Evaluation of the Humanitarian Programme in the Democratic Republic of Congo (DRC)

Full Report

Oxfam GB Programme Evaluation

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Commissioned by: Oxfam GB

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2. Acknowledgements

The evaluation team would like to thank our colleagues, partner staff and community members for the generosity with their time and thoughtfulness despite busy schedules. They appeared to value the opportunity to reflect and convey their experience. We do hope this is the case and that this document accurately reflects views expressed and will help guide future plans. Any errors lie with the authors.

3. Executive Summary

Oxfam GB has been working in DRC since the 1960s. In May 2004 a four-year Programme Implementation Plan for humanitarian work (PIP P00195) was created, aiming to 'save lives and protect the health of people affected by conflict and natural disasters throughout DRC by focusing on preparedness, response, and protection issues'. This evaluation was commissioned by the country team to assess progress over this four-year period. The country remains one of the most challenging operating environments Oxfam faces anywhere in the world. Around 3.8 million people have died and an estimated 1.4 million people remain displaced by ongoing conflict in the country. Following the first democratic elections, a peace process was initiated, and whilst there seems cautious optimism, the relative improvements in stability and security are very fragile.

The humanitarian programme currently has an annual budget of $6.5million, targeting 550,000 beneficiaries, with a staffing contingent of 160. This has exceeded the PIP target of 400,000 people. Given the challenging and expensive operating environment, this compares favourably with similar scale Oxfam programmes in cost and coverage. The humanitarian programme has focused on immediate and medium-term needs for public health (water, hygiene promotion and sanitation) and non-food items, currently carried out by field teams based in Beni (North Kivu), Bunia (Ituri) and Uvira (South Kivu). In late 2007 Oxfam also started up a programme for 40,000 people displaced by fighting to camps on the outskirts of Goma town. The field teams are supported by management and programme support functions in the Goma office. Oxfam's programmes are mainly operational but work with two local partners in North Kivu, and with the BCZS government health zone offices in North and South Kivu and Ituri.

Assessing the four-year programme lifespan proved challenging in a context that has changed considerably, and continues to do so. Very few current staff have been with the programme since 2004/2005. The PIP was designed with three high level objectives that sat above project level plans and logframes. Overall, the plans were found to be ambitious with high targets set for water/sanitation/public health work, as detailed out in logframes that have pronounced quantitative targets and indicators, but less well developed thinking on qualitative measures and a range of programme quality considerations set out in the overall PIP strategy. This apparent disconnect needs to be reviewed for the coming year. However, very good progress has been achieved in delivering these projects, with an overall completion rate of over 80% anticipated by the end of this financial year.

Much work remains in preparedness at all levels – from the overall contingency plan through to local level activities. However, some very good practices and outcomes were identified (that were at times unplanned) in the degree of flexibility, relevance and durability of public health work that leave communities feeling ownership & better placed to cope with the fluid context and future shocks.

In terms of impact on health, accurate, relevant data proved hard to obtain. The evaluation team were able to draw on statistics that at least enabled a strong sense of trends in key diseases rates in areas where Oxfam works. Of equal significance, if not more, is that informants (particularly community members, BCZS and partners) spoke consistently of reduced incidence of cholera & other water-borne diseases, and attributed this to improved public health facilities along with health promotion activities. In terms of classic public health related diseases there has been noticeable positive change.

The objective of ensuring the rights of conflict-affected people were better respected has not been systematically integrated into individual projects. However, some evidence was obtained of impact that was at times inadvertent, and relating to good analysis and programme choices that reduced risks to people.

The evaluation provides more detailed analysis against the DAC criteria (efficiency; effectiveness; impact; relevance; sustainability; coverage and connectedness).

The progress made in the DRC programme would not have been possible without an almost unprecedented commitment from the organisation towards a failing programme of four years ago. The DRC team has achieved a great deal in growing an effective and influential programme that meaningfully touches the lives of hundreds of thousands of people each year. The successes of the last few years underline again the importance of competent, committed staff at every level, and the coming period will need careful management to support new post-holders and protect against avoidable problems in continuity.

The evaluation team made four recommendations for consideration by the country management, summarised below.

- **Vision and strategy.** Oxfam DRC should re-define its future humanitarian vision and strategy for the coming 2-3 years, and set out intended scale, scope (including geographical) and capacity needs (Oxfam GB and partners). An essential component of this would be the development of location-specific contingency plans that identify response modalities and parameters. These should be signed-off in advance to enable swift decision-making and allocation of resources in the event that a new emergency response becomes necessary.

- **Programme quality**. In order to improve mainstreaming approaches and programme monitoring and learning, priority should be on:
  - "Demystifying" mainstreaming areas and translate these to clear objectives and activities in high-level strategy and project level objectives and activities. These should link clearly to development of improved advocacy objectives and activities at field level
  - Developing simple, useful systems to help field staff collect relevant information and monitor on a regular basis, supported by Goma advisors/coordinators
  - Considering simple mechanisms for improved cross programme learning

- **Management and team dynamics.** The Country Management Team should assess how to best to achieve optimal support for staff (particularly PMs), improve communications and ensure management (which is between Goma and Kinshasa) functions are more engaged and responsive to field office needs

- **Working with Partners.** As part of the overall vision and strategy development, Oxfam DRC should undertake partner assessments for current and emerging partners and develop a clear longer-term partnership strategy with clear commitments and exit intentions. Consideration should be given to allocating increased multi-year, unrestricted resources to develop partner capacity and work on this is ongoing. (Limitations on unrestricted funding and high running costs for the programme will continue to make this challenging.)

Annexes include a brief timeline constructed by staff; health data collected; partners' views on Oxfam and the evaluation Terms of Reference.

4. Introduction

Oxfam GB has been working in DRC since the 1960s. In May 2004 a four-year Programme Implementation Plan for humanitarian work (PIP P00195) was created, aiming to 'save lives and protect the health of people affected by conflict and natural disasters throughout DRC by focusing on preparedness, response, and protection issues' (extract from the PIP short description). At that time there were around 1.1 million IDPs in DRC. By 2006 there were an estimated 1.4 million people remaining displaced by ongoing conflict in the country, and an estimated death toll of 3.8 million due to many years of conflict and instability. Millions of others continue to live in areas affected by violence and disease. In late 2006, the first democratic elections took place and more recently a peace process was initiated. The process of demobilising armed groups has begun, and safer operating space for humanitarian actors has slowly opened up. Whilst very fragile, the relative degree of peace and stability is better than many have seen in recent years, although return to renewed conflict in North Kivu from August 2007 has again led to new displacements and threats to programme implementation.

Oxfam's DRC country programme includes a large humanitarian programme in the East of the country, education and livelihoods work, and policy and advocacy work. The main focus of advocacy efforts over the past year has been on the UN peacekeeping force, MONUC, seeking to extend and ensure full application of their mandate to protect DRC civilians against violence. Work also focuses on humanitarian reform and the quality of aid, under what is now the Oxfam International Rights in Crisis campaign that seeks to exert positive influence on protection and assistance. Oxfam GB works with an emerging network of NGO partner organisations and participates actively in the protection cluster.

The humanitarian programme has focused on immediate and medium-term needs for public health (water, hygiene promotion and sanitation) and non-food items, currently carried out by field teams based in Beni (North Kivu), Bunia (Ituri) and Uvira (South Kivu) and targeting over 500,000 people. In late 2007 Oxfam also started up a programme for 40,000 people displaced by fighting to camps in the outskirts of Goma town. The field teams are supported by management and programme support functions in the Goma office, including a well-resourced advisory team working on programme quality (public health, gender, HIV/AIDS, Protection, partnerships and holding the overview on programme learning). Oxfam's programmes are mainly operational but work with two local partners in North Kivu, and with the BCZS government health zone offices in North and South Kivu and Ituri. Unless otherwise stated, Oxfam refers to the Oxfam GB programme in this document.

5. Evaluation scope and methodology

The evaluation looks back at the last 4 years of humanitarian programming in the east of the country (see Terms of Reference annex 4). The process did not assess the longer-term development programmes and only looked at advocacy work that related directly to humanitarian objectives. The team sought evidence of progress under the high-level objectives as described in the PIP, and more detailed analysis using the standard OECD/DAC criteria as broad headings. This report follows that structure, and concludes with final sections on factors that proved critical in enabling or hampering progress, and recommendations. Annexes include a timeline of events identified by staff as significant internally or externally; epidemiological data; analysis of partners' views of Oxfam; and the Terms of Reference for the evaluation.

The team split into two and spent the majority of their time at field sites in Beni and Uvira, and with the Goma response. Using semi-structured interviews, team meetings and site visits / focus groups the evaluation team spoke to:

- Around 8 people in Oxford and former staff
- 4 Regional Centre staff
- Around 40 Oxfam DRC staff
- Around 15 staff from 5 partners
- 14 beneficiary groups in Uvira, Beni and Goma
- UNICEF & OCHA representatives
- 15 BCZS (local health zone) government officials

A final day was spent debriefing on findings with senior staff from the four offices, and discussing recommendations.

Constraints

It proved challenging assessing a four-year time scale in a context that has changed considerably, and continues to do so. Whilst Oxfam has been able to stabilise staffing and reduce turnover in key positions in recent years, very few current staff have been with the programme since 2004/2005. Current project operations started in Bunia in 2000 and Beni in 2004, whilst Uvira (2006) and current Goma (2007) operations were more recently set up – making it difficult at times to draw generic "whole programme" lessons. Having said that the evaluation team found high degrees of consistency on key findings across the different project areas and unless stated, commentary applies to the whole. The Bunia programme was not visited and only one and a half days were spent with the Goma team and their current programme (the year-long cholera response intervention initiated mid-2006 was not assessed). The team consisted of staff with programming, PHP and managerial backgrounds but lacked public health engineering expertise, thus limiting the depth of technical assessment of facilities. Some key informants were absent at the time of the evaluation and debriefing, and could only be interviewed by telephone. This did have an impact on cross-checking findings, rewriting the original draft, sourcing relevant documentation, and the general richness of debate. Exchanges of comments on the first draft of this report have helped address some of these gaps.

6. The Context

The working context remains very challenging, with the East of DRC continuing to be amongst the most difficult programming contexts that Oxfam faces anywhere in the world. The peace process feels fragile, and has seen some progress and increased access but security remains an immediate, almost daily, concern. MONUC forces have a visible presence on the main roads and towns but heavily armed groups remain and the demobilisation process is slow. Overall there is a sense of very cautious optimism, with families returning to their communities having endured multiple displacements within DRC or becoming refugees in neighbouring countries. In addition to significant unmet needs for communities currently in place, there is a significant growth in returnees as illustrated by figures from Uvira below:

Continuing fluidity: Returnee trends in Uvira

2005	6,737	
2006	16,502	
2007	24,756	82% women and children recorded
2008 estimate	40,000	
From Burundi 2008 est.	4,000	Pending tripartite discussions
Total including est.	**90,995**	

Sources: OCHA & UNHCR February 2008. 2008 figures are initial estimates. The "season" for return tends to be May – October. There are both spontaneous and facilitated returns.

UNHCR estimates 98,000 remaining in Tanzania and 32,000 in Burundi at present, and hope to assist repatriation of 40,000 returnees in 2008.

It seemed that everyone in communities the team spoke to had suffered multiple displacements, with each time seeing any remaining assets and crops looted, neighbours killed and women subjected to sexual violence. People interviewed in the Ruzizi Plain were forced to flee twice on 1997, and again in 2006 and 2007, each time for periods of 3-6 months. Most fled to the bush ("if you were lucky you had some food and plastic sheeting to shelter under"). They faced difficult choices each time as to whether to remain in the area or cross the border to Tanzania or Burundi. Women spoke of still going to their farms to find them looted and expressed fears of harassment and violence about travelling the 30-minute walk to their farms.

7. Overall Findings

The PIP Progress was designed with three high level objectives (see below) that sat above project level plans and logframes. More detailed commentary on these is given in section 8. Overall, the plans were found to be ambitious with high targets set for water and sanitation work, as detailed out in logframes that have pronounced quantitative targets and indicators, but less well developed thinking (at least on paper) on qualitative measures and a range of programme quality considerations set out in the overall PIP strategy. This apparent disconnect needs to be reviewed for the coming year. However, very good progress has been achieved in delivering these projects, with an overall completion rate of over 80% anticipated by the end of this financial year. Field teams possibly over-estimated the amount of opportunities for "quick win" rehabilitation projects of facilities such as spring protections and gravity schemes that had been destroyed or fallen into disrepair, as other agencies were also targeting these. Whilst a draft public health strategy does exist, the awareness of it and actual usage seemed confined largely to the Goma office. This appears to have impacted on the clarity and quality of monitoring systems and guidance for teams on how to make design decisions. This may in turn have contributed to an over-reliance on ambitious quantitative targets and thus this "quick win" approach rather than investing resources where they would have most impact.

7.1 Local communities are better prepared to assist conflict/disaster-affected people.

Overall, despite being a key objective of the PIP, preparedness was not taken up as clear objectives or sets of activities in any of the subsequent projects and does not feature in many logframes. Where progress was observed, it appeared to have been unintentional largely due to a good emphasis on participatory approaches and consultation with affected communities. Explicit, "live" preparedness plans do not exist, and given the context this is a serious weakness. However, senior staff pointed out that due to the context they were in a "perpetual state of contingency planning", with effective measures taken such as pre-positioned contingency stocks, and active involvement in cholera contingency planning at project level.

Much work remains in preparedness at all levels – from the overall contingency plan through to local level activities. However, some very good practices and outcomes were identified (that were at times unplanned) in the degree of flexibility, relevance and durability of public health work that leave communities feeling ownership & better placed to cope with the fluid context and future shocks. Examples of this include the clear planned phasing of emergency phase water trucking to rehabilitation of longer-term solutions such as gravity schemes and spring protection. This high level strategic intention may be better phrased as "local actors are better prepared…" given Oxfam's commitment to not only working with communities but building the longer term capacity and resilience of community structures (e.g. water committees),

local partners and government health zones, and exerting a positive influence on other actors in the sector.

To a large extent (the exception being the Goma IDP response), the current DRC programme is often not a "classic" emergency programme – at least not in terms of the usual characteristics of sudden large-scale population displacements more common in a large rapid onset crisis. However the programme does operate in a chronic emergency setting that remains highly fluid, insecure and unpredictable, and when emergencies do happen the programme deals with them within its overall framework. The evaluation team found that the analysis and choices made on trying to design programmes that would best meet the transition challenges in this context were strong.

7.2 Conflict/disaster-affected people have reduced health risks.

Accurate, relevant data proved hard to obtain mainly due to the lack of ongoing monitoring or data tracking being carried out in the field offices, or consolidation at the Goma level. This was a weakness and was surprising given the investment of specialist support in the Programme Quality & Learning Team (PQLT). The evaluation team were able to draw on statistics that at least enabled a strong sense of trends in key diseases rates in areas where Oxfam works. Of equal significance, if not more, is that informants (particularly community members, BCZS and partners) spoke consistently of reduced incidence of cholera & other water-borne diseases, and attributed this to improved public health facilities along with health promotion activities. In terms of classic public health related diseases there has been noticeable positive change. From Beni, statistics covering Oct 2006 and Sept 2007 show:

- Decrease of watery diarrhoea: 17% among under 5s and 24% among over 5s
- Decrease of worms infestation: 15% among under 5s and 17% among over 5s
- Decrease of malaria cases by 9% among under 5s. There is a notable increase by 4% among over 5s
- Decrease on conjunctivitis: 30% among under fives and 21% among over fives.

These global figures should be treated with caution and monitored over a longer time period (discussed more fully under section 8 – impact). However, any significant positive trend in these disease rates is to be welcomed in these circumstances. Given that Oxfam and its partners are major service providers in this sector (and apparently exerting a positive influence on others), the evaluation team feels confident in judging Oxfam's contribution to these health trends as noteworthy.

7.3 Rights of conflict-affected people are better respected.

This outcome has not been systematically integrated into individual projects documents and logframes, and very few specific indicators or outputs at project level related to this outcome. Advisors have fed back that current proposals for the future do now include more emphasis on mainstreaming into the programmes.

Some evidence was obtained of impact that was at times inadvertent, and relating more to good analysis and programme choices reducing risks rather than any significant impact on improving the respect for peoples' rights. Examples of this included increased water supply provided through expansion of existing system capacity or additional water points that had decreased the distance women travel for water and virtually eliminated water collection during the night in beneficiary communities. This reduced the risk of harassment and sexual violence according to the beneficiaries themselves. Also, in communities hosting high numbers of IDPs, ensuring that the water infrastructure was available to both IDPs and the host communities has reduced potential conflict between the two and enabled households

to support IDPs for longer periods of time. The WASH cluster review identified further good practice, finding that Oxfam was able to avoid disputes that have dogged other agencies by ensuring legal community title to the land on which water points were to be sited.

In some instances "conflict-blind" programming may have led to increased conflict (e.g. conflict between pastoralists and fishing communities as a result of Tagba gravity system in Bunia).

Staff acknowledged that a more joined-up approach by the advocacy team and Programme Managers / Humanitarian Programme Manager is needed for promoting the rights of beneficiaries, but some examples of better practice in this were provided, particularly in protection issues. These included raising local concerns with national or provincial for a, reporting on forced labour and attacks on IDPs, and advocating for greater coordination between MONUC and humanitarian actors.

8. Findings against DAC criteria

8.1 Efficiency

A detailed analysis of cost-effectiveness was not carried out, but some general observations could be made. The costs per beneficiary were highly variable by project but this could be explained at least partially by differing stages in investing in staffing and equipment and the nature of work undertaken (for instance heavy equipment costs such as pumps). DRC is an expensive operating environment. The evaluation team were pleasantly surprised to find semi-permanent latrines constructed in 2004 in Beni were still functioning and in full use well past the intended lifespan. The semi permanent latrines were found to offer some improved efficiency and cost effectiveness in comparison to permanent latrine designs.

It proved difficult to disaggregate figures at sub project level but construction work carried out through partners (particularly in the case of the experienced CEPROSSAN) appears more cost-effective than direct implementation by Oxfam. More detailed analysis would be needed to determine the extent that staff and overhead costs contribute to this, with due consideration of Oxfam's emphasis on, and investment in, public health promotion (not all watsan actors place this emphasis). Project site choices do have an impact on efficiency. Considerable direct and indirect costs mount up in implementing and monitoring programmes over large distances, and the field presence of partners would lessen these. Where this approach has been tried however, it seemed to yield good results. A comprehensive partner capacity-building plan and investment of unrestricted resources in strategic, longer-term relationships with key partners (such as Ceprossan) does not yet exist. This is a priority for the future, not just in terms of efficiency but in building a clearer overall strategy for humanitarian work and ensuring the best use of unrestricted resources.

The DRC programme has invested in a Programme Quality & Learning Team (PQLT), based in Goma and providing advisory support in a full range of programme quality issues. A review of this unit has been commissioned by the country team to guide decisions for the coming years and will be carried out in early May. The evaluation team therefore did not assess this in detail, but from field team feedback and the debriefing discussions, judged this investment as important, but questioned if the delivery model of PQLT could be more efficient. There has been significant investment in many different individual posts with a high cost implication, yet little evidence of significant impact on field programme strategy and approach. While ad hoc support and consultation between advisors and field staff was appreciated, there was no evidence of the PQLT working together to achieve key outputs, such as the

development of a proper monitoring system. The focus on a Goma-based team may have diverted senior management attention and support away from the Programme Managers and field offices, which are the key unit for quality delivery. Suggestions for improvements were discussed at the debriefing workshop. These included more of an emphasis on focused accompaniment for capacity-building at field level; integrating and translating mainstreaming themes into programmable activities within projects; more investment in strengthening monitoring systems and ensuring systematic analysis of data collected; developing a technical public health strategy and structured partner capacity-building plans; and facilitating improved cross learning between programme sites.

8.2 Effectiveness (includes timeliness)

Overall the projects are effective, with teams achieving over 80% of planned outputs (with some extensions to project periods negotiated). Activities were found to be delivered in a way that meets most of the objectives. There is largely a good integration of Public health engineering and Public Health Promotion at field and Goma level and this certainly has helped programme coherence and overall effectiveness as noted in the Impact section. Some technical weaknesses were observed at field sites and discussed with the teams, and there appears to be a need for final technical checking after construction. The technical quality of programmes has improved significantly from the low starting points of four years ago. Generally SPHERE standards have been met reasonably quickly, or plans are on place for reaching these on water quantity and latrine coverage. The use of Bio Enzymes (in the Beni project) as a latrine digester caused some debate. Communities and CEPROSSAN told the evaluation team that these have proved effective as a method of reducing the need for additional latrine construction in places where IDPs were imbedded within host community populations, but this is questioned by Goma Public Health Advisors.

Efforts on coordination were seen to be effective by both staff and representatives of other organisations interviewed, with Oxfam seen as open and collaborative and has built its reputation as a leader in the WASH sector. The organisation is judged to have had a good influence on others, especially partners.

The timeliness of programme responses in the main programme was judged to be generally good, and – importantly – responsive to the changing environment. There were mixed views expressed on the timeliness of new emergency responses both with the new programme in Goma and in response to new displacements or other crises in the geographic focus areas of the ongoing programmes. Examples included using Oxfam Catastrophe funding and fast-tracked Pooled Funds to scale up from zero to a $1 million programme within 2 weeks of the Goma IDP crisis, serving watsan needs of 40,000 people in the four camps, and in numerous responses to cholera outbreaks and IDP movements in the other project areas.

However, frustrations were expressed by both staff and other agencies on the amount of time taken to reach agreement on the intervention and then the time taken to set up the response. In certain cases the delay was so significant it rendered the agreed-upon technical approach irrelevant. Some of the problems encountered are internal to Oxfam (mainly due to extensive consultation with internal stakeholders the time it took to get agreement on the technical approaches and approval to intervene at Goma, Nairobi and Oxford levels), some problems in procuring non-standard specialist pumping equipment) and these have constrained the ability to respond in a timely manner, and make the best use of resources available. Beyond Oxfam's control, deteriorating security situations have necessitated evacuations at critical moments, and poor sectoral coordination and slowness in identifying camps have

also caused delays. Currently, the recognised first phase agency in water and sanitation responses (under the Rapid Response Mechanism – RRM) in Ituri and North Kivu DRC is Solidarites, with Oxfam tending to set up better quality programmes in following phases. It was pointed out that Oxfam has tighter security policies than Solidarites, and that Solidarites' operations enable the RRM to respond in areas that Oxfam cannot.

8.3 Impact

The evaluation team were able to note some key areas of impact on the lives of people Oxfam and partner organisations work with. From views expressed by beneficiaries themselves, zonal health authorities, community leaders, and random visits to households, it is evident that there has been positive behaviour change. Awareness of public health risks was found to be high, and the quality and quantity of water provided was consistently linked directly by community informants to declining water-related disease rates (see below). Informants also highlighted reductions in late night queuing for water and in the distance women had to walk to water points, and this is particularly noteworthy given the continuing high frequency of threats of violence and intimidation they face.

Despite the uncertainties and upheaval brought by circumstances well beyond the control of communities, social cohesion was found to be (perhaps surprisingly) strong. Activities implemented by Oxfam and partners have been discussed and carried out in ways that enabled communities (including IDPs and host communities) to work together and help build a strong, positive sense of ownership. Oxfam's approach in this regard was judged better than others' approaches (see annex 3 for feedback from partners). This influence was found to be noticeably stronger in longer-term work rather than six-month short projects.

In terms of building capacity for the future, partners were found to have been positively influenced by Oxfam's approaches and competences. This was evident on partners that Oxfam has worked with (both directly – for example PPSSP and CEPROSSAN, and the BCZS offices, and indirectly through the UN Pooled fund and advocacy at higher levels nationally and with clusters on programme practice).

Health data available from the health zones where Oxfam is working were assessed and collated (see graphs below) detailing reported cholera incidence in South Kivu over two years and watery diarrhoea in North Kivu over one year. These figures relate to health zones where Oxfam is working. The downward trends are very encouraging but need to be treated with caution. Comparative data from other health zones was not obtained, data sets were incomplete, and it is difficult to gauge the accuracy of reporting. Cholera (particularly in the case of DRC) is affected by other factors such as changes in temperature and salinity of water: the last year could simply have been a "quiet" year for cholera in that area. However, whilst it is not possible to reach any neat "cause-and-effect" conclusions on attribution to Oxfam and partners' work, the trends are positive and one could reasonably judge an important contribution by Oxfam to bringing these about.

It is equally important to note the positive community perceptions on disease reductions (as noted above) and indeed the uptake of hygiene education. It is also noteworthy given the fluid returnee rates of formerly displaced people. Arguably, with increased return rates of people (who by the nature of their circumstances are more likely to be forced into taking risks with personal hygiene and drinking water), one could have reasonably expected an increase in diarrhoeal diseases.

Observations on trends in malaria (see collated analysis in annex 2) sparked much discussion on the differences between incidence for under 5s (dipping, with some overall decrease over a year as a percentage of overall disease caseload)) and over 5s trends (showing overall increased incidence). This would appear to be consistent with the strategy of many agencies (including Oxfam) of target distribution of impregnated bednets and health promotion activities at households with mothers and children under five. Monitoring would certainly need to take place over a longer period of time to be more conclusive as many factors need to be considered such as returnees from non-endemic areas needing time to re-build resistance, and the fact that impregnated nets can have a "halo effect" with the insecticide providing protection not only to those under the nets but also those in close proximity. It is important to note that Malaria has replaced water related diseases as number one in both morbidity and mortality in areas where Oxfam works.

[Figure Removed]

8.4 Relevance / appropriateness

Water, sanitation and hygiene promotion remain high on peoples' felt needs, and the evaluation team were left with no doubts about continued work in this sector as being relevant and appropriate. Technically, the programmes were found to be of good quality and appropriate to the setting and capacities of users. Some good basic considerations have been given to addressing issues of dignity and creating the right environment to strengthen community ownership. Key enablers for this appear to include strong and principled commitment of staff and their skills bases (notably in community mobilisation and participation); the ability to resist short-term thinking; taking the longer-term view; and (most notably in Beni, but also observed in Goma) a constructive and long-sighted approach to partner accompaniment and capacity building. There does appear to be a need to consider the balance of large and technically heavy projects with simple and self-sustaining community based options (for example introduction of household water filters in areas where large gravity systems are prohibitively expensive).

With healthy levels of dedicated advisory capacity in areas such as protection, HIV/AIDS, gender and programme learning, it was surprising that it was difficult to see how these thematic areas were impacting on project design and implementation, or how progress was being tracked. There does not appear to be a strategy or clear understanding on how to embed and create a coherent "whole" for mainstreaming these areas beyond a traditional approach of training events carried out by advisors – and apparently in isolation. It may have been more relevant for field staff if the approach was more field focused and driven, led by Programme Managers and carried out through accompaniment at field level, rather than one-off events that regularly take people out of the field for training in Goma or elsewhere[1]. Whilst this remains the case, it will be extremely difficult to realise the full potential of these resources or be able to detect the added value. The lack of a good data collection and monitoring system, as noted above, is an obvious gap and means that programme learning processes or events (including this evaluation) have to start from a low point.

[Figure Removed]

It would appear that many concepts have been absorbed and raised levels of awareness and commitment within the programme teams. However, it seems that teams and individuals are struggling to see how best to integrate and prioritise these

[1] Similar conclusions were reached in Oxfam's Aceh programme in 2006.

most effectively within the programme. Practices observed in the field were often good (including some striking testimony in Uvira on the impact of Oxfam-initiated discussions on gender and empowerment issues) but this was apparently more due to individual field worker's skills and intuition rather than a clearly defined strategy that successfully articulates how these areas of work join up and complement each other. There is certainly a disconnect between high level strategy and project logframes as noted above, and this is the most obvious starting point for increasing clarity on this.

In terms of accountability to beneficiaries, community informants in Uvira seemed quite genuinely surprised when asked what they would do if they had negative feedback or complaints that they wanted to raise with Oxfam or partners (there was a similar reaction in Goma camps). It is hard to tell to what extent this was due to genuine satisfaction and appreciation for what had been provided (and this was strongly articulated – and appeared most felt in communities that had been deprived of facilities for longer periods) or perhaps a lack of awareness that they were entitled to complain if necessary. Most reactions spoke of going through the water committees and possibly BCZS office, less on speaking directly to Oxfam staff (as was pointed out – what if the complaint was against that staff member?)

The main other area of support expressed by communities were assistance to rebuild and diversify livelihoods. Sexual violence remains a widespread threat and there are many actors implementing activities and raising awareness of this problem. It seemed that posters and leaflets were present in every sizeable town, but there does not appear to be a clear sector strategy in DRC. Many women on public health committees are in leadership positions, and some are actively supporting victims of sexual violence, and there is considerable potential for the programme to develop ways to support what is already being done at community level.

With the prominence of malaria as the number one cause of morbidity, there is a clear case for considering a greater emphasis on this in future programming.

8.5 Sustainability

Where community mobilization has been undertaken adequately, it was evident that the community structures have been able to continue running facilities four years after installation. This is contrasted with problems encountered in areas where Oxfam implemented short-term (six months) projects. There are some good examples from Beni, such as the semi-permanent latrines in schools or the strong community management of the gravity water supply system in Kanyabayonga. This contrasted with the poor condition of the springs captured under the Pooled Fund project in Oicha – Eringeti, which had broken down due to the lack of community ownership.

Training and tools/equipment donated by Oxfam were found to have been useful in maintaining and running facilities. However supplies for some of the equipment (delagua kits) had run out and so could no longer be used. There is mixed success rates in generating user fee income for maintenance and spare parts for systems, with low success rates in Uvira, but more encouraging in Beni (c50% uptake). In numerous cases, (12 out of 16 springs in Beni project area) Oxfam has been forced to rehabilitate facilities previously implemented by other organisations and there is need to influence at cluster level for all organisations to improve construction, observe standards and ensure sustainability.

As noted above, it was readily apparent that a forward-looking approach on systems and facilities is paying dividends and strengthens the chances of longer-term sustainability. The Goma schemes have invested in systems and pumping equipment

that meet the needs of the 40,000 people in camps, but are designed to meet needs of 50,000 people (with little extra cost), which with the fluidity of people movements appears a prudent approach. Although there exists no structured partner capacity building plan, a careful step-by-step approach is being taken to help build up the capacity and profile of ASAF (the small local partner that runs two of the camp schemes) and includes funding and support to ASAF to recruit technical expertise. The decisions around the Goma schemes and partnership have been mindful of the fact that expansion of Goma town will be in the direction of these camps.

Significant effort has gone into developing partners and BCZS offices visited were largely very positive about the collaboration, rating Oxfam highly against the partnership policy principles. Some partners in Uvira (local Red Cross and SNHR) asked for clarification on future intentions and programming, having been working with Oxfam on some one-off initiatives. Generally there does need to be a long-term view of capacity building – both for local NGOs such as CEPROSSAN and ASAF, and the local authorities. BCZS offices are heavily reliant on INGOs for support, expert advice and funds and this will not change quickly. Oxfam's cumbersome financial procedures were the single biggest (and most consistent) criticism as they lead to delays in payments and implementation (see annex 3). However, the fact that low priority has been given to developing a comprehensive strategic investment in capacity-building with key partners is a constraint to sustainability.

8.6 Coverage

The Oxfam GB programme currently has a budget of $6.5 million, targeting 550,000 beneficiaries, with a staffing contingent of 160. This has exceeded the PIP target of 400,000 people. Crudely (budget and staffing figures used do not fully include Goma support) this gives a per head figure of c12 USD. If Goma support was factored in this would be around 13 or 14 USD per head, a reasonable figure given the operating environment.

Coverage in southern health zones

Total Population South Kivu:		4,715,056
(Pregnant women & children under 5:		1,079,748)
Of the 34 health zones, Oxfam works in 4 of these in public health		
Lemera:	139,048	
Nundu	216,597	
Ruzizi	215,415	
Uvira	231,578	
Total	**802,638**	**(c17% of South Kivu total)**

For Oxfam GB this level of coverage compares favourably with the programme in Darfur that faces similar operational constraints, high insecurity, and high costs on staffing and equipment. Oxfam in Darfur continues to service the public health needs of around 500,000 people (largely in camps with very few local partner organisations) and with an annual budget of around GBP 10 million.

The overall coverage appears appropriate to Oxfam's desired role as leading humanitarian actor, and within the staff groups there is an appetite to do more. Given the starting points of 2004/2005, the growth in programme, improvements in quality, and ability to build leverage for attracting restricted funds are significant achievements.

There are some key dilemmas, with mixed views expressed by staff. The first of these is in deciding on expanding the current programme to reach more people and

work in more areas, versus an opposing view that would favour consolidating the progress of the last few years and focusing more on improving quality. The senior management steer during the last year (in country and Regional Centre) has been on consolidation in order to strengthen programme quality and partnerships, before considering further expansion (unless there is an acute emergency). Another dilemma is on whether it would be best to focus on reaching large populations (in the plains areas) with rehabilitation schemes or there should be more emphasis on accessing more remote areas than are currently being reached but where these smaller, more scattered, and most marginalised populations (such as in the mid and upper plateaus) have arguably greater needs and certainly a dearth of humanitarian actors working in their area.

All of the above is constrained by funding opportunities and DRC is an expensive operating environment. The Humanitarian Action Plan, set by the Clusters and coordinated by OCHA, defines three key criteria for choice of operating area and this has a powerful effect on where funding is allocated.

- Number cholera cases
- Number returnees
- Number of displaced (for more than 3 months)

Humanitarian needs continue to outstrip available resources and whilst further analysis and greater responsiveness to changing circumstances is needed there does appear to be a need to have an explicit discussion with staff and partners to clarify strategy and resolve the ambiguity that exists at present (linked to comments above about the need for a coherent public health strategy).

8.7 Connectedness

The main focus of this exercise was on internal connectedness. The programme does not yet resemble a one-programme approach. This is by no means an issue confined to DRC, and the country programme is both geographically & progammatically diverse. There is an appetite to identify and make meaningful progress on a range of potential programme connectivity and on overall quality issues. Some of the lack of apparent connectedness seems hindered by “structural” issues, for instance partners working on HIV or advocacy in Beni having direct relationships with their key contacts in Goma or Kinshasa but little with the large team based in Beni and struggling to connect successful high level advocacy with Programme managers’ (PMs) day jobs. (Some of this disconnect appears to be due to partners being Oxfam International partners as opposed to OGB). The recent creation of posts in Beni and Goma with direct responsibility for partner management should help address some of these problems.Further clarity on field programming links to advocacy should also be possible if funding applications are successful to create protection programme officers at relevant field bases. The Advocacy Coordinator recommended improved coordination on programme and advocacy design that would lead to clearer advocacy objectives and activities at field level, and improved ownership by PMs.

The evaluation team found that there is considerable untapped potential for cross programme learning between projects and with other programmes outside DRC.

9. Overall conclusions

It is important to note the state of the DRC programme four years ago. There was an acute sense of failure. Despite massive unmet humanitarian needs in the classic forgotten emergency, Oxfam’s programme was under-performing and lacking a critical mass, suffering from very high turnover of key staff, poor management and

leadership, and facing extremely low donor confidence. A stark choice of closing down or seriously raising performance was discussed at the highest levels of the organisation. The critical steps taken at that time, and the commitments made to turn the DRC programme round are worth noting not just for the DRC programme staff, but as they may have a broader application to Oxfam programmes elsewhere facing similar challenges. These factors included:

- Senior management recognising the problem and taking action to address it, becoming fully involved, including direct involvement of the Regional, Humanitarian and International Directors
- Unrestricted fund investment of c£500,000 annually to grow the programme, buy essential equipment, and invest in quality support
- A strong management team was recruited, and steps were successfully taken to build the management team and increase retention
- Systems and risk management. The progress on tightening management controls and reducing risk as tracked by successive audits (most recent January 08) is a significant achievement
- Externally, there have been some improvement in the context and relative improvements in security
- The building of a programme of appropriate scale and quality led to increased donor confidence and further growth

The progress made in the DRC programme would not have been possible without this level of (almost unprecedented) commitment from the organisation. Much has been achieved by the DRC team in growing an effective and influential programme that meaningfully touches the lives of hundreds of thousands of people each year.

As noted above, more leadership is needed to establish greater clarity and improved use of available resources to meet aspirations in an ambitious range of programme quality themes and programme learning. There were concerns voiced to the evaluation team about levels of support being offered to field teams from support functions such as finance and HR, and programme mainstreaming disciplines, but excluding support from the public health team.

Problematic team dynamics in some offices were brought to the evaluation team's attention during visits. After a period of much-needed stability and continuity in staffing, three out of the four Programme Managers (pivotal posts in managing large programmes and staffing groups) are new to Oxfam, and other key roles (HPM and PQLT roles) have had recent changes, or changes happening over the coming months. The successes of the last few years underline again the importance of competent, committed staff at every level. The coming period will need careful, hands-on management to support new post-holders and protect against avoidable problems in continuity. Everyone says that every time there's a staffing change but it has never been a problem due to the way we work and manage—still it can still be raised if you'd like to.

With the exception of CEPROSSAN, current partner options seem limited – not surprising given a context that has not proved favourable to emergent civil society actors. Whilst the policy of working with the local authorities seems effective and certainly well-intentioned, it is hard to see significant improvements in resourcing and capacity for the BCZS offices in the near future, and the exit strategy for this is not clear.

Four key areas emerged that were discussed at the debriefing workshop with staff in Goma and these have fed into the recommendations as set out below.

10. Main recommendations

- **Vision and strategy.** Oxfam DRC should re-define its future humanitarian vision and strategy for the coming 2-3 years, and set out intended scale, scope (including geographical) and capacity needs (Oxfam GB and partners). An essential component of this would be the development of location-specific contingency plans that identify response modalities and parameters. These should be signed-off in advance to enable swift decision-making and allocation of resources in the event that a new emergency response becomes necessary.

- **Programme quality**. In order to improve mainstreaming approaches and programme monitoring and learning, priority should be on:
    - "Demystifying" mainstreaming areas and translate these to clear objectives and activities, with simple indicators developed. There should be strengthened connectivity between the mainstreaming approaches, and between high-level strategy and project level objectives and activities in these areas. These should include development of improved advocacy objectives and activities at field level
    - Developing simple, useful systems to help field staff collect relevant information and monitor on a regular basis, supported by Goma advisors/coordinators
    - Considering simple mechanisms for improved cross programme learning

Further discussion and recommendations relating to the team will take place through the PQLT Review process.

- **Management and team dynamics.** The Country Management Team should assess how to best to achieve optimal support for staff (particularly PMs), improve communications and ensure Goma functions are more engaged and responsive to field office needs: this does require improved communications both ways

- **Working with Partners.** As part of the overall vision and strategy development, Oxfam DRC should undertake partner assessments for current and emerging partners and develop a clear longer-term partnership strategy with clear commitments and exit intentions. Consideration should be given to allocating increased multi-year, unrestricted resources to develop partner capacity and work on this is ongoing. (Limitations on unrestricted funding and high running costs for the programme will continue to make this challenging.)

11. Other learning points and issues for consideration

- A follow up visit by PHE specialist should take place to advise on technical feasibility of proposed schemes for the coming year.
- Technical Quality concerns were identified in advisory reports over the last year and need to be followed up on
- A sample of a structured partner capacity building plan will be offered by the PH advisor
- Given the contradictory feedback, it would be useful to resolve the debate on use of bio enzymes as latrine digesters, and the challenges and lessons learnt

implementing an emergency programme for IDPs embedded with host community populations)

- The more experienced programmes in Beni and Bunia could offer some useful learning to the newer programmes in the south (seconded technical staff from Beni have been used to good effect in the recent Goma responses). Equally, the "newer" programmes will no doubt also have useful experience to share.

Annex 1: Timeline

Time	Internal to Oxfam	External events
Pre 2004	Bunia programme starts Sept 2000	Laurent Kabila assassinated 2001
2004	Scaling up in Bunia programme Opening Beni programme	Transition government Massacres in Ituri
June		Insurrection Nkunda & Mutebutsi
2005	Massisi programme closed	
July	First member of PQL team recruited Assessments for programme expansion in Uvira/Ituri/N Kivu	
October	Problems with ECHO funding in Bunia	Constitutional Referendum
December	CPM leaves	Presidential Elections
2006	PQL team started up this year	
February	Country management team moves to Goma from Kinshasa (excl Education & PAC)	
March	Oxfam CMT decision on investing in DRC programme New CPM arrives Uvira programme started with Cat funding	Nkunda launches rebellion against government
April	Advocacy workshop & beginning of new advocacy work	
June		Cholera outbreak in Goma town June – October: 1st democratic elections (President & Parliament) process. Joseph Kabila elected.
September	New HPM recruited North Kivu evaluation Strategic planning meeting & County management team building	
October	"LEAD" logs training	IDP movements Massisi to Mugunga
2007		
January	1st Protection advisor begins	
February	1st Gender advisor begins Protection assessment	
March	Protection training begins	J-P Bemba leaves DRC
April	Evaluation Bunia programme	1st allocation Pooled Fund approved for Uvira
May	2 health zones added to Uvira programme 1st Protection advisor leaves	ECHO programme mixage
August - December		2nd application for Uvira Pooled Fund rejected Fighting in N Kivu escalates, government offensives
September	OXFAM intervention in Mugunga (Goma) camps begins	IDPs arrive at Mugunga (Goma)
October	Completion of water system in Bulengo camps	
November	PM appointed for Goma programme Internal Audit visit	Attacks on Mugunga camps, and Cholera outbreak
December	Strategic planning revisions and	6 month UNICEF finding for Uvira

	budgeting Logs coordinator changes	programme arrives
2008		
January	International Director visits New HPM arrives New PM in Uvira Suspended use of DRC commercial flights over safety concerns Country learning review on partnerships Sanitation activities in Mugunga	Warring parties sign peace process in Goma but fighting continues in Massisi & Rutshuru
February	CPM moves to Kinshasa New structure takes effect 2nd Protection advisor arrives Goma logs manager seconded to Kenya programme	Fighting affects programme in Getty CIDA funding approved for Uvira 08/09
March	PM Bunia resigns National logs workshop Goma Water supply completed Mugunga camps Crimson training	Oxfam America delegation visit 3 attacks on INGO vehicles in Uvira/Ruzizi
May	Departure of PQLT leader and PH advisor — interim PQLT leader and PH adviser in place	
June	Intended completion / phase out date in Mugunga camps	

Annex 2: Further health data collected in North Kivu (under 5s and over 5s)

[Figures Removed]

Annex 3: What our partners think

In consideration of the recently developed Oxfam Partnership Policy, in meetings with partners, the evaluation team discussed the policy and asked the partners for their views on how well we meet the principles set out. Partner staff were asked to give a rating out of 10, and their reasons why. Generally partners seemed to appreciate the opportunity to talk to the evaluation team about Oxfam's aspirations in partnership and give their judgements on how well the organisation lived up to them.

Partner's views: ASAF Goma

Profile: very small organisation, with one coordinator and most of the rest of staff working as volunteers. Working with Oxfam for less than a year on the water systems for two of the four camps for IDPs in Goma.

Principles	Rating (1-10)	Comments
Complementary purpose & added value	8	Extending system that we were running added real value along with pump options to improve supply and increase investment in staffing. Others just give money and don't think of real capacity building
Mutual respect for values & beliefs	10	Very positive. "We were afraid Oxfam would laugh at us as a small NGO but they were different and it was easy to be open"
Clarity on roles, responsibilities & decisions	8	Largely positive in first phase (needs – options – agreement on what to do & resources needed) but current phase has not been as clear
Transparency & accountability	8	Capable of financial transparency and availability of quick decision-making, but funds late in arriving sometimes for reimbursing IDP volunteers. Would welcome being accompanied for visits to local authorities to help strengthen our presence and credibility
Commitment & flexibility	10	Not just money but advice that's helped us improve and get a vision for the future, get beyond the previous short-term thinking. Sustainability checks in discussions eg ok, want a vehicle but how will you be able to pay for fuel?

Partner's views: BCZS Lemara office (Government health zone)

Profile: The Lemara Health Zone (similar to a district) is the government health authority responsible for around 140,000 people and working on a range of health activities including immunisation campaigns, primary & secondary health care and water, sanitation & public health. Health Zones are very reliant on UN and INGOs for funding and support, and current coverage for clean water is less than 30%. Oxfam has been working with this Health Zone in public health for the last two years.

Principles	Rating (1-10)	Comments
Complementary purpose & added value	8	Oxfam is a "good model" – from beginning identifying needs, planning activities and assessment all being done jointly with BCZS and communities. Complementary, greater than sum of parts, with human and material support provided. Felt sustainability and community relations were high. Financial arrangements are the main problem – see below. "Sorry if we seem focused on money but we receive virtually nothing from the government and are heavily reliant on the NGOs for support"
Mutual respect for values & beliefs	8	Honest and open, even during major vaccine campaign provided transport support even though it wasn't part of our arrangement. Nothing imposed.
Clarity on roles, responsibilities & decisions	9	Protocols and procedures and who does what are very clear

Transparency & accountability	6	Actually since you are a “donor” it’s BCZS that has to be accountable! Transparency is 8 but the finance procedures are cumbersome and slow, leaving us with problems (cash-flow)
Commitment & flexibility	5	Commitment is 8, staff in field and working closely with BCZS. But flexibility on logistics and finance procedures are not flexible with months of overdue payments so 5 rating (suggestions made on improvements)

Annex 4: Terms of Reference

PIP00195 DRC Humanitarian Programme Mid-Term Evaluation
Terms of Reference (Draft 20 February 2008)

1. Introduction

In response to the Humanitarian Crisis in Eastern DRC, Oxfam GB has been present in Eastern DRC since the 1960s. In May 2004 a Programme Implementation Plan (PIP P00195) was created, aiming to 'save lives and protect the health of people affected by conflict and natural disasters throughout DRC by focusing on preparedness, response, and protection issues' (extract from the PIP's short description). Initially (in May 2004) there were around 1.1 million IDPs in Eastern DRC. By 2006 there were an estimated 1.4 million people remaining displaced by ongoing conflict in DRC. Millions of others live in areas affected by endemic violence and affected by disease.

Since the start, this programme has been managed using the one-programme approach, including advocacy (under PIP P00204 and PIP 00362) as well as direct relief and longer-term public health interventions. Most of the advocacy efforts have been directed to MONUC, in order to extend their mandate to protect DRC civilians against violence, rape and forced labour.

The response to date has focused on immediate and medium-term needs for public health (water, hygiene and sanitation), NFIs, and has been bolstered by a team considering issues of programme quality (gender, HIV/AIDS, Protection, M&E, SPHERE). The response has targeted around 400,000 men and women directly. With a staff of 250 and a budget of GBP 8m over 4 years, the programme is implemented through 4 offices in eastern DRC (Goma, Beni, Bunia and Uvira) and 2 field bases in Ituri. 2 Local partners have assisted with the implementation of the programme in N-Kivu (PPSSP and Ceprossan).

At the end of 4 years of programming, OGB now plans to conduct an evaluation of the humanitarian programme (P00195), led by an external evaluation team, but very much aimed at learning lessons that help improving the quality and outputs of our own programming as well as the needs of the team and beneficiaries in Eastern DRC.

At the time of writing, interventions in Eastern DRC have already been a part of 7 separate project evaluations (of which 2 belonging to PIP00195), 1 evaluation workshop, several audits, and monitoring visits by regional and global advisers. The evaluations and audits are listed in Table 1 below.

Table 1: Evaluations and audits performed in DRC

YEAR	LOCATION	TYPE OF INTERVENTION	EVALUATOR	TYPE OF EVALUATION
1996	Goma camps	Public Health	Shona McKenzie	Mid-term project evaluation
2001	N-Kivu (Kirotshe and Mweso)	Hygiene Promotion	Rick Neal (OGB) N.M.Rugenge (Sarcaf) F.M. Wasso (Save the Children)	End of project evaluation
2001	Kinshasa	Public Health	Rick Neal Yvette Mulongo	Impact evaluation
2002	Goma	Public Health (after volcano eruption)	Yoma Winder Raphael Mutiko Suzanne Ferron	End of project evaluation
2002	N-Kivu (ZS Kirotshe, Masisi et Mweso) and Maniema (ZS Kindu et Kalima).	CGO442 Public Health	Michel Becks Sally Crook	End of project evaluation
2002	Kinshasa Mbuji Mayi	Public Health	Begay Jabang Kevin Rodd	Internal programme audit

2003	Kisangani	HECA46 Public Health	Jane Bean	End of project evaluation
2003	Ituri	DRCA34 Public Health	?	End of project evaluation. Report not available? Did this evaluation take place?
2003	Ituri	DRCA34 Public Health	?	External Audit. Report not available? Did this report take place?
2004	Ituri	DRCA37 Public Health	?	Report not available? Did this evaluation take place?
2006	Grand Nord (Beni)	DRCA59 Public Health	DRC PQLT	End of project evaluation
2007	Ituri (Bunia)	DRCA77 Public Health	DRC PQLT	End of project evaluation
2007	South Kivu (Uvira)	DRCA??, Public Health	DRC PQLT	2-day workshop with OGB and partners[2]
2007	Country Programme	-	Kami Pandhi Nicodemus Odhiambo Tessa Clayton Jeffrey Sipma	Internal audit

2. Purpose of the Evaluation

The purpose of the evaluation is to provide an insight into what is working within the programme and what is not with suitable and realistic recommendations to enhance the intervention.

The primary recipients of the evaluation will be the DRC programme staff and those directly involved in the implementation and/or management and support of the programme. As such, the evaluation team will need to ensure ownership is felt within the team, and that the language of the final report is accessible to its intended audience.

3. Evaluation Objectives

The overall objective of the evaluation is to assess how effectively we have progressed towards the stated impact and outcome objectives, as outlined in the Programme Implementation Plan (PIP) for the intervention (attached, Annex 1).

The long-term impact expected from the programme is that people in DRC will be less vulnerable to death and disease caused by conflict and natural disasters.

The expected outcomes are:

- Local communities are better prepared to assist conflict/disaster-affected people.
- Conflict/disaster-affected people have reduced health risks.
- Rights of conflict-affected people are better respected.

The evaluation team is asked to assess the results that have been achieved, *how* we reached them at this current period of time, as well as *what* we have achieved in terms of changes in beneficiaries' lives.

In sum, the objectives of the evaluation are:

1. To assess the progress that he programme has achieved to date, against intended impact and outcomes, and the internal processes and approaches which made those achievements possible;

[2] Field research could not take place because of evacuation.

2. To determine the hindering factors, internal and external, which have affected both progress and quality of the intervention;
3. To assess the efficiency, effectiveness, relevance, sustainability, coverage and coherence, as defined in Annex 2;
4. To assess the consideration given to (mainstreaming of) cross-cutting issues: the use of international standards; gender equality; protection; capacity building; advocacy; vulnerable and marginalised groups (see Annex 2);
5. To recommend changes in programming approaches, which will lead to more effective and accountable programme delivery in 2008 onwards.

4. Evaluation Methodology

The evaluation will begin with a briefing in Goma with country management and key support staff, and with a literature review of some key documents in shaping the programme over time. Further documentation will be available to the team on request throughout the course of the evaluation, as needed.

The majority of the review is to be based in the field, with at least 50% of the time of the evaluation team spent with beneficiaries, and partners where appropriate. The remainder of the time is to be spent in discussions with key internal and external stakeholders, such as Oxfam management and technical staff, local government officials, staff from health centres and schools in the target areas. Ideally, quantitative as well as qualitative data collection methods are used for effective triangulation of the results.

The coverage of the evaluation has to extend to 4 field sites (Goma, Beni, Bunia and Uvira). A total of 1.5 weeks needs to be assigned to fieldwork. A sampling framework at project sites will be drawn up in conjunction with PMs at each project site. Sampling needs to ensure discussions with women and men beneficiaries of NFI and public health interventions, across IDP camps and in returnee areas.

The evaluation team will adhere to Oxfam's Gender Standards in Humanitarian Response (particularly standards on monitoring and evaluation), SPHERE common standards 6 and 7 on monitoring and evaluation, and HAP-I principles on beneficiary consultation.

5. Team Specifications

The team requires the expertise of Oxfam GB staff external to the programme, and well experienced in conducting humanitarian evaluations. The team members need to be in equal balance of male to female. The support of the Humanitarian Programme Manager (HPM) DRC and the Programme Quality and Learning Team (PQLT) will be the key link into the DRC team for planning processes, and may partly accompany the evaluation team where required. One to two DRC programme staff members may also form a part of the evaluation team. All evaluation team members need to be sensitive to gender and diversity issues and commitment to humanitarian principles.

6. Timetable

Dates depend on the availability of the evaluation team, but should be planned preferably before the end of the financial year 2008. A proposed timetable is as follows:

Day 1-2:	Briefing, literature review, team planning and interviews with CMT members and support staff
Day 3:	Travel to field sites
Day 4-8:	Fieldwork
Day 9:	Travel back to Goma
Day 10:	Debrief in Goma
Day 11-14:	Report writing (either in Goma or elsewhere)

7. Outcomes

Expected outcomes from the evaluation are the following:

a. One evaluation report, of not more than 25 pages, containing one executive summary of not more than 3 pages, incorporating findings with regard to the objectives of the evaluation and clear recommendations.

b. One PowerPoint presentation on key evaluation findings, to be used at the Goma presentation, and to be available to Oxfam for further internal dissemination.

Guidelines for the evaluation report are attached in Annex 2 and 3.

8. Budget and Logistics

The budget for the evaluation will be provided from within the resources of the donor-funded projects under the humanitarian programme, and the Programme Quality and Learning budget. Approximate costs will be as follows:

Evaluation Budget (USD)		
Per diem evaluators	1,120	4 evaluators (internal to Oxfam but external to the programme)
International travel	5,000	2 from Oxford and 2 from Nairobi
Travel in DRC	1,200	internal flights and fuel
Community meetings	800	Refreshments, per diem, transport etc, as needed
TOTAL	**8,120**	

Annex 5: Feedback from debriefing workshop

Participants were asked to score (1 = poor to 5 = excellent) and comments on the following:

1. To what extent did the evaluation accurately capture findings?

			12	**1**

"Very realistic according to the general overview of the programme"

2. To what extent was the discussion useful in helping think through the future?

		1	**10**	**2**

"Senior management missing"
"Very good especially the results of group work on future/monitoring/support of staff"

3. To what extent did the evaluation team carry out the exercise in a way that worked for you?

		1	**10**	**2**

"No discussion with Goma support teams [eg finance] before debriefing workshop"

DOCUMENT ENDS

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This document was originally written for internal accountability and learning purposes, rather than for external publication. The information included was correct to the evaluator's best knowledge at the date the evaluation took place. The views expressed in this report are those of the author(s) and do not necessarily reflect Oxfam's views.

For further information on the issues raised in this document email phd@oxfam.org.uk

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