Final Evaluation of

DEC Supported Emergency Response Project in Amran and Abyan Governorates, Yemen

Submitted to

CARE International in Yemen

May 2018

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Abbreviations

AWD	Acute Watery Diarrhea
CBCs	Community Based Committees
CFW	Cash for Work
CI	CARE International
CIUK	CARE International UK
CIY	CARE International in Yemen
DAC	Development Assistance Committee (of the OECD)
DEC	Disasters Emergency Committee
FCS	Food consumption Score
FGD	Focus Group Discussion
HHs	Households
IDP	Internally Displaced Person
IGA	Income Generating Activity
INGO	International Non-Government Organization
IYCF	Infant and Young Children Feeding
KII	Key Informant Interview
M and E	Monitoring and Evaluation
MoPHP	Ministry of Public Health and Population
NGO	Non-Government Organization
OCHA	Office for Coordination of Humanitarian Affairs
OECD	Organization for Economic Cooperation and Development
OMS	Organizational Management and Support
ORS	Oral Rehydration Solution
PHP	Public Health Promotion
SGBV	Sexual and Gender Based Violence
ToR	Terms of Reference
ToT	Training of Trainers
U-5	Under-5 (children under five-years age)
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Program
WHO	World Health Organization
YHRP	Yemen Humanitarian Response Plan
YR	Yemeni Rial

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Executive Summary

Under the Yemen Crisis Appeal and with the support from Disasters Emergency Committee, CARE Yemen has been implementing two emergency response projects in Abyan and Amran Governorates of Yemen with the aim of responding to the WASH, food insecurity and Cholera/Acute Watery Diarrhea (AWD) Crisis. This report provides the findings of the evaluation of the two phases of the DEC funded emergency response projects in Sawyer districts of Amran Governorate, Yemen.

The overall purpose of this evaluation was to ensure accountability and identify lessons learned and best practices so as to feed into and inform the decision making process of the project stakeholders, including the donor, beneficiaries, and government counterparts. In addition, the evaluation aimed to objectively assess the relevance, efficiency, effectiveness, and sustainability of the project in light of its objectives and provide recommendations for future programming. Furthermore, the evaluation assessed how the project ensured accountability to affected groups, considering the commitments of the Core Humanitarian Standards, and how the project ensured quality of implementation vis-à-vis emergency response standards such as SPHERE.

The evaluation utilized a mix of both quantitative and qualitative methodologies, such as review of project's documents; direct observation; interview with project staffs and other stakeholders; and household survey and Focus Group Discussions (FGDs) with beneficiary households. The evaluation team has conducted the following data collection processes:

a) Household surveys were administered (using a questionnaire) with randomly selected 357 households, which constitute 30% of the total beneficiary HHs;
b) Key Informant Interviews (KIIs) were conducted with 3 community leaders and 2 local authorities' officials;
c) Four FGDs (including both men and women) were conducted with direct beneficiaries and the project's Community Based Committees (CBCs). The FGDs were attended by 33 women and 35 men in two different targeted areas of Swuayr district.
d) Direct observation via field visits, where the team verified the physical achievements of the project (i.e. rehabilitation of water schemes).

The overall evaluation work – including preparatory activities and inception phase - was conducted from December 2017 to January 2018, where the field work took place in the last week of January 2018.

Findings

Overall, the project – in both phases - has met its intended objectives of meeting the basic and immediate needs of beneficiary households through cash-for-work intervention; increasing access to safe drinking water, and improving the knowledge of community members in key hygiene and sanitation practices. The rehabilitation of water schemes has addressed the critical needs of safe drinking water of the most vulnerable and underserved people in the targeted districts. These is still a need to work in the targeted communities with other forms of water harvesting interventions so the beneficiaries could

get the minimum quantity of water (15 lpd) in winter as in summer season. The rehabilitated schemes need also to install more water taps to ensure people are not waiting more than 30 minutes during collection of water as per SPHERE standards.

This intervention has saved community members from both physical injury and death (due to falling down to the well), and also by keeping it clean and safe from contamination by human and animal waste. The cash transfer activity under Phase 1of the project has enabled beneficiary households to meet their basic and immediate needs (mainly food) and thereby enhancing their food security and nutritional status. The interventions under Phase 2 of the project – comprehensive WASH and cholera/response programming – have contributed in the reduction of the incidence of AWD/cholera in the project targeted areas.

Lessons learned

- CARE has opted to implement a conditional cash programming in Phase 1 of the project in Amran and Abyan. This proved to be effective as the intervention, apart from meeting its objective of enhancing access to cash for basic and immediate needs, has increased access to key community assets (i.e. water schemes) and promoted communities' empowerment so that they can enhance their capacity to mitigate future shocks.
- The project has ensured participation of community members in the various interventions, such as establishment of community committees, selection of beneficiaries, and identification of water schemes for rehabilitation. The project also established community-based water committees to manage the rehabilitated water schemes effectively. This has increased the level of ownership by community members and contributes to sustainability.
- The rehabilitation of water schemes in Phase 1 of the project was not accompanied with hygiene/sanitation promotion activities. Had the project been involved in hygiene promotion activities, the incidence of cholera/AWD in the project locations might have been reduced. Therefore, future water schemes of rehabilitation and/or construction activities should be integrated with hygiene/sanitation promotion to reduce morbidity that may emanate from water-borne diseases.
- Cash transfer activities need to be further integrated with other livelihood-based interventions, as well as nutrition promotion activities. This will give beneficiaries the opportunity to engage in livelihood interventions and provide them with the knowledge and capacity to diversify their diet and improve the impact results of the project.
- Although it requires further study, participants in the FGDs claimed that the chlorination exercise had adverse effect on the few bee colonies that exist in the area, and many bees died consequently. To mitigate this challenge, the beehives' keepers needed to be warned and informed to find another water resource for watering their bees prior to the chlorination. However, the chlorination of water sources did not have any immediate negative impact on livestock within the timeframe of this evaluation.
- The project has been closely coordinated with the district level health office in provision of 15,000 soaps to 8 health facilities that have diarrhea treatment centers, as well as in training of community health volunteers with key

hygiene/sanitation and nutrition issues such as hand washing, symptoms/treatment of cholera/AWD, water treatment techniques, environmental sanitation, and Infant and Young Children Feeding (IYCF) practices, such as breastfeeding and complimentary feeding. These activities have complemented one another, allowing volunteers to have the right skills and supplies to implement nutrition-sensitive hygiene/sanitation promotion intervention.

- The project has hired skilled people to participate in the cash for work interventions especially in rehabilitating water wells and the final construction work, which must be technically done with ensuring safety and sustainability in mind. Having these skilled personnel in the implementation process have provided great opportunities for the youth in the targeted villages to transfer construction skills (learning by doing) due to their daily and closely participation on CFW activities. Now, the youth have more opportunities to work in construction activities in any place.

Recommendations

- Although water trucking in villages affected by AWD/Cholera is considered a life saving measure, there is a need to have an exit strategy for future similar projects before implementing water trucking activities. This includes informing beneficiaries (especially women as the main water collectors in their households) of the water trucking schedule, in particular before the water trucking is stopped.
- Women and girls are primarily responsible for fetching water from the sources as well as for preparing food in the household. Therefore, designing nutrition-sensitive hygiene promotion interventions that target women/girls is vital as there is direct correlation between hygiene/nutrition promotion and food safety. CARE should take the inclusion of nutrition themes into consideration in current WASH interventions as well as while designing new WASH programs.
- Targeted beneficiaries are in need of more integrated forms of assistance, in particular which should be provided in the form of cash for work to build up their sanitation services combined by behavior change activities to encourage the access and use of sanitation services. Accordingly, it is recommended to have a more integrated assistance as this maximizes impact at household level.
- It is recommended that CARE and other humanitarian actors hire high skilled personnel in the cash for work interventions especially in rehabilitating water wells and any other construction work to ensure quality training, better guidance and opportunity to local young people to acquire construction skills (learning by doing). This will provide beneficiaries with more opportunities to work in construction sector in the future and will add to the sustainability of the project capacity building activities.
- There is a need to secure enough time for implementing Cash for Work activities, especially that involves rehabilitation/construction of key communal assets such as water schemes so as to ensure quality implementation, sustainability, and also improving community's access to the assets.
- It is recommended that CARE conduct further studies/assessments in its operational areas regarding the effect of water chlorination on bees as might affect the local production of honey in the project areas.

- There was high participation of the community in the various phases of the project and this best practice is recommended to be taken as exemplary for similar future activities.
- The best practices and the lessons learnt from this DEC-supported project need to be shared with other relevant humanitarian actors through clusters meetings (i.e. WASH, food and livelihood clusters) to inform the design of similar future activities. Furthermore, CARE needs to replicate these best practices and lessons in on-going as well as future similar programs.
- Due to the great need in Suwayr District, it is recommended that CARE work on securing additional fund for a third phase in villages of the same district villages. The design of the project in the new phase should be informed by the lessons learned from the design and implementation of the current project.

Summary of the assessment against Evaluation Criteria

Relevance

The evaluation team found that interventions in both Phase 1 and 2 were relevant to the following strategic objectives;

1. Under the Yemen Humanitarian Response Plan 2017 (YHRP), strategic objective 1 which is **to provide life-saving assistance to the most affected people in Yemen through an effective and targeted response;** moreover, strategic objective 2 which is **to support and preserve services and institutions essential to immediate humanitarian action and the promotion of livelihoods and resilience**.
2. The cash transfer activity of Phase 1 was also in line with the 2017 YHRP objective of provision of life-saving assistance to the most vulnerable people and also with the Food Security and Agriculture Cluster objective of **improving availability of and access to food for the most vulnerable.**
3. WASH cluster objective 2, which is **to provide emergency WASH assistance to the most vulnerable so as to reduce excess morbidity and mortality.** The comprehensive WASH intervention was also aligned with the preventive approach integrated activities suggested in the Joint Cholera Response Plan – Yemen July 2017.

The conditional cash transfer (Cash-for-work) scheme was appropriate for integrating food security and WASH response, and facilitated more participation of HHs headed by women, children, elderly, IDPs and other marginalized groups/muhamasheen[1]. Men and women agreed during FGDs that all targeted groups have participated equitably by giving women less labor-intensive work such as bringing water needed for rehabilitation of the water wells, while persons with disabilities (PWD) sent someone else from their family instead. CARE had ensured such gender and PWD sensitive approaches within its emergency

[1] Muhamasheen are minority social groups who tend to suffer more acutely from long standing discrimination. While constitutionally they are Yemeni citizens with equal rights, widespread differential treatment has kept them in extremely disadvantaged conditions.

response so that vulnerable female-headed households, as well as vulnerable marginalized households were prioritized in the beneficiaries' selection process.

The rehabilitation of six water schemes in the targeted communities under this project was life-saving both through prevention of water from contamination from human and animal waste, as well as by facilitating the access to water at more appropriate times with the addition of solar pumps. By having more wells functioning, as well as being placed strategically near to the targeted communities it has helped to decrease waiting time to get enough water to less than 30 minutes for two thirds of the targeted beneficiaries. The rehabilitation of the water schemes by installing solar pumps is considered very relevant to the local context and needs, since the previous water pumps worked on fuel which required operation/fuel costs. Targeted communities cannot afford those costs due to loss of government salaries since August 2016, and loss of other livelihood opportunities due to the prolonged war. Although the WASH intervention under Phase 1 of the project has addressed the problems related to access to safe water for drinking and other household needs, it did not address the dire needs of the community for sanitation and hygiene intervention as this project did not have the hygiene/sanitation component.

The contribution of the DEC supported project towards mitigating the AWD/cholera outbreak in Suwayr and Al-Madan districts of Amran governorate was significant. The project has been implemented in a situation where there was high demand for NGO's interventions due to the low capacity of the government to prevent and control the outbreak. With close coordination with local authorities, INGOs and General Authority for Rural Water Supply Projects (GARWSPs), the project contributed to controlling the cholera outbreaks in two districts (Suwayr and Al Madan) through implementation prevention activities by close coordination with GARWSPs. Three main activities have been implemented, (1) chlorination of water sources (wells, stony water tanks), (2) distribution of chlorine tablets to the households where the areas have confirmed cholera cases, suspected cholera cases, and AWD, (3) disseminate awareness messages concerning cholera preventions and use of chlorine tablets. All these interventions helped to reduce the incidence of AWD/Cholera outbreak.

Efficiency

The evaluation team found that Phase 1 of the project was well integrated and jointly implemented with the General Food Distribution (GFD) interventions which implemented by CARE with support from WFP in the same district. As part of the program design and to reach greater impact, locations targeted for water schemes under Phase 1 were the same as those for CFW. Phase 2 of the project was successfully integrated with other interventions implemented by other agencies such as WHO through the health sub-office, UNICEF, Taiba Foundation, in the targeted district for prevention and response to AWD/Cholera outbreak. The health office officials and staff confirmed that CARE's activities were very important component of the cholera response efforts in the district. CARE provided hygiene kits to health facilities so patients both admitted into the hospital with cholera and those suspected of being infected, were able to benefit from the kits to help reduce and/or mitigate the infection when back home.

Local district authorities in Suwayr also confirmed that CARE's support has contributed to the districts' development plans to rehabilitate the water schemes, and asked for more

support as there are still many open water wells that were left and other WASH needs. They appealed for CARE (and other development partners) to continue implementing WASH projects. These strong coordination and integration of activities among local authorities and humanitarian agencies at the field level have contributed to achieving the intended outcome of the project.

Despite late start of the project, especially during the Phase 1 due to a delay in the approval by local authorities, all planned activities in both phases were implemented within the planned period. This is also in consideration of the deteriorated security conditions and challenging circumstances, as well as tight budget and timeline compared to the project objectives. Financial resources were allocated adequately and strategically to achieve the project's outcomes of enhancing access to comprehensive WASH services; reducing morbidity through preventing/controlling the incidence of cholera/AWD, and meeting the basic and immediate needs of beneficiary households. CARE has a strong financial system to regularly and constantly monitor the financial situation of the project. This helped to effectively utilize the project budget to implement the planned activities timely.

With regard to monitoring, evaluation, accountability and learning (MEAL), the project had developed a clear MEAL plan to monitor program implementation, enable program responsiveness, and ensure that the program achieves its objectives and goal. In addition to conducting regular field monitoring, beneficiaries' data were collected dis-aggregated by age, sex, and location. Post Distribution Monitoring Surveys (PDMS) have also been conducted to know the effectiveness of the project and to understand the satisfaction level of beneficiaries on the quantity and quality of distributed items including cash. Furthermore, project review sessions were conducted after the completion of Phase 1, and will be carried out for Phase 2 once it is completed, to collate lessons and best practices so as to feed into future similar programs. CARE also put in place a complaints and feedback response mechanism (CFRM) so that community members can voice their concerns on the project's activities.

Effectiveness and Outcomes

The effectiveness and outcomes of the project in different phases were examined as follows:

Phase 1:

During this phase, the project reached 390 HHs (2,742 individuals: 1,491 males and 1,251 females) with three rounds of cash transfer so that they have increased access to income to meet their basic and immediate needs. The full target of CFW as per the project's output table of 390 HHs was achieved. Each household received 108$/round. CARE followed a conditional cash transfer scheme whereby the beneficiary households participated in the rehabilitation of water schemes. Through the rehabilitation work, 2,543 HHs (17,801 individuals: 9,551 males and 8,250 females) have increased access to safe-drinking water.

Findings of this evaluation indicated that 86% of the cash assistance was utilized for purchase of food which signifies that the cash transfer intervention under this project contributed to enhancing the food security status of beneficiary households. This was

corroborated by the findings of the survey where the average Food Consumption Score (FCS) of beneficiary households was 45.2[2]. Comparing to the FCS results of 30.2 prior to the project (as per the need assessment survey conducted by CARE in December 2016 in Amran governorate) this shows a significant improvement. About 97% of the beneficiaries were satisfied of three cycles of cash for work (CFW) distribution that have been provided to 390 HHs. Although it is of small scale, young[3] people assured that it bridged the gap in their access to cash that contributed to more diversification of their food for three months and requested more cash assistance. However, all respondents in group discussions complained that the three months of Cash for Work was not enough due to loss of any opportunities of casual work in their areas and outside the district.

Women were appropriately involved in CFW activities, as well as in the community-based committees established for water scheme management. Participants of the FGDs mentioned that by having community accepted roles during rehabilitation of the water wells, such as bringing water for the rehabilitation work, was easier to encourage their participation. HHs with disabled people, IDPs and muhamasheen were all involved in planning and implementation of the CFW activities.

A total of six water schemes was rehabilitated via the CFW scheme and this intervention has increased access to safe water for community members residing in the area. The findings of the evaluation indicated that the percentage of beneficiary households that access water from protected water sources has significantly increased from 0% to 95%. However, in some areas, such as that of Bani Kobas village, people still need one other water well to be rehabilitated since the well rehabilitated by this project does not produce enough water during winter season. This results in the community drinking from other unprotected water sources, leaving them exposed to water-borne diseases.

Phase 2;

Prior to the implementation of Phase 2 of this project, more than 3,968 people were admitted to health facilities with AWD/Cholera, and with six registered deaths in Swuayr directly linked to the disease and 7,703 suspected cases of AWD/Cholera were reported in Al-Madan. This project has effectively complemented the activities and efforts of other partners in the district, by contributing to the reduction of this outbreak to zero admission to health facilities by the time of evaluation. This was done by chlorination of water sources and raising awareness at targeted communities on preventive measures, such as treatment of water by chlorine, boiling and or using water filters. Hygiene awareness activities also included hand washing at critical times, using oral rehydration solution, identifying signs and symptoms of cholera, and importance of quickly transfer patients to health facilities.

The water trucking activity to community members has also increased access to safe water. The project reached 2,137 HHs (14,950 individuals) through distributing 11,750,000

[2] The FCS is considered as a proxy indicator of current food security. The sum of the scores from different food groups is used to determine the FCS. The maximum FCS has a value of 112 which would be achieved if a household ate each food group every day during the last 7 days. The total scores are then compared to pre-established thresholds: Poor food consumption: 0 to 28; borderline food consumption: 28.5 to 42; and acceptable food consumption: > 42

[3] Yemen's Youth Employment Action Plan defines youth and adolescents as between 15-29 years.

liters of water via water trucking. In addition, 4,050 HHs (18,732 individuals) were supported with two rounds of consumable hygiene kits distribution and also with distribution of cholera kits. The project also conducted 585 sessions and reached 17752 individuals with hygiene promotion activities in Phase 2 which contributed to the knowledge of community members in key hygiene and sanitation practices, such as identifying the signs/symptoms of cholera/AWD, using soap/detergent for handwashing, and water treatment. However, there is a need for more hygiene promotion activities on handwashing during critical moments and the importance of using latrines as only 49% of survey participants practice handwashing during at least three critical moments of hand washing.

Sanitation also still needs to be addressed in more comprehensive approach considering high prevalence of open defecation. This is corroborated by the findings of the survey where only 10% of interviewed HHs have access to latrines. Women FGD participants In Al Ghanaya village mentioned that they still need assistance to build latrines as only two houses in the entire village have latrines and the rest of community members practice open defecation.

Sustainability:

Although the project has achieved the targeted activities, sustainability of the outcomes of the project needs much attention. The main sustainability aspects of the project interventions are:

- The rehabilitation of water systems: the project has established water-management committees to manage the water schemes beyond the project period. This along with working with the local water authority ensures the sustainability of the project outcomes.
- Awareness and trainings: As per the results of the survey, the awareness sessions and training of community volunteers have had a positive impact on the knowledge and practice of the community. As the community volunteers were trained by and also linked to the district health office, they are in a position to communicate with the health office during incidences of water borne diseases.
- Coordination with local authorities, health office, and water office: In order to avoid an abrupt exit, CARE has coordinated with the local councils, health office, and the GARWP in all phases of the project that to ensure
- its sustainability and continuity. The most important aspect was a focus on the community committee capacity building.

Section 1: Introduction, Purpose and Methodology:

1.1 Background

Under the Yemen Crisis Appeal and with the fund from Disasters Emergency Committee, CARE Yemen has been implementing two emergency response projects in Abyan and Amran Governorates of Yemen with the aim of responding to the WASH, food insecurity and Cholera/Acute Watery Diarrhea (AWD) Crisis. The Phase 1 of the project was implemented in two districts of Abyan and Amran Governorates from 16 December 2016 to 30 June 2017 and had two prongs: increasing household income through cash for work intervention and increasing access to safe drinking water through rehabilitation of water sources under the cash for work scheme. The Phase 2 of the project is being implemented in Suwayr and Al-Madan districts of Amran Governorate from 1 July to 31 May 2018 and it aims to prevent and respond to Cholera/AWD crisis through provision of safe water to cholera-affected communities, conducting hygiene promotion activities, and supporting health facilities.

1.2 Scope and purpose of the evaluation

1.2.1 Purpose

The overall purpose of this evaluation was to ensure accountability and identify lessons learned and best practices so as to feed into and inform the decision making process of the project stakeholders, including the donor, beneficiaries, and Government counterparts. In addition, the evaluation aimed to objectively assess the relevance, efficiency, effectiveness, and sustainability of the project in light of its objectives and provide recommendations for future programming.

1.2.2 Evaluation Objectives

The specific objectives of the final evaluation are primarily:

1. To provide evidence-based information on performance of the project against the intervention logic and existing project and program indicators;
2. To assess the project's efficiency, effectiveness, and validity of design/relevance of the project
3. To assess how the project ensured inclusion of vulnerable and marginalized communities and engaged with affected population and communities;
4. To assess the sustainability of the outcomes of the project, beyond the project lifetime
5. To document lessons learned and provide evidence-based recommendations for similar future interventions.

Further, the evaluation exercise will focus on collecting relevant data regarding best practices and recommendations for future interventions.

1.2.3 Evaluation criteria

The consultants ensured the whole evaluation is responding the following main questions derived from the standard OECD/DAC questions[4]:

Relevance	Were the most deserving community and persons targeted? Were project activities relevant, participatory, timely, culturally-sensitive?
Efficiency	Were resources used efficiently?
Effectiveness	Did the project achieve its aims and objectives?
Outcome	What has happened as a result of the project? What real difference has the activity made to the beneficiaries?
Sustainability	Are the positive effects of the project sustainable? To what extent did the benefits of the project continue after the completion of the project?

The evaluation consultants used three criteria in the table above with adding the sustainability through answering the following questions as stated in the TOR:

Relevance

A) Do you feel the assistance provided by CARE is relevant and supporting the community in meeting their priority needs? Explain.
B) To what extent has the project responded to the needs of your local community especially the most vulnerable and those in need to receive humanitarian assistance?
C) What other needs related to provided interventions (water rehabilitation interventions, cash for work, Cholera/AWD interventions) were not addressed by the project?
D) Do you feel that women had safe and equitable opportunities to participate in project planning implementation?
E) Do you feel that marginalized groups (Muhamasheen) and people with disabilities had safe and equitable opportunities to participate in projects' planning?

Efficiency

A) How has the project been efficient in allocating and managing resources (funds, human resources, time, expertise etc.) to achieve outcomes? Were the management capacities adequate- i.e. management of personnel, project properties, communication, relation management with elders, community leaders, other development partners, etc.?
B) Do the results achieved justify the costs (human resources, time, energy, money, materials)? If not, why not? Have project funds and activities been delivered in a timely manner? If not, why not?
C) Was there a clear understanding of roles and responsibilities by all parties involved?
D) Has the project received adequate technical and administrative support from DEC, CARE UK, and CARE Yemen?

[4] https://www.oecd.org/development/evaluation/dcdndep/47069197.pdf

E) How far and in what ways the project was able to strengthen local partners, communities, government, youth groups (and other relevant groups) and provide suggestions to further improve their capacities?
F) Review and assess the quality of the project monitoring and evaluation system, specifically: Assess the appropriateness of the indicators and also assess the robustness of the monitoring protocol and approaches in quantitative and qualitative data collection and compilation by project staff based on the log frame indicators.

Effectiveness

A) What are the most positive "things" that the project brought to you?
B) What did not work well?
C) Has the assistance provided by CARE caused any negative effects on the affected population/community'?
D) Are you satisfied with the type and quantity of assistance provided? If not, why?

Sustainability

A) What will remain after the project finishes?
B) Are the Community Based Committees (CBCs) willing and able to keep facilities operational and to continue activities on their own?
C) Is there local ownership?
D) Did CBCs participate in the planning and implementation of the intervention to ensure local engagement from the start?
E) Do CBCs possess sufficient governance structures and capacity to sustain the activity?
F) Did the project interventions take into account environment issues?

1.3 Methodology

The research team (8 persons in total', 4 men and 4 women, including the field team) has utilized a mix of methodologies (qualitative and quantitative) to collect pertinent data. The evaluation has focused on the criteria specifically relevance, efficiency, effectiveness and sustainability of the project. The methodology and tools were developed and shared with CARE staff for discussion and necessary modifications. The quantitative survey utilized tools such as the FCS to measure the level of food security and other WASH related to tools to measure access to safe water as well as changes in knowledge and practice.

Data collection techniques

1. Interviews with the project staff to collect data about the project design, implementation process, challenges and opportunities, etc.

2. Desk study of relevant documents

Key data sources that were consulted in this exercise include the following:

- Project documents for the two phases including objectives, expected results, log frame with baseline information;
- Work plans
- Progress reports and monitoring reports
- Post-distribution Monitoring reports
- Other relevant documents for the evaluation such as the National Strategy for Cholera, needs assessment conducted by CARE in four districts of Amran on December 2016 and lessons learned collected by the program staff in Amran as well as core humanitarian standards documents provided by CARE in Sana'a Office.
- Other project-related documents suggested by CARE team.

3. Field interviews and FGDs

In order to assess the impact and achievement of the project, interviews and focus groups were conducted with different stakeholders as follows:

e) **Interviews with 357 households (Household questionnaire**): A household survey was conducted with randomly selected 357 beneficiary HHs to understand the relevance and effectiveness of the project's interventions (water schemes, cash for work and the preventive AWD/ cholera activities) as viewed by the direct beneficiaries. The HHs were identified randomly by targeting the villages that have benefited from both CFW and WASH activities. **Interviews with 3 community leaders and 2 local authorities' officials.** This included the District Director and District Health office manager and 3 community leaders in Al Ghanaya sub-district.**4 Focus group discussions (2 for women, 2 for men)** with direct beneficiaries and Community Based Committees (CBCs) from this project. FGDs attended by 33 women and 25 men in two different targeted areas of Swuayr district, as it is the only targeted district by the field evaluation. The male and female participants of the FGDs were all from villages benefited from both CFW and WASH activities.

f) **Direct observation.** During the field visit, the team verified the achievements of the water scheme in Swuayr activities through direct observation of facts on the ground.

Triangulation of data

The data has been collected from FGDs, household questionnaire, key informant interviews and desk review, and was crosschecked. The data was compared with the project objectives, expected results and impacts to assess the net impact of the project.

Sampling Strategy

The TORs identified Suwayr District in Amran as the evaluation site as it is the only district where Phase 1and2 were implemented. Therefore, collecting data has been done only in Suwayr District and in particular the three sub-districts that are targeted by the project intervention; namely Tho Dahshan, Biathah and Shaib. Due to time limitation the fieldwork, as a result of challenges to coordinate with local authorities to return back to the district in recurrent visits due to inconsistency in coordinating check points, was limited to Shaib, Gathiah and Thodahshan.

Table 1: The assessment sample

Data gathering tools	Sample	Location	Remarks
Project Staff Survey	All staff including the field office staff	Sana'a and Amran (Suwayr District)	
Household Questionnaire	30% of target households in the three villages: 357 participants, 98 women, and 259 men	Amran (Suwayr District)	The two sub-districts • Tho Dahshan • Shaib • Gathiah village
Key Informant Interviews Survey	3 community leaders 2 local authorities at district level including officials in District Health Office	Amran - Suwayr District)	District Director and District Health sub--office Manager and 3 community leaders in Al Ghanaya sub-district
FGD Survey	Community Based Committees (CBCs) members in the two sub-district 2 FGDs with women /beneficiaries (33 women) 2 FGDs with men/ beneficiaries (25 men)	Amran - Suwayr District)	FGDs participants in Gaflat Kobas village, Shaib area 17 for men and 15 for women group, while in Al Ghanaya village Thodahshan area were 8 men and 18 in the women group.

1.4 Limitations to the Evaluation

1. According to the TORs, the field assessment has been limited to Suwayr district, because it is the only district where Phase 1and 2 of the project were implemented.
2. The security situation is still unstable and unpredictable. The military actions including airstrikes are unpredictable and arbitrary, which hindered the accessibility of the project sites. However, the evaluation team had carefully coordinated and planned the fieldwork with CARE project staff to minimize risks.
3. The project district has no infrastructure and services for visitors, which made it difficult for the evaluation team to stay long enough without adequate accommodation available. Also, it was a challenge to coordinate with local authorities to return back to the district in recurrent visits due to inconsistency in coordinating check points.

Section 2: Introduction to DEC Project Context and Content

2.1 Project Overview:

According to Yemen Humanitarian Response Plan 2018, Yemenis are facing multiple crises including armed conflict, displacement, and risk of famine and disease outbreaks that have created the worst man-made humanitarian crisis. Seventy- five per cent of the population – 22.2 million people – are in need of humanitarian assistance, including 11.3 million people in acute need who urgently require immediate assistance to survive – an

increase by one million since June 2017. Vulnerable populations in 107 out of 333 districts are facing heightened risk of famine and require integrated response efforts to avert a looming catastrophe.[5]

In late December 2017, the number of suspected cholera cases exceeded one million with 2,228 deaths in Yemen. The epidemic spread to almost all Governorates affecting 305 of the 333 districts in Yemen. With the deterioration of public services in health, WASH and other services, the disease could not be contained early in the course of the epidemic.[6] On 14 May, the MoPHP declared a state of emergency stating that the health system is unable to contain this unprecedented health and environmental disaster.[7]

While Phase 1 of the project was under implementation, the targeted districts were hit by the AWD/Cholera outbreak with the highest attack rate of 40% of the population.[8] As CARE was the most active humanitarian agency in Swuayr and Al Madan district, CARE had to allocate the urgent support to prevention and response to Cholera outbreak. According to the MoPHP sub-office in Suwayr, during 2017, the number of people admitted to health facilities suffering from AWD/Cholera was 3,968 patients, with 6 deaths reported from Suwayr, while 7,703 cases were admitted to health facilities in Al Madan district according to Humanitarianresponse.info Yemen cholera response dashboard.

The DEC Project Phase 1 responded to some of the most prioritized needs in two targeted districts, while Phase 2 was an urgent response to the widespread AWD/Cholera outbreak in the targeted districts.

Phase 1:
The project was mainly designed for enhancing access to cash for beneficiary households to meet their basic and immediate needs through conditional cash transfer scheme. The condition of the assistance was that beneficiaries had to participate in rehabilitation of water schemes so as to improve access to safe water for drinking in the targeted districts. CARE, in consultation with local communities' leaders and other cluster members operating in the targeted areas, has made every effort to identify and support the most vulnerable persons. Selection of target locations and cash beneficiaries was done jointly with community representatives based on the agreed vulnerability criteria such as female–headed HHs, households with pregnant and lactating women as well as those identified to be caring for the elderly and persons with chronic illnesses. Villages targeted for water schemes rehabilitation were those identified to be facing limited access to water, those with the highest number of non- functional water sources and those in remote locations with limited humanitarian assistance. Cash beneficiaries targeted the most vulnerable household

Cash has been provided to 390 highly vulnerable and food-insecure HHs in return for the work under the skilled guidance of project engineers. Beneficiary HHs received $108 per

[5] YHRP 2018, Page 4.
[6] YHRP 2018, Page 22.
[7] Integrated Response Plan: Yemen Cholera Outbreak (29 June 2017).
[8] Yemen: Cholera Attack Rate (%) of Population (WHO).

month for three months, in accordance with the standard set by the Food Security and Agriculture Cluster and the National Cash and Market Technical Working Group. Cash has been transferred to beneficiary locations through the outreach team of Al-Amal Bank which handed the cash to each beneficiary HH in person. Al-Amal Bank is a reputable and trusted financial institutions that is currently providing similar services to CARE and other INGOs. Cash transfer is assumed to help stimulate the local economy and provide beneficiary choice over expenditure.

Through the CFW modality, 6 water schemes (3 water wells in Amran and 3 water tanks in Abyan) have been rehabilitated and this has increased access to safe water by beneficiary households. The project has benefited 2,543 HHs (17,801 individuals; 9,551 males and 8,250 females) and the rehabilitation works mainly focused on desilting of wells, strengthening of walls, and replacement of pumping systems and installation of solar power systems. Training of water management committees on basic operation and maintenance was also conducted for each of the rehabilitated water schemes.

CARE has conducted field assessments and following meetings with local governorate and district level authorities, identified in Suwayr district of Amran Governorate and Sabah district of Abyan Governorate. Both districts are hard to reach areas and identified by the food security and nutrition clusters as priority districts for intervention. In addition, there have never been NGOs' presence for 4 years in Sabah district of Abyan and for 18 months in Suwayr district of Amran. In addition, CARE is currently implementing Cash Voucher and Food Distribution programs in partnership with WFP in the above-mentioned districts, which created windows of opportunity for integration and leverage of resources.

Phase 2:

In Phase 2, CARE targeted Al Madan and Suwayr district of Amran Governorate due to high vulnerability in the area and outbreak of cholera/AWD. CARE was acknowledged by local authorities as the most active NGO in both Suwayr and Al Madan districts and asked CARE to support them in the preventive and response interventions to combat the outbreak. CARE had allocated the necessary funding through this project in close coordination with DEC and has been implementing various interventions under Phase 2 from 1 July to 31 May 2018. The main objective of the Phase 2 is to prevent and respond to Cholera/AWD crisis through provision of safe water to cholera-affected communities, chlorination of water sources, conducting hygiene promotion activities, and supporting health facilities as well as AWD/Cholera affected villages with water trucking benefiting 14,950 individuals and distributed 2,700 hygiene kits in both Suwayr and Al Madan districts reaching a total of 18,732 individuals.

2.2 Main Challenges - Phase 1 and 2

The main challenges during the implementation of both phases of the project include:

The presence of multiple political actors and changing local authorities as a result of the new de facto authorities at governorate and district levels. This resulted in considerable delays in project approvals by local authorities. Several layers at national and governorate levels exist, and each are involved in providing approvals thereby delaying the start of

activities. CARE was however able to use its past relationships with authorities as well as good acceptance from the community to fast track this process.

- The overall security situation remained volatile and unpredictable. Field travels by international staff especially to Amran required approvals by authorities which sometimes delayed planned missions. However, senior national staff were able to undertake field monitoring.
- There were challenges in identifying skilled workers to undertake rehabilitation of water schemes in the targeted locations. In consultation with local authorities and community committees, skilled persons from outside the project sites (in the same district) were selected.

The project overcome these challenges through:

- Engaging community-based committees to facilitate project activities on a daily basis and making sure the right number of people are participating;
- Enhancing coordination with district level and governorate level authorities and keeping them informed with all progress of the work done;
- Implementation of strict security risk mitigation plan including regular security assessments, and good coordination with relevant stakeholders;
- Bringing skilled laborers from outside the project site needed for high quality of rehabilitation work (3-4 people who have skills to do the building tasks), while leaving all other parts of the work for targeted HHs.

2.3 Budget and Expenditure

As per the table below, CARE has efficiently utilized the budget to undertake the planned activities under the DEC supported project.

Table 2 - Approved budget and expenses (Phase 1&2)

	Phase 1	**Phase 2**
Revised budget	364,715	317,317
Expenditure	364,715	317,317
% Spent by the end of Project	**100%**	**100%**

Section 3: Evaluation Findings – Assessment against OECD/DAC Criteria

Relevance	Were the most deserving community and persons targeted? Were project activities relevant, participatory, timely, culturally-sensitive?
Efficiency	Were resources used efficiently?
Effectiveness	Did the project achieve its aims and objectives?
Outcome	What has happened as a result of the project? What real difference has the activity made to the beneficiaries?
Sustainability	Are the positive effects of the project sustainable? To what extent did the benefits of the project continue after the completion of the project

3.1 Relevance

The evaluation team found that interventions in both Phase 1 and 2 were relevant to the strategic objective 1 of the Yemen Humanitarian Response Plan 2017 (YHRP) and WASH cluster objective 2, which is **to provide emergency WASH assistance to the most vulnerable so as to reduce excess morbidity and mortality.** The cash transfer activity of Phase 1 was also in line with the 2017 YHRP objective of provision of life-saving assistance to the most vulnerable people and also with the Food Security and Agriculture Cluster objective of **improving availability of and access to food for the most vulnerable.** The comprehensive WASH intervention was also aligned with the preventive approach integrated activities suggested in the Joint Cholera Response Plan – Yemen July 2017.

Given the suffering of Yemenis from a large-scale humanitarian crisis as conflict has escalated since March 2015; large scale and prolonged displacement has placed additional burden on the already depleted safety-net of the community; and outbreak of cholera/AWD in almost all Governorates. The design and implementation of both phases of the project have been relevant to address the crises. The evaluation team found that CARE has been closely coordinating with community members, local authorities, and other relevant stakeholders in each cycle of the project cycle management including establishment of community committees, selection of beneficiary households, identification of water schemes for rehabilitation, implementation of project activities and review/monitoring of project activities. The project followed agreed vulnerability criteria to select beneficiary HHs and the most vulnerable community members such as female/child/elderly headed households; vulnerable pregnant/lactating women; households with severely malnourished children; and vulnerable marginalized HHs (muhamasheen) were given priority.

3.1.1 Water Interventions

In Phase 1: the project has been designed to rehabilitate water schemes in Sabah district of Abyan Governorate and Suwayr district of Amran Governorate with an aim to increase access 1500 HHs (10,500 individuals) residing in the target areas to safe water. Accordingly, it was able to rehabilitate six water schemes via cash-for-work scheme and reached 17,801 individuals. In Phase 2, the project has been implementing various activities that aim to prevent and respond to AWD/Cholera outbreak through provision of safe water to cholera-affected communities, conducting hygiene promotion activities, and supporting health facilities. These interventions have been implemented in Suwayr and Al Madan districts, Amran governorate.

Before the project:

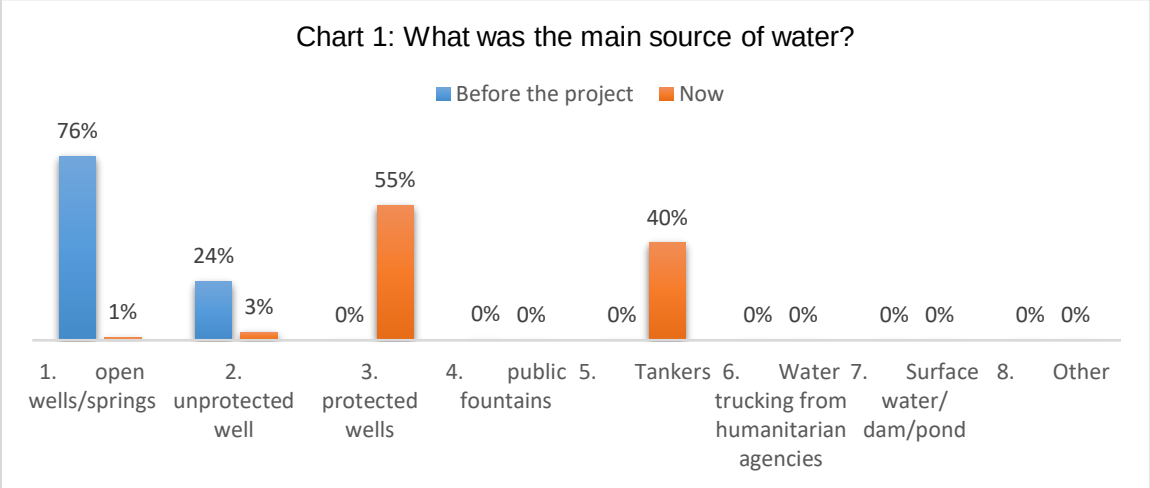
In Suwayr district, open water wells are the only sources of water and the wells are close to villages and weekly market places. These wells used to be unprotected and also were exposed to contamination with people and animal waste. Getting water was done manually using rope and water container. Some women and girls who need more water had to wait till night in the dry season, to ensure more water is collected in the well after every one leaves so they could get adequate amount of water to bring back home. Community members in the Shaib area mentioned that many women and girls have fallen down to the water wells during fetching the water, with one of them died and one injured. The injured was a girl who was saved but with severe disability as a result of the cut of her

leg. Community members also attested that they have found dead animals inside the water wells.

Despite the existence of many unprotected water wells in the district, CARE conducted field visits and coordinated closely with local authorities and community leaders to rehabilitate the wells in the neediest villages. Thus, the project selected the water schemes for rehabilitation using different criteria such as high number of population, limited access to water, those with the highest number of non- functional water sources and those in remote locations with limited humanitarian assistance. Accordingly, the project selected villages such as that of Shaib area where it is close to the weekly markets where hundreds of people are coming to the area for shopping makes this water well more exposed to garbage/solid waste.

After the project:

The evaluation team has visited the targeted district of Suwayr January 2018, which is considered the most difficult time in the year when water is scarce. Low yields of water, and no water streams or dams available in the area, making water number one priority in the district.



The finding of the survey revealed that the project has increased access to safe drinking water for the targeted beneficiaries. As indicated in chart (1), 95% of survey participants mentioned that they currently have access to water from safe/protected sources including protected wells and water trucking by CARE.

The evaluation team has visited two of the three rehabilitated water wells in Suwayr district. The water wells were built above land level and covered with concrete with small whole covered with steel. There were also water tanks built by the project about 200 meters away from the water well, but more than 500 meters far from most of targeted villages. Water was pumped from the water well by the water pump fueled by solar system. Both water pump and solar system were provided by the DEC project. There were also water taps fixed close to the water tank. These is still a need to install more water taps to ensure people are not waiting more than 30 minutes during collection of water as per SPHERE standards. Many men, women and youth insisted that six water taps were not

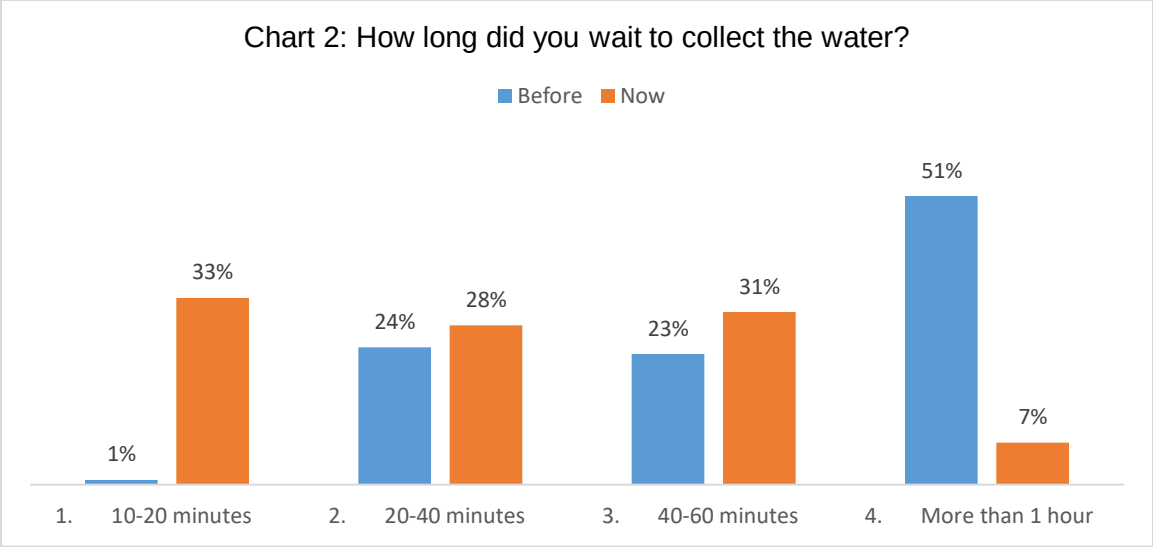
enough so they have to wait longer to fill in the needed water. As each water wells is actually targeting many villages, some of the population are considered to be far from the water wells. Many people, including people with disabilities, are still coming long distances (more than 30 minutes' walk) to be able to get the needed water.

The wells yield water differently throughout the year. Women in Shaib area confirmed that they get only 60 liters of water per day from the rehabilitated water well. Many families that have about 10 people, which means that most families have less than the minimum standards 15 liter per person per day. This water deficit may lead to HHs getting water from other open water wells leaving them under exposure to water-borne diseases. As the evaluation team visited the targeted areas in winter, women and girls were gathering close to the water tank waiting until pumping water to the project-built water tanks at noon because that time is the only appropriate time when the sun is strong enough to provide solar energy needed to make the pump functional. As much as possible, the project tried to ensure SPHERE standards were met in the rehabilitation of water schemes. These included:

- Water sources were reasonably close to the majority of beneficiaries, located between 500 to 800 meters to the nearest household; nevertheless, it is to be noted that some beneficiaries are still coming to the water source from far villages due to lack of other water sources in the area.
- The selected water sources for rehabilitation had high recharge capacity to meet additional needs generated by the IDPs; and
- Parts of the rehabilitation funds were utilized to undertake water treatment and hygiene promotion activities.

CARE had established three community based committees (CBCs) in the three water project sites. The team found them active, for example the CBC in Al Ghanaya area convinced the community to collect enough money to buy a small generator so they could use it to pump water to the tanks during cloudy days.

Participatory rehabilitation of water schemes through cash for work is considered a life-saving in the targeted areas, as the water wells were contaminated with waste of people and animals. This eventually has contributed to reducing the risk of AWD/Cholera outbreaks. The rehabilitation of the water sources has improved access to safe water sources that helped women/girls to spend more time in other productive activities in the household. Furthermore, it contributed to the alleviation of safety and security concerns that women/girls face while fetching water from the sources. According to chart (2), 51% of survey participants used to travel for more than one hour to fetch water from the source before whereas this reduced to 1% after the project.



The design of the water schemes with installation of solar pumps is considered very relevant to the local context and needs, since water pumps working on fuel will need operation/fuel costs, which is becoming more expensive and people cannot afford it due to loss of government salaries since August 2016 and loss of livelihoods due to the prolonged war.

Women in the targeted areas have suffered from fetching water from the open water wells, as they had to pull water from the bottom of the wells after waiting long times and they had to wait many times alone till nights come so enough water is collected. This had resulted too some dangers such as falling accidently to the water well leading to death and injuries of many women.

Water trucking was also implemented in villages with reported cases of AWD/Diarrhea morbidity and mortality. Although this activity seemed to contribute to reducing the incidence of AWD/cholera in the respective villages, the short period of time and lack of exit strategy that left women desperate waiting for water trucks to fill in the water tanks installed in their villages reflecting the lack of clear communication with the community especially women on the project details and expectations since this kind of interventions create dependency and undermine existing community coping strategies.

Conclusions:

1. The rehabilitation of water wells in the targeted communities is found to be crucial in responding to the primary critical needs of the most vulnerable households in the targeted districts. In addition to improving access to safe water, the rehabilitation activity was a life saving measure from both physical injury and death due to falling down in the well, and by keeping it clean and safe from contamination of people and animal waste.
2. There is still a need to implement other water harvesting interventions in the targeted communities so that community members could get adequate access to safe water in dry seasons. There is also a need to install more water taps in the rehabilitated schemes to ensure community members are not waiting for long period during collection of water.
3. Establishing community based/water committees is a crucial step in making water project more efficient and sustainable as they show higher level of ownership and help in managing the available water schemes.
4. Close coordination with local authorities and stakeholders helped in reaching the most in need villages with full agreement of community members.
5. There is a need to have an exit strategy before implementing water trucking activities. Although in this case the short term funding for Phase 2 do not allow for long term exit strategies which means that there was a need to limit the water trucking to health facilities and not to the affected villages.
6. Overall; the water interventions has delivered the intended output as per the project documented.

3.1.2 Sanitation and Hygiene Prevention and Response to AWD/Cholera Outbreak

During implementation of Phase 1 of the DEC project, the whole country has witnessed a huge AWD/cholera outbreak. In total, 22 out of 23 (96%) governorates and 300 out of 333 districts (90%) are affected by the outbreak. A cumulative total of 591,100 suspected cholera cases and 2,035 associated deaths have been reported across the country from 27 April 2017 to 30 August 2017. The five governorates with the highest cumulative attack rates per 10,000 are Amran (513), Al Mahwit (476), Al Dhale'e (462), Abyan (366) and Hajjah (268).[9] Suwayr district was one of the districts that experienced the highest attack rate of 40% of the population.[10] The government represented by Ministry of Public Health and Population had declared that it was unable to face this crisis and because CARE is the most active humanitarian NGO in the affected districts, it had to contribute in order to alleviate cholera outbreak in its operation areas.

According to project documents and reports, CARE, in close coordination with local authorities, INGOs and General Authority for Rural Water Supply Projects (GARWSPs), has contributed through the project to control cholera outbreaks in two districts (Suwayr and Al Madan) through implementing preventive activities by close coordination with GARWSPs. Three main activities have been implemented, (1) chlorination of water

[9] Situation Report No. 2: Emergency Operation Center. August 31, 2017.
[10] Yemen: Cholera Attack Rate (%) of Population (WHO).

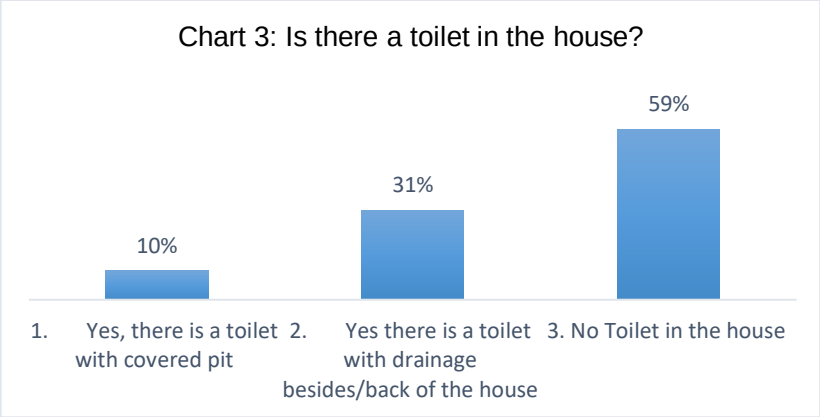
sources (wells, stony water tanks), (2) distribution of Chlorine tablets on the households where the areas have confirmed cholera cases, suspected cholera cases/Acute Water Diarrhea, (3) disseminated awareness messages concerning cholera preventions and use of chlorine tablets.[11]

Before the project

Swuayr and Al Madan districts are of the remote rural districts where people are still lacking the hygiene awareness and safe sanitation services. As all rural areas in Yemen, many HHs in both districts are practicing open defecation[12] and have low awareness level on the importance of safe sanitation that is the major cause of acute watery diarrhea. This situation had exacerbated by AWD/Cholera outbreak with admissions of more than 11,671 people (3,968 in Suwayr and 7,703 in Al Madan) to health facilities with suspected cholera and acute water diarrhea.

After the project

In Phase 1: The project has not considered sanitation and hygiene activities as a standard activity that should complement the rehabilitation of water schemes, although the knowledge of community members on key hygiene and sanitation practice is low and there is high prevalence of open defecation targeted districts. Furthermore, the districts hosted high number of IDPs that necessitated the need for hygiene/sanitation promotion activities.



Community members in the targeted districts, especially women, girls and children are suffering from lack of access to safe sanitation, with only 10% of the total population in Swuayr district have access to safe latrines with covered pits while 90% of the population are still practicing open defecation and using latrines with open drainage. This reflected the huge need for sanitation and hygiene awareness, especially for women and girls since they are primarily responsible for fetching water from the sources as well as for preparing food in the household. Therefore, nutrition-sensitive hygiene promotion intervention that target women/girls is vitally focusing on hand washing during critical moments, use of soap for hand washing, water saving chain, and the importance of using latrines.

The increased incidence of AWD/Cholera in most districts of the country made sanitation and hygiene promotion as a life-saving intervention. The evaluation found that 62% of the targeted HHs could identify/practice hand washing before meal time, while 29% wash hands after using the toilets and only 1% wash their hands before cooking. It shows that targeted areas are still in need to more comprehensive hygiene promotion activities

[11] DEC Project Final Report: CARE International in Yemen. July 19, 2017.

[12] CARE MIRA Assessment in 4 districts (Suwayr and Al Madan districts were in included) in Amran on December 2016 has stated that 9.9% HHs practice open defecation

targeting all segments of the society by activating the local hygiene promoters trained by the project in the targeted areas.

In Phase 2, the project has contributed to control cholera/AWD outbreak through implementing prevention activities. 3,286 strips of chlorine (0.33mg), 5,839 chlorine tablets (1.67g) were distributed and chlorination of water source in 14 villages /sub-villages was done in addition to disseminate hygiene awareness with related hygiene prevention among the targeted communities. A total 18,900 individuals had benefited from cholera response activities. Distribution of 4,050 cholera kits and consumable hygiene kits took place in both Suwayr and Al Madan districts. These interventions were relevant and life-saving especially that the health facilities have no operation costs provided by the government. By the time of field visit of the evaluation team to Suwayr district, there were no admissions of AWD/Cholera meaning that the project has contributed to saving lives in the targeted districts

Conclusions:

1. The AWD/Cholera outbreak reflected the importance of sanitation and hygiene awareness as complementary activities to all water interventions.
2. The targeted communities still need to be supported to improve sanitation and hygiene through CFW combined by behavior change activities.
3. Meanwhile, women and girls are primarily responsible for fetching water from the sources as well as for preparing food in the household. Therefore, nutrition-sensitive hygiene promotion intervention that target women/girls is vital as there is a direct correlation between hygiene/nutrition promotion and food safety.
4. Overall; Phase 2 of the project was a very important component to be conducted in the targeted areas since it has responded to the huge need to sanitation and hygiene awareness and services which contributed to the emergency response to AWD/Diarrhea in targeted districts.

3.1.3 Food Security

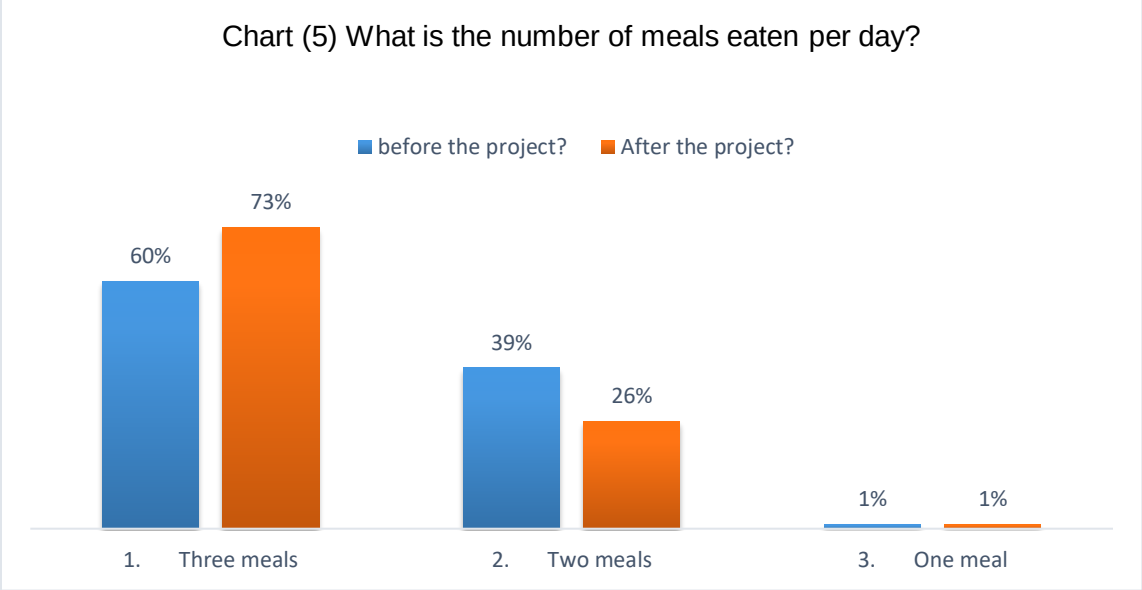
As Yemen is going through a complex emergency leading to a clear shift of humanitarian actors in Yemen towards integrated (Multi-Sectoral) programming in 2017 following the Integrated Food Security Phase Classification (IPC) results on acute food insecurity in Yemen in March 2017. The impact of the conflict, including internal displacement and import restrictions and the suspension of social protection programs, are also having devastating impacts on livelihoods forcing reliance on external aid and negative coping strategies to support basic household needs – commodities are on average 26% higher than pre conflict. According to the Integrated Food Security Phase Classification (IPC) of March 2017, Abyan Governorate was classified in an emergency phase (Phase 4), requiring immediate food assistance, and Amran Governorates, was classified into Crisis Phase (Phase 3), signifying the situation is extremely dynamic and fragile, requires close monitoring on key food security and nutrition indicators, and the continuation of humanitarian assistance. The food security situation in both targeted districts in Phase 1 was very precarious with high level of vulnerability and thereby a huge need for lifesaving interventions.

Before the project

On December 2016, CARE has conducted rapid multi-sectorial assessments in Amran and Abyan governorates and found out that household income is deteriorating with 95.2% of respondents in Amran and 88.2% in Abyan stating livelihood deterioration since March 2015. The assessment had informed CARE's programs both in terms of location within governorates and thematically to complement and enhance the on-going programs in the areas. As such, they proposed to work in Sabah and Suwayr districts of Abyan and Amran Governorates providing cash for work programs to repair and rehabilitate 6 water sources. Three cycles of cash distribution have been done to all beneficiaries (390 HHs, 195 HHs in each district) including 53 female headed households and each beneficiary HH received 108 USD per month.

After the project

The project opted a conditional cash transfer approach where beneficiary HHs from the cash transfer were participated in the rehabilitation of water schemes. This integrated approach had two intertwined benefits: support beneficiary HHs from the cash assistance to increase their access to food and also diversify their food; and enhance access to safe water for community members in the neediest villages. The project was able to engage 53 women headed households in the cash for work activities in less labor-intensive and culturally sensitive tasks such as to bring water for the rehabilitation work only. As depicted in chart 5, the survey measured the change regarding the number of meals eaten per day before and after the project using a recall method. Accordingly, the percentage of HHs who are having three meals per day have increased from 60% before the project to 73% after the project. In addition, the percentage of HHs who are having two meals per day has decreased to 26% from39% since the start of the project.

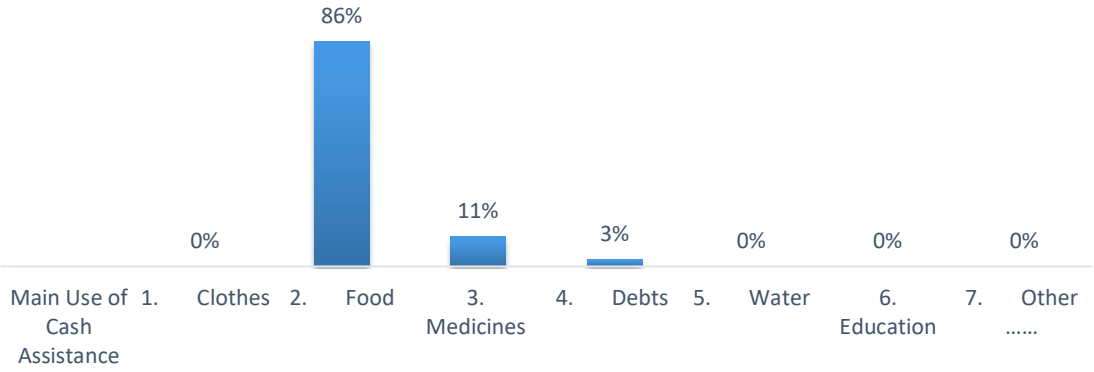


In Phase 1, CARE has implemented a conditional cash transfer intervention (CFW) in both targeted districts whereby 390 beneficiary HHs participated in the rehabilitation water schemes. The rehabilitation activity benefited the wider community in the project area who were the most in need. The CFW intervention has complemented the WFP-supported monthly General Food Distribution.

The evaluation team found that engaging the targeted men, women and youth within targeted villages, in the whole rehabilitation process of water schemes has improved feeling of ownership of the projects as well as provided work opportunities for 390 head of households, including 53 female headed households, which provided them more choices to diversify their food. Chart 6 showed that 86% of HHs respondents used that the cash received to increase their choices in getting diversified food, 11% of HHs used it for buying medicines and 3% used cash for paying back their debt, proving the huge need to integrating cash in all humanitarian interventions. Brining high skilled people was important in cash for work interventions especially that they were rehabilitating water wells and the final construction work must be technically done for safety and also sustainability purposes. In addition, having these skilled personnel have provided great livelihood

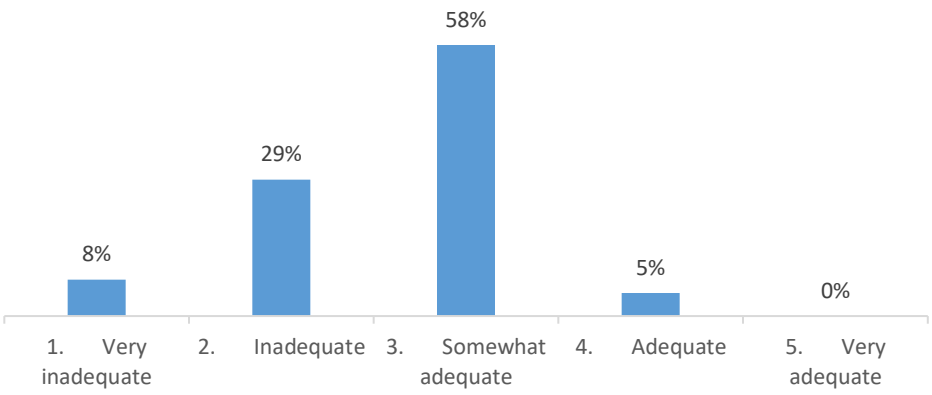
opportunity for the young people of the targeted villages as they learnt from them all construction skills due to their daily and closely participation on CFW activities.

Chart 6: Main Use of Cash Assistance

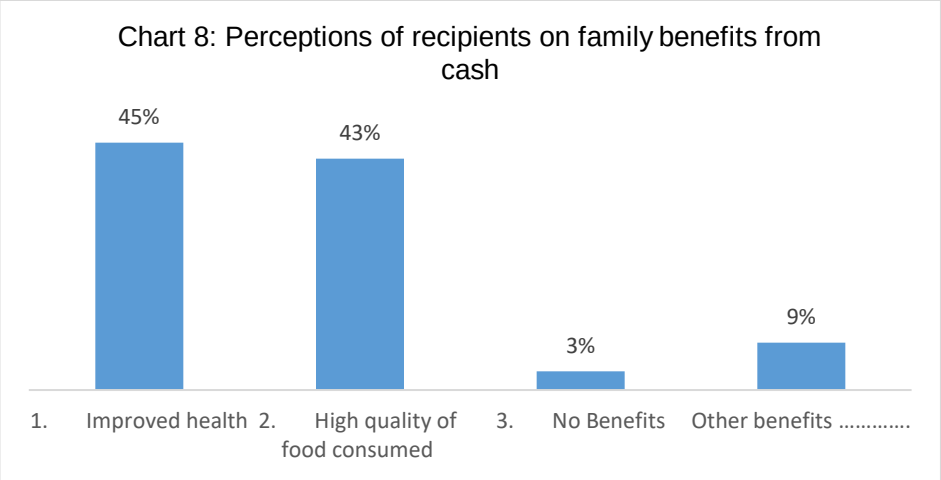


Although the majority of respondents found the amount of cash received as somewhat adequate as cash was only for short period of time and intended to cover their food needs, young men and women who participated in the cash for work activities insisted that they still need more cash for work opportunities as they keep all time looking for casual work with no success.

Chart 7: Opinion About the Amount Received



As shown in chart 8, the cash assistance had additional benefits as 45% and 43% of interviewees respectively mentioned that the assistance ‘improved their health’ and ‘helped to consume high quality of foods’.



Conclusions:

1. Cash for work modality is very efficient when integrated with other form of humanitarian assistance for bringing more choices of food and livelihoods to targeted HHs. The project has contributed to the improvement of the food security status of beneficiary households, corroborated by various indicators such as number of meals/day and the Food Consumption Score.
2. It is very important to hire construction high skilled personnel in cash for work interventions for better safety and sustainability of the constructed work and also for learning by doing purposes as the young people of the targeted villages could learn from these m all construction skills which will give these young people more livelihoods opportunities.
3. Overall; food security component of the DEC project has met its intended output stated within the project document.

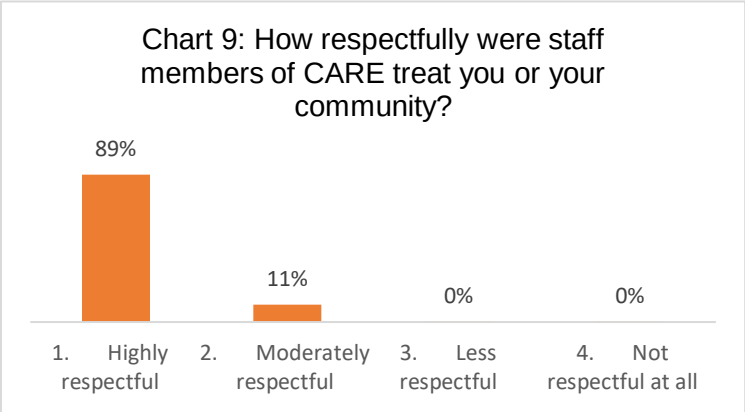
3.2 Efficiency

3.2.1 Management and coordination

The evaluation team has found that the project has been closely coordinated and collaborated with local authorities, health office, and GARWSP in implementing this project. Due to its long-term presence in implementing food security intervention, CARE has high reputation among community members and local authorities, which gives opportunities for this DEC supported project to have acceptance and smoothly implement the planned project's interventions. Both the local authority and health office managers confirmed that CARE has been coordinated with their respective offices before and during the implementation of the project. All relevant stakeholders including community members have participated in the planning and implementation phases of the project including selection of operational villages, establishment of community committees, selection of beneficiary households, and identification of water sources for rehabilitation. Communities' representatives also expressed their satisfaction in the identification and

rehabilitation of water schemes as it addressed the most pressing needs of the community. Local authorities in Suwayr also affirmed CARE's contribution towards the district's development plan through rehabilitation of water sources and asked for more support since there are many unprotected water sources that require rehabilitation.

Through series of discussion with community committees, it was able to convince community members not to come to cash distribution points with weapons although carrying weapons is a common tradition in the area. As indicated in chart 9, where 89% of respondents mentioned that CARE staffs have been highly respectful to them whereas the remaining 11% replied that the staffs have been moderately respectful.



3.2.2 Timeliness

Survey participants affirmed that the project interventions were timely since they were conducted when there was high need for cash to purchase food; and also when there is an urgent need to prevent and respond to the outbreak of cholera/AWD. Meanwhile, the project staffs responded that the duration of Phase 1 was short and it did not take into account the extended period that requires in undertaking some activities in the preparation phase, mainly signing project agreement with national/local authorities. Accordingly, the actual project implementation period for Phase 1 was short especially for the rehabilitation of the water schemes (since it was implemented via cash-for-work modality) and it made difficult to have enough time for budget revision. It was the long-term presence and high reputation of CARE in both Suwayr and Sabah districts that helped in accelerating the implementation of the project's activities in Phase 1. Furthermore, there have also been a delay in the approval of the re-allocated budget in Phase 2, which led to the delay of the implementation of some activities of the project such as water trucking. Water trucking was more expensive than what people are used to. The lack of exit strategy made women unable to cope especially when water trucking stopped and went to water tanks, so they had to wait for two consecutive days.

3.2.3 Sectoral interventions and outputs

All outputs of Phases 1 and 2 planned were achieved successfully, with exceeding the targets in some activities as shown in below output tables. Due to the huge need in the targeted districts, the budget was able to respond to the need of limited number of villages, while more villages are still in hope that CARE will continue to rehabilitate their water well too. The evaluation team found that the project was well integrated and jointly implemented with the GFD interventions implemented by CARE with support from WFP in the same district. The CFW was done mainly to support the WASH intervention which was found an efficient approach.

Table 3 - Output Indicators of DEC Project - Phase 1

No.	Indicator	Planned	Actual	Percentage	Remark
1	# of households have increased income to meet their basic and immediate needs	390	390	100%	
2	# of individuals have increased access to safe-drinking water	10,500	17,801	169.5%	
3	# of water schemes rehabilitated	6	6	100%	6 water schemes (3 in Amran and 3 in Abyan) rehabilitated

Table 4– Output Indicators of DEC Project – Phase 2

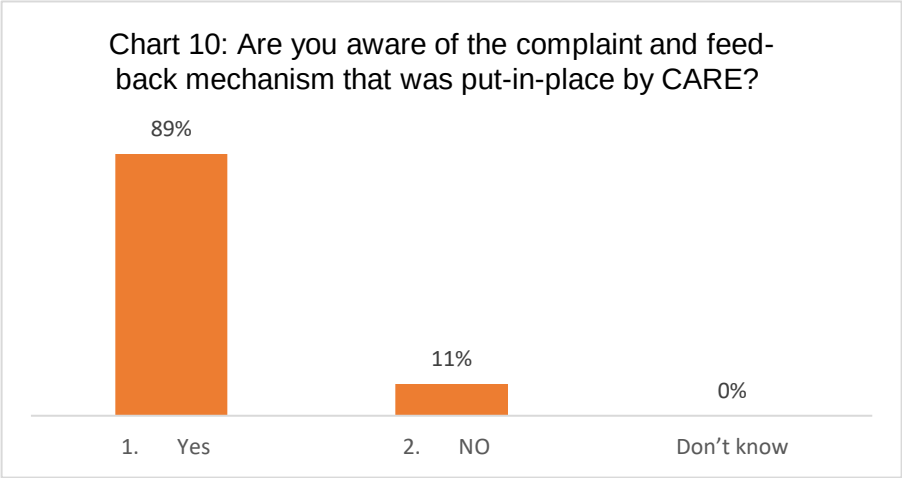
INDICATOR	Planned	Actual	Percentage	REMARK
1. Water trucking				
1.1 Liters of water supplied through water trucking	2,360,000	11,755,000	498%	
1.2 Number of HHs supported with water trucking	1,500	2,137	142.5%	
1.3 Number of individuals supported with water trucking	10,500	14,950	142.4%	
1.4 Number of plastic tanks installed	6	8	133.3%	
2. Support health facilities				
2.1 Number of health facilities supported with soaps	8	8	100%	
2.2 Amount of soap (in number) provided to health facilities	15,000	15,000	100%	
3. Provision of cholera kits to HHs				
3.1 Number of HHs supported with cholera kits	2,700	4,050	150%	
3.2 Number of individuals supported with cholera kits	9,450	18,732	198.2%	
4. Provision of cholera kits and consumable hygiene kits to HHs				
4.1 Number of HHs supported with consumable hygiene kits	1,350	4,050	150%	With two rounds
4.2 Number of individuals supported with consumable hygiene kits	9,450	18,732	198.2%	
5. Hygiene promotion				
5.1b. Number of IEC materials printed	18,000	18,000	100%	
5.2 Number of community volunteers trained	18	18	100%	
5.3 Number of hygiene promotion sessions conducted	40	585		
5.4 Number of individuals reached through hygiene promotion campaigns	18,900	17,752	93.9%	
6. Water Management Committees (WMC)				
6.1 Number of WMC established	6	8	133.3%	
6.2 Number of members of WMC trained	18	20	111.1%	

3.2.4 Performance tracking and M and E

The evaluation team has reviewed the project document, including the output table that has only two indicators and targets while no related verification methods/documents were stated in the document. However, CARE developed and implemented a comprehensive MEAL system with appropriate tools, including qualitative and quantitative data. The system included PDM survey tools, KAP survey tools, progress reports, complaints and response mechanism, and beneficiary statistics collected on different interventions of the project. Key MEAL activities included:

- Conducting a need assessment;
- Conducting more than three post-distribution monitoring (PDMs) following the CFW activities in the Phase 1 targeted districts;
- Conduct Knowledge, Attitude, and Practice (KAP) surveys;
- Collecting of beneficiary data for both phases dis-aggregated by age, sex, location, and type of activities implemented on the field;
- Implemented an official complaints and feedback mechanism as 89% of the beneficiaries mentioned that they were aware of the complaint and feed-back mechanism; and
- The program team has documented the lessons learned for Phase 1.

Overall, the project team has collected beneficiary updates on monthly basis, which reflects that the monitoring and evaluation in addition to performance tracking was implemented properly.



3.3 Effectiveness and outcomes

3.3.1 Results

CARE has supported 390 highly vulnerable HHs with cash assistance for three months and each HH received GBP 81/month[13]. The project adopted a conditional cash transfer scheme whereby beneficiary HHs participated in the rehabilitation of water schemes.

[13] The standard set by the FSAC during the implementation of the project was $108/month/HH (approximately 81GBP)

Although it was of small scale, young people assured that it bridged the gap in their needs to food support and provided them with work opportunities for three months and requested more cash for work interventions. The men involved in CFW were participating in all work related to rehabilitation of the water schemes, while women were participated in less labor-intensive works such as bringing water needed for the rehabilitation work. Disabled people were sending an adult person from their families to do the work instead. As chart 11 indicated, 61% of survey participants mentioned that they are either 'very satisfied' or 'slightly satisfied' with the amount of cash transferred. This is in line with the result of the PDM survey conducted by CARE where 64.6% of survey participants were satisfied with the amount of cash received. The remaining respondents reiterated that the amount of cash was not adequate to procure the most immediate/basic items due to ever-increasing price of commodities.

The evaluation of the project also encompassed a Food Consumption Score (FCS), which is a composite score based on dietary frequency, food frequency and relative nutrition importance of different food groups. The FCS of a household is calculated by multiplying the frequency of foods consumed in the last seven days with the weighting of each food group. The mean food consumption score of the targeted HHs is currently 45.2, which showed significant improvement compared to the FCS results of 30.2 prior to the project (as per the need assessment survey conducted by CARE in December 2016 in Amran Governorate).

Chart 11: Level of Satisfaction of the cash received

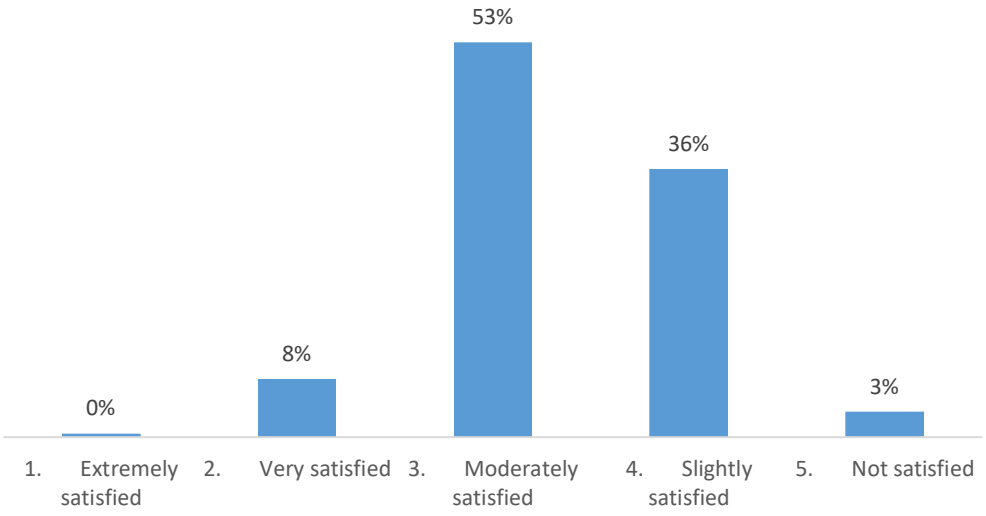
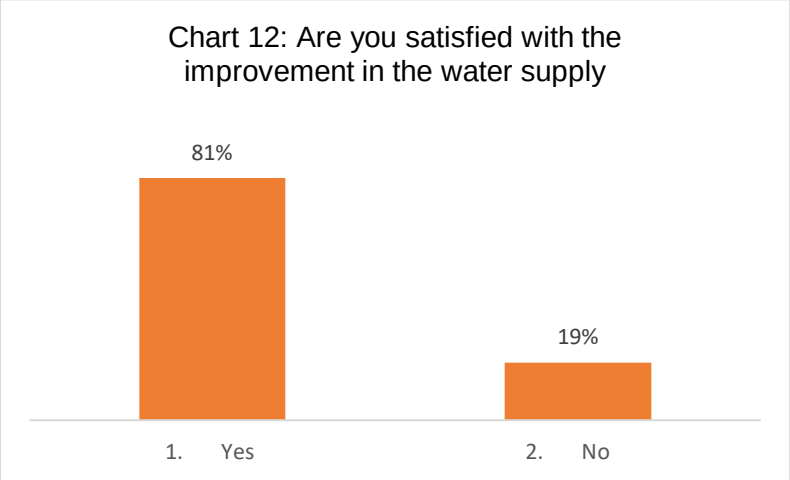


Table 2 - Food Consumption Score

Food Groups	Mean value (average 1 to 7 days)	Weight	Score
Rice, maize , maize porridge, sorghum, millet pasta, bread and other cereals	6.9	2	13.9
Beans. Peas, groundnuts and cashew nuts	5.5	3	16.4
Vegetables, leaves	0.6	1	0.6
Fruits	1.6	1	1.6
Beef, goat, poultry, pork, eggs and fish	0.3	4	1.3
Milk yogurt and other diary	2.0	4	8.2
Sugar and sugar products, honey	1.4	0.5	0.7
Oils, fats and butter	5.0	0.5	2.5
Spices, tea, coffee, salt, fish power, small amounts of milk for tea.	6.2	0	0.0
Average FCS			**45.2**

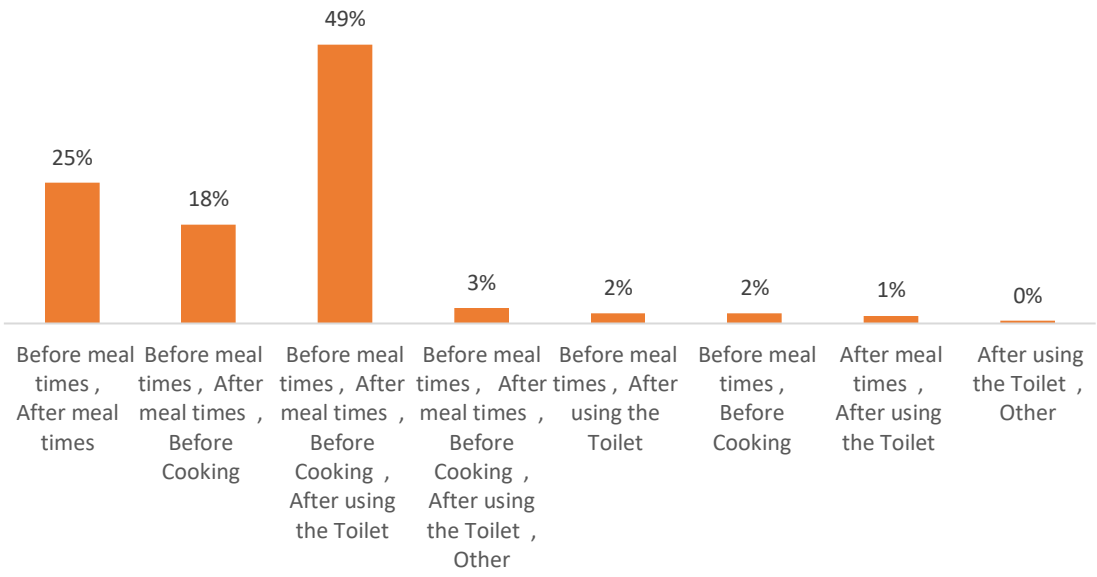


The findings of the survey also affirmed that there is significant improvement of water supply, which is attributed to the rehabilitation of water sources and water trucking intervention of the project. As chart 12 depicted, 81% of HHs are satisfied with the improvement of water supply. The main improvements were covering the rehabilitates water schemes to keep water safe from contamination as well as keeping women and children safe by getting water from a water tank easily at their preferred time. While many people from the targeted district were affected by AWD/Cholera outbreak, the project has effectively contributed to the prevention of this outbreak by chlorination of water sources and raising awareness at targeted communities.

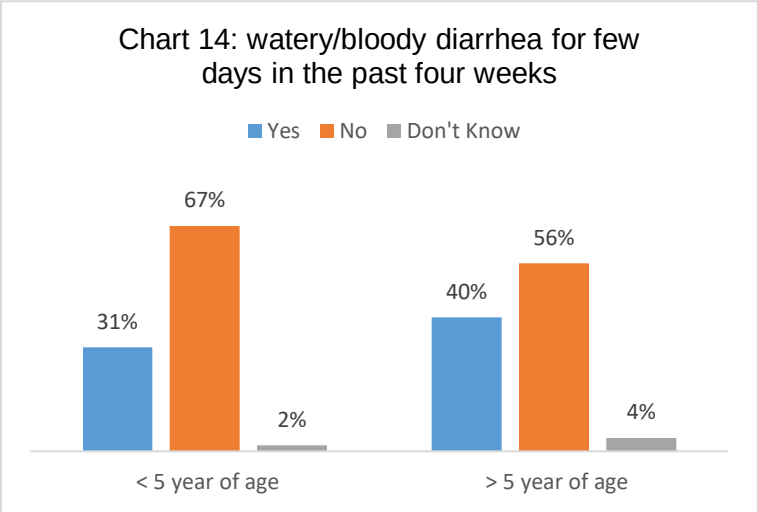
The increased incidence of AWD/Cholera in most districts of the country made sanitation and hygiene promotion as a life-saving activities. Consequently, the project designed and

implemented comprehensive WASH activities – such as water trucking, support health facilities with supplies, distribution of hygiene kits, and hygiene/sanitation promotion - to prevent and respond to the outbreak of cholera/AWD. However, despite the training of community volunteers and sub-sequent hygiene/sanitation promotion activities, the practice of community members in handwashing during critical moments was not satisfactory. As indicated in chart 13, only 52% of survey participants practice handwashing during at least in three critical moments. Comparing to the results of CARE's assessment in four districts of Amran Governorate in December 2016 where 71.3% of interviewees practice handwashing in at least three critical moments, there is still a need to more comprehensive hygiene promotion activities targeting all segments of the society.

Chart 13: When do you usually wash your hands?



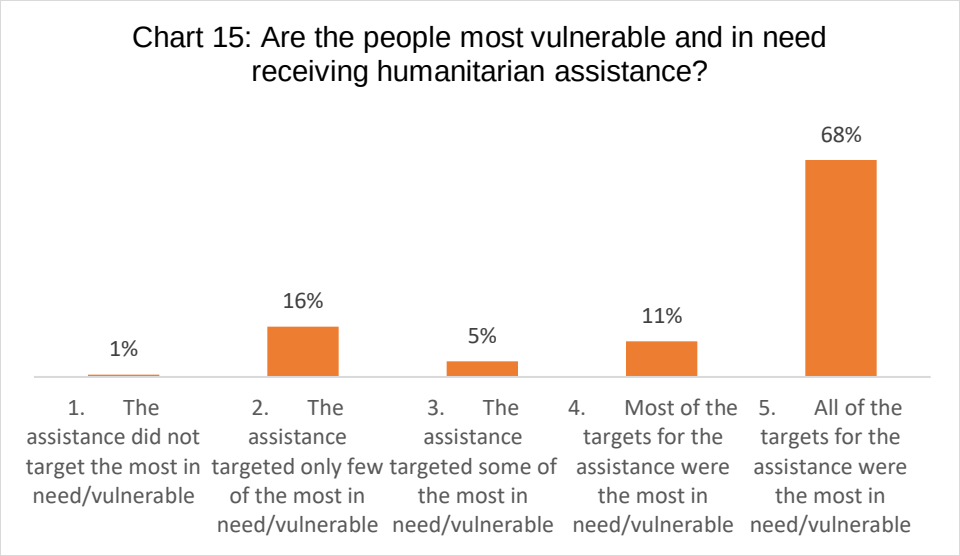
The HHs respondents in chart 14 clearly mentioned that watery diarrhea occurred in 31% of under 5 children during the last four weeks and in 40% of HHs members above 5 years of age. There is slight improvement comparing to the results of CARE's assessment in four districts of Amran Governorate in December 2016 where 53.6% of interviewees mentioned that diarrhea among children occurs in weekly/fortnightly/monthly basis. Nevertheless, there is still a huge need to improve access to safe water; enhance access to sanitation facilities; comprehensive awareness on sanitation-related issues targeting boys, girls, men and women; and long term sanitation support to change behavior of open defecation.



3.3.2 Targeting

Amran Governorate has been adversely affected by the war. CARE selected Suwayr (Amran) and Sabah (Abyan) districts under Phase 1 of the project and Suwayr and Al-Madan districts of Amran Governorate in Phase 2 of the project. These districts are hard to reach areas and identified by the food security and nutrition clusters as priority districts for intervention. Furthermore, the targeted areas are considered among the poorest districts in Yemen according to the Household survey conducted by the Social Fund in 2006. The escalation of conflict since March 2015 has led deterioration of livelihoods due to loss of key livelihood assets, absence of livelihood opportunities, and loss of income. This has caused high level of vulnerability and thereby a huge need for lifesaving interventions. Furthermore, large scale and prolonged displacement have placed additional burden on the already depleted safety-net of the community.

CARE has adopted Cluster-approved criteria to select beneficiary households. These criteria included vulnerable women headed HHs; elderly/ child headed HHs; chronically ill headed HH, marginalized groups; and high dependence with no income resources among others. During the start-up of the project, sensitization sessions were organized in each operational village to sensitize community members on the objectives/activities of the project, beneficiary selection criteria, and the roles/responsibility of community members. Participants of the FGDs also affirmed that they were aware of the criteria for selection of beneficiary households and they are satisfied with the selection process. This is also in line with the result of the PDM survey conducted by CARE where all surveyed beneficiaries reported to have been informed about the criteria for selecting HHs. Furthermore, according to the result of the PDM survey, 87% of the interviewees mentioned that the beneficiary selection process was very fair and transparent.



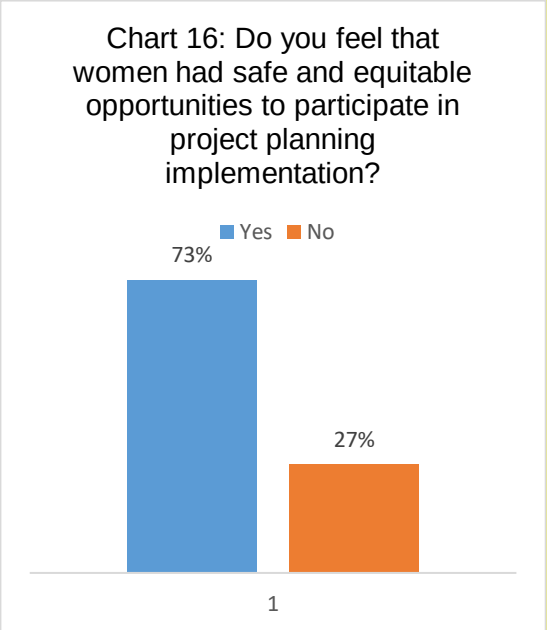
In Phase 2, CARE targeted villages in the districts of Swuayr and Al Madan where cases of AWD/Cholera have been reported. The prioritized activities for the response were chlorination of water sources, water trucking, distribution of hygiene kits, and awareness raising activities. The health facilities were also supported with clean water through water trucking activities and hygiene kits were provided for patients admitted in these health facilities with AWD/Cholera cases.

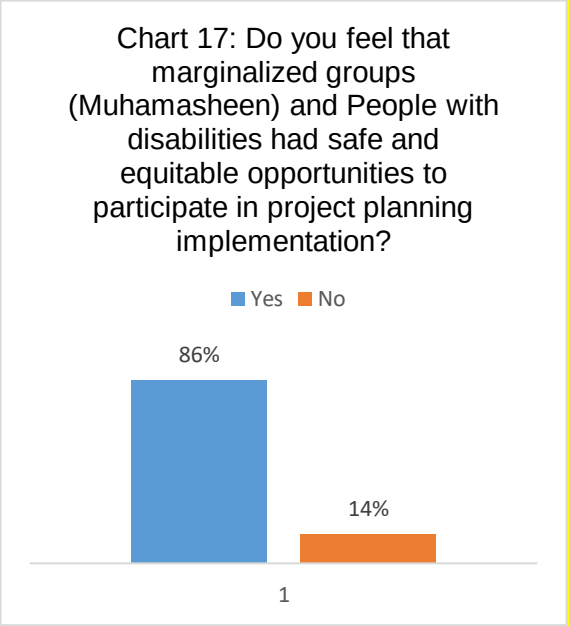
The community groups especially women and marginalized were involved in the project interventions through a detailed participatory approach. Initially, an orientation session was organized at governorate/district levels with local authorities to inform them about the objectives and key activities of the project and to discuss the identification of villages for intervention as well as the criteria for selecting of beneficiary households. In Phase 1, the main criteria for the selection of villages were high level of vulnerability, concentration of IDPs, severity in terms of safe drinking water, and existence of non-functional water sources with high discharge capacity. In Phase 2, in addition to the high level of vulnerability, villages with relatively high/suspected cases of AWD/cholera as well as villages close to confirmed cholera cases were prioritized for intervention.

In both phases of the project, project sensitization sessions were organized in operational villages with community members and this was followed by establishment of community-based committees through fair and transparent process and selection of beneficiaries using the agreed criteria. In Phase 1, the criteria for selecting beneficiary HHs included vulnerable female/child/elderly headed HHs; households with pregnant and lactating women as well as those identified to be caring for the elderly and persons with chronic illnesses; and vulnerable HHs from marginalized communities. In Phase 2, the criteria were extended to HHs with suspected/confirmed cases of AWD/cholera; HHs with members admitted to health facilities; and neighboring HHs with confirmed cholera/AWD cases.

After receiving the list of beneficiaries, the project conducted a verification survey with a sample of 30% of the sampled HHs to avoid inclusion/exclusion errors and ensure that the selected HHs meet the targeting criteria. The final beneficiary list was posted in public

places such as schools and market so that community members can voice their complaints. Following this, database of beneficiaries was prepared electronically. As chart 15 indicated, 68% and 11% of the survey participants respectively mentioned that 'all' and 'most' of the targeted households are the neediest where 5% of respondents reiterated that the assistance targeted some of the neediest HHs. In addition, 73% of interviewees mentioned that women had safe and equitable opportunities to participate in the project and 86% of respondents replied that marginalized groups and people with disabilities had safe and equal opportunities to participate in the project.





The project put-in-place a Complaint, Feedback, and Response Mechanism (CFRM) so that community members can lodge their complaints and provide feedback in the implementation of the project as well as selection of beneficiaries. Suggestion boxes were also placed in each village and community members were oriented about the CFRM and the channels (suggestion boxes, telephone….) to submit complaint and feedback. 89% of survey participants mentioned that they are aware of the complaint and response mechanism that was put-in-place by CARE and 78% of respondents replied that the complaint and response mechanism is accessible and confidential.

Conclusions:

1. The people in targeted districts are still very vulnerable to consequences of both prolonged food insecurity and low access to sanitation and hygiene services making them at high risk of malnutrition and AWD/Cholera and other water-born outbreaks.
2. The same beneficiaries need more opportunities of integrated forms of assistance that should be provided in the form of cash for work to build up the sanitation services and encourage the access and use of these services as well as to allow for more food options and diversification of food types.
3. Awareness of the importance of diversification of food is highly recommended to be included in all food programming of CARE and humanitarian partners.

3.4 Sustainability

The project has successfully rehabilitated the water schemes and established a community based committees (CBCs). Members of the CBCs were oriented and trained on management and minor maintenance of the water schemes rehabilitated by the project. The evaluation team affirmed that the CBC in Al Ghanaya area of Suwayr district is still functional and managing the water scheme, which – as per members of the community – enhanced their ownership sentiment. This, along with coordination with the local water authority, ensures the sustainability of the project outcome. With the collaboration of the local health office, the project has built the capacity of the community volunteers in key hygiene, sanitation, nutrition, and health issues so that the volunteers will continue to enhance the awareness of community members and are in a position to communicate with the health office during incidences of water borne diseases. CARE has also been actively coordinated with local authorities, health office, and water office and this helped to avoid a shocking exit.

Further, the hygiene promotion activities and support provided to health facilities will contribute to more preventative awareness and accumulated experience in the targeted areas in the future. However, it would have been more comprehensive and more sustainable if similar awareness activities such as campaigns, leaflets, awareness seminars, etc., were provided in integrated manner with the water interventions targeting all segments of the society.

Annexes

Annex1: Terms of Reference

CARE Yemen
Terms of Reference for Final Evaluation For Dec Supported Emergency Response Projects In Amran And Abyan Governorates, Yemen

Background
Under the Yemen Crisis Appeal and with the fund from Disasters Emergency Committee, CARE Yemen has been implementing two emergency response projects in Abyan and Amran Governorates of Yemen with the aim of responding to the WASH, food insecurity and Cholera/Acute Watery Diarrhea (AWD) Crisis. The first phase of the project was implemented in two districts of Abyan and Amran Governorates from 16 December 2016 to 30 June 2017 and had two prongs: increasing household income through cash for work intervention and increasing access to safe drinking water through rehabilitation of water sources under the cash for work scheme. The second phase of the project is being implemented in Suwayr and Al-Madan districts of the Amran Governorate from 1 July to 31 December 2017 and it aims to prevent and respond to Cholera/AWD crisis through provision of safe water to cholera affected communities, conducting hygiene promotion activities, and supporting health facilities.

Purpose and objectives
The purpose of this final evaluation is to ensure accountability and identify lessons learned and best practices so as to feed into the decision making process of the project stakeholders, including the donor, beneficiaries, and Government counterparts. In addition, the evaluation aims to objectively assess the relevance, efficiency, effectiveness, and sustainability of the project in light of its objectives and provide recommendations for future programming. Furthermore, the evaluation will assess how the project ensured accountability to affected groups considering the commitments of the Core Humanitarian Standard.
The specific objectives of the final evaluation are primarily:

1. To provide evidence-based information on performance of the project against the intervention logic and existing project and program indicators;
2. To assess the project's efficiency, effectiveness, and validity of design/relevance of the project
3. To assess how the project ensured inclusion of vulnerable and marginalized communities and engaged with affected population and communities;
4. To assess the sustainability of the outcomes of the project, beyond the project lifetime
5. To document lessons learned and provide evidence-based recommendations for similar future interventions

At the end of the evaluation, the external consultant shall produce a report and present it to CARE Yemen.

d) Scope of evaluation
The geographical scope of the evaluation is Suwayr and Al-Madan districts of Amran Governorate and Sabah district of Abyan Governorate. However, the field survey will only be conducted Suwayr district as both phases of the project have been implemented in the

district. The technical scope of the evaluation is to assess the relevance, efficiency, effectiveness, and sustainability of the project.
The main issues that the evaluation should address include:

Relevance

The consultant should look at the design of the project and assess the extent to which the stated project objectives address the identified problems or stakeholder needs.

- How has the project design (outcomes, outputs and activities) been relevant to addressing underlying causes of the identified problems?
- What alternative strategies would have been more effective in achieving its objectives?

Efficiency

- How has the project been efficient in allocating and managing resources (funds, human resources, time, expertise etc.) to achieve outcomes? Were the management capacities adequate- i.e. management of personnel, project properties, communication, relation management with elders, community leaders, other development partners, etc?
- Do the results achieved justify the costs (human resources, time, energy, money, materials)? If not, why not? Have project funds and activities been delivered in a timely manner? If not, why not?
- Was there a clear understanding of roles and responsibilities by all parties involved?
- Has the project received adequate technical and administrative support from DEC, CARE UK, and CARE Yemen?
- How far and in what ways the project was able to strengthen local partners, communities, government, youth groups (and other relevant groups) and provide suggestions to further improve their capacities.
- Review and assess the quality of the project monitoring and evaluation system, specifically: Assess the appropriateness of the indicators and also assess the robustness of the monitoring protocol and approaches in quantitative and qualitative data collection & compilation by project staff based on the log frame indicators.

Effectiveness and outcomes

- How the project was perceived by relevant stakeholders (Local Councils and community members) in light of achieving its planned objectives?
- How has the project been effective in achieving its planned activities and outcomes? If not, why?
- Which were the strengths in the project implementation and what are the constraints and challenges faced? How has the project mitigated these challenges?
- How gender and protection have been mainstreamed into project activities and what was the impact of the project on gender equity and related issues
- How have the approaches/modalities followed by the project been effective in ensuring inclusion of vulnerable and marginalized communities?
- Has the project followed conflict sensitivity approach in the various stages of the project so as to not create/trigger conflict due to the implementation of the project?
- Have the approaches/modalities followed by the project been effective in engaging with the communities affected by the crisis? How and why?

e) Methodology

The consultant shall use mixed methods including desk review, key informant interview, sample survey, and observation using simple but numerically sensitive tools to collect data. The sample size must be statistically representative of the population. The analysis will involve statistical and content analysis using appropriate packages as deemed fit by the consultant. The analysis among others should show trends and should be disaggregated by gender and age (to the extent possible).

f) Tasks

The consultant will undertake the following tasks:

1. Conduct meetings with key project staff of CARE, partners and/or other stakeholders
2. Design the evaluation, including data collection tools for the project and relevant program indicators (including translation into Arabic) and sampling technique and size.
3. Conduct desk reviews of secondary information and project documents including the project proposal (including log-frame), implementation and M&E plans of the project, project financing agreements, progress and financial reports, existing data collection and monitoring tools and any other relevant documents.
4. Obtain feedback on data collection tools from key CARE staff and finalize draft data collection tools to be tested
5. Train enumerators who will pre-test the data collection tools. If necessary, make final adjustments to data collection tools in consultation with CARE.
6. Collect data from a representative sample of individuals from the target groups and key project relevant stakeholders using household questionnaires, key informant interviews (KII) and Focus Group Discussions (FGDs)
7. Data processing (data entry, verification and analysis);
8. Report writing and submission of first draft report
9. Presentation of findings and recommendations to and validation by key stakeholders
10. Finalize the report incorporating feedback and submission of final report.

There should be adequate women representation and participation throughout the data collection process. Where necessary, especially in rural areas, focus group discussions should be conducted separately for men and women.

g) Deliverables and time-frame

The consultants will produce the following specific deliverables after signing the contract. The consultant will provide regular briefings to CARE Yemen and will report his/her preliminary findings before leaving the field.

Deliverable	Days
1. Inception report, including methodology, work plan and draft data collection tools	1 day
1. Training of enumerators and finalization of tested data collection tools	2 day
1. Fieldwork and draft report, including all annexes (see below)	8 days
1. Presentation of preliminary findings and recommendations to CARE, partners and/or other key stakeholders for verification	1 day
1. Final report, including all annexes (see below)	1 day

The draft and final report will have the following structure:

1. Executive Summary (max. 2 pages)
2. Introduction.
3. Methodology, including sampling.
4. Analysis and findings of the study.
5. Evidences of success/failures
6. Conclusions, recommendations, lessons learned and best practices.
7. Annexes
    a. ToR

b. Performance indicator tracking table reflecting the status on each indicator against target and previous results, if any
c. Relevant maps and photographs of the study areas
d. Bibliography of consulted secondary sources
e. Finalized data collection tools (in English and Arabic)
f. List of key informants
g. Raw data in an agreed format

The report will be written in English.
The consultant needs to produce three hard copies of all deliverables. The final report will also be provided in electronic copy (both PDF and MS Word format).
The consultancy is expected to take place in the month of December 2017 in a total of 13 working days, including preparation, evaluation design, field work, report writing and presentation of findings and recommendations to CARE Yemen, partners and external stakeholders.

h) Expertise required
The evaluator should be an experienced and independent consultant with the following expertise:

- Advanced university degree in International Development, Social Sciences or any other related field with a minimum of 5 years of professional in international development and project evaluation.
- Demonstrated experience in assessments and/or evaluations of interventions.
- Previous professional experience in Yemen is highly desirable;
- Excellent understanding of development and gender issues.
- Have an understanding of operating conditions in an insecure environment
- Advanced analytical and report writing skills.
- Be willing to travel extensively in the working areas of the project.
- Fluent in English and Arabic

i**) Management of the consultancy and logistical support**
The principal contacts for this consultancy will be CARE's Program Quality Coordinator. CARE Yemen will provide all reasonably available secondary information as the Consultant may require to perform his/her obligations under this Agreement. Logistical arrangements for fieldwork will be provided by CARE Yemen as agreed with the consultant. All data gathered in the field is property of CARE. The consultant shall ensure at all times the confidentiality of data, respect the privacy of all individuals concerned.
The Consultant will operate within CARE's established security systems. In the event of a deterioration of security, and evacuation being advised, CARE Yemen would do its upmost to ensure the safety the consultant.

k) Terms of payment:
The following is the term of payment:

- 20% upon receipt of inception report (incorporating methodology and tools) and approved by CARE and an invoice for payment
- 30% upon receipt of the draft report accepted by CARE and an invoice for payment.
- 50% upon the final presentation and final report accepted/approved by CARE and an invoice for payment.

l) <u>Application process</u>:
The deadline for submission of applications is **October 30th, 2017**. All applications should include the following:

- **Cover letter** (maximum 1 page) stating the candidate's availability during the month of December 2017 and **updated CV's** of all study team members, including **three references** with contact details
- **Technical proposal:** Which should include (i) brief explanation about the Consultant with particular emphasis on previous experience in this kind of work; (ii) profile of the Consultant to be involved in undertaking the evaluation, (iii) Understanding of the TOR and the task to be accomplished, (iv) draft plan and methodological approach
- **Financial Proposal**: Which should include all the costs (including consultancy fees, accommodation and living costs; transport cost; stationeries, and supplies needed for data collection; enumerators' fees; and costs related to other person/research assistants that will take part).

Interested consultants or firms should submit their applications to: fasil.demeke@care.org and basem.alaghbri@care.org . **Please indicate "DEC SUPPORTED PROJECTS IN AMRAN AND ABYAN GOVERNORATES – FINAL EVALUATION" as the subject heading.**

Applications will be evaluated based on the following criteria:

- Technical experience and expertise
- Quality of proposal
- Cost-effectiveness of proposal

Annex 2. List of documents reviewed

- Project documents for the two phases including objectives, expected results, log frame with baseline information;
- Work plans
- Progress reports and monitoring reports.
- Report of the workshop for internal evaluation of rehabilitation of water projects through CFW in Suwayr supported by DEC on 2017.
- Three PDM reports; two from Suwayr district in Amran and one for Sabah district in Abyan.
- Annual achievement report for Health sub-office in Suwayr.
- Sitrep No. 2 of the Emergency Operation Center (EOC) on Cholera, 31 August 2017.
- Weekly Epidemiological Bulletin; WHO, eIDEWS, Volume 05, Issue 51, Epi week 51, 18-24 December 2017.
- Report on Multi-sectoral Rapid Needs Assessment in Suad, Amran, Thula, and Jabal Yazid districts of Amran governorate, Yemen; CARE Yemen, December 2016.
- Joint cholera Response Plan, July 2017
- Yemen Humanitarian Response Plan 2017
- Humanitarianresponse.info

Annex 3. List of Persons/Organizations consulted

The list of households participated in Focus group discussion could be found in the separate soft files handed over together with the report.

The table below show other key informants who provided information for this evaluation

No	Names	Titles	Institutions
1	Wael Abo Helfah	General Director/Chairperson	Local Council in Suwayr district
2	Ahmed Kobas	Director	Health Sub-office in Suwayr
3	Ali Al Azab	Field Officer	CARE Amran Sub-Office
4	Ali Danah	Finance Officer	CARE Amran Sub-Office
5	Qasim Dahshan	Community Leader	Suwayr District
6	Adel Maish	Community Leader	Suwayr District
7	Taha Al Haweri	Community Leader	Suwayr District

Annex 3. Output Indicators of DEC Project - Phase 1 &2

Performance indicator tracking tables reflecting the status on each indicator against target are included in the efficiency part of the report. The following are detailed direct beneficiaries for water trucking and hygiene kits distributions:

Performance Indicator - Phase 1

No.	Indicator	Planned	Actual	Percentage	Remark
1	# of households have increased income to meet their basic and immediate needs	390	390	100%	
2	# of individuals have increased access to safe-drinking water	10,500	17,801	169.5%	
3	# of water schemes rehabilitated	6	6	100%	6 water schemes (3 in Amran and 3 in Abyan) rehabilitated

Water Trucking in Suwayr and Al Madan districts – Phase 1

District	Number of water points	Men	Women	Boys	Girls	Total Individuals	Total HHs
Suwayr	2	736	751	1,591	1,687	4,765	637
	1	279	297	381	394	1,351	211
Sub-Total	3	1,015	1,048	1,972	2,081	6,116	848
Al Madan	4	1,010	1,062	1,960	2,156	6,188	884
	1	644	741	628	633	2,646	405
Sub-Total	5	1,654	1,803	2,588	2,789	8,834	189
Total	8	2,669	2,851	4,560	4,870	14,950	2,137

Hygiene Kits distributed in Suwayr and Al Madan districts – Phase 2

District	Village	<5 yrs		5-17 yrs		18-59 yrs		>60 yrs		Total Individuals
		M	F	M	F	M	F	M	F	
Suwayr	Ghathiah	279	284	360	365	336	388	71	33	2,116
	Albatol	428	406	457	396	269	315	79	104	2,454
	Almithmar	630	596	486	418	360	352	57	58	2,957
	Manjarah	529	476	643	603	340	405	102	110	3,208
	Sara'a	122	93	234	200	102	106	15	23	895
Sub-Total		1,988	1,855	2,180	1,982	1,407	1,566	324	328	11,630
Al Madan	Bani Nawf	299	304	552	560	781	908	61	59	3,524
	Bani Nasr	228	194	362	327	265	412	33	43	1,864
	Bani Awf	161	155	281	291	364	333	53	76	1,714
Sub-Total		688	653	1,195	1,178	1,410	1,653	147	178	7,102
Total		2,676	2,508	3,375	3,160	2,817	3,219	471	506	18,732

Annex 4. Rating of program implementation vis-à-vis Core Humanitarian Standards

No	Standards	Level of achievement (1-5, where 5 is the highest and 1 is the lowest)	Explanation of the grade
1	Humanitarian response is appropriate and relevant	4	The response was very relevant to the needs of the local community and targeted the neediest beneficiaries and communities.
2	Humanitarian response is effectively and timely	4	The response came on a time where the living conditions were worsened and local communities were left without income sources and deteriorated services. Furthermore, the communities were suffering from access to safe water that make them vulnerable to water-borne diseases. The cash assistance helped beneficiaries to meet their basic and immediate needs as well as the rehabilitation of water schemes helped to improve access to safe water and lessened the burden of fetching water, and also reduced the safety and protection risks on women. The second phase of the project was launched when there is incidence of cholera outbreak in the area and the

			responses were effective in mitigating the problem.
3	Humanitarian response strengthened local capacities and avoids negative effects	5	Community committees were trained and this contributed to the building their capacities and providing them with knowledge and skills needed they had not possessed before. Furthermore, the project selected and trained community volunteers in key hygiene, sanitation, and IYCF practices that enhanced their knowledge. It is believed that this retention of knowledge shall contribute to the sustainability of the project.
4	Humanitarian response is based on communication, participation, and feedback	5	The establishment of community committees facilitated communication with the targeted beneficiaries and the local community. The project also maintained effective communication with local authorities and health and water offices. Community members have been adequately participated in the implementation of project activities.
5	Complaints are welcomed and addressed	4	The project put-in-place a complaint, feedback, and response mechanism in both Phases of the project. Most of members of the community affirmed that complaints have been welcomed and addressed. However, few beneficiaries expressed their dissatisfaction and lack of understanding of the complaints mechanism. Claims were made that they were not sure that authorities were serious to deal with their complaints.
6	Humanitarian response is coordinated and complimentary	5	The project was well coordinated with local authorities and health offices. Integrated WASH and cash assistance was provided in Phase 1 of the project whereas comprehensive WASH assistance was implemented in Phase 2 to curb the Cholera outbreak through supporting health facilities with supplies, water trucking activities, and awareness raising

			sessions. However, both phases did not incorporate activities related to sanitation (such as construction of latrines).
7	Humanitarian actors continuously learn and improve	5	Evidences indicated that the project demonstrated continuously learning and improving through conducting periodic project review sessions and conducting surveys.
8	Staff are supported to do their job effectively and treated fairly and equitably	4	Staffs expressed their satisfaction regarding their work as well as the support they received from the Country Office. However, there was some delays in terms of delay of approval of few requests.
9	Resources are managed and used responsibly for their intended purposes	5	Resources were effectively managed as the project delivered all the planned activities and budget utilization was highly efficient.

Annex 5. Evaluation Management Response

Evaluation title: **Final Evaluation of DEC supported emergency response projects in Amran and Abyan Governorates, Yemen**

Project name: **Comprehensive Emergency WASH and cash assistance to cholera affected households**

Evaluation Year: ***2018***

Person overseeing management response: ***Fasil Demeke***

Overall response to the evaluation: The evaluation was conducted as per the objectives stipulated in the Terms of Reference. Mixed methodologies were used to conduct the assessment, which enabled not only to have quantitative information but also to have clear understanding of the perceptions and insights of community members on the implementation of planned activities of the project. The overall evaluation process utilized the OECD criteria, which are relevance, effectiveness, efficiency, outcome, and sustainability. Feasible recommendations have been forwarded and lessons learned (best practices) were highlighted. CARE's M&E team as well as the program team have been providing continuous support and feedback to the consultants and the inputs were well taken by the evaluators. The evaluation is accepted by the Program Quality Unit and the respective program team of CARE Yemen as it meets the standards.

Although CARE implements the two phases of the project in two districts of Amran Governorate and one district of Abyan Governorate, this evaluation was limited to Suwayr district of Amran Governorate where both Phase 1 and 2 of the project were implemented. In addition, the unstable security situation in the area has hindered full accessibility of the project sites.

Planned use of the evaluation: CARE is currently implementing similar interventions in its various operational areas and the recommendations as well as the lessons learned from this project will be shared so that the lessons and the recommendations could be applied. The evaluation will also be published on the ANLAP website as per DEC requirements and promote learning and best practice within the humanitarian sector.

Response definitions:

Accepted: This recommendation should be completely implemented, and the response should show how, by whom and by when that is to be done.

Partially Accepted: The recommendation is in error and we will therefore not implement as recommended but we will take other action that we believe is more appropriate. Note that the reason for a partial acceptance must be given.

Rejection: The recommendation is based on inaccurate findings or does not address the findings in the correct way. The reason for non-acceptance must be stated.

Assigned editor:						
RECOMMENDATIONS and ACTIONS						
Evaluation Recommendation or Issue 1: Although water trucking in villages affected by AWD/Cholera is considered a life saving measure, there is a need to have an exit strategy for future similar projects before implementing water trucking activities.						
Management Response (Accepted, Partially Accepted, Rejected): Accepted						
If rejected or partially accepted then please give the reasons why:						
Actions planned	**Responsible office**	**Responsible person**	**Completion date** (please note if expected or achieved)	**Implementation stage:** • Not started • Underway • Completed • Cancelled.	**Actions taken**	**Supporting documents**
Develop an exit strategy for water trucking projects during design phase.	Program Unit	Thomas Charteris (Program Development Coordinator – PDC) Fasil Demeke (Program Quality Coordinator – PQC)	Future Programming	Underway	Discussion has been made in the program development coordination meeting to take this recommendation into consideration.	Meeting notes
Inform Field Offices (that are planning to implement water trucking activity under 2 projects in 2 location) to develop an exit strategy	Program Unit	Peter Egesa (Senior WASH Advisor)	On-going activity	Underway	CARE will start water trucking activity soon in 2 donor supported projects in Aden and Taiz Governorates and project staffs have been informed during the launching of these projects.	Minutes of the launching workshop
Evaluation Recommendation or Issue 2: Designing nutrition-sensitive hygiene promotion interventions that target women/girls are vital as there is direct correlation between hygiene/nutrition promotion and food safety. CARE should take the inclusion of nutrition themes into consideration in current WASH interventions as well as while designing new WASH programs.						
Management Response (Accepted, Partially Accepted, Rejected): Accepted						
If disagree or partially agree then please give the reasons why:						

Actions planned	Responsible office	Responsible person	Completion date (please note if expected or achieved)	Implementation stage: • Not started • Underway • Completed • Cancelled.	Actions taken	Supporting documents
Reinforcing nutrition-sensitive hygiene promotion programming during design and implementation through modifying training and IEC materials as well as training of hygiene promoters.	Program Unit	Peter Egesa (Senior WASH Advisor)	On-going activity	Underway	Training and IEC materials updated; hygiene promoters trained	Training and IEC materials; training report
Evaluation Recommendation or Issue 3: Targeted beneficiaries are in need of more integrated forms of assistance, in particular which should be provided in the form of cash for work to build up their sanitation services combined by behaviour change activities to encourage the access and use of sanitation services. Accordingly, it is recommended to have a more integrated assistance as this maximizes impact at household level.						
Management Response (Accepted, Partially Accepted, Rejected): Partially accepted						
If rejected or partially accepted then please give the reasons why: Although many donors support and encourage integrated response, some donors might not fund integrated assistance depending on their scope, strategy, as well as the nature of response.						
Actions planned	**Responsible office**	**Responsible person**	**Completion date** (please note if expected or achieved)	**Implementation stage:** • Not started • Underway • Completed • Cancelled.	**Actions taken**	**Supporting documents**
Design projects that focus on integrated assistance	Program Unit	Thomas Charteris (Program Development Coordinator – PDC) Fasil Demeke (Program Quality Coordinator – PQC)	On-going activity	Underway	Two recently designed proposals took into consideration integrated assistance at HH level to maximize impact	Proposals
Evaluation Recommendation or Issue 4: It is recommended that CARE and other humanitarian actors hire high skilled personnel in the cash for work interventions especially in rehabilitating water wells and any other construction work to ensure quality training, better guidance and opportunity to local young people to acquire construction skills (learning by doing). This will provide beneficiaries with more opportunities to work in construction sector in the future and will add to the sustainability of the project capacity building activities.						

Management Response (Accepted, Partially Accepted, Rejected): Partially accepted						
If rejected or partially accepted then please give the reasons why: Although it is ideally a valid recommendation, it is very difficult to find and recruit high skilled people in CfW activities. In addition, the recommendation is not too relevant for CfW activities that do not demand skilled labor.						
Actions planned	**Responsible office**	**Responsible person**	**Completion date** (please note if expected or achieved)	**Implementation stage:** • Not started • Underway • Completed • Cancelled.	**Actions taken**	**Supporting documents**
Recruit skilled personnel wherever possible in the CfW intervention and monitor the process.	Program Unit	Essam Masoud (Deputy Director of Operations)	ASAP	Underway	Communications were made to Area Offices (that implement CfW interventions)	*Notes*
Build in CFW technical advisor into project design.	Program Unit	Essam Masoud (Deputy Director of Operations)	ASAP	Underway	*The structure of the food security team is adjusted to incorporate positions related to CfW Field Engineer*	*Country Office structure, job descriptions*
Evaluation Recommendation or Issue 5: There is a need to secure enough time for implementing Cash for Work activities, especially that involves rehabilitation/construction of key communal assets such as water schemes so as to ensure quality implementation, sustainability, and also improving community's access to the assets.						
Management Response (Accepted, Partially Accepted, Rejected): Partially accepted						
If rejected or partially accepted then please give the reasons why: The recommendation is relevant only for CfW activities related to construction/rehabilitation of relatively big community assets that serve wider community.						
Actions planned	**Responsible office**	**Responsible person**	**Completion date** (please note if expected or achieved)	**Implementation stage:** • Not started • Underway • Completed • Cancelled.	**Actions taken**	**Supporting documents**
Design CfW intervention (for construction or rehabilitation of big	Program Unit	Thomas Charteris (Program Development Coordinator – PDC)	On-going activity	Underway	As per the Food Security Cluster guideline, the duration of CfW	Food Security Guideline; proposals

communal assets) with reasonable time frame		Fasil Demeke (Program Quality Coordinator – PQC)			activities is 6 months, which is a reasonable timeframe. CARE follows this guideline	
Evaluation Recommendation or Issue 6: It is recommended that CARE conduct further studies/assessments in its operational areas regarding the effect of water chlorination on bees as might affect the local production of honey in the project areas.						
Management Response (Accepted, Partially Accepted, Rejected): Partially Accepted						
If rejected or partially accepted then please give the reasons why: CARE and other humanitarian actors have been implementing WASH interventions (including chlorination of water sources) for several years in various areas of Yemen, including areas with high numbers of bee colonies. However, this finding is a new one and it needs further investigation.						
Actions planned	**Responsible office**	**Responsible person**	**Completion date** (please note if expected or achieved)	**Implementation stage:** • Not started • Underway • Completed • Cancelled.	**Actions taken**	**Supporting documents**
Conduct a rapid research	Program Quality Unit	Fasil Demeke (Program Quality Coordinator)	September 2018	Not started	Discussion initiated on how to conduct and funding the rapid research	Discussion notes
Evaluation Recommendation or Issue 7: There was high participation of the community in the various phases of the project and this best practice is recommended to be taken as exemplary for similar future activities.						
Management Response (Accepted, Partially Accepted, Rejected): Accepted						
If rejected or partially accepted then please give the reasons why:						
Actions planned	**Responsible office**	**Responsible person**	**Completion date** (please note if expected or achieved)	**Implementation stage:** • Not started • Underway • Completed • Cancelled.	**Actions taken**	**Supporting documents**
Best practices will be shared to Field Offices	Program Quality Unit	Waleed Al-Amrani (MEAL Advisor)	July 2018	Not started		

Evaluation Recommendation or Issue 8: The best practices and the lessons learnt from this DEC-supported project need to be shared with other relevant humanitarian actors through clusters meetings (i.e. WASH, food and livelihood clusters) to inform the design of similar future activities.						
Management Response (Accepted, Partially Accepted, Rejected): Accepted						
If rejected or partially accepted then please give the reasons why:						
Actions planned	**Responsible office**	**Responsible person**	**Completion date** (please note if expected or achieved)	**Implementation stage:** • Not started • Underway • Completed • Cancelled.	**Actions taken**	**Supporting documents**
Disseminate the evaluation report to the WASH Cluster	Program Unit	Peter Egesa (Senior WASH Advisor)	August 2018	Not started		
Evaluation Recommendation or Issue 9: Due to the great need in Suwayr District, it is recommended that CARE work on securing additional fund for a third phase in villages of the same district villages. The design of the project in the new phase should be informed by the lessons learned from the design and implementation of the current project.						
Management Response (Accepted, Partially Accepted, Rejected): Accepted						
If rejected or partially accepted then please give the reasons why:						
Actions planned	**Responsible office**	**Responsible person**	**Completion date** (please note if expected or achieved)	**Implementation stage:** • Not started • Underway • Completed • Cancelled.	**Actions taken**	**Supporting documents**
Lobbying with potential donors to implement integrated programming in the district	Program Unit	Jolien Veldwijk (ACD – Programs)	On-going activity	Underway	Discussion initiated with WFP to increase the caseload of beneficiaries in the district.	Discussion notes

Annex 6. Data collection instruments (questionnaires; interview questions; etc.)

1. **Focus group guide with project beneficiaries**

Introduction

Introducing the evaluation team to the group, provision of background about:

- The purpose of the discussion
- Explain the overall objective of the evaluation task and results to achieved.
- Who are the intended recipients of findings and how they will be used
- Assuring the confidentiality of the content of the group discussion and issue of anonymity
- Rules of conducting the FGDs and time amount needed for the meeting ;i.e. between 60-80 minutes)

Questions

1) **Knowledge about the project interventions**
   - What activities were provided by the project during the year 2017?
   - Where did these activities implemented?
   - How these areas were selected? Water schemes and cash for work in particular.
   - Who were the beneficiaries? Do you know about the beneficiaries' selection and registration process in this program? If so, describe the process.
   - Are you satisfied with the criterion and mechanisms of selection? Do you think the selection was fair? If no, why do you think it was not fair?
   - Have you been consulted by CARE about safety and access issues (such as selection of distribution points, type of cash for work activities)
2) **Relevance**
   - Do you feel the assistance provided by CARE is relevant and supporting the community in meeting their priority needs? Explain.
   - To what extent has the project responded to the needs of your local community especially the most vulnerable and those in need to receive humanitarian assistance?
   - What other needs related to provided interventions (water rehabilitation interventions, cash for work, Cholera/AWD interventions) were not addressed by the project?
   - Do you feel that women had safe and equitable opportunities to participate in project planning implementation?
   - Do you feel that marginalized groups (Muhamasheen) and people with disabilities had safe and equitable opportunities to participate in project planning

3) **Effectiveness**
   - What are the most positive “things” that the project brought to you?
   - What did not work well?
   - Has the assistance provided by CARE caused any negative effects on the affected population/community’?
   - Are you satisfied with the type and quantity of assistance provided? If not, why?

4) **Sustainability**

- What will remain after the project finishes?
- Are the Community Based Committees (CBCs) willing and able to keep facilities operational and to continue activities on their own?
- Is there local ownership?
- Did CBCs participate in the planning and implementation of the intervention to ensure local engagement from the start?
- Do CBCs possess sufficient governance structures and capacity to sustain the activity?
- Did the project interventions take into account environment issues?

Closing up the discussion

- Is there anything further anyone would like to add about any of the issues we've already discussed, that you feel you've not had a chance to say?
- Is there anything anyone would like to add about any issue we've not really covered which you feel reflects an important aspect of the project and what you gained/did not gain from it?

Thanking participants for attending and giving feedback

2. Households questionnaire

Questionnaire Code: …….. Researcher Name ……..
Location/Sub-district/Village…… …… Date ……..

Section 1: Household background

1.1	Name of the head of household	
1.2	Sex of the head of the household	Female (1) Male (2)
1.3	Age of the head of the household	
1.5	Household status	Host ☐ IDP ☐ Returnee ☐ Refugee ☐
1.6	Main occupation of the head of household	…….
1.7	Size of household (number	( ) males females ( )

Section 2: Water scheme interventions

2.1	What was the main source of water before the project?	1. open wells/springs 2. unprotected well 3. protected wells 4. public fountains 5. Tankers 6. Water trucking from humanitarian agencies 7. Surface water/ dam/pond 8. Other ……

2.2	What is the main source of water now?	1. open wells/springs 2. unprotected well 3. protected wells 4. public fountains 5. Tankers 6. Water trucking from humanitarian agencies 7. Surface water/ dam/pond 8. Other ……
2.3	Is the water resource you use accessible (easy to reach and to get water with no barriers)?	1. Yes 2. No
2.4	How long does it take you to walk to the water resource/ water well before the project?	1. 10-20 minutes 2. 20-40 minutes 3. 40-60 minutes 4. More than 1 hour
2.5	How long does it take to walk to the water resource/ water well now?	1. 10-20 minutes 2. 20-40 minutes 3. 40-60 minutes 4. More than 1 hour
2.6	How long did you wait to collect the water before the project?	1. 10-20 minutes 2. 20-40 minutes 3. 40-60 minutes 4. More than 1 hour
2.7	How long did you wait to collect the water now?	1. 10-20 minutes 2. 20-40 minutes 3. 40-60 minutes 4. More than 1 hour
2.8	How much water did you collect per day before the project	Check the type and size of the plastic containers that are used by the family 1. 20 -50 liters 2. 50-80 liters 3. 80-110 liters 4. More, identify ……..…...
2.9	How much water do you collect now per day?	Check the type and size of the plastic containers that are used by the family 1. 20 -50 liters 2. 50-80 liters 3. 80-110 liters 4. More, identify ……..…...
2.10	Who do usually collect water in your family	1. Adult women 2. Adult men 3. Young female child : under 15 years old 4. Yong male child: under 15 years old
2.11	How many times did you go to fetch water before the project?	1. Once 2. Twice a day

		3. Three times 4. More, specify ……
2.12	How many times do you go to fetch water now?	1. Once 2. Twice a day 3. Three times 4. Only when the water is pumped If this is a true option, how many time the water is pumped ……
2.13	Were you consulted about the best time to pump the water?	1. Yes 2. NO 3. Don't know
2.14	What do you usually do to the water to make it safer to drink?	1. Boil 2. Strain it through a cloth 3. Add chlorine 4. Use a water filter (ceramic) 5. Let it stand and settle 6. Nothing (I do not treat water before drinking) 7. Other (specify)……..
2.16	Are you satisfied with the improvement in the water supply	1. Yes 2. No Other ……

Section 3: Sanitation and Hygiene interventions

3.1	Is there a toilet in the house?	1. Yes, there is a toilet with covered pit 2. Yes there is a toilet with drainage besides/back of the house 3. No Toilet in the house
3.2	When do you usually wash your hands?	1. Before meal times 2. After meal times 3. Before Cooking 4. After using the Toilet 5. Other ……
3.3	Do you have children under three years old?	1. Yes 2. No If No, move to Question No. 3.5
3.4	The last time your child passed stools, what was done to dispose of the stools?	1. Child used toilet/latrine 2. Put/rinsed into toilet or latrine 3. Buried 4. Thrown into garbage 5. Put/rinsed into drain or ditch 6. Left in the open 7. Other (specify)

		8. Don't know
3.5	Has anyone in your households < 5 year of age had unusual diarrhea (watery/bloody diarrhea for few days) in the past four weeks?	1. Yes 2. No 3. Do not know
3.6	Has anyone in your households > 5 year of age had unusual diarrhea (watery/bloody diarrhea for few days) in the past four weeks?	1. Yes 2. No 3. Do not know

Section 4: Cash for work intervention

4.1	What is the number of meals eaten per day before the project?	1. Three meals 2. Two meals 3. One meal
4.2	What is the number of meals eaten per day before the project?	1. Three meals 2. Two meals 3. One meal
4.3	What was your main source of income before the project?	1. NGO/UN assistance only. 2. Paid labor 3. Asking for money 4. Small business 5. Remittances 6. Salary from government 7. Agriculture 8. Other sources
4.4	What is your main source of income in the past six months?	1. NGO/UN assistance only. 2. Paid labor 3. Asking for money 4. Small business 5. Remittances 6. Salary from government 7. Agriculture 8. Other sources
4.5	Opinion About the Amount Received	1. Inadequate 2. Somewhat adequate 3. Adequate
4.6	Main Use of Cash Assistance	1. Clothes 2. Food 3. Medicines

		4. Debts 5. Water 6. Education 7. Other ……
4.7	Level of Satisfaction of the cash received	1. Very satisfied 2. satisfied 3. Not satisfied
4.8	Perceptions of recipients on family benefits from cash	1. Improved health 2. High quality of food consumed 3. No Benefits 4. Other benefits …….

4.9	The **Food Consumption Score** (FCS) is a composite **score** based on dietary diversity, **food** frequency, and the relative nutritional importance of different **food** groups. **NOW, I WOULD LIKE TO ASK YOU ABOUT THE TYPES OF FOODS THAT YOUR HOUSEHOLD ATE DURING THE LAST SEVEN DAYS? (Write 7 if the HH ate the types of foods for 7 days of the week; Write 6 if the HH ate the types of foods for 6 days of the week; Write 5 if the HH ate the types of foods for 5 days of the week etc; write 0 if the HH did not ate the types of foods throughout the week).**	
Food Groups		Number of days/week
A	Rice, maize , maize porridge, sorghum, millet pasta, bread and other cereals	
B	Beans. Peas, groundnuts and cashew nuts	
C	Vegetables, leaves	
D	Fruits	
E	Beef, goat, poultry, pork, eggs and fish	
F	Milk yogurt and other diary	
G	Sugar and sugar products, honey	
H	Oils, fats and butter	
I	Spices, tea, coffee, salt, fish power, small amounts of milk for tea.	

Section 5: Questions related to Core Humanitarian Standards

1. Do you feel the assistance provided by CARE is relevant and supporting the community in meeting their priority needs?	1. Does not meet 2. Partially meets 3. Fully meets 4. Highly exceeds
2. Do you feel the assistance provided by CARE was timely?	1. Yes 2. No
3. Are the people most vulnerable and in need receiving humanitarian	1. The assistance did not target the most in need/vulnerable

assistance? *(Tick one: 0 is the lowest and 5 the highest)*	2. The assistance targeted only few of the most in need/vulnerable 3. The assistance targeted some of the most in need/vulnerable 4. Most of the targets for the assistance were the most in need/vulnerable 5. All of the targets for the assistance were the most in need/vulnerable	
4. Did you have the information needed to access the humanitarian assistance provided by CARE?	1. Not informed at all 2. Moderately informed 3. Well informed	
5. Do you feel that you are involved in the way the humanitarian assistance is provided	1. Not involved at all 2. Involved few times 3. Involved some times 4. Involved mostly 5. Fully involved	
6. Do you feel that women had safe and equitable opportunities to participate in project planning implementation?	1. Yes 2. No	
7. Do you feel that marginalized groups (Muhamasheen) and People with disabilities had safe and equitable opportunities to participate in project planning implementation?	1. Yes 2. No	
8. Do you know about the beneficiaries' selection and registration process in this program? If the answer is YES, ask the interviewee to describe the process. If s/he is not able to describe the process, please put the answer as NO	1. Yes 2. No	
3. Do you think that the process of selection of beneficiaries was fair?	1. Yes 2. No	If the answer is 'NO', go to the next question. If the answer is 'YES'. go to Question 4.
4. Why do you think that the selection of beneficiaries in your community was not fair?		
5. Have you been informed about the items that you were entitled to during the start-up of the project?	1. Yes 2. No	
6. Are you satisfied with the type and quantity of assistance provided	1. Yes 2. No	
7. If not, why		
8. Has the assistance provided by CARE caused any negative effects on the affected population/community'?	1. It caused high negative effects 2. It caused few negative effects 3. It did not have any negative effects	

9. Have you been consulted by CARE about safety and access issues (such as selection of distribution points, type of cash for work activities)	1. Yes 2. No
10. Are you aware of the complaint and response mechanism that was put-in-place by CARE?	1. Yes 2. No
11. Do you think that the complaint and response mechanism is accessible and confidential>	1. Yes 2. No
12. How respectfully were staff members of CARE treat you or your community?	4. Highly respectful 5. Moderately respectful 6. Less respectful 7. Not respectful at all

أسئلة نقاش المجموعات البؤرية مع المستفيدين من المشروع

المحافظة: ..... المديرية : ..... المجتمع/القرية/ الحارة .....

الحاضرون : ذكور ( ) إناث ( ) اليوم والتاريخ .....

اختيار العينة

كما هو متبع عادة في مجمعات النقاش البؤرية، يجب ان يكون متنوع. من ناحية العمر والوضع التعليمي الاقتصادي والاجتماعي .. وحالتهم في المجتمع (نازحين وسكان أصليين في المجتمع وغيرهم من الفئات الاجتماعية الموجودة بالمجتمع)، يجب ألا يكونوا من أسرة واحدة او اقرباء.

المقدمة

:قم بتقديم فريق التقييم للمجموعة، وتوضيح الفكرة عن

- الغرض من المناقشة.

.اشرح الهدف العام لمهمة التقييم والنتائج التي يريد تحقيقها -

- من هم المستفيدون من نتائج التقييم وكيف سيتم استخدامها.

- ضمان سرية محتوى مناقشة المجموعة

- مراعاة قواعد إجراء مناقشات المجموعات البؤرية و واخبار المجموعة بزمن الاجتماع ومدته (لا تتجاوز 80 دقيقة)

الأسئلة

1) المعرفة حول تدخلات منظمة كير :

- ما هي الأنشطة التي قدمها المشروع خلال عام 2017؟

- أين تم تنفيذ هذه الأنشطة؟

.- كيف تم اختيار هذه المناطق؟ وكيف تم اختيار مشاريع المياه والنقد مقابل العمل على وجه الخصوص

- من هم المستفيدون؟ هل تعرفون كيف تم اختيار المستفيدين وعملية التسجيل في هذا البرنامج؟ إذا كانت الاجابة بنعم (استحث رفع الايدي ، كم عدد من اجابوا بنعم وكم عدد من اجابوا بلا) أوصف كيف حدث ذلك.

- هل أنت راض عن معيار وطر ق الاختيار؟ هل تعتقد أن الاختيار كان عادلا؟ إذا كان الجواب بالنفي، لماذا تعتقد أنه لم يكن عادلا؟

- هل تمت استشارتكم من قبل منظمة كير حول قضايا السلامة ومدى الاستفادة من الانشطة وسهولة الوصول اليها (مثل اختيار نقاط التوزيع، ونوع أنشطة النقد مقابل العمل).

2) الملائمة:

.- هل تشعرون أن الانشطة التي تقدمها منظمة كير مناسبة وتدعم المجتمع في تلبية احتياجاتهم ذات الأولوية؟ اشرح

- إلى أي مدى استجاب المشروع لاحتياجات مجتمعكم المحلي وخاصة احتياجات الفئات الأكثر ضعفا والمحتاجين لتلك الانشطة ؟

- ما هي الاحتياجات الأخرى مقارنة بالتدخلات المقدمة (التدخلات المتعلقة بإعادة تأهيل المياه، والنقد مقابل العمل، والتدخلات المتعلقة بالكوليرا والاسهالات المائية الحادة) لم يتناولها المشروع؟

- هل ترون أن المرأة حصلت على فرصة آمنة ومنصفة للمشاركة في تخطيط وتنفيذ المشاريع؟

- هل ترون أن المجموعات المهمشة (االمهمشين) والأشخاص ذوي الإعاقة لحصلوا على فرص آمنة ومنصفة للمشاركة في تخطيط وتنفيذ المشروع؟

3) الفعالية:

- ما هي "الأشياء" الأكثر إيجابية التي جلبها لكم المشروع؟

- ما الذي لم يعمل بشكل جيد؟

- هل تسببت المساعدات المقدمة من منظمة كير في إحداث أي آثار سلبية على السكان / المجتمع المحلي المتضررين؟

- هل أنت راض عن نوعية وكمية المساعدات المقدمة؟ (احسب عدد الاصوات سلبا" او ايجابا) إذا لم يكن كذلك، لماذا؟

4) الاستدامة

- ما الذي سيبقى بعد انتهاء المشروع؟

- هل اللجان المجتمعية مستعدة وقادرة على المحافظة على المشاريع وتشغيلها وصيانتها ومواصلة الأنشطة من تلقاء نفسها؟ (نعم أو لا ، كم عدد الاصوات)

- كمجتمع هل تشعرون بأن هذا مشروعكم وانه ملكية خاصة لكم قادرون / مستعدون على الحفاظ عليه وصيانته ؟

هل شاركت اللجان المجتمعية في تخطيط وتنفيذ المشروع لضمان المشاركة المحلية منذ البداية؟ (تحسب الاصوات) -

- هل تعتقدون أن اللجان المجتمعية مهيأة وقادرة على تنظيم نفسها حتى تضمن استدامة النشاط ؟

- هل تعتقدون أن المشروع قد سبب أي ضرر للبيئة (للمنطقة) كيف ؟ (يتم احتساب الاصوات)

اختتام المناقشة

- هل هناك أي شيء آخر يود أي شخص أن يضيفه عن أي من القضايا التي ناقشناها،

- هل يوجد أحد يود ان يضيف شيء لم يتمكن من اضافته ويعكس جانبا هاما من المشروع حصلتوا عليه أو لم تحصلوا عليه؟

شكر المشاركين على الحضور وتقديم التغذية الراجعة.

تقرير النقاش البؤري الذي سيكتبه الباحث بعد اللقاء

في بداية تقرير النقاش البؤري يجب كتابة وصف وافي وشامل عن التالي:

1. وصف للمجتمع الذي تم فيه النقاش: اجتماعية اقتصادية وغيره
2. وصف لخصائص المبحوثين الذين تم مقابلتهم (من هم/ اعمالهم؟ خصائص او مواصفات اقتصادية واجتماعية
3. كيف تم اختيار المبحوثين وكيف تمت المقابلة وزمنها
4. الصعوبات
5. نتائج الحوار ترتب بحسب المحاور الاربعة:
   - المعرفة حول تدخلات المشروع
   - الملائمة
   - الفعالية
   - الاستدامة
6. يجب ان يتم ذكر ماذا اجمع عليه الاغلبية وماذا كان رأي الاقلية
7. ابراز أهم الاختلافات بين أفراد المجموعة وفي أية قضايا مع تفسير ذلك
8. يتم وضع اقتباسات قوية من اقوال المبحوثين
9. وضع خاتمة للتقرير تلخص اهم ما استخلصه الباحث ورأيه في نتائج النقاش
10. يتم ارفاق النسخة اتي تم توثيقها اثناء الحوار

التقييم النهائي لدعم مشاريع الاستجابة الطارئة للجنة طوارئ الكوارث في محافظة عمران

استبيان الأسرة

رمز الاستبيان:..... اسم الباحث: .....

الموقع /المديرية / القرية :..... التاريخ: .....

الجزء الاول: خلفية عن الاسرة

1.1	اسم رب الاسرة	
1.2	جنس رب الاسرة	أنثى (1) ذكر (2)
1.3	عمر رب الاسرة	
1.4	الحالة الاجتماعية	متزوج ☐ عازب ☐ أرمل/ة ☐ مطلق/ة ☐
1.5	الحالة الاسرية	مستضيف ☐ نازح ☐ عائد من النزوح ☐ لاجئ ☐
1.6	المهنة الاساسية لرب الاسرة	

1.7	حجم الاسرة (رقماً)	ذكور ( ) اناث ( )

الجزء الثاني: تدخلات مشاريع المياه

	عمود (أ)	عمود (ب) لايتم قراءة هذه الخيارات للمبحوثين بل يتم استحثاثها
2.1	ما هو مصدر المياه الرئيسي قبل بدء المشروع؟	1. الابار المفتوحة / الينابيع 2. الابار غير المحمية 3. الآبار المحمية 4. الغيول العامة 5. الخزانات 6. وايتات ماء مدعومة من منظمات 7. المياه السطحية/السدود/البرك 8. أخرى.....
2.2	ما هو مصدر المياه الرئيسي في الوقت الحالي؟	1. الابار المفتوحة/الينابيع 2. الابار غير المحميه 3. الآبار المحمية 4. النوافير العامة 5. الخزانات 6. شاحنات الوكالات الإنسانية لنقل المياه 7. المياه السطحية / السدود / البرك 8. أخرى.....
2.3	هل تصل إلى مصدر الماء بسهولة؟	1. نعم 2. لا
2.4	كم تحتاج وقت للمشي من البيت إلى مصدر الماء/ بئر الماء قبل المشروع؟	1. 10-20 دقيقة 2. 20-40 دقيقة 3. 40-60 دقيقة 4. أكثر من ساعه
2.5	كم تحتاج وقت للمشي من البيت إلى مصدر الماء/ بئر الماء قبل المشروع حالياً؟	1. 10-20 دقيقة 2. 20-40 دقيقة 3. 40-60 دقيقة 4. أكثر من ساعه
2.6	كم من الوقت كنت تنتظرحتى يتجمع الماء بشكل كافي قبل المشروع؟	1. 10-20 دقيقة 2. 20-40 دقيقة 3. 40-60 دقيقة 4. أكثر من ساعه
2.7	كم من الوقت تنتظرحتى يتجمع الماء بشكل كافي حالياً؟	1. 10-20 دقيقة 2. 20-40 دقيقة 3. 40-60 دقيقة 4. أكثر من ساعه
2.8	كم كنتم تجمعون ماء في اليوم الواحد قبل المشروع؟	يرجى معاينة نوع وحجم العبوات البلاستيكية التي تستخدمها العائلة

		1. 20-50 لتر 2. 50- 80 لتر 3. 80-110 لتر 4. أكثر. حددها.....
2.9	كم تجمعون في اليوم الواحد حاليا ؟	يرجى معاينة نوع وحجم العبوات البلاستيكية التي تستخدمها العائلة 1. 20-50 لتر 2. 50- 80 لتر 3. 80-110 لتر 4. أكثر. حددها.....
2.10	من يقوم عادة باحضار المياه في أسرتكم؟	1. النساء الكبار 2. الرجال الكبار 3. البنات: تحت سن 15 سنة 4. الاولاد: تحت 15 سنة
2.11	كم مرات تذهبون لاحضار الماء قبل اصلاح المشروع؟	1. مره واحده 2. مرتين في اليوم 3. ثلاث مرات في اليوم 4. أكثر. أذكرها.....
2.12	كم عدد مرات تذهبون لاحضار الماء حاليا؟	1. مره واحده 2. مرتين في اليوم 3. ثلاث مرات في اليوم 4. عندما يتم ضخ المياه فقط. إذا كان هذا هو الخيار الصحيح، كم عدد مرات ضخ المياه .....
2.13	هل أخذوا رأيكم حول أفضل وقت لضخ المياه؟	1. نعم 2. لا 3. لا أعرف
2.14	ماذا تفعل في العادة لجعل المياه أكثر أمنا للشرب؟	1. الغلي 2. تصفيه الماء باستخدام قطعه من القماش 3. اضافة الكلور 4. استخدام فلتر المياه (السيراميك) 5. تركها حتى تصفى وتنزل الشوائب إلى أسفل 6. لا شيء (أنا لا أعالج الماء قبل الشرب) 7. أخرى (حددها) .....
2.16	هل أنت راض عن التحسن الذي حصل في مشروع المياه؟	1. نعم 2. لا 3. لا أعرف

الجزء الثالث: تدخلات الصرف الصحي والنظافة

3.1	هل يوجد حمام في المنزل؟	1. .نعم، هناك مرحاض مع حفرة مغطاة

		2. نعم هناك مرحاض مع صرف صحي (جانبي / خلف المنزل) 3. لا يوجد حمام في المنزل
3.2	متى تغسل يديك عادة؟	يرجى وضع دائرة حول اكثر من رقم في حالة ذكرها من قبل الشخص: 1. قبل وقت الوجبات 2. بعد الوجبات 3. قبل الطبخ 4. بعد استخدام الحمام 5. غيرها.....
3.3	هل لديك أطفال دون سن الثالثة؟	1. نعم 2. لا 3. إذا كانت الإجابة "لا"، انتقل إلى السؤال رقم 3.5
3.4	في المرة الأخيرة التي تبرز فيها طفلك، ما الذي تم القيام به للتخلص من البراز؟	1. الطفل يستخدم الحمام / المرحاض 2. وضع / شطف إلى الحمام أو المرحاض 3. تغطيتها بالتراب 4. رميها في القمامة 5. وضع / شطف في التصريف أو حفرة 6. تركها في العراء 7. أخرى (حددها) **8.** لا أعرف
3.5	هل يوجد أي شخص في أسرتكم اكبر من 5 سنوات وتعرض لإسهال غير اعتيادي (إسهال مائي / دموي لبضعة أيام) في الأسابيع الأربعة الماضية؟	1. نعم 2. لا 3. لا أعرف
3.6	هل يوجد أي شخص في أسرتك اصغر من 5 سنوات و وتعرض لإسهال غير اعتيادي (إسهال مائي / دموي لبضعة أيام) في الأسابيع الأربعة الماضية	4. نعم 5. لا 6. لا أعرف

الجزء الرابع: النقد مقابل العمل

4.1	كم كنتم تأكلون وجبات في اليوم الواحد قبل المشروع؟	1. ثلاث وجبات 2. وجبتين **3.** وجبه واحده
4.2	كم تأكلون وجبات في اليوم الواحد حاليا؟	1. ثلاث وجبات 2. وجبتين **3.** وجبه واحده
4.3	ما هو مصدر دخلك الرئيسي قبل المشروع؟	1. مساعدات من المنظمات 2. العمل بأجر يومي

		3. طلب المال من الناس 4. معنا مشروع صغير 5. حوالات من مغترب من العائلة 6. مرتبات من الحكومة 7. الزراعة 8. مصادر أخرى
4.4	ما مصدر دخلك الرئيسي في الأشهر الستة الماضية؟	1. مساعدات من المنظمات 2. العمل بأجر يومي 3. طلب المال من الناس 4. معنا مشروع صغير 5. حوالات من مغترب من العائلة 6. مرتبات من الحكومة 7. الزراعة 8. مصادر أخرى
4.5	ما هو رأيكم حول المبلغ المستلم؟	1. غير كافي على الاطلاق 2. غير كافي 3. كافي إلى حد ما 4. كافي 5. كافية جدا
4.6	فيما استخدمتم المبالغ النقدية التي استلمتوها؟	1. شراء الملابس 2. شراء مواد غذائية 3. شراء أدوية 4. تسديد الديون 5. شراء مياه 6. في تعليم الاطفال 7. أخرى .....
4.7	ما هو مستوى الرضا عن المبالغ النقدية التي استلمتوها؟	1. راضي للغاية 2. راضي جدا 3. راضي إلى حد ما 4. راضي قليلا 5. غير راضي
4.8	تصور الأسر حول استفادتهم من المبالغ النقدية.	1. ساهمت في تحسن صحتهم 2. اشتروا مواد غذائية جيدة ومتنوعة 3. لا توجد فائدة 4. فوائد أخرى .....
4.9	يعتبر مؤشر استهلاك الغذاء مؤشر مركب يستند إلى التنوع الغذائي وتكرار الأغذية ومستوى أهمية القيمة الغذائية للأصناف الغذائية المختلفة.	

	والآن، أريد أن أسألكم عن أنواع الأطعمة التي أكلتها أسرتكم خلال السبعة الأيام الماضية؟ (اكتب 7 إذا كانت الأسرة قد تناولت الصنف المذكور من الأطعمة لمدة 7 أيام في الأسبوع؛ اكتب 6 إذا كانت الأسرة قد تناولت الصنف المذكور من الأطعمة لمدة 6 أيام من الأسبوع؛ اكتب 5 إذا كانت الأسرة قد تناولت الصنف المذكور من الأطعمة لمدة 5 أيام من الأسبوع الخ؛ اكتب 0 إذا لم تتناول الأسرة الصنف المذكور من الأطعمة طوال الأسبوع.	
	أصناف الغذاء	**عدد الأيام التي تناولت الأسرة فيها هذا الصنف من الطعام في الاسبوع**
أ	الأرز، الذرة، عصيدة الذرة، الشعير والذرة الرفيعة والمعكرونة الدخن والخبز والحبوب الأخرى	
ب	فاصوليا، البازلاء والفول السوداني والكاجو	
ج	أي نوع من الخضروات	
د	الفواكه	
هـ	لحوم الأبقار والماعز والدواجن والبيض والأسماك	
و	اللبن و الزبادي وغيرها من الاجبان	
ز	السكر ومنتجات السكر، العسل	
ح	الزيوت والدهون والزبدة	
ط	البهارات والشاي والقهوة والملح، ومشروبات الطاقة ، وكميات صغيرة من الحليب للشاي	

الجزء الخامس: الاسئلة المتعلقة بالمعايير الإنسانية الأساسية

1. هل تشعر أن المساعدة التي تقدمها منظمة كير مناسبة لاحتياجاتكم وتدعم المجتمع في تلبية احتياجاتهم الأساسية؟	1. لا تلبي الاحتياج 2. تلبي الاحتياج نوعا ما 3. تلبي الاحتياج تماما 4. تلبي الاحتياج بدرجه كبيره
2. هل تشعر أن المساعدة التي قدمتها منظمة كير أتت في الوقت المناسب؟	1. نعم 2. لا
3. هل ذهبت المساعدات للناس الأشد تضرراً واحتياجاً؟ (اختر: 1 هو الأدنى و 5 الأعلى).	1. لم تستهدف المساعدة الفئات الأشد تضرراً و احتياجاً 2. استهدفت المساعدة عددا قليلا فقط من أشد الفئات الأشد تضرراً و احتياجاً 3. استهدفت المساعدة بعض من الفئات الأشد تضرراً واحتياجاً 4. معظم الناس المستهدفين بالمساعدات هم الفئات الأشد تضرراً واحتياجاً 5. جميع الناس المستهدفين للمساعدات هم الفئات الأشد تضرراً و احتياجاً
4. هل تم اخباركم بطريقة الوصول إلى المساعدات الإنسانية التي قدمتها منظمة كير؟	1. لم يتم الابلاغ عنها على الإطلاق 2. تم الابلاغ عنها الى حد ما 3. تم الابلاغ عنها بشكل ممتاز
5. هل تشعر بأنك شاركت في الطريقة التي تم بها تقديم المساعدة الإنسانية؟	1. لم اشترك على الإطلاق 2. شاركت لمرات قليله 3. شاركت لبعض الأوقات 4. شاركت أغلب المرات

	5. شاركت بشكل كافي	
6. هل تشعر أن المرأة لديها فرص آمنة ومنصفة للمشاركة في تنفيذ المشاريع المخططة؟	1. نعم 2. لا	
7. هل تشعر أن الفئات المهمشة والأشخاص ذوي الإعاقة حصلوا على فرص آمنة ومنصفة للمشاركة في تنفيذ المشاريع المخططة؟	1. نعم 2. لا	
8. هل تعرف كيف تم اختيار المستفيدين وعملية التسجيل في المشروع؟ إذا كان الجواب نعم، اطلب من الشخص الذي تمت مقابلته وصف العملية. إذا لم يكن/تكن قادرا على وصف العملية، يرجى وضع الجواب على أنه لا	1. نعم 2. لا	
9. هل تعتقد أن عملية اختيار المستفيدين كانت عادلة؟	1. نعم 2. لا	إذا كان الجواب "لا"، انتقل إلى السؤال التالي. إذا كان الجواب نعم'. انتقل إلى السؤال 11.
10. لماذا تعتقد أن اختيار المستفيدين لم يكن عادلا؟		
11. هل تم إخبارك عن الأشياء التي يحق لك الحصول عليها منذ بدء المشروع؟	1. نعم 2. لا	
12. هل أنت راض عن نوع وكمية المساعدة المقدمة؟	1. نعم 2. لا	
13. إن كنت غير راضي، لماذا؟		
14. هل تسببت المساعدة التي قدمتها منظمة كير في إحداث أي آثار سلبية على السكان أوالمجتمع؟	1. تسببت في آثار سلبية كبيره 2. تسببت في القليل من الآثار السلبية 3. لم يكن لها أي آثار سلبية	
15. هل تم استشارتك من قبل منظمة كير حول قضايا السلامة والوصول (مثل اختيار نقاط التوزيع، ونوع النقد مقابل أنشطة العمل)	1. نعم 2. لا	
16. هل عرفت عن طريقة تقديم الشكاوى و آلية الاستجابة التي وضعتها منظمة كير؟	1. نعم 2. لا	
17. هل تعتقد أن آلية الشكاوى و آلية الاستجابة سرية و يمكن الوصول إليها ؟	1. نعم 2. لا	
18. كيف تعامل موظفو منظمة كير معكم أو مع المجتمع ككل؟	1. بطريقة محترمة جداً 2. بطريقة محترمة متوسطة 3. أقل احتراما 4. غير محترم على الإطلاق	