicator performance tracking table (IPTT) was used effectively to monitor progress and accountability mechanisms such as the CRM were found to well trusted and used by the community, including women. No negative feedback or complaint was received against SC throughout the project. Another best practice related to connectedness was that SC regularly coordinated with the respective Health, Nutrition, WASH and food security and livelihoods (FSL) sub clusters which include United Nations agencies, international non-governmental organisations (INGOs) and governmental authorities. However, it was noted by SC staff that coordination was primarily focused on the national level and that more efforts could have been driven for better coordination and advocacy at the district level, and with the cluster in regarding to campaigns.

Overall SC country office and field office staff are and feel well-supported, they receive key briefings on Child Safeguarding and Fraud. It was noted that the project staff are using project resources efficiently, they stick to the financial and HR protocols in terms of procurement procedures. Furthermore, the integrated approach provided a cost-effective solution for both SC and beneficiaries. However, the project stock shortages and delays due to the international procurement process for medication. This resulted in some negative perception of the project but should be caveated by the fact that there were high expectations of what medication would be provided and in what quantity, especially in regard to secondary health services which are not supported by the project.

Some of the key recommendations identified were:

At policy level:

- To strengthen the advocacy work of the project through a dissemination plan to present the project achievements to engage other donors to fund such integrated programmes and encourage cluster members to adopt the same approach.

At programmatic level:

- Rather than each project phase copying each other, programme teams should consider testing out more innovative approaches. For example, establishing supervisors at HC level, communicating through a unified reporting system, phasing in to other remote locations instead of working with the same health facilities without an exit strategy with a collapsed health system.
- The project theory of change was based on a community-based approach, raising health awareness at community level to drive demand for health and nutrition services. A good strategy in selecting such volunteers is ensuring that they come from the same location as their place of work to avoid people dropping out when the project ends and they no longer receive incentives that enable them to take transport means. Their roles and responsibilities towards ensuring programme quality should also be better communicated and understood.
- Plan for the availability of a buffer stock of medications to enable the project to start on time and avoid delays caused by international procurement processes, and to avoid shortages during implementation.
- Ensure that a gender and disability sensitive approach is adopted equally across all activities.
- SC to ensure a clear commitment with the MoPHP to sustain project outcomes. A sustainability/exit plan should be developed with the MOPHP and communities, including consultations with other partners.

At management level:

- To ensure that SC Yemen continues to ensure that its accountability mechanisms are accessible to the most vulnerable and hard to reach communities, and that they are aware of how to use these mechanisms.
- Strengthen the capacity and resilience of fixed health facilities so that they are able to respond to out-breaks e.g. Malaria, Diphtheria and cholera.
- To conduct the project planning with the local field offices according to the agreed implementation calendar taking into consideration the preparatory needs as well as the procurement and admin timeline

Introduction

Save the Children (SC) has been present in Yemen since 1963 and has one of the broadest geographical footprints in the country of all international non-governmental organizations (INGOs); implementing both emergency and development programming. SC's Yemen Country Office is in the capital, Sana'a and there are nine field offices in nine governorates (Aden, Amran, Ibb, Hajjah, Hodeida, Lahj, Sana'a, Sa'ada and Taiz). SC implements programmes in six different sectors (child protection & child rights governance, education, health, nutrition, water, sanitation and hygiene (WASH), and food security & livelihoods (FSL). SC employs over 400 national and 25 international staff across the nine governorates.[3]

Since mid-March 2015, the conflict in Yemen has spread to 21 of 22 governorates, prompting a large-scale protection crisis and aggravating an already dire humanitarian situation in the poorest country in the Middle East. Decades of poverty, poor governance, conflict and instability meant that Yemen was already ranked 160 out of 188 by the Human Development Index. It's almost four years into the conflict, and Yemen continues to experience one of the most severe humanitarian crises in the world, with large-scale displacement, severe deterioration of water and sanitation services, breakdown of the health care system, collapse of the economy and significant erosion of income generating capacity.[4]

In December 2016, SC received financial support from the Disaster Emergency Committee (DEC) to respond to the humanitarian needs in Lahj and Taiz governorates. This humanitarian response was implemented in two phases; the first ran from December 2016 to June 2017 (six months), then funding was extended into phase two from July 2017 to end of August 2018 (14 months). During Phase 1, SC supported health facilities with emergency medical supplies (that included supplies for the cholera response), general medical supplies for health & nutrition, distributed mosquito nets & hygiene kits and rehabilitated latrines & water schemes in all supported Health Facilities. All activities under the project were conducted in coordination with the Ministry of Public Health & Population (MoPHP). For Phase 2 SC has been focusing on the cholera response, conducting awareness sessions on cholera prevention, rehabilitating community water schemes to provide clean water, building latrines at community level and continuing the provision of medical supplies to HFs. SC has also been conducting measles vaccinations in its area of intervention and continued to work in coordination with the MoPHP.

SC proposed an intervention to help the most vulnerable populations, including internally displaced persons (IDPs), returnees, and host communities in hard to reach areas in Lahj and Taiz governorates access quality, integrated and evidence-based lifesaving health, nutrition and water, sanitation and hygiene (WASH) interventions.
The objectives of this project were to:

- Facilitate access to quality, integrated, primary health care for vulnerable populations, including IDP, returnee and host communities. (Health sector).
- Contribute to a reduction in morbidity and mortality related to acute malnutrition amongst children under 5 years of age and pregnant and lactating women. (Nutrition sector).
- Facilitate access of children and their families to safe water, improved sanitation facilities and the knowledge and attitude towards practicing good hygiene behavior (WASH sector).

Lifesaving nutrition activities targeted the most vulnerable malnourished children and pregnant and lactating women (PLWs), through treatment of malnourished cases and prevention of malnutrition through protection, promotion and support of infant and young child feeding (IYCF) practices and micro-nutrient supplementation. The health activities were included to provide relief to conflict-affected communities through the treatment of communicable diseases, maternal and child health care, community preventive services and provision of medical commodities. All these are in the line with DEC's mandate is to save lives, alleviate human suffering, and reduce the social and economic impact of disasters.

[3] SC Yemen moved from the structure of Area offices to an operational structure in September 2017.
[4] Humanitarian needs overview 2018 - Yemen

Phase 2 saw a fast increase in cholera cases from the end of April 2017, with 417 confirmed deaths in a month. It was therefore extremely important to act quickly to prevent the rapid spread of the disease. For this reason, a special focus on cholera was included in Phase 2. SC committed to conduct awareness sessions with specific cholera prevention messages, rehabilitate water schemes to provide clean water, build latrines at community level and continue providing medical supplies to the health facilities. Furthermore, SC agreed to conduct a measles vaccination campaign during Phase 2 in its area of intervention, in coordination with the MoPHP. Other outbreaks continued to be monitored and addressed if required.

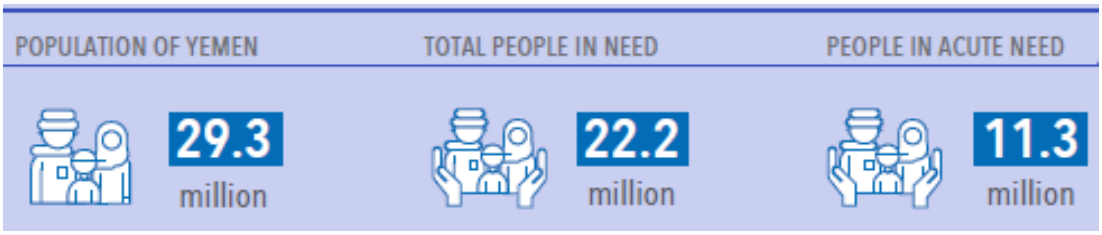
In September 2018, Save the Children Yemen Country Office (CO) hired both national and international consultants to carry out a final evaluation of this project to assess the project achievements and also to inform SC future strategies and programme design in Yemen.

Context

More than three years since the escalation of the conflict, Yemeni people continue to bear the brunt of ongoing hostilities and severe economic decline. Humanitarian needs have increased sharply across all sectors since the escalation of the conflict in 2015, which has exacerbated pre-existing vulnerabilities, degraded community resilience and accelerated the collapse of public institutions. Severe restrictions on imports, movements and financial transactions are stifling the commercial sector, which is essential to people's survival, and hindering the delivery of humanitarian aid. According to Humanitarian Needs Overview (HNO) 2018, an estimated 22.2 million people in Yemen are in need of some kind of humanitarian or protection assistance, including 11.3 million who are in acute need. This is an increase of more than one million people in acute need since June 2017.[5]

The escalation of the conflict since March 2015 has dramatically aggravated the protection crisis in which millions face risks to their safety and basic rights.[6]

Yemen is now the world's largest man-made food security crisis. However, this crisis is not driven by a lack of food in the country. Rather, Yemen's food crisis is driven by factors constraining the supply, distribution and people's diminishing purchasing power. Ongoing conflict and economic decline have steadily eroded people's coping mechanisms, leaving large parts of the population at the risk of famine. According to 2018 HNO estimates, 17.8 million people are now food insecure – a 5% increase over HNO 2017 figures. Out of this, approximately 8.4 million people are severely food insecure and at risk of starvation. This figure has jumped from 6.8 million in 2017, translating to a worrying increase of 24 per cent. Some 1.8 million children and 1.1 million pregnant or lactating women are acutely malnourished, including approximately 400,000 children under age 5 who are suffering from severe acute malnutrition. The current estimation is that 15 per cent of children under the age of 5 is acutely malnourished in a country that is already breaching World Health Organization (WHO) emergency thresholds, and the Global Acute Malnutrition (GAM) prevalence is even higher. A total of 107 of 333 districts are now facing heightened risk of sliding into famine, an increase by 13 per cent since April 2017.[7]



Due to collapsing public institutions, people's access to essential services such as water, sanitation, health care and education has been further constrained. Only 50% of the total health facilities are functioning, and even these face severe

[5] OCHA, Humanitarian needs overview (HNO) – Yemen 2018
[6] Ibid.
[7] Ibid

shortages in medicines, equipment, and staff.[8] Similarly, some 16 million people lack adequate access to clean water, sanitation and hygiene, which is attributed to the physical damage to infrastructure, lack of resources (including fuel), suspension of salaries, decline in revenue generation and non-payment of water bills by the consumers. Crippled public health and WASH systems contributed to the unprecedented scale of the 2017 cholera outbreak. At the beginning of May 2017 Yemen experienced a second wave of Cholera outbreak which has been referred to as the worst ever Cholera outbreak in human history and had claimed just above 2000 lives by November 2017.[9]

The state of the health sector is equally dismal; with only 50% of health facilities fully functional, and even these face severe shortages in medicines, equipment, and staff. There has been a disruption of salaries paid to health personnel. It is estimated that 16.4 million people in Yemen require assistance to ensure adequate access to healthcare – 9.3 million of whom are in acute need. The overriding humanitarian need is access to minimum healthcare for people whose lives are at risk due to illness or injury. The latest cholera outbreak has underscored the impact of the failing health system. For nutrition, some 1.8 million children and 1.1 million pregnant or lactating women are acutely malnourished, including 400,000 children under the age 5 who are suffering from severe acute malnutrition. An estimated 7.5 million people are in need of nutrition assistance, with 2.9 million people who required treatment for acute malnutrition in 2017. Under WASH, an estimated 16 million Yemenis need humanitarian assistance to establish or maintain access to safe water, basic sanitation and hygiene facilities, out of which 11.6 million are in acute need. Collapsing urban water and sanitation systems, deteriorating water and sanitation conditions in rural areas, and lack of means to maintain personal hygiene and purchase safe drinking water all contributed to one of the worst cholera outbreaks.[10]

Most public-sector salaries – on which about 30 percent of the population depend – have been paid irregularly paid in the past several months.[11] The collapse of the public sector is increasingly pressuring humanitarian organizations to compensate for the absence of government spending, which goes beyond their mandate and capacity to respond. For example, the recent cholera outbreak has forced humanitarian partners to cover the operating costs of hospitals and health facilities and to pay incentives to public servants in critical roles, especially health care. This sets a potentially problematic precedent by stretching scarce humanitarian resources beyond their mandate and into the public sector to compensate for the failing social services.

Objectives and Scope

In September 2018, the SC Yemen country office hired an experienced consultant to carry out a final evaluation of this project to assess the performance of phase two of the DEC-funded response in Lahj and Taiz governorates implemented between July 2017 and August 2018 in the areas of emergency Health, Nutrition, and WASH.

The purpose of the final evaluation was:

- To assess the project's performance and achievements vis-à-vis the project's overall objectives, the project indicators in the logical framework
- To assess the effectiveness and the efficiency of the methodologies used throughout the project.
- To generate lessons learned from the implementation of the project's activities and the outcomes achieved
- To develop specific recommendations to guide future programme management and design.

In addition, the evaluation questions sought to assess the programme against the nine Core Humanitarian Standards (CHS), these questions are available in the annexes. The lessons learned through this evaluation will be applied by SC to inform future strategies and programme design for similar project that SC is implementing in Yemen. Findings will also be shared by SC through its networks and with peer agencies in Yemen.

Methodology

[8] Ibid.
[9] OCHA, Humanitarian needs overview (HNO) – Yemen 2017
[10] OCHA, Humanitarian needs overview (HNO) – Yemen 2018
[11] OCHA, Humanitarian needs overview (HNO) – Yemen 2017

Taking into consideration accessibility challenges, the methodology was based on the collection of primary qualitative data collection through key informant interviews, and a review of both qualitative and secondary data. The two methods were used for triangulation and validation of findings. The programme team worked with the MoPHP to identify relevant secondary sources to be reviewed.

Secondary Data Collection

A review of secondary data relevant to the programme included documents such as:

- National/governorate data related to health, nutrition and WASH in the three governorates.
- Documents related to the strategic direction and positioning of SC Yemen (i.e. country strategic plan and country annual plan)
- Project documents (i.e. proposal and progress reports)
- Indicators Performance Tracking Table (IPTT)
- The final report from Phase 1
- Relevant available studies conducted at the areas of the interventions.

An inclusive list of all reviewed documents is available in Annex I.

Primary Data Collection

After consultation with project technical advisers and the monitoring and evaluation team, the qualitative methodology was designed around in-depth interviews and focus group discussions (FGDs), as well as case studies. Participants for the in-depth interviews were selected through a purposive sampling method. Due to the nature of FGDs participants were selected through convenient sampling based on the availability on the day of the discussion and were conducted until saturation was reached. The semi-structured interview and FGD tool are available as Annex 3.

Qualitative tools were developed and utilized through a Participatory Rapid Appraisal Approach[12] technique. Participants were identified using random sampling from beneficiaries attending the HC during the assessment day. Special care was given to ensure a wide range of participation across project stakeholder groups, including women and children. Children's FGDs were held separately and included child friendly techniques such as risk mapping and drawing. Participants were given the opportunity to discuss their feelings/thoughts in a safe context, and with complete confidentiality and respect for each other's point of views. FGDs were facilitated by local community-based data collectors that had been nominated by SC and were trained by the national consultant; attention was given to ensure enough female data collectors to conduct female-only FGDs.

The detailed work plan is included as Annex 4.

Data Quality Management

Information during the FGDs was recorded using paper forms that have been stored safely by the national consultants according to the SC Data Protection Policy. All discussions were recorded anonymously as agreed with the participants, so information has been anonymized.

As part of the data quality management for this final evaluation, data collectors were brief on the objectives of the evaluation and its tools (going through the questions one by one). They were also trained on the use of informed consent forms and that signature by each interviewee was mandatory prior to beginning an interview. Finally, data collectors were trained on gender equality and ensured that analysis was gender sensitive and took into consideration significant differences between male and female responses to questions.

[12] This is a standardized approach to conduct the qualitative arm in a participatory way, where stakeholders will have the full potentials to express their ideas and build upon each other in a participatory way.

Ethics and Child Safeguarding

The research was guided by the following ethical considerations and those principles were applied in all situation throughout the field work:

- Openness and transparency of information given to the highest possible degree to all involved, this was through clearly explanation of the purpose of the discussion to stakeholders involved.
- Public access to the results when needed unless in the case of confidentiality restrictions. This had been explained to all interviewed personnel.
- Broad participation of the interested parties to be involved where relevant and possible
- Reliability and independence: the research should be conducted such that its findings and conclusions are correct and trustworthy. This was through quality data management and ensuring confidentiality.
- Child-sensitiveness, Child participation and gender sensitiveness. Respecting culture, so only females conducted FGDs with females.

Data collectors received training on the SC Child Safeguarding Policy (which they were obligated to sign), In practice, children were interviewed after taking their consent and approval of their parents/key persons. They were given the space to provide their feedback independently with complete anonymity. Researchers prioritized the best interest of the child and the do no harm approach, so interview time was identified when suitable for children, care was taken to ensure that the venue was child friendly, and we explained the voluntarily nature of their participation and that there should be no direct benefits or harm as a result.

Stakeholder Analysis

All the stakeholders who participated in the project were identified at the start of the evaluation based on the review of the secondary documents and the list of stakeholders was confirmed through consultations with the evaluation focal point in SC.

Community members:

- Households, mothers of infant and young children, community leaders involved in the program implementation).

Health interventions:

- Ministry of Public Health and Population (MoPHP)
- Governorate Ministry of Health Offices (GHO)
- District Ministry of Health Office (DHO)
- Managers of health facilities
- Coordinators of the two mobile clinics
- Trained community health workers
- Referral system coordinator (MOPHP staff)
- Trained health workers include (Mid-wives, doctors, nurses, vaccinators and community health workers)

Nutrition interventions:

- Families who benefited from moderate acute malnutrition (MAM) treatment
- Community Health Workers who carried out Community Management of Acute Malnutrition (CMAM)
- Mother to mother support groups (MTMSGs)
- Other MoPHP and GHO members,

WASH interventions:

- Community members received hygiene promotion
- Hygiene volunteers trained

This is in addition to SC staff, including the thematic managers and their staff at both central level and field levels.

Risk Assessment

1. Time required to obtain necessary accessibility permission to the field locations results in delays.
Our mitigation: The local consultant conducted a majority of the field work through visits to the locations, and the international consultant conducted in-depth interviews with Technical Advisors (TAs) and SC staff via Skype. Close communication was kept between the two consultants to double check findings and validate results.

2. Safety and security constraints means primary quantitative data cannot be collected (for example, the use of mobile phones is regarded as suspicious).
Our mitigation: The consultants reviewed pre-collected quantitative data as part of the project's monitoring, evaluation, accountability and learning (MEAL) strategy which they triangulated with the qualitative information collected as part of this final external evaluation.

Findings

Commitment 1: Humanitarian response is appropriate and relevant.

There was consensus among all the respondents that the project had responded to the priority health and nutrition needs of both IDP and host communities in the target areas. "The project interventions are highly relevant…"it improves our response as a health centre to the health needs of the surrounding community" said the head of the health centre (HC) in Taiz Governorate. Furthermore, the project's interventions were in-line with the priorities of Yemen HNO) as well as SC Yemen Country Strategy Plan. Given the dire humanitarian situation in Taiz and Lahj governorates, there is no doubt that the project reached vulnerable populations in need, however it faced challenges in systematically accessing the most vulnerable located in hard-to-reach areas due to insecurity. Therefore, many of the locations reached had been previously targeted by SC. To mitigate against some of the limitations of this, SC established mobile health services to ensure that health and nutrition services could reach those remote locations whenever possible. However, the benefit of using mobile health clinics was not always recognised by MoPHP staff. A health manager in Taiz, for example, reported that, "the mobile HC was a helpful approach in reaching remote areas, however, it was not seen by MoPHP as a priority, they advised to focus on making the closed health facilities functioning".

The project was designed taking into account other similar interventions and a vulnerability analysis of the selected districts based on available data from the Office for the Coordination of Humanitarian Affairs (OCHA) as well as the consultations conducted with MoPHP and cluster members prior to the start of the project. The project was also designed in response to an analysis of needs that included disaggregation by sex and age.

It was also felt by respondents that the project had adequately addressed the capacity needs of the MoPHP, enabling them to better serve their communities. "The MoPHP system [had] collapsed, no fund, no incentive, no motivation, no maintenance. The MoPHP itself relied totally "100%" on the funds and aids from UN and international organizations. And not just the needs but also the political directions influencing the direction of funds distributed, in general all our locations are in urgent needs for support and this will continue for the coming years", a respondent for the Lahj Health Directorate reported.

In addition, it was felt that the project design, objectives and target areas remained relevant throughout the fluctuating emergency context due to the persistent unavailability of trained health personnel and medication in an emergency context and the resulting lack of quality health services provided at HCs. The nutrition component remained relevant to the chronic malnutrition situation in Yemen.

It was also felt that the trainings provided to HC personnel, including general management, were relevant to the capacity needs. Training topics included, the management of mobile and fixed health clinics, establishment of a surveillance system, case management and general management of the HC. According to a respondent for the Lahj HC, "the training component supported the relationship between [him] and the health care personnel, it empowered [his] management skills in dealing with both people and the facility". Training also responded to emerging needs such as in response to a cholera outbreak which enabled a stronger local response.

The selection of the water points and rain water harvesting systems to be rehabilitated was done in consultation with local communities and authorities. One of the criteria for consideration was ease of access for women and children as they bear the primary responsibility for water collection. The target locations were chosen to reduce the distance from households to the waterpoints (according to SPHERE Standards) to less the burden. A female child respondent (nine years old) said that, "before the project we and our mothers were carrying the water from the pool to our houses, it was a heavy-duty task but now we are comfortable that the water coming to us at the points of use through the project network". Another adult female respondent said, "the SC waterpoint helped me to get pure water for food, I was afraid during the Cholera outbreak and I was boiling the water, regardless of the source". However, it should be noted that for cultural reasons in Yemen public waterpoints are mostly utilized by children and men, rarely women go and fill tanks from waterpoints.

Whilst it was recognised that efforts were made to ensure that the WASH component of the project was gender-sensitive, the opposite was found for the HCs. One of the female beneficiaries taking part in the FGDs in Lahj reported

that "in the HC, there is no separate toilets for men and women, sometime a male can enter the examination room while woman is there, so we separate ourselves randomly at the point of service." Future projects should ensure that a gender-sensitive approach is adopted as a cross-cutting project design element rather than being sectoral or activity based. It is also important to note that HCs lacked the design of a disability sensitive environment. Personnel with disabilities found it difficult to access the structures. This was confirmed through the field observation and also FGDs with beneficiaries in Taiz where one woman reported, "I have a disabled husband and it is really hard to bring him to the centre here, as he can't get into the place, sometimes the doctor [has to] come out to see him to give him the medications".

During the planning phase, the target beneficiaries' needs were addressed based on sex and age disaggregated analysis, against which activities were designed. During the implementation, all the services were based on addressing the supported activities according to the gender and age role and responsibilities in the community. Furthermore, the reports were compiled to ensure a systematic capture of gender and sex disaggregated data. Whilst the project specifically targeted women and children, in order to encourage behaviour change at household and community level, it was equally important to include men, especially as they are often the key influential household decision makers. Achieving behaviour change in the household therefore necessitates reaching men with key messages. Community Health Volunteers and Community Health Workers took care to ensure the equal participation of men in awareness raising initiatives at both household and community level. A male head of household in Lahj said, "They come to my house to talk to my wife about the health practices and how to use safe water, they talked to me firstly, and I see that the messages they provided are useful".

The rehabilitation was also designed to reduce the time required at the water point. However, it was found that the design of the water points and rainwater harvesting systems lacked an innovative approach. A SC technical advisor reported that when "comparing the project design and rational of the source of fund with the previous phases of the project you can find that each cycle is a continuation of the previous year, without new interventions." They added that a more innovative and integrated approach should be included in future projects, for example the inclusion of a protection component as a rights-based entry point to both nutrition and health components.

It was found that the scale of these needs sometimes exceeded the capacity of the project and for this reason some respondents expressed lower levels of satisfaction. For example, one of the project limitations reported was that it only provided primary health care services. The health manager in Taiz said "The majority of health units and centers only do primary health care, we support those types of services only, and our referral is either from community to primary or primary to secondary health care facilities whether private or supported by MoPHP. We don't have any interventions in the quality of the secondary health care. In a few cases we provided support to secondary interventions but only on exceptional cases". This feeling was corroborated by one of the female respondents during the FGDs in Taiz: "There are only limited/similar types of health services, so the HC has no different departments, if I have any derma issue for me or my children or any other specialty, I need to travel, and this is hard in our situation, additionally the quality and waiting time at those centers are to bad".

Commitment 2: Humanitarian response is effective and timely

Communities valued the project's integrated approach as it meant they could access a variety of services from the same location and near to their communities. During a FGD in Lahj, a female respondent reported, "I came to the HC to seek nutrition for my baby, and they provided me as well with family planning [advice]". Integrating family planning with nutrition services at the same HC had a positive effect on the utilization of health services. A midwife from one of the supported HCs in Lahj said: "The population in the catchment area of [this] village is about 10,161 people. The people in the first and the second levels benefited from the services provided through antenatal acre, delivery services and family planning". However, the respondent did make a note that those living in the third level could not access services due to the distance and high cost of transportation. The value of an integrated approach was also reflected by an MoPHP representative who said: "the integrated approach of the project, increased the community satisfaction about such integrated services (free medication, referral cases for secondary health care, nutrition etc..) compared to other organizations, who are working on specific topics such as moderate acute malnutrition (MAM) and severe acute malnutrition (SAM), so this enhance the acceptance of the organization."

Community-based activities such as Mother to Mother Support Groups (MTMSGs) and malnutrition screening by Community Health Volunteers enabled greater coverage than if the project had solely relied on health centres. Beneficiaries reported positively about the added value of these community-based initiatives in ensuring an effective response. As one female respondent in Lahj said, "this project cover all the areas and volunteers reach every place". Another reported that "reproductive health services are one of the best services, especially both antenatal (ANC) and prenatal (PNC) visits conducted home to home visits through the community health workers".

The project was effective in increasing the capacity of health care personnel and services. For example, previously there had been no surveillance system in place and now a weekly surveillance report is standard practice running in all the targeted HCs. This served as an early warning system for the cholera outbreak. Additionally, capacity building enabled health care personnel to provide a better service to the community. Beneficiaries reported positive interaction with HC personnel and satisfaction with the quality of services.

The project was also successful in identifying effective mitigation measures in the face of insecurity and fluctuating accessibility to the project areas. For examples, SC supported the HCs remotely via phone, receiving reports and communicating with the MoPHP Coordinator through WhatsApp who was able to conduct supervision visits when SC staff access was limited and to follow-up on reports. SC also coordinated closely with the MoPHP to ensure remote management and follow up of project activities when the security situation prevented SC from conducting monitoring visits and report collection in the target areas.

The effectiveness of the project on behaviour change can be considered as positive based on some of the qualitative feedback given by the respondents. For example, the MoPHP confirmed that the utilization of health services had increased. A health centre manager in Lahj reported that "our HC catchment area is now much bigger that before, beneficiaries come to the centre to obtain the available nutrition services, which is available here due to the project". This is also evidenced by the achievements against targets of indicators indicative of behaviour change, such as '# of people (m/f) getting safe water access and safe sanitation' which reached 3,095 individuals against a target of 2,978. However, the programme could have included additional indicators to assess behaviour change.

Effective preparatory activities meant that the project started not far off from the expected start date. These preparations included training of health care providers and signing the Memorandum of Understanding (MoU) with the MoPHP. However, the provision of health services at the HCs started a few weeks later than planned due to delays in the procurement of medications and nutrition formula as well as lengthy recruitment and human resource (HR) procedures. As an SC representative in Lahj office said, "HR is too slow, it takes a lot of time and is not at the pace of emergency interventions, even for local recruitment process". Another member of staff at field level mentioned that delays also affected recruiting assistances of community mobilizers, not just fixed posts.

During implementation, the project faced a number of challenges due to the difficult context which resulted in operational delays or suspension. However, in adopting a flexible approach and close coordination with local actors helped to mitigate the impact of these delays. For example:

- Shortage of non-food items (NFIs): a shortage of hygiene kits and water ceramic filets compared to the coverage. This was mitigated through the close coordination between SC, the NFI sub cluster and local authorities by making mapping for actors working at the same area and divided the IDPs number between them, so the project covered the gaps in term of NFIs distribution.
- At the start of 2018, there was increased violence on the border between Lahj and Taiz that reached Tur-Albaha district in Lahj and forced SC to suspend its operation in the district for 1.5 months. Even after the violence subsided many areas in this district were still considered "hotspots" and therefore inaccessible by project staff. A mitigation strategy was to coordinate with local partners to deliver services in those locations, which enabled SC to partially ensure the continuation of support though this had a significant impact on our ability to reach the most vulnerable.
- Operational challenges were also experienced which included delays of medication arrival, staff turnover over the project duration as well as the delays in HR process at SC level.

Identified targets and expected outcomes in relation to health, nutrition and WASH remained on track throughout the project cycle, all health facilities and WASH service points were continuously supported. This included additional health activities that were not initially planned but for which a need was identified during implementation, such as the cholera

response, and measles and diphtheria campaigns. Regarding the nutrition component, outpatient therapeutic programme (OTP) and target supplementary feeding programme (TSFP) targets were revised at the start of the project based on the level 1 catchment population since SC supported the fixed HCs while the 2nd and 3rd levels of the catchment population were supported by other INGOs. However, this revision had no impact on the quality of the project.

The project had a well-established MEAL system with powerful indicator performance tracking tool (IPTT) and functioning accountability system. An analysis of data from the accountability system showed that it was well utilized and trusted by the community. The IPPT is a comprehensive tracking tool that programme managers can use to assess progress on a quarterly basis to inform their decision-making. The utility of this tool was expressed by programme teams in both Lahj and Taiz, who reported seeing the IPTT as the reference for the progress of their efforts and to take corrective actions based on it.

It is also worth noting some of the positive feedback received from respondents vis-à-vis Save the Children specifically, and especially in regard to its strong partnership with field-level and government-level actors. One of the HC managers in Taiz reported that "Save the Children is a highly reputable organization…it has good geographical coverage, good relations with the MoPHP, [and] good technical and management staff". Positive feedback was noted while conducting FGDs with beneficiaries at the HCs. One of the male beneficiaries in Taiz said: "Save the Children by its name, has an influence in our community they improved the HC and they send social workers who do health awareness at our doors."

Commitment 3: Humanitarian response strengthens local capacities and avoids negative effects

MoPHP staff and a sample of community leaders were consulted during the project design phase to identify project priorities and approve district level targeting (ensuring alignment with national priorities). The project improved the awareness of the right holders (community members) to claim their health and nutrition rights, through the different awareness raising components as well as the home visits. For example, as reported by a HC representative in Aden: "the continuation of the project for such long period contributed to the coherence of the core activities. People can easily know about the different activities, and they start claiming nutrition rights with primary health care service". In turn, this also enhanced the capacities of the health care providers as duty bearers to fulfil their duties. A HC manager in Lahj said: "the support provided through SC enhanced beneficiaries accessibility to the HC and helped us to fulfill our duties to provide health service to surrounding communities"

In fact, one of the positive unintended effects of this project was its contribution to developing the Yemen's first ever IYCF strategy; an opportunity that came to SC because of the effective engagement with MoPHP and other nutrition cluster members. SC led along with UNICEF and the MOPHP the development process for a five-year strategy to address bottlenecks around IYCF including the capacity of health workers, and the challenges and malpractices related to infant formula and its availability in Yemen markets (there is wide spread practice of nutritionists unnecessarily prescribing infant formula).

The project created several conditions to support the sustainability of the results generated. For example, implementing the project activities in line with the existing government or traditional systems and protocols and, for example, using the local services and suppliers as much as possible, developing MoU between the community committees and government authorities for the WASH facilities rehabilitation, water points etc. However, it should be noted that local structures will struggle to carry forward activities without external support as long as the conflict continues, though SC will endeavour to continue working with MoPHP and building the management capacity at the local level. One of the practices that was developed through the project and which respondents felt will continue is the awareness of the community members to claim their health rights at the HC facilities. For example, a male beneficiary member of a Water Management Committee (WMC) in Taiz said, "after [SC] formed the water points, they trained us on how to check the water quality through strips, so we can know the level of pollution, and they gave us free kits to assess water quality".

The project heavily focused on building the capacity of health workers as one of the means to ensure sustainable impact however the degree to which this will be successful may be limited by the fact that a majority of health care personnel are not originally from the same locations they are working at, so there is a possibility that they will return back after the cessation of the available funding especially with the challenges faced by MoPHP to cover the running costs of the HCs including the payment of the medical personnel. Additionally, there are no transition plans to ensure that resources

made available by the project, especially at the HC level, are maintained which will significantly impact the sustainability of the health services even if capacities have been strengthened. A major weakness of the project is that there is no clear operational exit strategy.

For this reason, the team tried from the beginning to ensure a sustainable work through capacity building, always implementing the project activities in line with the existing government or traditional systems and protocols and, for example, using the local services and suppliers as much as possible, developing MoU between the community committees and government authorities for the WASH facilities rehabilitation, water points etc. Even though these local structures are in place, it will remain a challenge for them to carry forward these activities without external support as long as the conflict continues, based on this SC will continue mobilising resources to support these communities until there is stability through this award and other sources of funding. Our goal is to delivery emergency interventions with a view to building long term sustainability and capacity of local communities in order to build brighter futures.

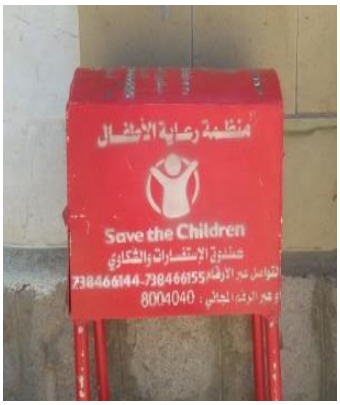
Commitment 4: Humanitarian response is based on communication, participation and feedback.

Project design was informed by a situation analysis and consultation meetings with MoPHP, community representatives and cluster members. The project's community-based approach meant that community members – both IDPs and host community members - were an inherent part of implementation. WMC members for example identified locations most in needs and ensured sustained WASH investment at the local level. Members of these committees, and leaders of other groups such as the MTMSGs, had been selected by their communities and served as the link between SC and the community. A Health Manager in Lahj mentioned, "The role of CHVs [community health volunteers] was powerful as they supported us in reaching the hard to reach population and also refer them to the HCs when needed".

Furthermore, the programme team held regular meetings with CHVs, social worker, and Integrated Community Case Management staff. IDPs and vulnerable people targeted were selected and registered through community case management committees. SC shared information about the project objectives and the activities planned in the target areas during the kick off meeting, coordination meetings, program review meetings, supervision and follow up visits and focus group discussions that were conducted as part of a learning workshop to get the community feedback, satisfaction and needs. The regularity of such meetings varied from location to another, some were on monthly basis, and some were just ad hoc. The feedback out of those sessions are taken into consideration and led to project management actions. The health coordinator in Lahj said "We visit beneficiaries and did consultation and feedback sessions with them, they provide suggestions based on their awareness of the communities, and sometimes we adopt such suggestions".

Commitment 5: Complaints are welcome and addressed

Information about SC and its operations was publicly available and accessible to the targeted population. One of the observations of the evaluation team was the powerful existence of the visibility of SC and the awareness of the population about the services provided by the organization. This also was clear from the consultation meetings with targeted groups; they use the hotline to know about the services and provide feedback. The target population had a range of options for providing complaints and feedback, such as a toll-free number, suggestions boxes (see photo) and verbally to programme staff through community-based groups or directly. Having different options for submitting complaints or feedback enabled people to choose the appropriate way that fits their needs. SC also captured feedback through post distribution surveys. SC records all complaints and feedback into a database against seven different categories as presented in table below:



Category	Recording category
Category 0	Positive feedback
Category 1	Request for information
Category 2	Request for assistance
Category 3	Any dissatisfaction with our programming

Category 4	Allegations of fraud
Category 5	Allegations on inappropriate behaviour or misconduct towards adult beneficiaries
Category 6	Allegation on breaching child safeguarding policy by SC staff and affiliates
Category 7	Allegation on breaching child safeguarding policy by non-SC affiliates

The recorded information on feedback and complains is analysed and reported in the accountability report that is produced monthly. During this project SC received 76 complaints/feedback linked directly to DEC activities; of which none were related to categories 4,5,6 and 7. SC received requests for information about the distribution time and place for FSL distributions, requests for assistance on WASH, FSL and Health, to include/register their names or to add more beneficiaries to the FSL list of beneficiaries and to re-new & support again health facilities and hospital's in their areas. All the requests for information were responded to within 2 working days. Positive feedback was received related to the health component through the suggestion boxes. One general point of dissatisfaction noted was regarding FSL and WASH beneficiaries who went and dug trenches for the sewage pipes and were not paid; an issue that was reported through SC complaints response mechanism (CRM) channels. It was later clarified and communicated back to them that they had offered to do community service and the service they offered was not a planned activity under DEC nor any of SC's FSL/ WASH projects and there had never been agreements on paying the volunteers and the volunteers welcomed the feedback.

During the FGDs with women, all participants confirmed that they are aware and use the accountability hotline. Data from the received calls at the call centre confirmed that women knew and use the hotline as reflected in the CRM report which showed that 40% of all received calls were from females. One female FGD participant said: "there is a complaint box and SC reply our complaints and they usually tend to improve the services provided. They do have a hotline (8004040) which is accessible all the time".

Commitment 6: Humanitarian response is coordinated and complementary.

It is worth noting that globally SC actively participates in all clusters and is a co-lead of the health and CP clusters at national level in Yemen. SC regularly coordinated with the respective Health, Nutrition, WASH and FSL sub clusters which include UN agencies, INGOs and governmental authorities as members. In fact, prior to this project the health cluster in Lahj was not fully functional but was re-activated through SC's engagement. These coordination forums provide a platform for the exchange of information, sharing lessons learned, discuss challenges, advocate for priority needs, and ensure full gap coverage by partners in the ground whilst avoiding duplication. For example, in the case of SC shortages in nutrition supplies due to the delays in international procurement processes, the gap is filled from UNICEF and WFP for OTP and TSFP respectively. No major coordination issues were identified at this level.

SC also coordinated with the MoPHP, governorates/districts health officials, local authorities and community leaders in planning and design according to the needs of the targeted communities. In fact, it should be noted that part of the success of this project was down to the leadership in the district and targeted villages and their commitment to their community needs. GHO/DHOs were involved in the selection of the targeted health facilities and community volunteers (CHVs, ICCM and MTMSGs leaders) and participated in joint supervision visits with SC as well as attending the quarterly review meetings to discuss progress, challenges as well as providing solution. During in-depth interviews with the MoPHP at local level they said, "coordination roles is perfect at health level – National health cluster is working effectively. Earlier the main issue was that it has no sub cluster at governorate levels, and this didn't give a proper chance to coordinate health activities at the governorate level, this has been solved 3 months ago by having sub national health cluster at the governorate levels".

On a programmatic level, collaboration and integration between primary and secondary health care providers is an area that would enhance the effectiveness of primary health services as well as the quality of secondary services provided. As previously highlighted, the project only focused on primarily health care and did not have the scope to expand to secondary health care. Despite the importance of advocacy work there was agreement within SC staff at field office level that advocacy and district-level coordination efforts need an improvement as it is limited or conducted only centrally, as described above. For example, according to an SC representative in Lahj Governorate, "we have a very limited advocacy work [here], even if people are happy about our work, we need to do advocacy on some of the uncovered areas such as the secondary health care services and referral system, I think we should even work more on

awareness campaigns on preventing acute malnutrition, yes we worked on media but this needs to be fostered". Advocacy work in the form of the campaigns such as for World Diabetes Day or hand washing campaigns should be coordinated with other cluster members to be more effective.
The delay at the start of the project led to rushing the services provided towards the end of the project. So, for example, water quality kits were provided for beneficiaries in certain locations, because the project wasn't able to access the hard to reach locations

Commitment 7: Humanitarian actors continuously learn and improve.

The project adopted a participatory approach throughout the project cycle, consulting with MoPHP staff, community members and cluster members. The MEAL strategy, specifically the IPTT tool, was effective in providing information for decision-making at both central and field level. SC field staff in both Lahj and Taiz highlighted the importance of the information they got from the MEAL system. An SC Staff member in Lahj said, "we got figures on any protection issues through the field team as well as the hotline, and we respond directly, and this improved the child protection situation in the project locations". A female FGD respondent in Taiz reported that she "used the hotline to provide feedback on the lack of water testing kit, and they immediately responded and provided the kit in a few days".

Commitment 8: Staff are supported to do their job effectively, and are treated fairly and equitably

Communication between country office and field office staff was found to be effective. However, field staff want to be more engaged with the central team especially at the stage of design and planning for the project. The organization values are well communicated to all new staff, and both staff, volunteers and consultant are oriented on the Child Safeguarding Policy and Anti-Fraud policy and have to sign adherence to these prior to starting their work. Staff are also oriented to the channels for submitting complaints or a fraud case in a confidential way. Field staff confirmed that they get opportunities for development and exposure at both the country level as well as outside the country. It should be noted that staff wellbeing was not addressed.

During the evaluation some of the health workers reported that prior to the project, they had not been paid for a long time which affects their motivation. that some of the health workers didn't get paid for long time, which affects their level of passion towards work. A HC representative in Lahj said, "Save the Children gave incentives to some workers, but on the other hand, some of the other workers in the centre who are not part of SC didn't get paid which affect their commitments towards their job".

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

It was noted that the project staff are using project resources efficiently, they stick to the financial and HR protocols in terms of procurement procedures. All project management staff are train on such policies and procedures. The financial expenditure is being monitored by the finance team and they report the figures to the project management to feed into the project management decision.

The project faced some issues related to the internationally procured medication, according to several respondents there were issues during implementation with the availability of medication at certain times. A male beneficiary accessing the health clinic in Taiz governorate reported that "some of the essentials medicines like antibiotics [were] not there all the time, some of the equipment [were] not available, for laboratory, we always know that CBC is the only test available and doctors refer us to other private clinics to have the rest of lab services". One of the medical doctors in a HC in Taiz said: "the project is providing free medication, but at some point, there is a lack of medicine which may last for a couple months, at this time, I do medical examination and ask them to buy the medication from outside the clinic, this hugely affects the accessibility as well as the satisfaction of beneficiaries". A respondent for the Bokean Health Centre (Taiz governorate) said that "SC did the best within this DEC project, but they did not ask us about our needs, for example the medicine they provided is not enough, they provide us 15 bottles of paracetamol syrup for three months which is not enough at all". This issue was looked into with SC programme staff during the final evaluation and it was clarified that the short age was due to blockages at the borders for international shipments that affects the timely arrival of stock. Furthermore, programme staff noted that there were high expectations from beneficiaries in terms of medication that should be provided, especially in regard to secondary health services which are not supported by the project.

One of the major challenges to ensuring the availability of medicine is the lengthy procurement process. A SC representative reported that, "medicines is one of the attractive elements to access the HCs, and for us the procurement process is the main concern due to the lengthy of the international procurement process. Unfortunately, if medicines procurement starts with the start of the project, medicines arrives after about five months". They added that "to mitigate this, we started the coordination with the health centres at the start of the project September 2016, we conducted training for the medical staff, but the actual effect on the health centre started Jan 2017 as we got a stock of medicines from another project as a loan till we got our procured medicine which arrived in May 2017". However, despite this plan, still there are gaps as a result of the uncontrolled factors such as ports blockages.

The integrated approach was cost effective for both SC and beneficiaries who were able to utilize different services at the same location. for the project also cost on beneficiaries' side to utilize different services at the same location. Additionally, the construction of a solar system was a cost-effective source of energy to the health facilities instead of using the generator that requires fuel and is more expensive to purchase over time. It also enabled a more regular provision of health services. For health, one of the health managers in Lahj reported that "with the availability of the solar system we are able to provide vaccination services for children every day instead of one day /week in the past". Furthermore, rather than having CHVs for each sector, they provided a multi-sectoral package combining messaging during their visits which kept the cost of incentives and transport down. However, it should be noted that volunteers were still asked to produce separate reports for each sector using different forms which was not an efficient use of their time.

SC provided unconditional cash transfers to vulnerable beneficiaries based on pre-set criteria, however due to the budget limitation the project failed to make the Food Security and Agriculture Cluster (FSAC) recommended six distribution cycle. To cover the gaps, additional distribution cycles were completed using funds from a DFID-funded project in Lahj, and in Taiz 3 distribution cycles were covered under the SC-UK flexible fund, this can be seen as a good mitigation strategy, but also indicates an issue with the planning.

A key factor for efficient utilization of resources was the clarity of roles in the project's multi-layered structure, between for example the different field offices and in-country headquarters. This is especially crucial with the expansion of the number of health centres to remote locations. As one SC staff member in Taiz said, "community mobilizers should be directed to enhance the quality [of the programme], their roles shouldn't be related to trainings preparation and admin work, this consumes their time and pulls them from the field work. They should be linked to the M&E officer at field level. So, their plans should be addressing the work on the quality".

There should be a clear follow up mechanism to equally distribute the visits to the health centres, some HCs for example were visited only once or twice over the project duration as there were accessibility issues or there were no employees from those communities.

Lessons learned, Conclusions and Recommendations

Lessons learned

A number of emerging good practices demonstrated by the project have been highlighted throughout this report. Based on these, the following are lessons learned through the project experience:

- Respecting the local community's culture and adopting community-based solutions that fits the needs and context have a powerful impact on achieving the desired changes at community-level and enhances community acceptance.
- Flexibility and transparency allowed the project to respond efficiently to emerging needs identified and tailor interventions to fit these challenges.
- Integrated programmes are more beneficial to both affected communities and organization compared to individual interventions, both in term of cost-efficiency but also impact of activities. However, an integrated approach at implementation level should be consistent with an integrated approach to reporting and other project elements.
- Reproductive health corners should be standardized, and with involvement of males as they are the decision influencers, involvement of men (as a family gate keepers) has powerful impact on reaching out to the full family members.
- Volunteers were trained to deliver multi-sectoral key messages which was a most cost-effective solution than having individual volunteers for each sector.

Recommendations

The following action-oriented recommendations are based on the evaluation results.

At policy level:

- To strengthen the advocacy work of the project through a dissemination plan to present the project achievements to engage other donors to fund such integrated programmes and encourage cluster members to adopt the same approach.

At programmatic level:

- To integrate the cash component and make it conditional to obtaining child health and nutrition services, also foster the gender lens by providing it to women in such conditionality status.
- Rather than each project phase copying each other, programme teams should consider testing out more innovative approaches. For example, establishing supervisors at HC level, communicating through a unified reporting system, phasing in to other remote locations instead of working with the same health facilities without an exit strategy with a collapsed health system.
- The project theory of change was based on volunteers who go and provide key messages, raise health awareness at community level and push them to access health and nutrition services. A good strategy in selecting such volunteers is ensuring that they come from the same location as their place of work to avoid people dropping out when the project ends and they no longer receive incentives that enable them to take transport means. Their roles and responsibilities towards ensuring programme quality should also be better communicated and understood.
- Consider integrated community case management (ICCM) approach to increase health service access to populations who cannot reach health service providers.
- Plan for the availability of a buffer stock of medications to enable the project to start on time and avoid delays caused by international procurement processes, and to avoid shortages during implementation.
- Ensure that a gender and disability sensitive approach is adopted equally across all activities.
- Enable partial coverage of major secondary health interventions or at least better coordination with secondary health service providers.
- SC to ensure a clear commitment with the MoPHP to sustain project outcomes. A sustainability/exit plan should be developed with the MOPHP and communities, including consultations with other partners through the clusters to increase their engagement, as well as that of donors.
- To conduct cost analysis to the running costs with support from health centers, then plan together on how

these costs can be covered to ensure sustainability, build on the minimum service package applied to develop a full exit strategy.

At management level:

- To ensure that SC Yemen powerful accountability mechanisms are accessible to the vulnerable and hard to reach communities in the project, also ensure that they are aware on how to use such mechanisms.
- Establish a plan with thematic Technical Advisors to increase the number of supervisors and make them responsible for health centers, with clear roles and responsibilities.
- Strengthen the capacity and resilience of fixed health facilities so that they are in a position to respond to out-breaks e.g. Malaria, Diphtheria and cholera.
- To conduct the project planning with the local field offices according to the agreed implementation calendar taking into consideration the preparatory needs as well as the procurement and admin timeline
- To develop an applicable standardized monitoring plan from the supervisors to their respective social worker as well as the targeted HCs under their supervision.

Annexes

Annex 1: Secondary Documents reviewed

1. Project proposal document and logical framework
2. Internal Project quarter progress reports
3. IPTT
4. Donor progress reports
5. OCHA Humanitarian Needs Overview 2018
6. OCHA Humanitarian Needs Overview 2017
7. Baseline and previous end-line reports
8. Project Monitoring and Evaluation Plan
9. SC Child safeguarding Policy and Code of Conduct

Annex 2: Project performance indicators tracking table (IPTT)

Indicator	DATA TYPE	PROJECT TARGET	CUMMULATIVE ACHIEVEMENT
# of people treated for communicable diseases and mass-casualty or violence-related injuries, by sex and age	*# of Men*	*11446.26*	*30222*
	# of Women	*11913.45429*	*56265*
	# of Boys	*28615.65*	*63903*
	# of Girls	*29783.63571*	*66324*
	Total # of People	*81759*	*216714*
% of births assisted by a skilled attendant among women who received ANC services at the target health facilities	*# of Women*	*4088*	*14772.96*
# and % of pregnant women who have attended at least two comprehensive antenatal clinics	*# of Women*	*8176*	*12574*
	% of Women	*0*	*0.677139921*
# of women and new-borns that received postnatal care within three days after delivery.	*# of Mothers*	*3270*	*5928*
# of health care facilities supported	*primary*	*2*	*135*
	secondary	*13*	*36*
	tertiary	*2*	*1*
	Total # of HFs	*17*	*172*
# of health care facilities rehabilitated	*primary*	*2*	*13*
	secondary	*13*	*4*
	tertiary	*2*	*1*
	Total # of HFs	*17*	*18*
# of health care providers trained	*# of Men*	*85.5*	*7*
	# of Women	*85.5*	*85*
	Total # of People	*171*	*92*
# of cases with moderate acute malnutrition (MAM) newly admitted for treatment	*# of PLWs*	*13154*	*4444*
	# of Boys	*6445.46*	*3016*
	# of Girls	*6708.54*	*3378*
	Total # of Children	*13154*	*6394*
# of cases with severe acute malnutrition (SAM) newly admitted for treatment	*# of Boys*	*1356.81*	*747*
	# of Girls	*1412.19*	*977*
	Total # of Children	*2769*	*1724*
# of health care providers and volunteers trained in the prevention and management of CMAM	*# of Men*	*20*	*4*
	# of Women	*20*	*24*
	Total # of People	*40*	*28*
# of cases with severe acute malnutrition (Admitted) receiving treatment	*# of Boys*	*678.65*	*746*
	# of Girls	*706.35*	*977*
	Total # of Children	*1385*	*1723*
# of cases with moderate acute malnutrition receiving treatment	*# of PLWs*		
	# of Boys	*3222.73*	*3016*

	# of Girls	3354.27	3408
	Total # of Children	6577	6424
# of SAM Cure	# of Boys		701
	# of Girls		921
	Total # of Children		1622
# of SAM Death	# of Boys		1
	# of Girls		1
	Total # of Children		2
# of SAM Defulter	# of Boys		30
	# of Girls		34
	Total # of Children		64
# of SAM unresponsive	# of Boys		7
	# of Girls		8
	Total # of Children		15
	Total exit SAM		
# of MAM Cure	# of PLWs		
	# of Boys		2524
	# of Girls		2804
	Total # of Children		5328
# of MAM Death	# of PLWs		
	# of Boys		0
	# of Girls		0
	Total # of Children		0
# of MAM Defulter	# of PLWs		
	# of Boys		61
	# of Girls		58
	Total # of Children		119
# of MAM unresponsive	# of PLWs		
	# of Boys		11
	# of Girls		22
	Total # of Children		33
	Total exit MAM		
# of CHWs trained and supported	# of Men	32.5	12
	# of Women	32.5	121
	Total # of People	65	133
Number and percentage of CHWs specifically engaged in public health surveillance	# of Men per HF	17	13
	# of Women Per HF	17	33
	Total # of People	34	46
# of community member who received health education.	# of Men	4772.04	9952
	# of Women	4966.817143	64281
	# of Boys	11930.1	33843

	# of Girls	12417.04286	47136
	Total # of People	34086	155212
# of health care providers and volunteers trained in IYCF	# of Men	0	4
	# of Women	40	76
	Total # of People	40	80
# of caregivers reached with specific nutrition message (IYCF)	# of Men	2701.5	5851
	# of Women	2701.5	51829
	# of boys		20255
	# of girls		28352
	Total # of People	5403	57680
# of people reached by IYCF counseling in the HFs	# of Men	0	2306
	# of Women	2715	23120
	Total # of People	2715	25426
# of mothers reached with IYCF messages through MTMSG	# of Mothers	1200	24391
# of children and PLW screened for acute malnutrition	# of PLWs	25724	20710
	# of Boys	12862	26946
	# of Girls	12862	27282
	Total # of Children	25724	54228
# of people receiving direct hygiene promotion (excluding mass media campaigns and without double-counting)	# of Men	19493.6	16443
	# of Women	20289.25714	20030
	# of Boys	48734	39947
	# of Girls	50723.14286	41908
	Total # of People	139240	118328
# of water points, open dug wells, small public water networks and rain water harvesting systems rehabilitated	# of Water points	9	15
# of people (m/f) getting safe water access	# of Men	3528	6638
	# of Women	3672	6815
	# of Boys	8820	9060
	# of Girls	9180	9455
	Total # of People	25200	31968
# of water quality surveillance tests conducted in targeted project sites	# of tests	9	13
# of beneficiaries (m/f) drinking water supplies with 0 fecal coliforms per 100 mL sample	# of Men	3528	822
	# of Women	3672	777
	# of Boys	8820	2014
	# of Girls	9180	1901
	Total # of People	25200	5514
# of water management committees established	# of committees established	9	12
	# of Men	44.1	48

	# of Women	18.9	36
	Total # of People	63	84
# of water management committee members trained on operation and maintenance of water schemes	# of Men	44.1	32
	# of Women	18.9	20
	Total # of People	63	52
# of water management committees supplied with operation & maintenance plubming tools.	# of Men	44.1	42
	# of Women	18.9	22
	Total # of People	63	64
# of individuals who receive water purification ceramic filters, PVC water storage buckets with lids	# of HHs	700	300
	# of Men HHh	98	201
	# of women HHh	102	69
	# of Boys HHh	245	6
	# of Girls HHh	255	24
	# of Men	686	309
	# of Women	714	408
	# of Boys	1715	492
	# of Girls	1785	509
	Total # of People	4900	1718
# of schools with rehabilitated and gender segregated WASH facilities	# of Schools	6	6
# of people (m/f) getting safe water access and safe sanitation	# of Men	42	129
	# of Women	30	38
	# of Boys	1426	1343
	# of Girls	1480	1585
	Total # of People	2978	3095
# of institutions with at least 02 admin staff (including 50% female) trained on operation and maintenance of the WASH Facilities at the institutions	# of institutions	6	5
	# of Men	6	7
	# of Women	6	5
	Total # of People	12	12
# of rehabilitated institutions supplied with maintenance and operation plumbing toolkit.	# of institutions	6	6
	# of Men	6	9
	# of Women	6	6
	Total # of People	12	15
# of community health volunteers (m/f- at least 50% female) trained on gender-sensitive hygiene promotion message dissemination methodologies	# of Men	30	45
	# of Women	30	45
	Total # of People	60	90
# of community health volunteers (m/f) equipped with gender-sensitive hygiene promotion kits	# of Men	30	45
	# of Women	30	45
	Total # of People	60	90
# of IDP & returness who received basic hygiene kits	# of HHs	700	1100
	# of Men HHh	98	642
	# of women HHh	102	451
	# of Boys HHh	245	0

	# of Girls HHh	255	7
	# of Men	686	1999
	# of Women	714	2037
	# of Boys	1715	2212
	# of Girls	1785	2141
	Total # of People	4900	8389
# of individuals with access to a functioning toilet	# of latrines functioning	75	85
	# of Men	73.5	192
	# of Women	76.5	138
	# of Boys	183.75	967
	# of Girls	191.25	1215
	Total # of People	525	2512
# of IDPs households receive monthly unconditional food / Cash transfer	# of Male HHs		917
	# of Female HHs		283
	Total # of HH	600	600
	# of HH Male		2355
	# of HH Female		2278
	# of child Male		490
	# of child Female		552
	# of elderly male		173
	# of elderly Female		170
	Total # of People	4200	6018

Annex 3: Target persons for KIIs and FGDs

Date/Day	Targeted persons	Governorate
Wednesday 17/10/2018	**Five KII:** 1. Abdu Rgeeb Al Bukiri (DG of Tora Albaha district) 2. Mansoor Ahmed (head of Al Homarah water committee) 3. Reemah (female beneficiary from Al-Mahamasheen group) 4. Wnees Saeed Raoh (male beneficiary from Al-Mahamasheen group) 5. Faheem Saleh Thabet (Head of Al-Mahamasheen group) **Three FGDs:** 1. one for community hygiene volunteers: Merfat Jamal, Afrah Salam, Itdal Ahmed, Saba Mohammad 2. one FGD for families benefited from WASH intervention: Om Awab, Om Asem. Om Adrees, Om Aseel, Ibthal and Lol, Ali Fadhel, Naoman , Waheeb, Abdu Hazaaand Saeed Abdu 3. one FGD for Children in Al-Homerah village: Suleman Aidh (14 years), Ahmed Mansoor (9 years), Waheed Mustafa (10 Years)	**Lahj governorate** (Tor Al-Baha district)
Thursday 18/10/2018	**Six KII** 1. Inthathar Ahmed Ali (Manger of al-Farshah health unit) 2. Hiam Abdu Ahmed (Manager of Al-Gool health unit, 3. Adillah Mohammad saad (female nurses form Algool health unit) 4. Muneer Abdu Rasool (Male medical assistant in Algool health unit) 5. Miasah Abdu Hazaa (midwives from in Algool health unit) 6. Muna Ali Bin Ali (Medwife in Al-Furshah health unit). **Three FGDs:** 1. Community health and nutrition volunteers from Al-Furshah village: Hasna, Sumia, Sara Mymonah 2. Community health and nutrition volunteers from Al-Gool village: Miadah, Asrar, Feryal, Bushra, Khalofah, Semma, Linda and Daleen 3. families benefited from health and nutrition interventions in Al-Farshah village: Intsar, Aidah, Sadi, Munea, Yasmeen, Ibtsam, Osan, Rina and Samar	
Sunday 21/10/ 2018	**Eight KII**: 1. Ahmed Hikl (MOPH director of Tor Abaha district) 2. Fahman Mohammad Ali (manager of Tor Al Baha hospital 3. Busheer Thabet Salem (vice director of Tor Albaha district) 4. Muntaha Awad Ahmed (head of labor room) 5. Saad Mohammad Awad (responsible person for SAM program in Tor Albaha district) 6. Dekra Guide Turki (Manager of maternity center) 7. Jamal Saif Ali (responsible person for SAM program in the maternity center) 8. Tahani Ahmed Mohammad (midwife in the maternity center). **One FGDs** 1. six community health and nutrition volunteers : Nuha, Jala, Fatheah, Suzan and Islah	
Monday 22/10/2018	**Four KII** 1. Mohammad Ali Al-Syni (The general director of Al-Mudarabah district) 2. Abdu- Al-Gawi Ali (MOPH director of Al-madharabah district) 3. Jalal Ahmed Mohammad (manager of Al-Shut rural hospital) 4. Kholah Abdu-Al-Jaleel (female volunteer responsible for SAM program in Al-Shut district). **One FGDs**	**Lahj governorate** Al-(Madhrabah and Ras Al-Ara district)

	1. Four community health and nutrition volunteers including one housewife: Lina, Inhadh, Aml, Aswan,	
Tuesday 23/10/2018	**Two FGDs :** **1.** seven male community members: Fadel Ali (Head of the water project), Hafed Mohammad Qasem, Awad Mohammad Awad, Ali Mohammad Salem, Mohammad Ali Belal**,** Yaser Abdulla and Musaab 2. four housewives: Hamamah, Mazeka, Hibah and Bazoka	
Sunday 28/10/2018	**Three KIIs** 1. Mohammad Maheob (Manager of Bokean health center) 2. Rashad Abdu (member of the local authority of Sam'a district) 3. Nabeha Mushref (Head of reproductive health and counseling department) **Two FGDs** 1. Community health and nutrition volunteers: Amat Al-Aleem, Hadethah Hail, Taibah Foad, Soni Abdu-Al-Salam, Izah Abdu-Al-Rahman and Basmah Saif 2. Families benefited from health and nutrition intervention:Kafa Guude Ali, Zahrah Abdu saif, Nada Abdu-Al-Jaleel, Rehab Abdu Al-Aleem, Aisaha Mohammad	**Taiz Governorate** (Sam'a district)
Monday 29/10/2018	**Four KII:** 1. Azizah Abdu Al-Kareem (Manager of Al-Kaliabah health center) 2. Iftham Abdu Al-Jabbar (Head of reproductive health) 3. Badraiah Abdu Al-Ghani (medical assistant responsible for nutrition) 4. Nasrah Ali Abdulla (nurse volunteer) **One FGD** 1. Families benefited from health and nutrition intervention: Safa Mohammad, Samirah Hassan, Om Mohammad Ryadh, Om Wesam, Nadiah Abdu, Motemer Ahmed Haza and Tafkeer saeed	**Taiz Governorate** (Al-Maafer district)
Tuesday 30/10/2018	**Five KIIs** 1. Abdu Al-Wadood Abdu AlGhani (Manager of Al-Mesrakh district hospital) 2. Noreah Abdu Al-Azis (Nutrition officer in Al-Mesrakh hospital) 3. Abdu AlGhani Alqubati (Vice director of Al-Saweedi Hospital in Taiz) 4. Ahmed Abdu Al-Aziz ((Manager of Alshorah health center) 5. Alma Abdu (housewife in Akmah village)	**Taiz Governorate** (Al-Mesrakh district and Taiz city)
Wednesday 31/10/2018	**Three KII**s 1. Mohammad Abdu Lateef (Head of the Local water project in Al-Nageel village of Al-Mesrakh district 2. Saba Ali Ahmed (female WASH volunteer in Al-Mesrakh district) 3. Farooq Ali Ahmed (male WASH volunteer in Al-Mesrakh district). **Two FGDs**: 1. one for men beneficiaries of the local water project in Al-Doh and Al-Akdan villages in Al-Mesrakh district: Mohammad Abdulla Ahmed (Head of the A;-Akdan water project), Ahmed Mohammad, Abdu Hail, Abdu Rahman Ahmed, Abu Mohammad Qasem, Yahea Abdu Qasem, Qasem Abu Al-Majeed, Abu Al-Aziz farae 2. one for women beneficiaries of the local water project in Al-Doh and Al-Akdan villages in Al-Mesrakh district: Saeeda Ahmed, Intsar Abdulla, Horeah Abdulla, Roa Ahmed, Jamilah Abdu and Nabellah Quide	**Taiz Governorate** (Al-Mesrakh district)

Annex 4: Semi – structured interview tool for data collection

Qualitative data collection – Semi structured interviews "Health component"

1. What do you know about the project and its implemented activities and components?
2. What was your role in this project? How did you contribute towards the objectives of the project?
3. What is the impact of the project (positive and negative) in supporting mothers and children health, nutrition and clean environment in such emergency situation in your community?
4. To what extent do you think beneficiaries are satisfied with this project?
5. How children and their families participated in the project? Has the community participated in planning? Do you think they should have had a bigger role? What?
6. Was there any advocacy component has been implemented in the project to enable children and mothers' health?
7. Do you think you have increased your awareness of WASH, health and nutrition issues as a result of this project? How?
8. Do governmental authorities support the implementation of the project? Did the project help them to take their responsibility as a duty bearer in such emergency situation? How?
9. Did you know about the mobile clinics supported by SC? What services they offer? Contribution?
10. Are there any established mechanisms for project sustainability? (Administrative - financial - technical)?
11. What was the added value of SC in implementing this project (compared to other bodies)?
12. What are the criteria for beneficiary selection - marginalized? Any vulnerability criteria?
13. What do you know about the project M&E? Did you participate in any of its activities? Was data collected, analyzed and disaggregated by sex?
14. What were the biggest challenges facing the project?
15. Did the project take into consideration the participation of girls? Program gender sensitive approach?

Health questions Arabic:

- ماذا تعرف عن المشروع وماهى مكوناته؟
- ماهو دورك فى هذا المشروع؟ كيف ساهمت نحو اهداف المشروع؟
- ماأثر المشروع (ايجابى وكذلك سلبى)على الحياة فى مجتمعكم فيما يخص الصحة والتغذية والمياه ولنظافة فى مثل ذلك الأوضاع الطارئة؟
- الى اى مدى ترى ان المستفيدين راضيين عن هذا المشروع؟
- هل شارك المجتمع المحلى (خاصة الأطفال والشباب) في التخطيط المشروع؟ كيف كانت مشاركتهم؟ هل ترى انه يجب ان يكون لهم دور اكبر؟ ماهو؟
- هل هناك اى مكون من مكونات الدعوة وكسب التأييد تم تنفيذه فى المشروع داخل المجتمع لتمكين المشروع من تحقيق نتائج إيجابية فيما يتعلق بصحة الأم والطفل؟ (هل يتم ذلك بمشاركة كافة الاطراف فى المجتمع)
- - هل كانت هناك مشاركة من الجهات الحكومية فى تحمل مسئولياتها في تحسين الوضع الصحى والتغذية؟
- هل ترى انه زاد وعيك بقضايا الصحة والتغذية كنتيجه لهذا المشروع؟ كيف تقيم ذلك؟
- هل أفاد المشروع الفئات المهمشة والأطفال ذوي الاعاقة؟ كيف؟
- هل هناك اى تغير طرأ على شخصية افراد المجتمع وخاصة الأمهات والأطفال الذين تم استهدافهم عن طريق المشروع؟ هل تغير امكانية وصولهم الى الخدمات الصحية والتغذية؟ كيف تصف هذا التغير؟
- هل هناك اليات لاستمرارية المشروع؟ (ادارية – ماليه – تقنية – مجتمعية)
- ما القيمة المضافة التى تقوم بها منظمة رعاية الأطفال فى هذا المشروع فى مجتمعكم (ماذا يميزه عن غيره من الهيئات)؟
- ماهى مواصفات اختيار المستفيدين – كم عدد المهمشين؟
- ماهو نظام المتابعة والتقييم للمشروع ومن شارك فى المتابعة والتقييم للمشروع؟ هل يتم تحليل البيانات حسب النوع الاجتماعى؟
- ما أكبر التحديات التى واجهت المشروع

Annex 5: Work plan

Day	Task	Responsibility
30th Sep	Draft Inception report	Ahmed
3rd Oct	Comment from SC	SC- Yemen
9th Oct	Final inception report	Ahmed
10th Oct	Tools development/revision for the field work (IDI and FGDs guidelines)	Abduallah + Ahmed
17th Oct – 23rd Oct	Field work in Lahj	Abdallah
23rd Oct – 31st Oct	Field work in Taiz	Abdallah
2nd – 14th Nov	Data analysis (nodding, thematic)	Ahmed
24th Nov	Draft report	Ahmed
29th Nov	Comments on the report	SC - Yemen
30th Nov	Final report	Ahmed

The table below summarize the exact primary data collected during the evaluation.

Date/Day	Activity	Governorate
Wednesday 17/10/2018	- Five KII (DG of Tora Albaha district, head of Al Homarah water committee and two males and one female marginalized persons forl Al-Mahamasheen group) - Three FGDs (one for community hygiene volunteers, one FGD for families benefited from WASH intervention and on FGD for Children in Al-Homerah village)	**Lahj gov.** (Tor Al-Baha district)
Thursday 18/10/2018	- Six KII (Manger of al-Farshah health unit, Manager of Al-Gool health unit, and one males and one female nurses form Algool health unit and two midwives from both health units. - Three FGDs (Two for community health and nutrition volunteers (one from each village), one FGD for families benefited from health and nutrition interventions in Al-Farshah village.	
Sunday 21/10/ 2018	- Nine KII (MOPH director of Tor Abaha district, manager of Tor Al Baha hospital; vice director of Tor Albaha district, head of labor room, responsible person for SAM program in Tor Albaha district, Manager of maternity center, responsible person for SAM program in the maternity center and midwife in the maternity center. - One FGDs (six community health and nutrition volunteers (three from the catchment area of the district hospital and three from the catchment area of the maternity center).	
Monday 22/10/2018	- Four KII (The general director of Al-Mudarabah district, MOPH director of Al-madharabah district, manager of Al-Shut rural hospital; female volunteer responsible for SAM program in Al-Shut district. - One FGDs (six community health and nutrition volunteers including one housewife) + one case study	**Lahj gov.** Al-(Madhrabah and Ras Al-Ara district)
Tuesday 23/10/2018	- Two FGDs (seven male community members and four housewives)	
Sunday 28/10/2018	- Three KII (Manager of Bokean health center, member of the local authority of Sam'a district, Head of reproductive health and counseling department) - Two FGDs (one for community health and nutrition volunteers, one FGD for families benefited from health and nutrition intervention)	**Taiz Gov.** (Sam'a district)

Monday 29/10/2018	- Four KII (Manager of Al-Kaliabah health center, Head of reproductive health, medical assistant, and nurse volunteer - One FGDs (FGD for families benefited from health and nutrition intervention)	**Taiz Gov.** (Al-Maafer district)
Tuesday 30/10/2018	- Five KII (Manager of Al-Mesrakh district hospital, Nutrition officer in Al-Mesrakh hospital, Vice director of Al-Saweedi Hospital in Taiz, manager of Alshorah health center and housewife in Akmah village	**Taiz Gov.** (Al-Mesrakh district and Taiz city)
Wednesday 31/10/2018	- Three KII (Head of the Local water project in Al-Nageel village of Al-Mesrakh district female WASH volunteer in Al-Mesrakh district, male WASH volunteer in Al-Mesrakh district. - Two FGD: one for men and one for women beneficiaries of the local water project in Al-Doh and Al-Akdan villages in Al-Mesrakh district +one case study	**Taiz Gov.** (Al-Mesrakh district)

Annex 6: Evaluation TOR

Background

Save the Children (SC) is an apolitical international non-governmental organization and has been working in Yemen since 1963, implementing health, nutrition, child protection, food security, livelihoods and WASH interventions. SC has operational presence in nine Governorates in Yemen. In all of the thematic areas, SC is working to address both immediate humanitarian needs and their underlying causes as well as chronic underdevelopment. To achieve its goals SC works with line ministries and local authorities within its sphere of operation.

After over 3 years of conflict, Yemen continues to experience one of the most severe humanitarian crises in the world, with large-scale displacement, severe deterioration of water and sanitation services, breakdown of the health care system, collapse of the economy and significant erosion of income generating capacity. The Yemen Humanitarian Needs Overview (HNO) of 2017 estimated that 18.8 million people in Yemen were going to be in need of humanitarian assistance for the year 2017, including 10.3 million people in acute need. Out of the 18.8 million people estimated to be in need of humanitarian assistance, 3.8 million people were from Aden, Lahj and Taiz Governorates (southern part of Yemen). At the beginning of May 2017 Yemen experienced a second wave of Cholera outbreak which has been referred to as the worst ever Cholera outbreak in human history, which had claimed just above 2000 lives as of November 2017. SC received financial support in December 2016 from the Disaster Emergency Committee (DEC) to respond to the humanitarian needs in Lahj and Taiz.

The humanitarian response by SC under the DEC project was implemented in two phases. The first phase of the response ran from December 2016 to June 2017 (six months). Funding was extended into DEC phase 2 from July 2017 running up to April 2018 (10 months). During Phase 1, SC supported health facilities with emergency medical supplies (that included supplies for the cholera response), general medical supplies for health & nutrition, distributed mosquito nets & hygiene kits and rehabilitated latrines & water schemes in all supported Health Facilities. All activities under the project were conducted in coordination with the Ministry of Public Health & Population (MoPHP). For Phase 2 SC has been focusing on the cholera response, conducting awareness sessions on cholera prevention, rehabilitating community water schemes to provide clean water, building latrines at community level and continuing the provision of medical supplies to HFs. SC has also been conducting measles vaccinations in its area of intervention and continued to work in coordination with the MoPHP.

Objectives of the evaluation

The objectives of the evaluation will be to:

i. *Assess the extent to which the project met set objectives as stipulated in the project log-frame*
ii. Assess the extent to which Save the Children met key CHS commitments during implementation of the DEC project
iii. Assess service satisfaction of the beneficiaries
iv. *highlight lessons learnt, and recommendations to feedback into current and future SC programming*

Scope and purpose of the evaluation

The evaluation will be an end of program evaluation to assess the performance of a SC implemented emergency response programme on health, nutrition and WASH in Lahj and Taiz Governorates supported by DEC. The main purpose of the evaluation will be to obtain lessons learnt during the whole program cycle, from program design and throughout implementation. The lessons learnt from this evaluation will be used to inform SC's current and future programmes. Objectives and questions on the evaluation will be formulated following the Core Humanitarian Standards on Quality and Accountability (CHS) commitments. Suggested key themes to be explored during the evaluation will be:

CHS commitment on humanitarian response	Notes
Assistance is appropriate and relevant	Communities and people affected by crisis receive assistance appropriate and relevant to their needs
Response is effective and timely	Communities and people affected by crisis have access to the humanitarian assistance they need at the right time

Actions strengthens local capacities and avoid negative effects	Communities and people affected by crisis are not negatively affected and are more prepared, resilient, and less at-risk as a result of humanitarian action
Action is based on open feedback and inclusive participation	Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them
Complaints are welcomed and addressed	Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.
Action is coordinated and complementary	Communities and people affected by crisis receive coordinated, complementary assistance
Actors continuously learn and improve	Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection
Staff are supported to do their job effectively, and are treated fairly and equitably	Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers
Resources are managed and used responsibly for their intended purpose	Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically

In addition to the generic CHS commitments for programme and/ or project evaluation non-discrimination will be explored to understand the extent of gender sensitiveness and/ or promotion equality & equity. The consultant should be also assessing the program's use and adherence to SC's quality benchmarks in ensuring quality programming.

Evaluation questions

The draft evaluation questions are outlined below. The consultant will be able to review and revise the questions in consultation with SC Yemen country office MEAL team.

1. ***Communities and people affected by crisis receive assistance appropriate and relevant to their needs***

   Key questions will include:
   - *To what extent were the interventions in the DEC project relevant to the needs of key stakeholders (local authorities/ MoH and affected communities)?*
   - *To what extent did the DEC project take into account the needs of different groups (girls, boys, women, men, people with disabilities, Muhamasheen etc.)?*
   - *How satisfied are girls, boys, women and men with the DEC project and Save the Children?*
   - *Are we responding in the most affected/most vulnerable geographic areas (taking into account needs and gaps)?*
   - *Are the activities and outputs of the programme consistent with the overall mission and goals of Save the Children International and its Yemen Response Strategy?*
2. ***Communities and people affected by crisis have access to the humanitarian assistance they need at the right time and the response is effective***
   - To what extent were targets met as set in the log frame?
   - Were activities delivered according to the implementation plan? If not, what caused delays/changes in the implementation plan? And how did the team address them?
   - What were the major factors influencing the achievement or non-achievement of set objectives?
   - What factors influenced or undermined program quality? What could we do differently in the future to ensure our programmes are of high quality?
   - To what extent were interventions integrated across themes (health, nutrition and WASH)?
   - To what extent various cross cutting issues mainstreamed into the interventions such as protection and inclusion of marginalized groups - especially children & women?
3. ***Communities and people affected by crisis are not negatively affected and are more prepared, resilient, and less at-risk as a result of humanitarian action***

   a) To what extent does the DEC project build on local capacities and how does the response work with the local community, local partners and government authorities?

b) How has the DEC project influenced the affected communities (positively or negatively)? Was the project able to monitor, mitigate and respond to any unintended negative effects?

4. ***Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them***
   - ***a)*** *During the DEC project how well did SC provide information to communities and people affected by crisis about the organisation, the principles it adheres to, how it expects its staff to behave, the DEC project and what they intend to deliver?*
   - *b) How is information sharing mechanisms/ channels identified and how is accessibility and cultural appropriateness considered? How is information sharing planed as part of programme activities?*
   - *c) Were beneficiaries/ communities including children engaged/ able to participate in various stages of programming in the DEC project: design, implementation, monitoring? How are gender, age and diversity considered? What works well and how improvements could be made?*
   - *d) How are we utilising feedback from children and communities in our programming? Is beneficiary feedback influencing our future programming?*
5. ***Communities and people affected by crisis have access to safe and responsive mechanisms to relay complaints.***
   - *a) Are there ways for affected people to provide feedback and/or lodge complaints? How well does SC manage and document complaints from affected people? Does SC do so in a timely, fair and appropriate manner that prioritises the safety of the complainant and those affected at all stages?*
   - *b) What was the response rate and quality of response to complaints and suggestions from stakeholders?*
6. ***Communities and people affected by crisis receive coordinated, complementary assistance***
   - To what extent did SC coordinate with all stakeholders (e.g. local authorities at national and sub-national level, communities and other actors) during the DEC project and what effect has such coordination made to the project?
7. ***Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection***
   - a) How is learning from evaluations and reviews of similar programmes consulted and incorporated when appropriate in programme design? What processes and good practices are in place? What can be improved and how?
   - b) How is learning shared and disseminated with relevant stakeholders? What good practices exist? What can be improved and how?
8. ***Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers***
   - a) To what extent were staff at various levels and locations trained and supported to apply technical approaches, standards relevant to their work and management competencies to fulfil their role during the DEC project? What are good practices? Are there any major gaps? How can improvements be made?
9. ***Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically***
   - *a) Are there any measures to ensure resources are well used balancing quality, cost and timeliness within the DEC project? What processes and good practices are in place? What needs to be improved and how?*

Evaluation methodology

The methodology will be determined by the consultant, with approval from SC's commissioning manager. However, the consultant must follow the evaluation guidance as set out in the SC Evaluation Handbook. The consultant should ensure that there is meaningful participation from children in the evaluation for programmes that had activities planned for children.

Suggested methodologies are as follows:

- Desk review of all existing key documents, monitoring data and reports from the program such as but not limited to the Project proposal, M&E Plan, IPTT and Progress reports.
- Key informant interviews (KII) with relevant key stakeholders (from national & field offices) such as beneficiaries and staff from MoPHP, other NGOs and SC.
- Visiting of the project site.

Evaluation team

The evaluation will be led by an independent external consultant with a respective independent team of enumerators.

The following qualifications and skills are expected of the lead consultant:

- *An advanced university degree in public health/ health systems management or related health field.*
- *At least 7 years' experience in the area of health, nutrition or WASH.*
- *Technical expertise in evaluation, preferably health and nutrition programmes in chronic emergency contexts;*
- *Previous experience in M&E, including conducting end of project evaluations for large-scale projects*
- *Thorough understanding of data collection methods*
- *Strong skills in quantitative and qualitative methods*
- *Strong interpersonal and communication skills;*
- *Fluency in English is a must, fluency in Arabic (preferred) and an added advantage;*
- *Experience/knowledge on gender sensitive programming*
- *Understanding of child safeguarding and child participation procedures*
- *Experience of working in the middle east and/ or Yemen is a plus*

Roles and responsibilities

- *The following is expected of the consultant:*
- *Review project documents*
- *Submit the inception report.*
- *Development and review of data collection tools.*
- *Ensure data collection, entry and analysis.*
- *Training of enumerators and project team (internal)*
- *Debrief on preliminary findings at both field office and country office*
- *Submission of the draft evaluation report for review – as per SC format.*
- *Submission of final evaluation report and datasets*
- *Dissemination of findings to experts and national stakeholders where necessary.*
- *Seek clearance, authorization and approvals from all relevant authorities*

Expected outputs

The expected outputs of this evaluation are as follows:

- Inception report (not exceeding 30 pages)
- methods and tools
- data sets
- Final report. (with an executive summary of max 2 pages)
- Power point presentation of the findings (not exceeding 15 slides)
- Presentation of findings to key stakeholders

Administration and Logistics

SC will provide all the necessary logistics needed for field visits, monitoring and verification processes. The commissioning manager for this evaluation will be the field managers of Lahj and Taiz with technical support from the respective field offices' health and nutrition managers, MEAL Coordinators and country office technical team.

Copyright and intellectual property rights

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Timeline/ schedule

The whole process from Data collection, analysis and reporting is expected to be completed in not more than 21 days. Work progress equivalent to the schedule below is expected.

Activity	**Timeframe**
Application deadline	24-July-2018
Inception report submission	31-July-2018
Field work	5-Aug-2018 to 16-Aug-2018
Final report submission	23-Aug-2018

Application process

Interested candidates should submit an expression of interest which will includes

A technical proposal: *The technical proposal should briefly and clearly describe the following aspects; Understanding of the task, Technical aspect of the proposal, Methodology (Evaluation strategy, Sampling design, Data collection tools, Data Processing & Analysis, Data quality control measures and timelines or operational plan.*

A detailed curriculum vitae (CV): *detailed CV of the lead consultant with contact details (the CV should include at least two traceable references)*

Financial proposal*: A signed financial proposal/ budget of the tasks should be broken down into modules, detailing the following: Consultancy fees, Questionnaire development cost, Data processing & analysis, Communication, and Reporting costs and other Miscellaneous (stationeries, printing, etc.).*

Sample of previous: The lead consultant must be willing and ready to share a sample of the his or her previous work upon request.

Applications should be sent to Yemen.Jobs@savethechildren.org with the subject title "Yemen Crisis Appeal DEC Phase II Final Evaluation Consultant".