PAKISTAN FLOODS 2010

Evaluation of CARE's DEC Phase 1 and DFID Dadu projects

Final Report

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EXECUTIVE SUMMARY

Overview of the disaster: The Pakistan floods crisis 2010 began in July 2010 following heavy monsoon rains in the Khyber Pakhtunkhwa, Sindh, Punjab and Balochistan provinces. UNOCHA estimates indicate that almost 2000 people were killed, over 1.7 million homes were destroyed and almost 18 million people were seriously affected, exceeding the combined total of individuals affected by the 2004 Indian Ocean tsunami, the 2005 Pakistan earthquake and the 2010 Haiti earthquake.

Overview of the projects:

The DEC Phase 1 project was implemented from August 2010 to February 2011 with a budget of £1,146,331 in partnership with HANDS, Takhleeq Foundation (TF) and the Strengthening Participatory Organisation (SPO) and targeted 9,128 households (7 people per household) in the districts of Qamber-Shahdadkot (TF), Sukkur, Shikarpur, Kashmore (HANDS), Ghotki and Dadu (SPO) in Sindh province. It focused on health, food, shelter, NFI, sanitation, livestock vaccination and psychosocial activities.

The DFID project was implemented over 9 months (October 2010 to May 2011) with a 2.5-month no-cost extension with a budget of £1,999,443 through three local NGOs—JORDAN, RDF and HIN to benefit 100,000 individuals in Sindh province – district of Dadu and focused on WASH, healthcare and NFI activities.

Overview of the evaluation: The evaluation was conducted between July 1 and August 15, 2011. The main evaluation tools included documents review, interviews with CARE and partner staff, focus group discussions within communities, and transect walks. Given that the DEC phase 1 project had ended almost six months prior to this evaluation, some of the relevant staff members from the relief phase had left CARE Pakistan. As such, it was difficult to get relevant perspectives in many cases. The findings below are presented according to the main criteria in the evaluation TORs.

Findings

Needs assessments and project designs

The evaluation team did not come across any written assessment forms or reports from CARE or the partners related specifically to either project. CARE would have done better by focusing more on the people displaced and living on the bunds during the relief phase and once people had returned to their villages by focusing on more isolated villages where a high percentage of houses were destroyed and where people had little access to agricultural land. In terms of the sectors, greater focus on cash and livelihoods was advisable. However, the water, sanitation and health services provided during the camp phase were critical.

Impact

Overall achievements

The project has generally met the targets in all sectoral areas and has in fact exceeded targets along several outputs and indicators

Individual level impact: Reduced hunger; improved health; improved hygiene habits, increased convenience, improved ability to engage in work; reduced need to take debt and sell animals
Community level impact: The committees formed increased the ability of communities to participate more meaningfully in the project and deal more effectively with external stakeholders.
Broader level impact: The increased capacity of partners also helped them implement other projects more effectively. The provision of supplies to hospitals and BHUs enhanced the access to health for a much larger number of indirect beneficiaries.

Efficiency and cost effectiveness
The evaluation team compared the Program supplies line as a percentage of the total DEC1 budget for all DEC agencies. Under this analysis, CARE had the fifth best ratio, mainly due to the low number of expatriates and use of local partners.

Longer-term risk reduction
The hygiene promotion activities have improved long-term hygiene practices and reduced disease risk. Some of the NFI items will last 2-3 years, e.g., kitchen items, mosquito nets, tens and blankets. This will reduce the risk for people for the future. The hand pumps and latrines being provided in villages will last several years and reduce the risk of diseases from water and sanitation problems. Similarly, the health equipment given to partners and the government will likely last several years and help in disease control during future disasters.

Evaluation of the health component
Health is clearly a very critical sector for the displacement phase and for the first few weeks even after people return to villages. Relatively few agencies provide health services. So there is clearly rationale for CARE to look into this sector. However, it is also the most technical sector and the one in which it is the easiest to be in violation of the "do no harm" principle. Thus, CARE will have to develop considerable capacity within its own team and partners if it wants to do a good job in health. This may not be easy to do given that health is not a CARE global priority. Thus, it should either develop this capacity or develop a collaborative relationship with another health INGO.

CARE's partnership approach
CARE has done well to choose to work though national partners despite the significant challenges involved. However, it is important that CARE ensures that this choice does not lead to inordinate delays that undermine life-saving work. It has also undertaken some capacity building activities for partners. Partners are generally happy with CARE and describe CARE as a flexible and respectful donor who also helps them in increasing their capacity. It is time for CARE to decide which of them constitute sustainable partners for the future, look to sign standing MOUs for future emergency work and also develop a systematic

approach to building their capacities in coordination with other long-term donors. In working with a large number of partners, CARE must make sure that its overall program does not become a collection of disparate projects of different partners which lacks cohesion.

Adherence to the Code of Conduct and Sphere standards

Compliance with the NGO code of conduct

*T*here was some delay in the start of both the projects, which undermined the achievement of the humanitarian imperative. There was no evidence of any violation of the codes related to neutrality and cultural sensitivity. CARE refused significant US funding because of the donor's branding requirements. No evidence was found of the agency undertaking community-level capacity-building, beyond the hygiene promotion work done. However, most of the service delivery was through national NGOs and some capacity-building activities were undertaken for them. Some of the partners set up village committees to manage the implementation of the project within villages and camps. However, people's participation in the selection of sectors can be improved. Hygiene promotion, hand pumps, latrines and some NFI activities reduced long-term risk.

Sphere standards

While information was not available for the DEC project, the figures for the DFID project reveal that the Sphere standards were generally adhered to for the major activities.

Humanitarian Accountability Framework

CARE has its own Humanitarian Accountability Framework with following key benchmarks.

1. CARE bases response on impartial assessment of needs, vulnerabilities and capacities

No assessment forms or reports available

2. CARE uses good design and monitoring to drive improvements in our work

CARE has maintained an office in Sindh so that it could monitor the work closely. Partners felt that its regular monitoring helped them improve project quality, especially in the area of watsan construction. CARE also maintains a Grants unit which provides regular support through frequent field visits. However, the monitoring in the area of health was inadequate given the absence of a highly experienced Health coordinator having experience of implementing emergency health programs to international standards.

3. CARE involves the disaster-affected community throughout our response

Covered under Code of Conduct section

4. CARE puts formal mechanisms in place to gather and act on feedback and complaints

The evaluation team did come across formal complain mechanisms in most communities visited. However, there does not seem to be a clear mechanism with most partners to document and analyze the complaints and share them with CARE regularly. Furthermore, women did not seem familiar with these mechanisms in most communities.

5. CARE communicates our mandate, projects and what stakeholders can expect from us

Due to the security situation, CARE has adopted a low profile in the field. Thus, communities were generally unfamiliar with CARE in most places visited by the evaluation team.

6. CARE uses impartial reviews and evaluations to improve learning and accountability

This evaluation is living proof of this commitment. However, in Islamabad, we did not find uniform commitment to the evaluation and it was difficult to access key staff and documents, though ultimately access did come through to ensure a quality evaluation.

7. CARE supports its staff and partner agencies to improve quality and accountability

CARE has undertaken trainings on accountability issues for its own staff and partners. However, accountability commitments are not part of the contracts signed with partners.

Lessons from previous and current experience

The evaluation team found very little evidence of the incorporation of previous lessons learnt. For documenting the lessons from this emergency, the agency held an AAR on overall management issues recently. However, there is a need to have similar sessions for each sector and province and by having departing staff members develop written hand-over notes.

Recommendations

1. Update emergency preparedness and/or contingency plan in light of current experience, preferably in coordination with other agencies

2. CARE should develop a clearer idea of its program priorities and share them with potential partners so as to enhance the overall cohesiveness of its program.

3. Develop a long-term approach with selected partners, including signing standing MOUs and developing capacity-building plan in coordination with other donors

4. Develop a strong national team over the medium-term to enhance institutional memory, enhance program quality reduce logistical overload and reduce costs

5. Improve sectoral focus for the relief and early recovery phases, with

6. Develop a clear strategy about continuing engagement in the health sector and ensure adequate senior-level capacity if it is decided to remain engaged.

7. Improve the targeting of districts, sub-districts, villages and families based on the suggestions provided in the main body of the report

8. Develop appropriate needs and impact assessment and lessons learnt systems so as to enhance program cohesion, evidence collection and improved program quality

9. Identify evaluative criteria at the start of emergency and develop an MIS system that can provide constant feedback to SMT continuously and ultimately to evaluators

10. Strike a balance between visibility and security concerns, e.g., by verbally providing information about CARE to communities.

INTRODUCTION

Overview of the flood

The Pakistan floods crisis 2010 began in July 2010 following heavy monsoon rains in the Khyber Pakhtunkhwa, Sindh, Punjab and Balochistan provinces. UNOCHA estimates indicate that almost 2000 people were killed, over 1.7 million homes were destroyed and almost 18 million people were seriously affected, exceeding the combined total of individuals affected by the 2004 Indian Ocean tsunami, the 2005 Pakistan earthquake and the 2010 Haiti earthquake. Floods submerged 17 million acres (69,000 km^2) of Pakistan's most fertile crop land, killed 200,000 heads of livestock and washed away massive amounts of grain. At the worst point, approximately 20% of Pakistan's total area was underwater. The country suffered extensive damage to crops and health, educational, transportation and communication infrastructure. The total economic impact is estimated to be $10 billion.

Flood waters soon receded from the north enabling livelihoods and reconstruction to take place, whereas large areas in Sindh province remained submerged under flood waters for several more weeks. Therefore, many farmers were unable to meet the autumn deadline for planting new seeds in 2010, which implies a massive loss of food production in 2011, potential long term food shortages and price increases in staple goods. Sindh province had the highest number of people affected (7.2 million) followed by Punjab with 6 million people and KP with 3.8 million people. Sindh was also the most badly affected area in terms of the percentage of area covered at the sub-district level with 12 of the 17 sub-districts that had more than 50% of their areas affected being in Sindh. Outbreaks of diseases, such as gastroenteritis, diarrhea, and skin diseases, due to lack of clean drinking water and sanitation soon posed a serious risk to flood victims. The elderly, disabled, women and children were especially made vulnerable due to a lack of aid. Relief work was also hampered by the difficult logistical terrain, the destruction of infrastructure and the threat of terrorist attacks against aid agencies. All these factors made this emergency response one of the most difficult ones in recent times. While camps have largely been dismantled and the overwhelming percentage of people has returned home, huge recovery needs persist in the areas of shelter, water, sanitation, infrastructure and livelihoods in villages.

Overview of the evaluated projects

The DEC Phase 1 project was implemented from August 2010 to February 2011 with a budget of £1,146,331 in partnership with HANDS, Takhleeq Foundation (TF) and the Strengthening Participatory Organisation (SPO) and targeted 9,128 households (7 people per household) in the districts of Qamber-Shahdadkot (TF), Sukkur, Shikarpur, Kashmore (HANDS), Ghotki and Dadu (SPO) in Sindh province. The main purposes of the project were as follows:

- Health hazards reduced through access to primary healthcare through mobile health clinics
- Access to daily food rations and clean drinking water improved
- Access to shelter and non-food items improved

- Access to adequate sanitation facilities improved through pit latrines construction
- Livestock deaths reduced through provision of vaccines
- Family mental wellbeing improved through provision of psychosocial support in camps

The DFID project was implemented over 9 months (October 2010 to May 2011) with a 2.5-month no-cost extension with a budget of £1,999,443 through three local NGOs—JORDAN, RDF and HIN to benefit 100,000 individuals in Sindh province – district of Dadu. The main outputs were as follows:

- 100,000 people have their emergency WASH needs met
- 100,000 people have their basic primary healthcare needs met through NFIs
- 100,000 people have their basic primary healthcare needs met through health services

The following constraints faced by CARE must be kept in mind while reviewing the findings:

- Not present in Sindh at the time of flood: This meant that CARE not only had to start the response but first establish itself, find office space, local staff and partners and understand the local context in Sindh. All this understandably delayed the timing and the quality of the initial response.

- The scale and complexity of the disaster, covering the length of the country: The challenge in the first point was magnified by the fact that CARE also had to manage emergency responses in Punjab and KP at the same time.

- Shortage of high quality capacity nationally and internationally: Given the scale of the operation and on-going other international emergencies, it proved difficult to find quality national and international staff quickly which affected the timing and the quality of the initial response. The visa restrictions and security situation in Pakistan further affected the availability of international staff

- Funding shortage, especially in the beginning of the disaster as donors were slow to commit: As the scale of the flood openly became apparent as it spread throughout the country over the weeks, donor funding, including collections under the DEC, got delayed. This again delayed the CARE response.

Overview of the evaluation

The evaluation was conducted between July 1 and August 15, 2011 by Dr. Niaz Murtaza, an independent consultant, and Annie Devonport, Program Advisor, DEC. The specific objectives of this evaluation were to assess and describe:

i. the strengths and weaknesses of CARE's needs assessment and project design processes and outcomes, including the input of IPs;

ii. the relevance and impact of all activities at both household and community levels against indicators and planned results;
iii. the efficiency and cost effectiveness of Phases I and II;
iv. the extent to which activities have reduced or exposed beneficiaries and their wider communities to risks;
v. key lessons learnt specifically in relation to health activities, which may inform CARE's strategy in future emergency response operations in Pakistan;
vi. the strengths and weaknesses of CARE's partnership approach relevant to these DEC and DFID-funded activities;
vii. the extent to which CARE and its IPs adhere to Code of Conduct and Sphere standards;
viii. the extent to which CARE and its IPs adhere to CARE's own Humanitarian Accountability Framework, specifically in terms of accountability to beneficiaries;
ix. the extent to which CARE has applied lessons from previous or current experience in Pakistan and elsewhere;

The main evaluation tools included documents review, interviews with CARE and partner staff, focus group discussions within communities, and transect walks. Given that the DEC phase 1 project had ended almost six months prior to this evaluation, some of the relevant staff members from the relief phase had left CARE Pakistan. As such, it was difficult to get relevant perspectives in many cases. Some of the relief communities were also not traceable as they had been helped within camps. Even for those available, recall was sometimes an issue as they had received aid several months back. Given staff schedules, it was also difficult to access staff and key documents initially, though by the end of the evaluation, enough access was available to ensure a quality evaluation.

FINDINGS

Needs assessments and project designs

The evaluation team did not come across any written assessment forms or reports from CARE or the partners related specifically to either project. Their absence is to some extent understandable for the DEC 1 project, which started in early August at the peak of the emergency when there was hardly any time to undertake comprehensive assessments and write detailed reports. However, a more systematic approach to assessments would have been advisable for the DFID project which started many months later when the situation had settled down somewhat. Even for the DEC, it would have been advisable if CARE had given some overall guidelines to the partners on how to conduct assessments with the understanding that these would be rapid, ad-hoc and informal. The intervention in Dadu was informed partly by a health needs assessment undertaken by Merlin, WHO and IRC at the end of September 2010. Thus, even though it did not conduct its own assessments, it did use secondary assessment information available from cluster meetings extensively.

In the absence of its own assessments, it is difficult to figure out how CARE selected the project designs for both the projects and the appropriateness of the selections. Thus, the evaluation team judged the suitability of the project designs based on the understanding that it developed of the situation in Sindh in the aftermath of the floods by talking with government officials, aid workers and communities. The main population groups and their relative needs in the immediate aftermath of the flood from August until October before they started returning to their villages as the water receded were as follows:

Population Group	Level of needs
Living in own villages	Low
Living with relatives after displacement	Medium; difficult to trace
Living in camps in main towns	High; some access to work and aid
Living in open on bunds in isolated areas	Very high; little access to aid and work

Thus, the main priority group should have been people living on bunds in isolated areas, many of whom lived under the open sky for weeks, exposed to rain, sunlight, cold, heat and the elements of nature. Starting from early August, these displaced people were in need of food and NFI until these items were not available in the local markets and cash once these things were locally available in markets in order to enhance community choice and self-reliance. They also needed water, latrine, hygiene promotion and health services for the duration of their displacement. This period coincides mainly with the DEC1 project. Thus, we compare its actual project design with this ground situation.

The project design adopted by HANDS came closest to this “ideal” project design. It started implementing its services during the last week of August (against the ideal of early August) and focused on a mix of IDPs living on the bunds and major towns. It provided food, NFIs, water, sanitation and health services for the duration of their displacement as well as some additional services. A second partner (Takhleeq Foundation) started a few weeks later in September 2010 and focused mainly on IDPs living in camps in or near main towns but did

not provide critical water and sanitation services till very late (ultimately from another CARE project), which created significant problems for IDPs. Finally, the last partner (SPO) only got started in November and mainly provided food and NFI to people after they had returned to their villages and when these items were available easily in the market. Thus, cash distribution would have been much better. Thus, the adherence to the "ideal" project design is mixed across the three DEC1 partners. However, CARE does have a practical template of good practice available for the future from the work of HANDS. There was however wide variation in the services provided by the three partners, with HANDS providing daily food, daily clinic services, education, watsan, hygiene promotion and recreational services, SPO providing just one-off food and NFI and TF providing health, hygiene promotion and NFIs. There was also a huge difference in the number of beneficiaries reached by each, with SPO reaching 32,000 people with one-off services, TF reaching almost 30,000 people and HANDS reaching around 1800 people with fairly extensive and perhaps overgenerous services. Thus, CARE would be well advised to develop a more uniform package across different partners.

From November onwards, IDPs started returning to their villages in large numbers as the water receded. This can be characterised as the start of the early recovery period roughly and coincides with the DFID project which started in late December. The main decisions for CARE again were selecting the appropriate locations (specific districts, sub-districts/UCs, villages and families within villages) and sectors and starting on time. With respect to locations, the focus should have been on areas that had high vulnerability (damage due to the flood) but also low resilience or recovery potential on their own. The NDMA and UNOCHA put out lists that identified the most severely affected districts in each province. Dadu appears on both lists (high vulnerability) and is also one of the poorest districts in Sindh historically (low resilience) as reflected by its low human development index scores. Thus, CARE selected the district for the DFID project appropriately. Information about the most badly affected and historically poorest sub-districts and UCs within Dadu was available from the DCO office. IPs and CARE seem to have coordinated well with the DCO office in identifying the specific sub-districts and UCs.

The most practical, easy to apply and objective criteria for identifying villages with high vulnerability and low resilience in the opinion of the evaluation team are distance from main towns, percentage of houses destroyed (the most expensive asset that rural households generally have after animal herds) and access to agricultural land. It is also advisable to work with smaller villages (less than 150 households) as it is easier to work with smaller villages and they also tend to be generally more poor and isolated than larger villages. This type of information can relatively easily be collected from interviews with government officials and rapid village visits. In talking with staff and visiting the selected villages (which varied significantly in their resilience and vulnerability), the evaluation team does not get the impression that such a systematic approach was adopted.

Finally, the selection of the specific households in a village is often the most difficult decision as agencies are unable to usually cover everyone within the village with the more

expensive early-recovery phase inputs. Their choices, based usually on the traditional individual household level criteria such as widows, aged and disabled, often create conflicts within villages as they do not correspond with people's own priorities and worldviews. Based on the lead evaluator's significant experience in evaluating the projects of over a dozen agencies' flood response, the best approach is to use the traditional extended family courtyard concept that exists in most parts of rural Sindh as well as elsewhere, under which multiple individual households live together and share some of the basics of life, such as hand pumps, latrines and other resources. Thus, in a village of 100 households, there may be around 8-10 extended family courtyards. Agencies are advised to start by making a map of all the extended family courtyards in the village and then locating all the individual households in the village into them along with information about their size and vulnerability status such as widows etc. The next step should be to develop a village committee which includes one person from each extended family courtyard. This will help ensure that the committee does not get dominated by certain families in the village and will give a sense of participation and fairness to the whole village. Agencies could then equitably divide their inputs across all the extended family courtyards based on their size and other relevant characteristics through the active inputs of the village committee. While it may be difficult to help all 100 families in a village, it is certainly possible to help all 8-10 extended family courtyards in a village, thus giving a sense of participation and fairness to everyone in the village. Some of the partners adopted this approach at least in a rudimentary form, reducing conflicts significantly in those villages. Thus, in summary, the geographical selection at the district and sub-district/UC levels was good but mixed at the village and within-village levels, though some examples of good practice for the future are available even there.

In terms of sectoral selection, hand pumps had been destroyed or contaminated in many villages. Secondly, health problems were higher from November until February as people were living in tents even when back home, there were stagnant water pools around villages and winter was approaching. Finally, people were in desperate need to rehabilitate their houses and livelihoods. However, food and NFI were available in local markets. Thus, the focus should have been on water, health, cash and livelihoods. While water and health services were provided under DFID Dadu project, there was too much emphasis on in-kind distribution of food, NFIs and latrines and insufficient focus on cash and livelihoods provision. Finally, the project also started a couple of months too late from the point of view of needs on the ground.

Impact at household and community levels

Overall achievements of the projects

DEC project

The main outputs/indicators and achievements for the DEC projects were as follows:

i) 33,600 people receive primary health care for 45-90 days.

CARE achievements were almost double the targets as a total of 66,307 people were provided primary health care given the massive scale of the needs.

ii) 257 households receive clean water, milk, biscuits and food packets daily for 45 days

This target was also achieved as 1800 people (257 households) received milk and biscuit rations, basic meals and drinking water through HANDS in camps across 3 districts.

iii) 2,300 households receive food packets once
Again, CARE doubled achievements on this target as 32,200 people (4600 Households) received food packages through SPO

iv) 4,020 households receive tents or NFI kits
This target was also overachieved as 5472 families received shelter support and NFI kits benefitting 38,304 people. An additional 695 NFI kits were prepositioned for future emergency response to benefit an additional 4,865 people (695 households).

v) 84 pit latrines constructed and hygiene activities undertaken
This target was also over-achieved as 1848 people (264 Households) got access to 65 newly erected latrines constructed by HANDS, and 3465 people (495 households) got access to 100 newly constructed latrines and 20 bathing stations provided by Takhleeq Foundation (TF). All received health and hygiene awareness education, and hygiene kits. A water filtration was also installed that benefited 357 households with access to potable.

vi) 90 psychosocial sessions conducted
2168 children received recreational kits while 17,222 adults benefitted from psychosocial sessions in the camps conducted by HANDS and Takhleeq Foundation (TF). The activity was initially to support children only partners also conducted psychosocial sessions for the adults due to the level of need.

vii) 1,200 livestock are vaccinated
315 families received support for livestock in the form of vaccination and drenching.

DFID project

The DFID project also largely achieved its targets as follows:

Sector	Planned beneficiaries	Percent of Target Achieved
WASH	100,000 people	102%
Health	100,000 people	101%
Sector #3. NFI	1500 HH	95%

These impressive overall achievements resulted in multi-faceted impacts at various levels. While the evaluation did not include an in-depth impact assessment exercise through baselines and surveys, a number of clear impacts were visible in talking with communities in focus group discussions as follows:

Individual level impact

- Food aid: Reduced hunger; improved health; improved ability to engage in work; reduced need to take debt and sell animals

- NFIs: increased convenience; blankets and mosquito nets improved health and ability to engage in work and house repair

- Water: increased convenience by reducing travel need; improved health and ability to engage in work

- Sanitation: reduced diseases, improved health and the ability to work

- Health: covered separately below

- Hygiene promotion: improved hygiene habits; reduced disease. The pre and post KAP surveys conducted by one partner (RDF) confirmed a significant improvement in the hygiene practices of targeted communities.

Community level impact

The committees formed by some partners in camps and villages increased the ability of communities to organize themselves immediately and in the long-run, participate more meaningfully in the project and deal more effectively with external stakeholders.

Broader impact

Beyond the impact on the targeted communities, some broader, indirect impacts were also observed. The increased capacity of partners also helped them implement other projects more effectively as some partners used CARE program approaches in other projects too. The provision of supplies to hospitals and BHUs enhanced the access to health for a much larger number of indirect beneficiaries.

For the future, CARE must develop its own impact assessments processes, more basic for the relief phase (mainly qualitative and post-hoc) and more elaborate for the early recovery phase (some baseline and impact surveys).

Efficiency and cost effectiveness

The evaluation team compared the Program supplies line as a percentage of the total DEC1 budget for all DEC agencies in order to judge the cost-effectiveness of CARE. This analysis produced the following picture:

Average for all agencies	75%
Highest	93%
Lowest	35%
CARE	79%

Thus, CARE emerged with the fifth best program supplies percentage out of the 13 DDEC agencies. The corresponding figure of the DFID project is around 60%. Some of the factors that helped achieve this relatively high cost-efficiency were the decisions to use local partners and to keep the number of expatriate staff within reasonable limits. However, the above percentages must be viewed with some caution as the nature of programs, types of agencies and their other funding sources vary significantly. It must also be understood that cost-efficiency is not only about cutting support costs-program quality is also important. Thus, in the case of health services, it would have been good to have an experienced expatriate Health coordinator based in Sindh even though it would have increased the support cost ratio.

Longer-term risk reduction

While both projects are essentially short-term projects, they still had some long-term impact on reducing risks for the direct and indirect beneficiaries as follows:

The hygiene promotion activities have improved the long-term hygiene practices of targeted communities and consequently their disease risk for the future. People back in villages who had received such training in camps confirmed that they were still practicing the improved hygiene habits that they had learnt earlier and that this had helped reduce diseases compared not only with the flood period but also the pre-flood period.

Some of the NFI items will last 2-3 years, e.g., kitchen items, mosquito nets, tens and blankets. This will reduce the risk for people for the future. For example, if there were a flood this or next year, people will easily be able to transport their tents, mosquito nets and blankets with them. Thus, instead of being completely under the open sky on bunds, as during last year's flood, people will at least have some protection until the agencies are able to reach them.

The hand pumps and latrines being provided in villages will last several years and reduce the risk of diseases from water and sanitation problems. People even took the hand pumps built on camps on bunds back to their villages. Similarly, the health equipment given to partners and the government will likely last several years and help in disease control during future disasters. Finally, some of the capacity-building exercises undertaken for partners means that they are better equipped to deal with future emergencies and provide better quality services to disaster-affected people.

Detailed evaluation of health component

The initial primary healthcare programme with DEC 1 funding during the emergency phase was in Sukkur, Kashmore and Shikapur (HANDS) and Kamber-Shahdadkot (Takhleeq Foundation). Later, an assessment of Dadu district by WHO, IRC and Merlin showed health services to be particularly inadequate which informed CARE's decision to shift the focus of their response to that area with funding from DFID from late December 2010. Both projects

consisted mainly of mobile health unit visits to camps and villages with teams that included both male and female staff. The services offered included preventative and curative care; reproductive health; child health screening; and health and hygiene promotion. Child malnutrition was subsequently recognised as an urgent problem and a nutrition element was added which provided Community Based Management of Acute Malnutrition.

Relevance of the program and the specific approach

The key question is whether primary health care was a relevant sector for CARE to engage in and if so whether the way in which it was delivered was appropriate. Whilst people were displaced from their villages, whether in camps or on bunds, their vulnerability to health problems was high. Risks included outbreaks of diarrhoeal disease, malaria, skin diseases and other water and vector borne diseases. Whereas many NGOs were engaged in other sector activities, such as food and NFI, health was undertaken by a relatively small number. In these circumstances, it was both a relevant and appropriate response which provided life saving services to IDPs. A focus group discussion in Dadu also showed that health was an identified need. The inclusion of women doctors ensured access to a fuller range of health services, particularly reproductive health, than available before the flood. However, the services back in villages under DFID were provided somewhat late due to the problems in finding suitable staff and excessive workload. HANDS provided health services in the immediate aftermath of the floods (though still 2-3 weeks late), while TF provided them a few weeks later under DEC However, in Dadu the services under DFID did not arrive until late December once IDPs had returned to their homes. By February, their most urgent health needs had already passed while the DFID project continued till May, though a large number of health facilities were still badly damaged.

To complement the health camps, CARE re-equipped the Hospital at K N Shah, provided funds for key female medical staff (including an obstetrician), and repaired two ambulances. However equipment to undertake C-sections currently lies redundant as the post of obstetrician is vacant since the end of the project. Several basic health units (BHUs) were also repaired. The justification for this costly intervention was that the hospital and BHUs act as the referral units for the mobile units. Even though the tangible assets will remain available for several years, the lack of human resources means that the receiving units are not able to make full use of all the medical equipment; e.g. an incubator has not yet been unpacked as there is no paediatrician to use it. The issue of sustainability is a key one when introducing human resources which are unlikely to be maintained at the end of the project. CARE may want to consider for the future the value of providing such extensive support to one hospital for a relatively short period in a major town against the opportunity to increase the reach of primary health services which would benefit a far greater number of disaster affected people living in more isolated areas. This is not to say that equipping the hospital did not help, but only that primary services in isolated villages from the same funds would have been more useful.

Best practice states that health services should not be set up in parallel to national systems. In Pakistan there is far from adequate service coverage with two bodies responsible for

delivering health care already running in parallel, although there is no duplication or overlap. The PPHI (Prime Ministers Public Health Initiative) delivers services to certain areas with the remainder coming under the management of the Executive District Offices [EDO]. Early assessments in August 2010 estimated that throughout Pakistan15% of health units had been destroyed in flood affected areas. CARE and partners coordinated with the EDO throughout to ensure there was no overlap of services. Coordination also took place within the Health Cluster locally with both CARE and partners attending meetings. Indeed there was no evidence of any duplication and given the huge need, the risk of gaps was more likely. However, even with the coordination, the CARE project was still running in parallel to government services and was not completely integrated with the government services. CARE may wish to consider looking closely at the modality employed by Merlin which provides support to the EDO to strengthen the delivery of health care through the government structures at all levels. Even though this was an emergency response, in the medium to long term a stronger integration with the EDO would likely result in a more sustainable, longer-term benefit for the local population. Besides the immediate benefit, such long-term benefit is of importance to CARE, as reflected by the inclusion of an objective about long-term risk reduction in the evaluation TORs. It is not necessary that CARE works directly and only with the EDO in the implementation. It could still build the capacity of partners to deliver services at the local level. Whereas this model does add a level of complexity into the relationships it has the potential for greater sustainability and also reduces the risk of parallel systems being established. Such a modality would have been especially useful under the DFID project which started a few months after the peak emergency period when there was more time to pay attention to the longer-term issues.

Standards

Information on the achievement of Sphere health standards was largely anecdotal obtained from CARE health personnel and the partner with some verification at community level.

Access to health care

- Provision of health services at an appropriate level

Following the floods the majority of government health staff moved from the area as their health units and own homes were flooded. Given the vastness of the devastation CARE and partners attempted to reach those who were displaced through mobile health camps. Data does not exist to support the coverage of the mobile clinics but the strategy was reasonable in order to gain the greatest reach. In one area, however, it was found that a relatively small group who were camping on a main road, and therefore arguably with access to services in nearby towns, were served daily by a clinic by HANDS under the DEC project, as it was doing for all its communities. It would have been better to reach other less accessible areas by reducing the frequency of services to each community.

- Adopt standardised care protocols and utilise standard referral protocols

The evaluation team was informed that each clinic had access to Pakistan treatment and referral protocols but this could not be verified as no functioning clinic was seen.

- Inclusion of health promotion

One of the major successes of the response in terms of sustainability and risk reduction was in the health and hygiene sessions. Each community visited enthusiastically said they had learned from these and that the incidence of diarrhoea in the community, especially in their children, had reduced.

- Avoid establishing parallel health services or mobile clinics

There are qualifications in the guidance relating to this standard that acknowledges there are circumstances when mobile clinics are needed. This flood response would be included in those. However, as discussed above, there could be a modality of working that avoided setting up a parallel service as done by Merlin.

- Design health services that ensure patients' rights to privacy

Both DEC 1 and DFID projects were designed to ensure that patients' dignity and privacy was preserved as far as possible. Employment of female doctors provided women with the opportunity for consultation on personal matters that were only available before the flood through private doctors. The construction of women friendly spaces gave an even greater degree of privacy to women.

Control of communicable diseases

The key indicator for communicable disease control is that the incidence of disease is stable for the context. In the case of Sindh there were in fact no widespread outbreaks although the incidence of measles did rise with some deaths reported verbally to the evaluation team by CARE health staff. Incidence of scabies, a parasitic skin infection, was particularly high. Anti-scabies medication was included on the list of available drugs and some communities reported that the treatment was effective. Factors that contributed to the control of disease in the very vulnerable displaced population included the provision of clean water by CARE partners as well as others and repair to water pumps; hygiene promotion; provision of latrines; and distribution of mosquito nets. It was not clear how many nets had been supplied as these were generally included as part of the NFI package.

Sexual and Reproductive health

Even before the floods access to skilled birth attendants was low and this became even worse afterwards. Most women are delivered by traditional birth attendants who have little or no training. As part of the response some of these were included in the health and hygiene promotion undertaken by CARE partners. One local 'midwife' interviewed confirmed that she had learnt something and she had changed her practice as a result. Provision of clean delivery kits to pregnant women will also have been beneficial. Emergency obstetric care is also a scarce commodity. The addition of a female obstetrician at KN Shah Hospital and the equipment support given led to the first caesarean section for many years. Access to female doctors did improve the chance for women to be examined as they will not allow a male doctor to deal with intimate issues including family planning. One community visited with a watsan partner but where the DFID project health partner was also providing services

however were extremely unhappy with the services they received although this was not found elsewhere.

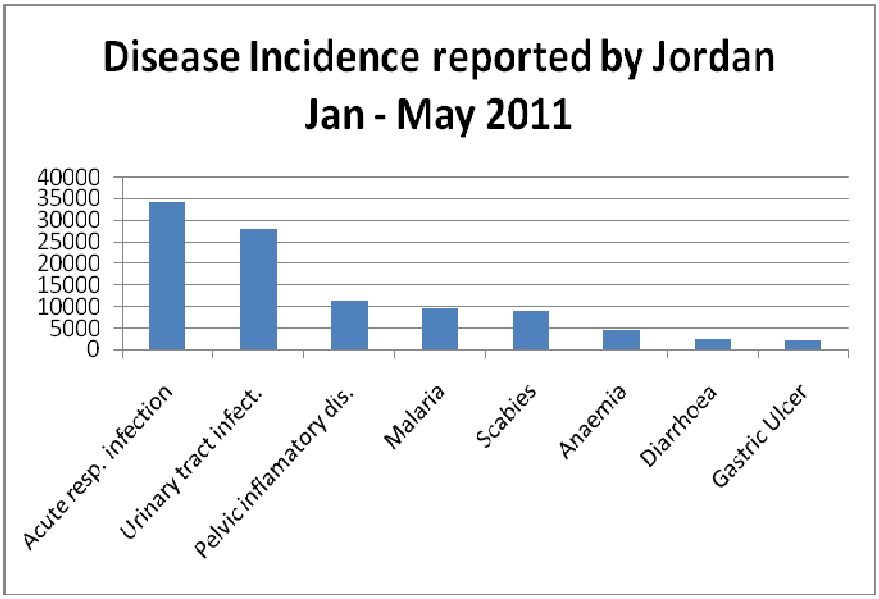
Child Health and Nutrition

Immunisation coverage in Pakistan is woefully low, leaving children especially vulnerable to diseases such as polio, measles and tetanus. Secondary data obtained by Merlin from EDO offices on immunisation before the floods showed 45% coverage for OPV^3, DTP^3 and 42.4% measles. A nutrition survey[1] showed vitamin A coverage to be higher at > 80% in South Sindh. Verbal reports stated that CARE partners worked with the EDO to provide vaccination to around 800 women during the mobile camps but no data was available on how many children were reached. To address this issue CARE should engage with other health focused NGOs to strengthen advocacy efforts within coordination meetings to push for a comprehensive roll out of EPI across the country. Data from the same nutrition survey showed significant levels of stunting across all age ranges which indicates a chronic level malnutrition that existed in the population before the floods; levels of severe malnutrition [SAM] of 7.2% of boys and 4.9% of girls; moderate malnutrition [MAM] of 17.9% of boys and 15.6% of girls. Global malnutrition was extremely high at 25.1% of boys and 20.5% of girls. No oedema was found[2]. Although not part of the original project design nutrition was added to the mobile health clinics to respond to the emerging need by provision of supplies from Unicef & WFO. This included not just screening children but providing them with Plumpynut and biscuits. Those with severe acute malnutrition were referred to nutrition centers for more intensive treatment. No data was made available on number of children entered into the nutrition programme or referred but all were said to improve with the high energy food. Communities visited gave varying reports to support this from those who confirmed their children grew stronger to those who said children were not screened and did not receive any additional food. This was due to inadequate funding to cover all communities.

Reporting

Disease surveillance: Through the health cluster Disease Early Warning Systems [DEWS] was set up across Pakistan after the 2005 earthquake. CARE and partners collected data on disease incidence as presenting at health camps, reporting to the EDO. The table below was prepared from information provided by Jordan but no source information was available.

[1] Department of Health, Government of Sindh, Nutrition Survey. 29th October – 4th November 2010
[2] Ibid.



Reporting/recording patient attendance including new patients: Patient attendance was recorded and reported although no examples of these reports were seen by the evaluation team. The numbers submitted in donor reports included all visits.

Impact

The mobile health programme reduced the incidence of diseases in the short-term but did not appear to have any long term benefits and came too late for the emergency time when people were displaced or just returning home with high disease incidence likelihood. However, re-equipping the hospital and undertaking structural repairs has enabled it to function again as a referral unit. Although medical staff reported that they only received replacement for what was lost at least this was new and should last for a few years. The 2 ambulances were still functioning although another remains broken. It is questionable whether there would have been any replacement and repair without outside support. Until the shortage of hospital staff is addressed, in particular the vacant gynaecologist post and lady doctors for the community, any gains felt during the project will be ephemeral. Wash activities have left tangible benefits for the communities which will survive for some time. Along with the hygiene education and kits, women from different groups who received these reported a reduction in diarrhoeal disease and other stomach upsets.

CARE's management of health services

Even though health is not a CARE global priority, CARE did have experience of running health services in Pakistan from the interventions in KPK during 2007 IDP crisis. At the height of the flood emergency there was a national medical director in Islamabad supported by a reproductive health advisor. For a brief period an expatriate nutritionist advised on the nutritional component. Sindh has its own medical staff comprising of 2 doctors to monitor activities.

The health project was set up rapidly at the onset for DEC 1 but more time was available with DFID funds to ensure that standards were carefully set out and maintained. Partners generally

spoke confidently of their monitoring of clinics and indeed one was able to show an electronic report of these activities along with recommendation. However, given the varying reports from the communities on the service provided, both in frequency and quality and from discussions with CARE staff it was apparent that monitoring of the mobile clinics was inadequate to ensure minimum standards by both partners and CARE. Thus, the recruitment of a Sindh Health Coordinator, with significant experience of managing emergency health projects to international standards and managing large budgets and teams during emergencies (perhaps and expatriate one), may have been advisable.

Documentation was difficult to obtain on elements of the basic management of the project although most were eventually produced. Partners, rather than CARE senior medical staff, seemed to be deciding on the drugs list in the field. However, CARE later clarified that it was also involved in these decisions. Delivery of health services is the most highly technical of all emergency response sectors and in order to 'do no harm' it is vital that those involved in the planning, implementation and monitoring have the necessary competences to do this. If further health delivery programmes are considered CARE should consider increasing the capacity at senior level to ensure that standards are clearly set and communicated to partners and that partners' capacity is fully assessed, as suggested earlier. Greater supervision of the partner, down to community level and service delivery, should be undertaken by CARE through an experienced field-based Health Coordinator (preferably and expatriate with sufficient experience) to ensure those standards are maintained. The fact that health is not a global priority makes it more difficult, though not impossible, for CARE in Pakistan to develop such capacity. However, it should either develop this capacity or look to develop a close collaborative relationship with a health INGO which can provide critical health services in camps and for a period back in villages where CARE works on other sectors.

CARE's partnership approach

CARE has done well to choose to work though national partners despite the significant challenges that this additional layer in the project implementation mechanism adds, especially in the context of emergency work where the fast response needed can be more easily achieved by working directly. However, working through local partners leads to a more sustainable approach in the long-run. However, given the life-saving imperative in emergency work, it is important that CARE ensures that this choice does not lead to inordinate delays that undermine life-saving work as happened in the case of the SPO component. However, the fact that HANDS was able to respond fairly quickly validates the basic feasibility of being able to respond quickly even when working through partners.

In the absence of many existing partners in Sindh, CARE has also done well to experiment with a large number of national NGOs-a total of six in the two projects and several others in other projects. It has also undertaken some capacity building activities for partners on international standards, accountability, project management and financial management. Partners are generally happy with their relationship with partners and describe CARE as a flexible and respectful donor who also helps them in increasing their capacity.

However, there is also a need for CARE to become more strategic and systematic about its engagement with national NGOs. To begin with, having experimented with almost a dozen national NGOs in Sindh alone, it is time for CARE to decide which of them constitute sustainable partners for the future. This decision should obviously be taken on the basis of its current experience. Some partners have shown a greater capacity to implement better programs while others have stronger reporting and financial capacity. It is felt that the reporting and financial capacity can be developed more easily than program capacity and CARE should prefer those better at program work without compromising on minimum financial standards. Once the choice has been made, the partners who are not seen as suitable ones should be informed accordingly in a professional and constructive manner. Currently, there a number of partners who are unclear about where they stand with CARE in terms of future engagement. One partner is especially upset as it feels that it did a good job in the past but has been neglected in favor of a new agency for a future project. It is important to let agencies know where they stand.

Subsequently, with those agencies seen as sustainable partners, CARE should look to sign standing MOUs for future emergency work and also develop a systematic approach to building their capacities based on in-depth participatory capacity assessments of each partner. It should also look to develop capacity-building plans for each retained partner in coordination with its other long-term donors so as to avoid duplication and save money. CARE currently has a due diligence process for selecting partners which provides some information that could serve as the starting point for such in-depth capacity assessments.

In working with a large number of partners, CARE must also make sure that its overall program does not become a collection of disparate projects proposed by different partners which lacks cohesion. This happened to some extent in the current response as CARE essentially was led by partner assessments and priorities with the result that it became too thinly stretched sectorally and geographically. For example, sectors like psychosocial and recreational services were implemented by 1-2 partners and did not seem part of an overall CARE program nor essential for the relief phase. Thus, having a clearer idea of its own of the sectoral and geographical priorities and its global and country capacities and specializations will help develop a tighter sectoral and geographical focus.

Adherence to the Code of Conduct and Sphere standards

Compliance with the NGO codes of conduct

- *The Humanitarian imperative comes first*: There was some delay in the start of both the projects, which undermined the achievement of this imperative. Some of the delay was due to not being present in Sindh (DEC project) before the floods while some of it was due to lack of donor funding earlier (DFID). However, as the difference in the

start of work by different partners under DEC1 shows, some avoidable delays also occurred which CARE should have managed better.

- *Aid is given regardless of the race, creed or nationality of the recipients*: The evaluator did not come across any evidence of any sort of bias, and aid seems to have been given across all affected provinces, races and creed without distinction

- *Aid will not be used to further a particular political or religious standpoint*: This principle was generally adhered to.

- *We shall endeavor not to act as instruments of government foreign policy*: No evidence found of non-compliance. In fact CARE refused significant US funding because of the donor's branding requirements which may have undermined CARE's neutrality in Pakistan. Even though this is not directly related to this project, branding for some projects would have had some indirect impact on even these two projects.

- *We shall respect culture and custom*: There was a very high degree of appreciation among communities about the polite behavior of agency staff and their adherence to local cultures and norms.

- *We shall attempt to build disaster response on local capacities*: The evaluator did not find any evidence of the agency undertaking any community-level capacity-building, beyond the hygiene promotion work done. This is perhaps understandable given the scale of the relief operation and the time constraint. However, most of the service delivery was done by using local capacities of national NGOs and as mentioned earlier some capacity-building activities were undertaken for them.

- *Involve programme beneficiaries in the management of relief aid*: Some of the partners set up village committees to manage the implementation of the project within villages and camps. However, people's participation in the selection of sectors can be improved as people preferred cash and livelihoods to food, NFIs and latrines in the early recovery phase.

- *Relief aid must strive to reduce future vulnerabilities besides meeting basic needs***:** Covered earlier under "reducing long-term risks" section

- *Accountability to beneficiaries*: Covered under accountability section below

- *Recognize disaster victims as dignified humans, not hopeless objects***:** Compliant

Sphere standards

While information was not available for the DEC project, the figures provided by CARE for the DFID project reveal that the Sphere standards were generally adhered to for the major activities as follows:

Activity/Sub-activity	Sphere Standards	Delivered on Ground	Remarks
Water			
Water Supply	15 Liters /Person/Day	15 Liters/Person/Day	8 Liters/Day/person were provided through trucking and remaing 7 L/Person/Day were provided via hand pumps installations
Access	Minimum 500 Meters	Minimum 500 Meters	Most of the Hand-Pumps were installed inside their house compounds
Queuing Time	Min 15 Mins	Min 10 Minutes	Water was provided in 200 number of tanks
Filling Time	3 Mins / 20 L contianer	3 Mins / 20 L contianer	Jerry Cans were provided to the community
Water Quality	No Fecal Coliform/100 ML	No Fecal Coliform/100 ML	Water Quality was tested on weekly basis
Turbidity	Min 5 NTU	Min 5 NTU	Water Quality was tested on weekly basis
Water Use	2 Containers per HH (10-20 L)	2 Containers per HH (10-20 L)	Jerry Cans were provided to the community
Hygiene Promotion	2 Hygiene Promoters / 1000 peoples	2 Hygiene Promoters / 1000 peoples	500 Hygiene Sessions were done for 100,000 Population.
Sanitation Latrines	20-25 person/Latrines	20-25 Person/Latrines	3000 Latrines were provided to the 100,000 Population
Distance from Latrine	50 Meters Maximum	50 Meters Maximum	Most of the latrines were installed inside their houses
Solid Waste Bins	100 Liters / 10 Families	100 Liters / 10 Families	1100 Solid Waste Bins were Installed

Humanitarian Accountability Framework

CARE is a signatory to HAP and as required by HAP has developed its own Humanitarian Accountability Framework (HAF) with 8 benchmarks. This section evaluates those benchmarks that pertained to programming at the ground level

1. CARE leaders demonstrate their commitment to quality and accountability

Not related to ground-level programming

2. CARE bases emergency response on impartial assessment of needs, vulnerabilities and capacities

The quality of assessments was discussed under the "Assessments and project design" section

3. CARE uses good design and monitoring to drive improvements in our work

The quality of project design was discussed in detail under the "Assessments and project design" section. With regard to monitoring, CARE has maintained an office in Sindh despite working through partners so that it could monitor the work closely. Partners felt that its regular monitoring helped them improve project quality, especially in the area of watsan construction where the technical input provided by CARE engineers was seen as very helpful. CARE also maintains a Grants unit which provides regular support through frequent field visits to partners to ensure that they meet donor requirements. However, as mentioned earlier, the evaluation team feels that the monitoring done in the area of health was inadequate.

4. CARE involves the disaster-affected community throughout our response

Covered under Code of Conduct section

5. CARE puts formal mechanisms in place to gather and act on feedback and complaints

The evaluation team did come across formal complain mechanisms in most communities visited although these mechanisms were missing in some places. The mechanisms consisted of complain boxes and banners containing the telephone numbers of partner staff. However, there does not seem to be a clear mechanism with most partners to document and analyze the complaints and share them with CARE regularly. Furthermore, women did not seem familiar with these mechanisms in most communities.

6. CARE publicly communicates our mandate, projects and what stakeholders can expect from us

Due to the security situation in Pakistan, CARE has adopted a low profile in the field. Thus, its cars are not marked and the partner project boards and banners in villages do not carry CARE's name. Nor were communities generally familiar with CARE in most places visited by the evaluation team. Security is paramount. However, CARE could look into providing information about itself to communities verbally so as to maintain both security as well as publicity and transparency considerations.

7. CARE uses impartial reviews and evaluations to improve learning and accountability

This evaluation is living proof of this commitment. However, in Islamabad, we did not find uniform commitment to the evaluation (due to implementation commitments) and it proved difficult to meet key staff and obtain key documents. While the pressure of implementation is understandable, evaluations must be seen as a key part of the implementation cycle and provisions made in people's schedules to allow them to participate adequately.

8. CARE supports its staff and partner agencies to improve quality and accountability

CARE has undertaken trainings on accountability issues both for its own staff and partners. The accountability framework is also shared with all new employees as part of their orientations. However, accountability commitments are not part of the contracts signed with partners, as recommended by HAP, but are reflected in-project proposal and accountability work plan.

Lessons from previous and current experience

The evaluation team found very little written evidence of the incorporation of previous lessons learnt from emergencies in Pakistan or elsewhere. This could have been achieved by sharing lessons learnt one page summaries from previous emergencies with staff and partners or preferably by having special sessions on lessons incorporation during program meetings and meetings with partners. Neither CARE staff nor partners reported such activities. However, there was a steady stream of technical support staff who came from CARE International. These visits did provide an opportunity for the informal incorporation of lessons from all over the CARE global programming map. CARE was also attending coordination meetings regularly in Sindh and Islamabad which helped it incorporate lessons from the experiences of other NGOs in terms of partner selection, suppliers, government regulations and other issues.

With respect to documenting the lessons from this emergency, the agency held an AAR on overall management issues recently and has also held accountability reviews with some of the partners. However, there is a need to have similar sessions at other levels, for example learning lessons for each sector and province and by having departing staff members develop written hand-over notes with a lesson learnt section. CARE is losing staff frequently and it would be advisable to hold such sessions before the collective wisdom resident in implementing staff dissipates further. The CARE health team is planning such a workshop.

RECOMMENDATIONS

Update emergency preparedness plan in light of current experience with other agencies

In the immediate aftermath of major disasters, agencies are expected to respond with high speed with little time for detailed data collections and deliberations but still make accurate assessments and decisions. These two mutually conflicting goals can only be achieved by having a strong emergency preparedness plan in place. CARE developed one in 2009. However, it would be advisable to update it in light of the experiences with this disaster in terms of the geographical and sectoral priorities, suitable partners, likely donors, logistical details and other programmatic and support dimensions. It would also be useful to coordinate this exercise with other major NGOs through coordination forums so as to minimize the problems of lack of interagency coordination after disasters. It has proven difficult to develop emergency plans with other agencies. So it is now focusing on developing contingency plans, which focus on the next season emergencies only, in coordination with others.

Develop a clearer idea of its program priorities and share them with potential partners

CARE's current programs for these two projects displays clear signs of being overstretched sectorally and geographically as it was developed mainly by the disparate priorities of its partners. Developing its own priorities will help develop a cohesive future program.

Develop a long-term approach with selected partners, including signing standing MOUs and developing capacity-building plan in coordination with other overlapping donors

It is advisable for CARE to identify a smaller number of long-term partners and inform all current partners accordingly stating clear and transparent reasons. CARE is advised to sign standing MOUs with selected partners and develop their capacity before the next disaster based on a thorough capacity assessment and in coordination with other long-term donors of each partner. CARE has clarified that it is already starting to do so.

Develop a strong national team over the medium-term

CARE wisely restricted the number of expatriates in comparison with many other DEC-funded agencies. However, in order to enhance its emergency response capacities, it is advisable to develop a strong national team with a low turn-over in order to enhance institutional memory, enhance program quality reduce logistical overload and reduce costs. This may take several years, but is certainly doable in the Pakistani context, especially given CARE's higher than average salaries among INGOs. For example, one DEC-funded agency managed a $25 million flood response with just 1-2 expatriates based on a strong and low-turnover national team and easily had one of the best program quality that the lead evaluator has seen among the 16 DEC and AGIRE-funded agencies that he has evaluated recently.

Improve sectoral focus for the relief and early recovery phases

As described in the "Assessments and design" section, the main requirements of IDPs in the first few weeks are water, latrines, hygiene promotion and health services for the duration of their displacement and food and NFI until these things are not available in local markets and after that cash. After returning to villages, some communities may need hand pump repairs, but beyond that their most important requirements are cash and livelihoods support. Thus, for

the relief phase, the agency is advised to enhance its focus on cash. However, it should remember that money cannot buy everything (water, latrines, hygiene and health services) and is advised either to develop capacities in all these sectors or develop a close relationship with a "conjoint-twin" where both work in the same areas with a clear division of sectoral labor. For the early recovery phase, the agency is advised to enhance focus on cash and livelihoods and reduce focus on food, NFI and latrines. CARE has clarified that it is focusing much more on cash and livelihoods in other projects now.

Develop a clear strategy about continuing engagement in the health sector.
Health is a critical sector for IDPs and for the first few weeks even for returnees. Relatively few agencies provide health services. However, being the most technical sector, it is the easiest to be in violation of the "do no harm" principle. Thus, CARE will have to develop considerable capacity within its own team and partners if it wants to do a good job in health or develop a close collaborative relationship with another health INGO.

Improve the targeting of the most deserving districts, sub-districts, villages and families
CARE did well in selecting the priority districts and sub-districts but its targeting at the village and intra-village levels in these two projects was mixed. A number of guidelines have been provided in the "assessments and design" section to improve targeting at this stage, some of them based on the good practices of some partners.

Develop appropriate needs and impact assessment and lessons learnt systems
CARE was currently guided by the assessment approaches adopted by each partner while impact assessment systems are still in embryonic stage. CARE is advised to help the different partners adopt more uniform needs and impact assessments systems so as to enhance the cohesiveness of its overall program and ensure that programs more truly reflect community priorities based on its accountability commitments. These systems will be more basic for the relief phase and more elaborate for the early recovery phase. Lessons-in exercises can include document sharing or special session while lessons-out exercises could include written hand-over notes and sectoral and provincial AARs, besides country level AAR.

Identify evaluative criteria/TORs at the start of emergency and develop an MIS system that can provide constant feedback to SMT continuously and ultimately to evaluators
It would be advisable to have the evaluation criteria/TORs in place right from the beginning of the emergency and then for the SMT to continuously collect and analyze information related to each criteria on the TORs so that corrective action can be taken much before the evaluation. This will require setting up a comprehensive MIS system.

Strike a balance between visibility and security concerns.
CARE has adopted a no-branding policy so that its name and logo does not appear on its vehicles and the project boards and banners set up by partners in villages. Thus, most communities had no idea who CARE was. This conflicts with its commitments to transparency and publicity under its accountability framework. CARE is advised to provide information about itself to communities verbally to strike a balance between these goals

List of people interviewed

Individual interviews

Waleed Rauf, Country Director
Chris Necker, ACD, Emergencies
Betty Kweyu, Deputy ACD, Emergencies
Nida Khalid Khan, Grants & Contracts Coordinator
Nafeesa Mushtaq, Grants & Contracts Officer
Karuna Soosaipillai, Team Leader, Sindh
Steve Mutisya, Shelter Specialist:
Malik Umair, Health Advisor:
Hadia Nusrat, Gender Advisor
Raja Husrat, M&E Advisor
Dr. Rizwan, SRH
Mohamad Ziauddin, ACD Program Support
Mohammed Tariq, Shelter Advisor
Amir Khan, Procurement Officer

Group interviews

Sindh Health staff
Sindh Program technical staff
Group interviews with program staff of 6 implementing partners

Documents reviewed

DEC proposal, budget and progress reports
DFID proposal, logframe, budget, no-cost extension request and progress reports
After Action Review Workshop report, April 2011
Accountability review reports
Damage Assessment Report, RDF
Emergency Preparedness Plan documentation, Pakistan
Contingency planning documentation, Pakistan
Emergency Response Strategy, Pakistan
CARE Accountability Framework
DEC RTE Report, Pakistan, November 2010
Partner proposals and reports
Sphere achievements sheet, DFID
Rapid report of focus group discussions
RDF pre and post KAP survey reports
Due Diligence Reports for Partners
Contracts for partners
Health data for partners

DETAILED RESEARCH METHODOLOGY FOR THE EVALUATION OF CARE INTERNATIONAL'S DEC- AND DFID-FUNDED FLOOD RESPONSE PROJECTS IN SINDH, PAKISTAN

By Dr. Niaz Murtaza

Provisional schedule

July 6-8 Methodology development etc

July 13-14 Travel to Pakistan

July 15-17 Islamabad meetings

July 15	10-11	Security briefing
	11-12	Logistics briefing
	12-1pm	Briefing by evaluator on approach to key CARE staff
	1-2pm	Lunch
	2-5pm	1 hour individual meetings with key program (line managers, technical) and program support (Finance, logistics and HR) staff
July 16	9-5pm	Meetings with key program and program support staff, contd
July 17	9-5pm	Meetings between evaluation team; preparation

July 18-25 Sindh trip

July 18	Morning	Travel to Sukkur
	1-2pm	Lunch
	2-5pm	One hour individual meetings with 3 partners
	5-6pm	One hour meetings with key CARE program staff
July 19-23	5 days-	Field trips to 4-5 districts -One day with each partner 2-3 locations each day. In each location: -1 hour separate FGDs for 15 men and women each -1 hour-interviews with 4-5 individual heads of households -30 minute-transect walks -select locations that maximize sectoral coverage in each location
July 24	9-11 am	-Preparing for debrief
	11-1pm	One hour meetings with remaining 2 partners
	1-2pm	Lunch
	2-3:30pm	Debrief
	3:30pm	Collecting additional info from CARE staff
July 25		Travel to Islamabad
July 26	9-11am	Debrief
	11-5pm	Collect additional information from CARE staff

July 27-28 Write first draft in pakistan 2 days
July 29th Travel to USA/review/feedback by CARE 1 day
July 30-31st Revise final draft 2 days
Final report Submit to Care Sunday, July 31st

EVALUATION CRITERIA AND QUESTIONS

Outcomes and goals	Type of evidence	Information sources
Quality of needs assessments and project design processes	-Scope, quality and coverage of needs assessment exercises; participation of cross-section of communities; extent to which assessment results guided program design formulation	-Assessments tools, forms and reports -Interviews with CARE and partner staff -Discussions and interviews with community groups and individual households
The relevance and impact at household level	-Was project design relevant to people's needs, especially women and the most vulnerable? -What has been the impact at household level of activities?	-Reports -Interviews with CARE and partner staff -Discussions and interviews with individual households -Transect walks
The relevance and impact at community level	Community perceptions about relevance of activities and their impact	-Reports -Interviews with CARE and partner staff -Discussions and interviews with individual households Interviews with 'community leaders' and local govt officials Transect walks
Were humanitarian standards met? (Sphere, Code of Conduct)?	-Knowledge about guidelines among CARE staff at various levels, partners and communities -Incorporation of guidelines in planning and implementation	-Reports; frameworks -Interviews with CARE and partner staff -Discussions and interviews with individual households Transect walks
Was the response efficient and cost effective?	-Evidence of cost-effectiveness of overall program modality available with CARE -Comparison of efficiency with 15 other agencies recently evaluated in Pakistan	-Reports -Interviews with CARE and partner staff -Transect walks -Interviews with community groups
Risk reduction or enhancement within communities	-Analysis of impact of different sectors and how long the impact will likely last -Impact on future vulnerabilities/resilience -Link with long-term development	-Reports -Interviews with CARE and partner staff -Transect walks -Interviews with community groups and households
Strengths and weaknesses of CARE's partnership approach	Analysis of communication, support provided, capacity-building undertaken; respectful behaviour; degree of freedom provided; procedures followed for donor compliance	-reports, MOUs, frameworks -Interviews with CARE and partner staff
To what extent was the 'accountability to the beneficiaries' promoted and what progress was made against the achievement of HAP principles/benchmark?	-HAP principles mentioned in plans? -Knowledge among staff at various levels? -Evidence of application in field? -Participation/transparency/Complain mechanisms?	-Reports, reviews and frameworks -Interviews with Care and partner staff -Transect walks -Interviews with community groups and households
Identify lessons to be learned to inform the future emergency responses of CARE.	-Lessons gathered by Care from this response? -Best practices observed by evaluator within programs and program support functions -Areas of improvement observed by evaluator in program and program support work -Special focus on the two health components	-Secondary documents -Interviews with Care and partner staff -Transect walks -Interviews with community groups and households