緊急人道支援活動における評価手法セミナー
（医療セクター）

ワークショップ

東京　2004年3月10～11日
主催：外務省、ジャパン・プラットフォーム

目　次

ワークショップ グループワーク A

Ms. Assefa による グループワークまとめ

Dr. Burkle, Jr. による Overview

Mr. Good による Overview

ワークショップ グループワーク B

Ms. Assefa による Overview

Dr. Burkle, Jr. による Overview

ワークショップグループワーク C

はじめに

ごあいさつ

外務省経済協力局民間援助支援室長　城所　卓雄

「緊急人道支援活動における評価手法セミナー」は、日本のNGOの専門性や組織能力の向上を目指した「外務省NGO活動環境整備支援事業」のひとつとして、平成15年度に初めて実施されました。

日本のNGOによる緊急人道支援活動については、平成12年のジャパン・プラットフォームの設立および翌年からの政府資金のマネープール拠出により、迅速な初動活動が可能となった他、その他NGOにおいても国際機関等との連携の経験を重ねることなどを通じて、着実にその規模や内容が発展しつつあり、最近ではアフガニスタン、イラク、イランなどにおける活動振りが記憶に新しいところです。

一方、一般的に緊急人道支援活動では、現地での各団体間の活動の調整やその約束のタイミングが難しい、安全確保をどう図るか、活動の評価が困難である、といった課題が指摘されていると承知しています。

今回のセミナーは、ジャパン・プラットフォームと外務省が初めて共同で開催したもので、豊富な経験・知見を持つ海外講師とともにスタンダードな評価手法を学び、事例演習を通して実際に評価を試みるワークショップと、国内外のパネリストを中心に広く緊急人道支援の課題について議論するシンポジウムにより構成されました。

この試みが、緊急人道支援活動に取り組んでおられるNGOや援助機関の関係者の方々にとって、国際的な取り組みの流れを学習するとともに、今後の支援のあり方を学ぶ有意義な機会となったことを期待します。また、これから緊急援助や国際協力活動に関わっていこうとしている方々にとっても、より一層その関心を高めていくための足がかりになったことを期待しています。

この報告書には、ワークショップで使用した海外講師によるテキストやシンポジウムの議事録など、参加された方々はもちろん、その他の多くの人々にも有効に役立てていただける資料が掲載されています。今後皆様が緊急人道支援や評価を考えていく上での一つの指針となれば幸いです。

最後に、本セミナーを開催するにあたってご尽力いただいた関係者、講師およびパネリストの皆様、後援団体である国際協力機構（JICA）、国際連合児童基金（ユニセフ）、財団法人三菱財団、財団法人庭野平和財団、また参加者の皆様に心より御礼申し上げます。

NGOにとっての最高の学びの場
―― 緊急人道支援活動における評価手法セミナー ――

ジャパン・プラットフォーム　評議員
中村　安秀（大阪大学大学院人間科学研究科）

ワークショップおよびシンポジウム「緊急人道支援活動における評価手法セミナー」は、ジャパン・プラットフォームと外務省が初めて共同主催した画期的なセミナーでした。緊急人道支援分野における国内関連NGOのキャパシティ・ビルディングを図るという目的をもち、本年は評価手法にテーマを絞り、現場でのニーズの高い保健医療という分野に焦点を当てました。

英語で行われたワークショップにおいては、講師の先生方から経験や知識を得るだけでなく、ジャパン・プラットフォームとして実施したNGO活動（ヨルダン、アフガニスタン、北イラク）に対して、ワークショップ参加者が評価デザインを作成しました。緊急人道支援にかかわるNGO、外務省、経団連、国連機関、大学や研究者、メディア、学生などが集うジャパン・プラットフォームという組織が、自分たちの活動を自分たちの手で評価しようとする試みでした。また、シンポジウム「緊急人道援助の課題」では、豊富な経験に裏打ちされた講演を受けて、6名のパネリストによる「セキュリティーの課題」「NGOと軍との協働」など、本音で熱い議論が交わされました。世界的にみても、解決されていない課題を抱えつつ、緊急人道援助の現場は動いていることを実感することができました。

このワークショップおよびシンポジウムに参加していただいた、Dr. Frederick M. Burkle, Jr.、Mr. Jim Good、Ms. Fitsum Assefa、喜多悦子氏、鵜飼卓氏他の講師の先生方およびパネリストの方々に厚く感謝するとともに、講師依頼やプログラムの作成などオーガナイザーとして大活躍していただいた神谷保彦氏（特定非営利活動法人HANDS）および勝間靖氏（ユニセフ駐日事務所）に感謝の意を表したいと思います。

今回のワークショップおよびシンポジウムを通じて、SPHEREプロジェクトの意義や人道支援活動の評価に関する継続的な勉強の必要性など、企画した私たち自身も多くのことを学ばせていただきました。今後も、緊急人道支援活動の評価に関心を持つ参加者同士のネットワークが継続し、今回の試みが日本のNGO活動の質的向上につながることを期待します。

プログラム

Workshop Time Schedule

10 March (Wed.)	Morning	Afternoon
	9:00 ~ 10:00 Registration **10:00 ~ 10:30** Opening Session • Welcome 5 min. from MOFA & JPF • Lectures & Participants Self-introduction 15 min. • Introduction 10 min. **10:30 ~ 12:30** 2 hr. Overview 1 by Mr. Jim Good "Evaluation in Humanitarian Response-Scope, Criteria, TOR, The Sphere Project, ALNAP" Questions & Answers	**15:30 ~ 15:00** 1 hr. 30 min. Overview 2 by Dr. F. M. Burkle, Jr. "Assessing Emergency Health Needs: Problems, Approach, Guideline" Questions & Answers **15:00 ~ 15:20** Break **15:20 ~ 16:50** 1 hr. 30 min. Overview 3 by Ms. Fitsum Assefa "Monitoring & Evaluation in UNICEF Health & Nutrition Program" Questions & Answers **16:50 ~ 18:00** • Explanation of group-work 5 min. • Presentation 15 min. x 3 1. HuMa_BHN_JEN Iraq-Jordan border Project 2. PWJ Northern Iraq Project 3. MeRU Afganistan Project
11 March (Thu.)	**10:00 ~ 12:30** Exercise / Group-work Task Making TOR of evaluation of the case projects Setting Objectives of Evaluation Identify Evaluation Criteria Address Evaluation Questions	**13:30 ~ 14:45** Group work continue and Preparation of presentation by summarizing the morning task **14:45 ~ 15:00** Break **15:00 ~ 16:15** Presentation by 3 groups Each 25 min. x 3 Presentation 15 min. Discussion 10 min. **16:15 ~ 16:30** Break **16:30 ~ 17:00** Wrap-up and summary By Jim Good with Dr. Burkle, Ma. Assefa

講師略歷

Frederick "Skip" M. Burkle, Jr., MD, MPH, FAAP, FACEP

Dr. Burkle is currently serving as Senior Scholar & Scientist, and Visiting Professor, The Center for International Emergency, Disaster & Refugee Studies, The Johns Hopkins Medical Institutes and the Schools of Medicine, and Hygiene & Public Health. From 2002-03 he served as Deputy Assistant Administrator for the Bureau of Global Health at USAID. From 1989 to 2000, he was Professor of Pediatrics, Surgery and Public Health and Chairman, Division of Emergency Medicine, Department of Surgery, University of Hawaii Schools of Medicine and Public Health. He is Adjunct Professor, The African Center for Strategic Studies, the Uniformed Services University of Health Sciences, and the Tulane University School of Public Health in New Orleans. He served as the Senior Advisor in Medicine and Public Health for the Defense Threat Reduction Agency and as a Research Scientist for the Centers for Disease Control and Prevention.

He is a graduate of Saint Michael's College (1961) and the University of Vermont College of Medicine (1965). Dr. Burkle holds post-graduate degrees from Yale, Harvard, Dartmouth, the University of California at Berkeley, and a Diploma from the University of Geneva, Switzerland, in Health Emergencies in Large Populations. He is qualified in Emergency Medicine, Pediatrics, Pediatric Emergency Medicine, and Psychiatry and holds a Master's Degree in Public Health. He is a Fellow of the American College of Emergency Physicians and the American Academy of Pediatrics, and received the Emergency Physician of the Year Award in 1999 from the Governor of Hawaii.

Dr. Burkle was the founder and Director of the Center of Excellence in Disaster Management and Humanitarian Assistance from 1994-2000 a World Health Organization (WHO) Collaborating Center for humanitarian civil-military cooperation, the only one so designated. The Center facilitates integrated military and civilian education, training and research in complex humanitarian emergencies.

Professor Burkle has published over 100 scientific articles, abstracts and book chapters, four books, two on disaster management including Disaster Medicine a sentinel text on the emergency response to disasters (1984). He has consulted on numerous humanitarian emergencies and large-scale international disasters in Asia, Africa and Eastern Europe and serves as an International Health Delegate to the Red Cross. He served as Joint Civil-Military Liaison for the Kurdish Crisis in southern Turkey, northern Iraq, and Baghdad, and again in the humanitarian crisis in Somalia where he also served as a UN Delegate to the 3rd Somalia Conference in Ethiopia. In 1996, he headed a global health assessment for the International Rescue Committee in the former Yugoslavia, Central Africa, and Pakistan and in 1999 was a member of the Presidential Delegation to Kosovo. In 2003 he served as the Senior Medical Officer in Iraq on the Disaster Assistance Response Team (DART) for the Office of Foreign Disaster Assistance, USAID. He also served as the Interim Minister of Health in Iraq during the relief phase of the crisis, and as Senior Advisor for WHO on Health Emergencies in Liberia.

Dr. Burkle has received numerous "Excellence in Teaching" and humanitarian service awards. These in-

clude the prestigious Gorgas Medal for "distinguished work in preventive medicine, groundbreaking work in disaster management and humanitarian assistance and the training of an entire generation of U.S. and international personnel," and the Cook Award for Humanitarian Service. He is a member of the Board of Directors of the International Rescue Committee, the world's largest refugee NGO, headquartered in New York City and was their Executive Medical Director in 1999.

A retired Captain in the U.S. Naval Reserve he completed combat tours in the Vietnam and Persian Gulf Wars with the 1st, 2nd and 3rd Marine Divisions and with the US Central Command in Somalia. His awards include the Bronze Star Medal with Combat "V" for valor (2 awards), Defense Meritorious Service Medal, Navy Commendation Medal, Army Commendation Medal, Combat Action Ribbon (2 awards), Joint Meritorious Unit Citation (2 awards), Vietnamese Cross of Gallantry, Vietnamese Meritorious Medical Medal, the Humanitarian Service Medal (2 awards) and the Military Outstanding Volunteer Service Medal.

Curriculum Vitae

Proposed Position: Disaster Management Consultant
Name of Firm: InterWorks, LLC
Name of Staff: James Patrick Good
Nationality: U.S.A.

Key Qualifications

Mr. James Patrick Good has 15 years of experience in the disaster management field. He has a successful record of designing, delivering training programs in emergency and disaster response for UN agencies, NGOs and national governments and has developed training modules, exercises and distance education materials in several disaster management topics. In the past 4 years, Mr. Good has been deeply involved with the ongoing development of the Sphere project (Humanitarian Charter and Minimum Standards in Disaster Response), in both the Shelter and Settlement technical sector as well as in the Common Standards development of the latest edition of the Sphere guidelines. He has also led several trainings in the Sphere technical sectors as well as Trainings of Trainers for the Sphere project.

Mr. Good has also specializes in the design and implementation of table top exercise, role plays, and emergency response simulations. He has designed interactive exercises related to storm and earthquake response, refugee influx, and civil-military coordination in response to humanitarian emergencies. Mr. Good is also a licensed Architect, and has participated in design and evaluation of several post-disaster shelter programmes and projects.

EDUCATION

Tulane University School of Architecture, New Orleans, LA 1976-1981 awarded Professional Architectural Degree (5 year program) in May 1981.

Professional Registration: Licensed and Registered Architect in the State of Wisconsin (1985)

EMPLOYMENT RECORD

Partner -InterWorks, Madison, WI (formerly Intertect Training Services)　1989-present

- Designed and facilitated Technical Sectors and Security for Field Staff Course for UNHCR e-Centre training program, 2004
- Designed and facilitated SPHERE Technical sectors Course for Red R Australia, March 2003

- Coaching of Sphere Extension Service for Afghanistan (SESA) staff, January 2003
- OFDA - DART Management Workshops — 2002 - 2004
- SPHERE workshop - Tokyo, Japan, - January 2002
- UNHCR Civil/Mil Coordination Exercise, Melbourne, Australia - December 2001
- SPHERE Training of Trainers Workshop - Washington, DC - November 2001
- UNHCR/E-Centre Hands On Workshop - Nagoya, Japan - October 2001
- UNHCR Contingency Planning - Abidjan, Cote d' Ivoire - September 2001
- UNHCR/E-Centre Training of Trainers - Kuala Lumpur, Malaysia - August 2001
- SPHERE workshop - Peshawar, Pakistan- August 2001
- Field Disaster Assessment Exercise for Save the Children - Leon, Nicaragua - June 2001
- Module author and trainer/facilitator for the Sphere Project - Training of Trainers Event in Geneva, May, 2000.
- Workshop Designer and Lead Facilitator for the Indonesian Emergency Management Workshop in Jakarta, Indonesia in August of 2000 (Sponsored by UNHCR and BAKORNAS)
- Project consultant for the formation of a National disaster management working group and for the preparation of a national disaster preparedness plan for Kazakhstan, UNDP, 1998-1999.
- Shelter specialist for USAID/BHR/OFDA DART (Disaster Assistance Response Team) in Kosovo, designed humanitarian programming for USG emergency shelter response, material requirements and initial programme logistics, (Summer/Fall 1999.)
- Facilitator and designer, Partnership for Peace complex emergency simulation for peacekeepers, 1998.
- Designed and facilitated the Advanced Emergency Management Seminar (AEMS) for UNHCR Country Representatives, 1998.
- Findings and Recommendations for the 1994-1995 Heating Season Energy Crisis in Mongolia - Preparedness and Response Strategies for USAID/OFDA
- Co-author of the training module Emergency Migration Management on the topics of Early Warning and Program Implementation, for IOM (1994)
- An Assessment of the Dhamar Self-Help Reconstruction Program in the Republic of Yemen, USAID/OFDA
- Madagascar: Training for Safer Construction after Cyclone Kamisy, USAID/OFDA
- Mission Specialist, OFDA Winter Emergency Preparedness Assessment for Mongolia, (1994)
- Development of criteria and terms of reference for Armenia Winter Emergency Preparedness Assessment team for IOM (1993)
- Team Leader - Disaster Preparedness and fuel crisis assessment mission- Mongolia, for USAID, (1992)

Project Architect, University of Wisconsin, Madison, Wisconsin,　1985-1988

Design and construction specialist, Mr. Good designed new and remodeled spaces for University of Wisconsin. He prepared bidding documents and oversaw construction of building projects on and off campus.

Planner, Provincial Development Office, Philippines, (US. Peace Corps)　1982-1984

Mr. Good was a U.S. Peace Corps volunteer assigned to the Office for Local Development and Administration, Siquijor Province, Philippines. He developed local disaster reconstruction plans following a major typhoon, and designed and managed other provincial construction projects in the public sector.

Draftsman, Barron & Toups Architects, New Orleans, Louisiana,　1981-1982

Mr. Good was a draftsman for residential and small commercial architectural projects.

LANGUAGES

English — native, Russian: speaking (fair), reading (fair), Visayan (Philippines): speaking (fair), reading (fair)

Fitsum Assefa **UNICEF Afghanistan** — Kabul, Mobile +93-702-88363

Education

- MSc (Human Nutrition and Metabolism) University of Aberdeen, Scotland, September 1997.
- Post graduate diploma in Maternal and Child Nutrition (with Honor); International Agricultural Centre, Wageningen, The Netherlands, June 1994
- Certificate in Health Emergencies Preparation; Medicines Sans Frontiers - Holland, Amsterdam, The Netherlands, July 1994
- Diploma in Home Science and Technology (with Distinction); Addis Ababa University, Awassa College of Agriculture, Ethiopia, July 1988

Professional Experiences

Project officer- Micronutrient s, UNICEF, Kabul, Afghanistan

- Led the development of national plan and stratagy for micronutirent interventions, in conjanction with MOH
- Led the the implementation of universal salt iodization project, in partnership with private sector and various ministries.
- Support MOH in coordnating micronutrient related activities thughout the contry.
- Supprt to MOH in developing nutriton policy, protocols and guidelines.
- Assist in capacity building of MOH nutriton department staff on various nutrition isses (assesment, planing, implenatation and M & E of nutrition interventions)
- Managing a national micronutrient survey
- Supported and led various rapid health and nutrition assesments

Nutrition/food Security Advisor, Emergency Response Unit, SCF/USA — Washington DC, May 2000 — June 2002

- Technical support to SCF/US emergency food/nutrition programs, in various countries, field works included Ethiopia, Afghanistan, and Mozambique.
- Development of strategy to strengthen the agencyÅfs capacity for emergency nutrition/food security interventions
- Food security/nutrition surveys/monitoring and program development in Ethiopia/Somali region, Afghanistan and Mozambique
- Evaluation of Therapeutic (TFP) and Supplementary feeding programs (SFP) and development of sim-

plified TFP/SFP guidelines and procedures based on best practice international guidelines and on job training of staff in implementing these recommendations.

Consultant Nutritionist, Médicins Sans Frontières - Holland, West Timor and East Timor, March 2000-May 200

- Evaluation of the emergency health and nutrition intervention for East Timories refugees (Kefa district-West Timor)
- Development of a medium/long term strategies for treating severely malnourished children through existing health facilities in East Timor.

Food and Nutrition Officer, Policy Unit, Concern Worldwide, Dublin, Ireland, May 1998 — November 1999

- Assisted in the implementation of the organizational strategic plan with respect to developing nutrition as a core competency.
- Oversee assignment as a member of the Rapid Deployment Unit (RDU) for emergency response of Concern worldwide; Food security/nutrition assessment in Ethiopia, Setting up livelihood monitoring systems in Cambodia, nutrition program evaluation and development of medium/long term strategy for Concern Bangladesh, emergency needs assessment and design of rehabilitation facilities for Burundian Refugees in transit to permanent camps in Tanzania and team member in the initial country assessment/program design and implementation of Concern's Southern Sudan emergency interventions during the 1998 crisis.

Nutritionist, Medicins Sans Frontiers — Holland, Jalalabad, Afghanistan, November 1995 — May 1996

- Conducted four food security/nutrition survey in IDP camps and resident urban/rural population in Jalalabad province
- Evaluation of MSF-H nutrition interventions and designed phase-out strategy for selective feeding programs.

Project coordinator/Nutritionist, Médecins Sans Frontières - Holland, Wollayita, Ethiopia, March 1995 — October 1995

- Overall responsibility for the design, planning and implementation of MSF-Holland Ofa project; budget management, technical support to project staff, representation of the agency with government and other NGOs, preparation of monthly internal and external project reports, selection and recruitment of project staff and direct supervision of 4 senior project staff members: nutritional team leader, medical team leader, logistician and administrator of the project (both national and international staff).

Consultant Nutritionist, Médecins Sans Frontières - Holland, Addis Ababa, Ethiopia, February 1995 — March 1995

- Team Leader for a food security/nutrition assessment conducted in collaboration with the national Relief and Rehabilitation Committee (RRC) in famine affected districts of south west Ethiopia.

Nutritionist, MSF-Holland, Liberia, August 1994 — December 1994

- Food security/nutrition/vaccination coverage survey and rapid assessments in IDP camps and monitoring of the general food and nutrition situation in the project area.
- Technical support (guidelines) and supervision of supplementary feeding centers.

Nutritionist, Médecins Sans Frontières — Holland, Ogaden, Ethiopia, June 1992 — December 1993

- Assistance to an expatriate nutritionist in setting up, supervising, evaluating and monitoring large scale therapeutic and supplementary feeding programs in three refugee/returnee camps.
- Daily management of feeding centers/programs in one of the three camps, and supervision of about fifty local employees and local volunteers.
- Performed a number of nutritional and vaccination coverage surveys, analyzed and presented results together with an expatriate nutritionist as well as independently.

Assistant Nutritionist, American Joint Distribution Committee, Addis Ababa, Ethiopia, December 1990 — June 1991

- Conducted nutrition/health education and demonstrations to an average of 40 mothers participating in the program daily.
- Managed the case work of the severely malnourished mothers and children, making referrals to physician when needed.

Publications

- Author: Malnutrition and Mortality in Kohistan District, Afghanistan, April 2001: JAMA, December 5th, 2001
- Co-author: Malnutrition, Measles, Mortality and the Humanitarian Response during a famine in Ethiopia. Journal of American Medical Association (JAMA), August 1, 2001.
- Scurvy outbreak and erosion of livelihoods masked by low wasting levels in drought-affected Northern Afghanistan, ENN, Issue#13, and August 2001.
- The Use of BP-5 Biscuits in Supplementary Feeding Programs, ENN, Issue 2, August 1997

Teaching and Training experience

- Training for Improved Practice: Public Health and Nutrition In Emergencies, UNICEF Core Corporate Commitments Training in collaboration with Tufts University, Columbia University and Center for Disease Control, Katmandu June 2003.

- Public health in complex emergencies, Colombia university- New York, July 2001, Ghana-Accra: thought the two days nutrition module.

- International Diploma in Humanitarian Assistance, Royal College of Surgeons, Dublin, Ireland, 1999: Meeting the nutritional needs of the vulnerable in Emergencies, monitoring and follow up of malnourished individuals and monitoring effectiveness and efficiency of nutrition interventions.

- APSO: Nutritional interventions in emergencies, food and livelihood security, and 1999.

出席者リスト

No.		敬称	姓	名	所属機関／社名
講　師		Dr.	Burkle, Jr.,	Frederick M.	Johns Hopkins Medical Institutes and Schools of Medicine
		Mr.	Good,	James P.	InterWork SLLC
		Ms.	Assefa,	Fitsum	UNICEF
コーディネータ		Dr.	勝間	靖	UNICEF
		Dr.	神谷	保彦	Health and Development Service
司　会		Ms.	山本	理夏	ピース　ウィンズ・ジャパン
出席者	1	Ms.	大谷	敬子	国境なき医師団日本
	2	Mr.	大友	仁	内閣
	3	Ms.	川井	理恵子	国境なき医師団日本
	4	Ms.	木村	陽子	インターナショナルSOSジャパン
	5	Ms.	工藤	ちひろ	アムダ
	6	Ms.	斎藤	由樹	ピース ウィンズ・ジャパン
	7	Mr.	坂田	英樹	独立行政法人国際協力機構
	8	Ms.	杉野	正枝	国境なき医師団日本
	9	Ms.	鈴木	瑛子	東京国際大学
	10	Ms.	高井	史代	IDCJ
	11	Ms.	田中	亜新	信州大学医学部(学生)
	12	Mr.	田渕	俊次	佐賀医科大学
	13	Ms.	東梅	久子	なし
	14	Dr.	仲佐	保	国立国際医療センター
	15	Mr.	中根	誠人	独立行政法人国際協力機構
	16	Ms.	西山	綾子	国立国際医療センター研究所
	17	Ms.	野口	瑞恵	ネットワーク地球村
	18	Ms.	橋本	明朱花	NPO 2050
	19	Mr.	長谷川	淳	なし
	20	Mr.	原田	勝弘	日経新聞社
	21	Ms.	原田	靖子	ピース　ウィンズ・ジャパン
	22	Ms.	松本	直美	なし
	23	Ms.	三木	照	セーブ・ザ・チルドレン・ジャパン
	24	Ms.	宮薗	夏美	鹿児島大学
	25	Ms.	山本	朋子	なし
	26	Ms.	林	晴実	香日向クリニック

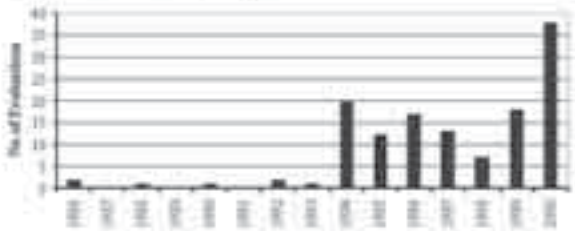
Overview

Overview 1（James P. Good）

JAPAN PLATFORM

Evaluation of Humanitarian Response

The evaluation field is a "growth industry".



From the ALNAP Annual Review 2001
Humanitarian Action: Learning from Evaluation

E A QUICK OVERVIEW…

- Evaluation is extremely important…if you make it so.
- Almost all projects should be planned and budgeted from the beginning to include and facilitate evaluation
- Serious evaluators must focus on 6 key things:
  - •End-Use
  - •Scope
  - •Depth
  - •Bias
  - •Causality
  - •Tools & Methods
- Professional evaluators are familiar with Sphere & ALNAP… you should be familiar with them too.

End-Use

Why is this evaluation being done?
Who will use it?
For what purpose?

Scope

What questions will you answer?
How much time will you spend?
How far do you go?

Depth

How far do you go? How much detail do you collect? How long will it take and how much do you spend to find out?

How much should you spend?

"While information on the overall level of resources devoted to evaluation of humanitarian action is not readily available, evidence from a benchmarking study, being undertaken by the ICRC at time of publication, is indicating that humanitarian agencies devote on average the equivalent of 0.5% of their humanitarian action expenditure to inspection, audit and evaluation activities"

From the ALNAP Annual Review 2001
Humanitarian Action: Learning from Evaluation

Causality

How can you prove that your program or project is responsible for any improvements in the overall situation?

Take the "Quick Evaluation Quiz" on page 13 of your workshop guide.

Bias

How will your evaluation address the problem of bias?

See pages ⑥ & ⑦ for examples of different types of evaluation bias

Tools/Methods

TOP – Left :Participatory Evaluation of Agricultural Technologies, Right: Focus group consultation

BOTTOM - Participatory evaluation with local villagers of low-cost road, water supply, small-scale irrigation and school projects in Cambodia for UNDP.

KEY TERMS

Please see pages 4 And 5 in the workshop notes

- Efficiency
- Effectiveness
- Impact
- Relevance/Appropriateness
- Coverage
- Sustainability/Connectedness
- Coordination
- Protection
- Coherence

Methods and Limitations

please see page 7

- Key Informant Interviews
- Focus Group Interviews
- Community Interviews
- Informal or mini- Surveys
- Direct Observation

Always Include Beneficiaries in Every Evaluation

- Resist the top down pressures - move accountability of staff downwards
- Beneficiaries have a right to participate
- Beneficiaries (and non-beneficiaries) can be the richest sources of information
- Find them and test assumptions

ESSENTIAL ELEMENTS OF EVALUATION REPORT

- Executive summary
- Introduction
- Project relevance
- Efficiency
- Effectiveness
- Impact of project
- Sustainability/connectedness
- Lessons learned
- Conclusions
- Recommendations
- Annexes

QUESTIONS?

Two more things you should know about...

SPHERE

ALNAP

April 1994 - Rwanda Genocide

1994 - Summer - IFRC/NGO Code of Conduct
1994 - Winter - Rwanda Multi-Donor Evaluation Study Begun
1996 - Study findings published
1997 - Sphere initiative started
1997 – ALNAP initiative started
1998 - Sphere First Edition, 2000 - Second Edition
2004 - 2004 Edition

Those involved....

- 1 representative from each agency of the Steering Committee for Humanitarian Response (SCHR) : CARE International, Caritas Internationalis, ICRC, International Federation of Red Cross and Red Crescent Societies, Save the Children UK, Lutheran World Federation, ACT, OXFAM GB, World Council of Churches,

- 2 representatives from InterAction: Interaction, Mercy Corps

- 1 representative from each organization with consultancy status: VOICE, ICVA

What they produced.....

- A rights - based approach
- The Humanitarian Charter
- 5 Chapters
  - Standards
  - Indicators
  - Guidance Notes

Real evaluation can lead to real improvement!

STRUCTURE

- The Humanitarian Charter
- Minimum Standards Common to All Sectors
- Minimum Standards in Water, Sanitation and Hygiene Promotion
- Minimum Standards in Food Security, Nutrition and Food Aid
- Minimum Standards in Shelter, Settlement, and Non-Food Items
- Minimum Standards in Health Services
- The Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief

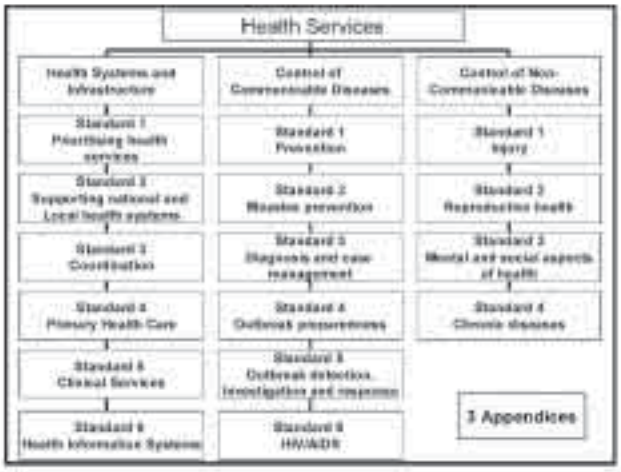
SPHERE AND EVALUATION

Common standard 6: evaluation

There is a systematic and impartial examination of humanitarian action, intended to draw lessons to improve practice and policy and to enhance accountability

Key indicators:

- The programme is evaluated with reference to stated objectives and agreed minimum standards to measure its overall appropriateness, efficiency, coverage, coherence, and impact on the affected population
- Evaluations take account the views and opinions of the affected population, as well as the host community if different
- The collection of information for evaluation purposes is independent and impartial
- The results of each evaluation exercise are used to improve future practice



ALNAP

www.alnap.org

ALNAP DEFINITION OF EVALUATION

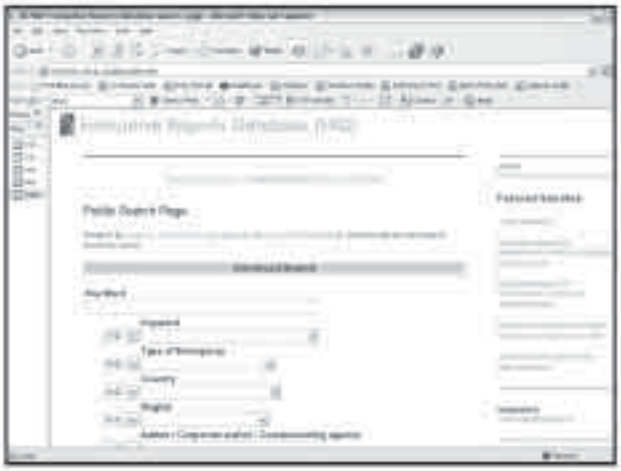
"A systematic and impartial examination of humanitarian action intended to draw lessons to improve policy and practice, and enhance accountability. It has the following characteristics:

i). it is commissioned by or in cooperation with the organization(s) whose performance is being evaluated;

ii). it is undertaken either by a team of non-employees or by a mixed team of non-employees and employees from the commissioning organization and/or the organization being evaluated;

iii). it assesses policy and/or practice against recognized criteria (eg. efficiency, effectiveness/timeliness/coordination, impact, connectedness, relevance/appropriateness, coverage, coherence and as appropriate, protection); and,

iv). it articulates findings, draws conclusions and makes recommendations."



ANY QUESTIONS ABOUT SPHERE OR ALNAP?

ETHICAL CONSIDERATIONS

- Have you ever faced any of the ethical situations described on page XX? What did you do, or what would you do in each case?

Cultural Intrusion, Anonymity/confidentiality, Individual responsibilities, Participation/privacy, Fundamental values, Omissions and wrongdoings, Evaluations of individuals, Disclosure, Integrity

PROBLEM 1

You are in Peshawar, Pakistan to evaluate a health programme in the refugee camps nearby. Your team all arrived last night from Tokyo. One member of your evaluation team (from another agency) is inappropriately dressed to visit a refugee camp on the Pakistan/Afghan border - (tight blue jeans and short sleeve t-shirt). She demands to go together with the team to the site, and has not brought any other suitable clothing from Japan. What do you do?

PROBLEM 2

You are visiting the camp, and were just told by a local nurse that some of the medical supplies are being stolen and sold in the market by one of the doctors. She confided this information to you, but begged you not to use her name for fear of reprisals from the doctor. What do you do?

PROBLEM 3

In preparing your report, you and another team member cannot agree on one finding in particular. You both strongly believe you are right, and the other is wrong. The report must be completed tomorrow. What do you do?

PROBLEM 4

You are in the country for a very limited time only to complete your evaluation mission, and have come all the way from Japan. You realize after you have landed in the capital city, that all of the offices are very busy preparing next year's budget, and in addition, staff are working overtime trying to relocate the programme to a new building after and bomb attack on the old compound yesterday. No seems to have time to talk to you. What do you do?

PROBLEM 5

You are visiting camps in a tribal area and want to talk to women in the area about food preparation and cooking issues related to a food and firewood programme. When you meet with the local village head, he explains that women from his tribe are not allowed to talk to "outsiders". What do you do?

PROBLEM 6

After reviewing the records of the warehouse where your shelter materials are being stored, you believe that someone is stealing the supplies and falsifying the distribution reports. If you make the report public, local workers in the warehouse may be taken by the local police and beaten, imprisoned , or worse. What do you do?

PROBLEM 7

You have been evaluating a social services project designed to help vulnerable groups in a refugee camp. You have interviewed many people, both beneficiaries as well as key staff members. All interviews indicate that the entire programme is performing poorly because of the actions of one person alone – the project director at the field office. No one likes him, and everyone you meet begs you to include his shortcomings in your report. What do you do?

PROBLEM 8

You just completed an internal evaluation of a large food distribution programme in Africa in a country suffering from a devastating drought. You learned that there was widespread corruption in the food delivery system and that some staff of your own organization are responsible. You have included all of this information in your report and have submitted it to the local office who commissioned the evaluation report. You are afraid that the report will not be sent to the higher headquarters, and that the problems will not be corrected locally. What do you do?

PROBLEM 9

You submitted your report in draft form to the local office in the field yesterday. The head of the local office just now asked you to change your findings so that his project will look better in the report. You are scheduled to leave for Japan tomorrow. What do you do?

Conclusions on ethics and evaluation ?

THANK YOU

Overview 2 (Frederick M. Burcle, Jr.)

Health Program Evaluation

- Success dependent on ASSESSMENT
- Assessment done poorly, incomplete
- Inappropriate indicators
- Program does not pay attention to results of assessment
- Poor management
- Poor coordination

The Basic Objective of an emergency program is to reduce excess mortality and morbidity

The Basic Goal of an emergency health assessment is to identify the health effects of the disaster, the most vulnerable populations, and determine priority needs

Direct Effects

- Injuries/Illness
- Deaths
- Human rights abuses
- International Humanitarian Law abuses
- Psychological stress
- Disabilities

Indirect Effects

- Population displacement
- Disruption of food
- Destroyed health facilities
- Destroyed public health infrastructure

TYPES OF INTERNATIONAL DISASTERS

- NATURAL
- TECHNOLOGICAL
- HUMAN-GENERATED

COMPLEX EMERGENCIES

- Internal war & conflicts
- Primarily civilian victims
- Many internally displaced (IDPs) & refugee populations
- Majority of mortality & morbidity result from indirect effects

---

At least three epidemiological models of complex emergencies exist:

Developing country model

(e.g., Congo, Somalia, Afghanistan, Liberia, Timor)

Chronic or Smoldering country model

(e.g., Sudan, Haiti)

Developed country model

(e.g., Former Yugoslavia, Macedonia)

What differs with each model is the existing baseline capacity of a country to respond to a health disaster

Similar risks and vulnerabilities occur within each model whether the disaster is human generated, natural, or technological

---

What is the baseline capacity in a developed country model?

Problem : Managers and health specialists do not adequately understand the overall health situation of large, moving or displaced populations.

Curative, clinical care is believed by many to be the first and dominant priority in all emergencies. It's not. Rarely is it even a high priority.

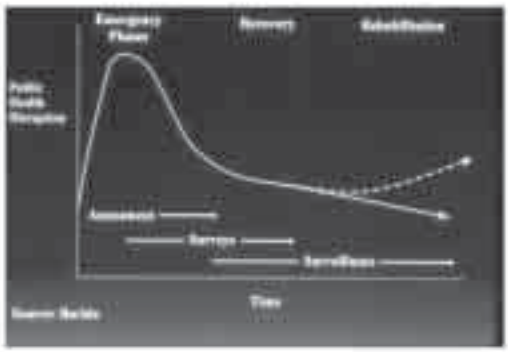
Sphere recommendations

Analysis Standard #1

*The initial **assessment** determines as accurately as possible the health effects of a disaster, identifies the health needs and establishes priorities for health programming."*

Assessments represent a sequence of events

- First: Rapid assessment
- Second: Surveys
- Third: Surveillance



MALNUTRITION

- Best to understand malnutrition as PROTEIN ENERGY MALNUTRITION (PEM)
- 3 Elements:

1. Malnutrition
2. Micronutrient deficiencies
3. Secondary infections

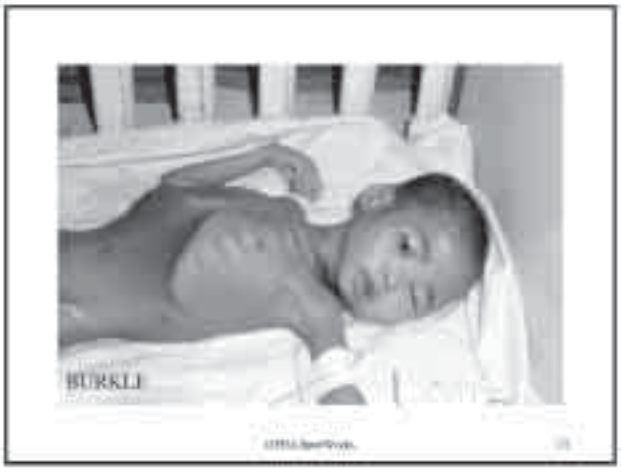
ASSESSMENT

MALNUTRITION:

- Do you have malnutrition in the population?
- If so, how severe?
- Is this acute or chronic?

MEASUREMENT

- Mid-upper arm circumference (MUAC)
- Weight/height
- Z-Scores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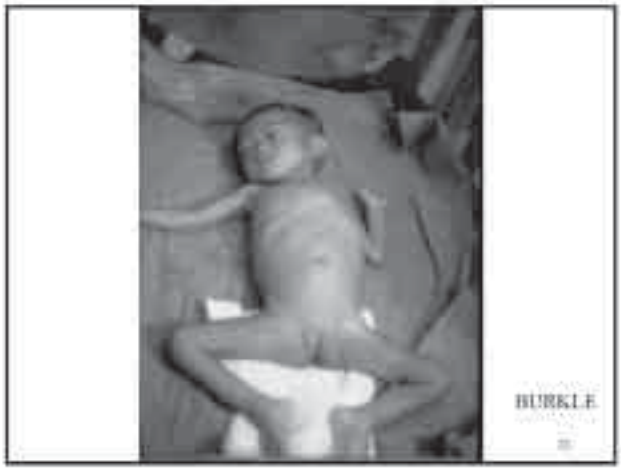
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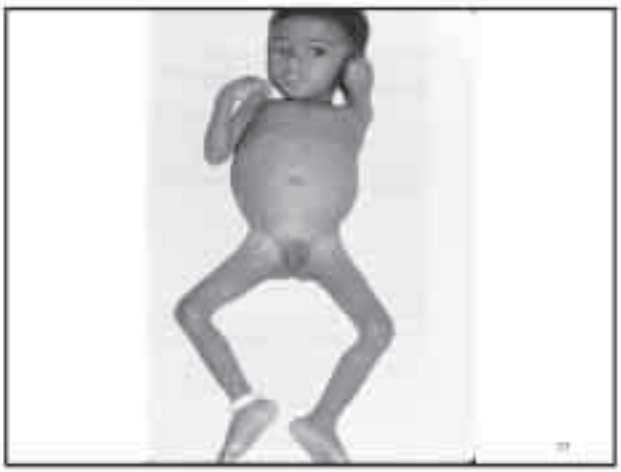
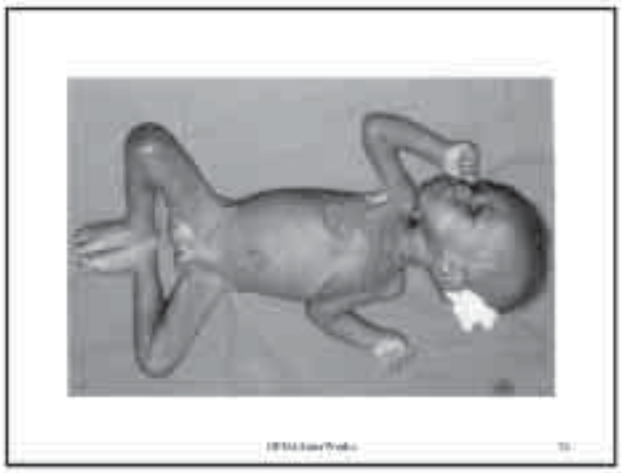
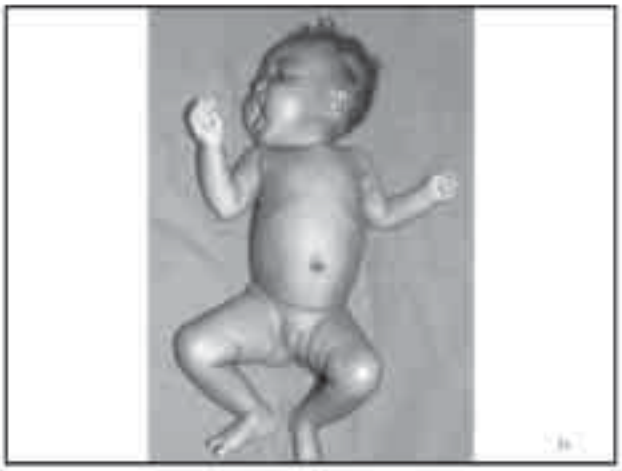
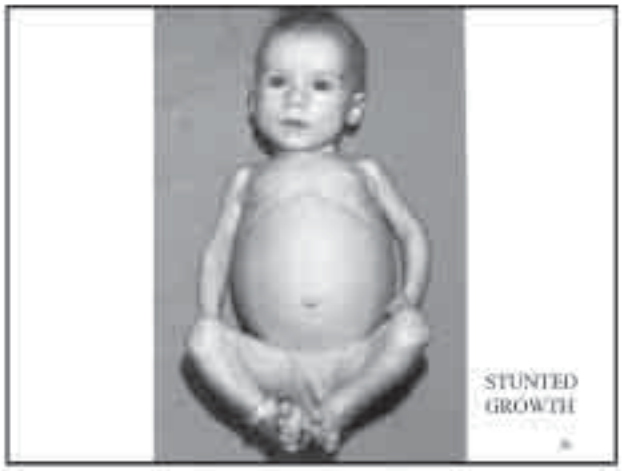
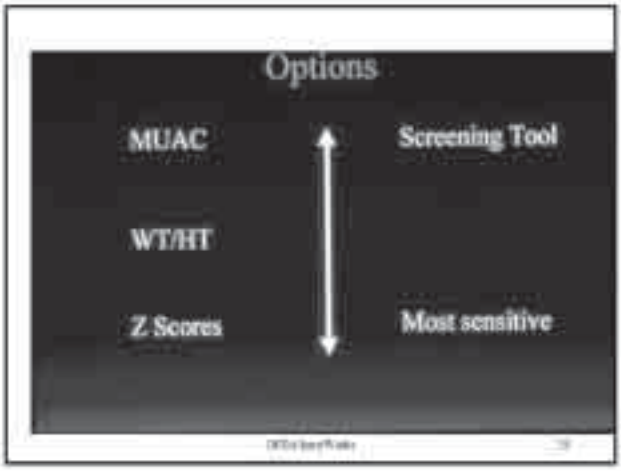







STUNTED
GROWTH


BURKLE


Options
MUAC
WT/HT
Z Scores
Screening Tool
Most sensitive


Preventing Malnutrition and Reducing Health Risks
Adequate general food ration and distribution system, cooking utensils, firewood...

MICRONUTRIENT DISEASES

Assume:

- Vitamin A
- Vitamin C
- Vitamin B6

Correct for region: for example zinc and iodine

MALNUTRITION & SECONDARY INFECTIONS

- All have greater risk of secondary infections
- Assume they have a hidden infection
- Vitamin A dependent infection process is universal

QUESTION:

Of the many malnourished children in Somalia, what did they most commonly die from?

Infant Mortality/Morbidity: Characteristics

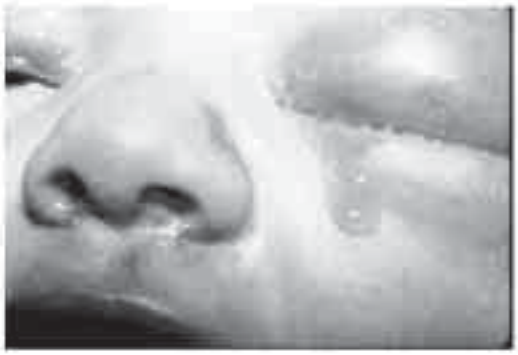
Kurdish Crisis	Somalia	Rwanda
- dehydration - common pathogens	- starvation - measles	- dehydration - cholera/ dysentery

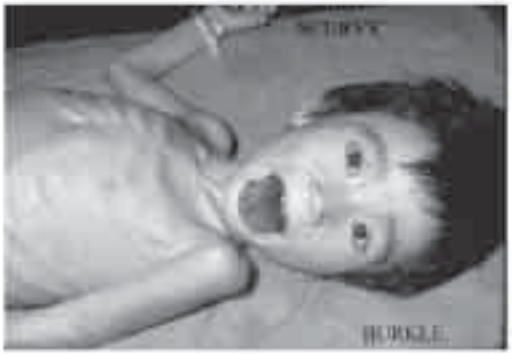
Prevention of Measles

Immunization of all children 6 months - 12/15 years

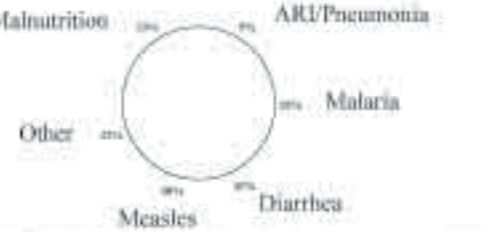
Distribution of vitamin A

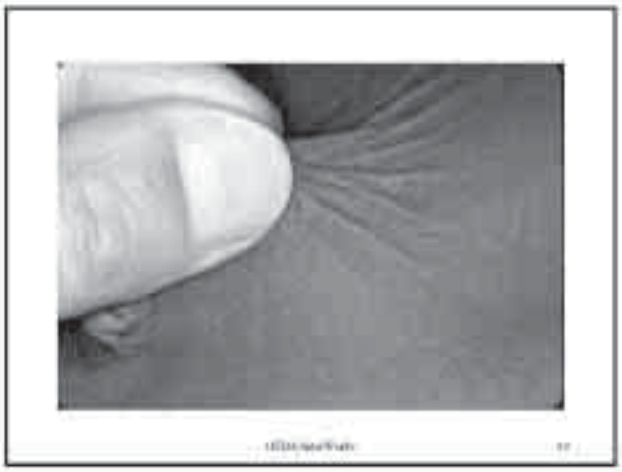
- Medical Supplies
  - Measles vaccine for all children 6 months – 12 years: equals 1 cent/dose
  - Vitamin A: For mass campaign 6 mo – 1 yr receive 100,000 IU, 1 yr & older receive 200,000 IU
  - WHO New Emergency Health Kits: 1 kit/10,000 for 3 months

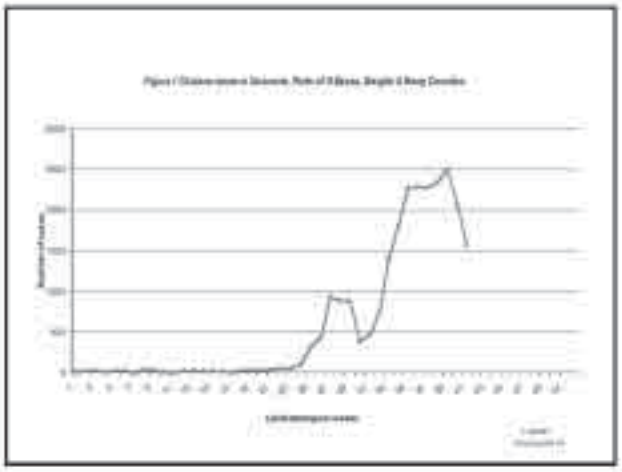


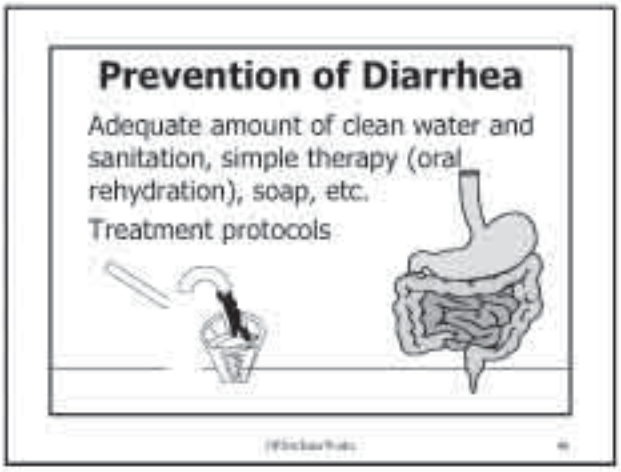


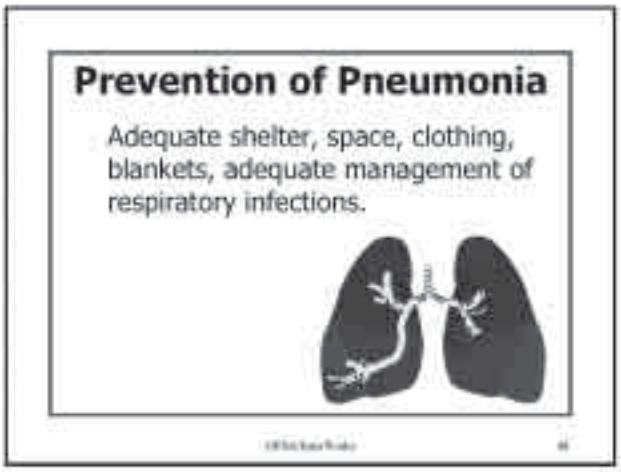
PROBLEM : Disaster affected populations, especially children in displaced populations, are particularly susceptible to five killer diseases

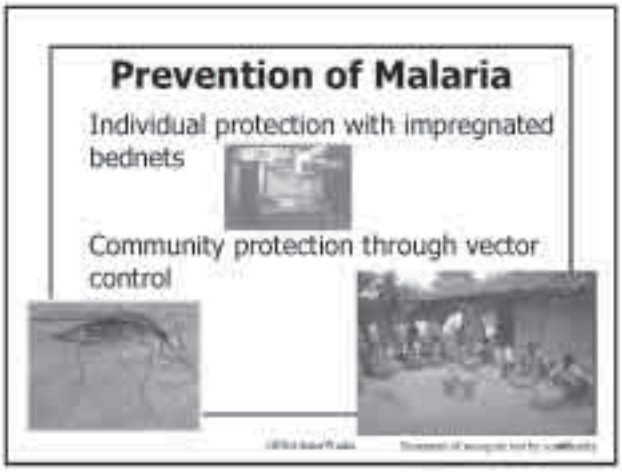







Prevention of Diarrhea
Adequate amount of clean water and sanitation, simple therapy (oral rehydration), soap, etc.
Treatment protocols


Prevention of Pneumonia
Adequate shelter, space, clothing, blankets, adequate management of respiratory infections.


Prevention of Malaria
Individual protection with impregnated bednets
Community protection through vector control

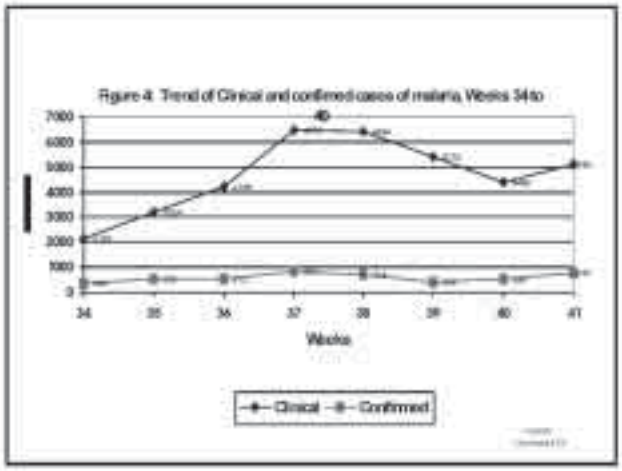
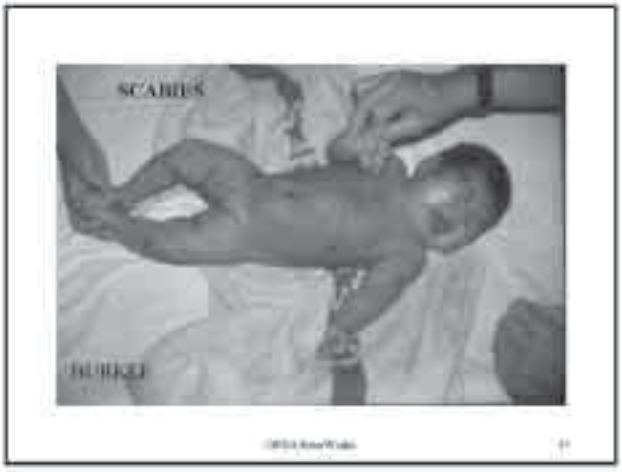
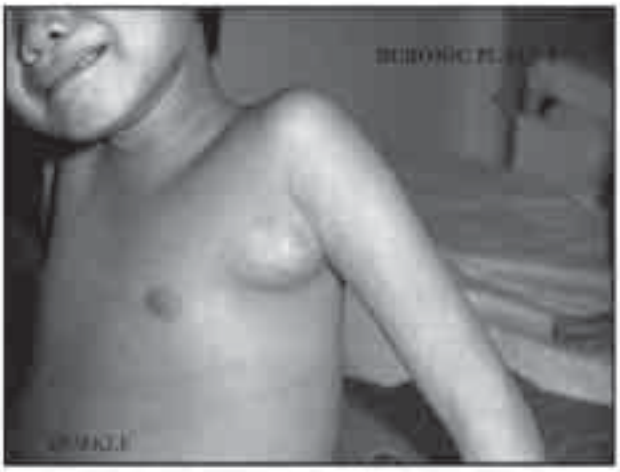


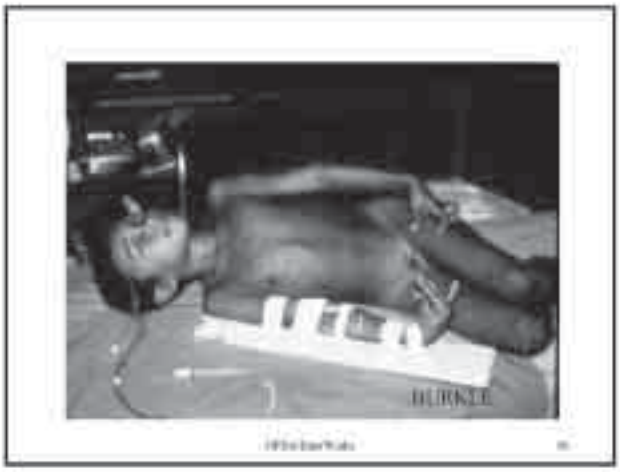
Figure 4: Trend of Clinical and confirmed cases of malaria, Weeks 34to
Weeks
Clinical
Confirmed


A MINOR INFECTION WILL KILL ME?!


SCABIES


SCABIES & IMPETIGO

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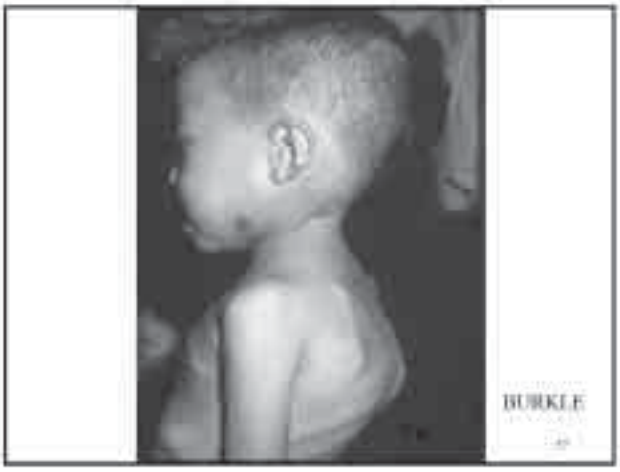
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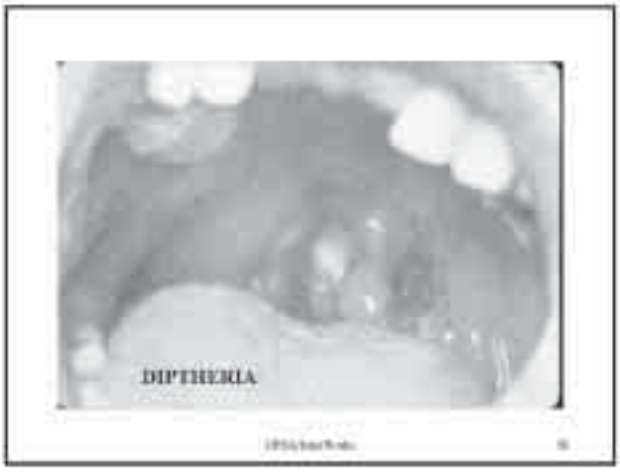
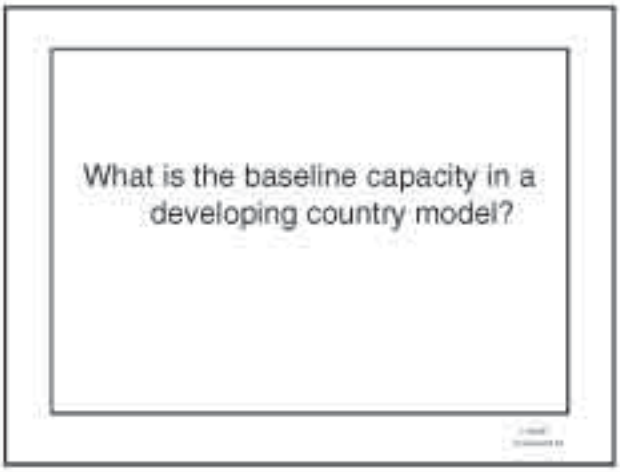

DIPTHERIA


What is the baseline capacity in a developing country model?


BURKLE

Effects of War on Birth Statistics in a Developed Country

Sarajevo (Kosevo Hospital): WHO Data

Issue	Pre-War	War
Infant Mortality	15.8 per 1000	26.9 per 1000
Still Births	7.5 per 1000	12.5 per 1000
Premature Births	5-6%	12%
Serious Malformations	0.25%	0.75%

VULNERABLE POPULATIONS

- Traditionally: Women, children, elderly, disabled
- Assessment must be sensitive and inclusive enough to recognize hidden vulnerability
- Examples: Unaccompanied/orphaned children, malnutrition in elderly, abused/raped women, refugees from high altitude, malaria free environments

Problem : Lack of consultation with the refugee population—and women in particular—results in health services not reaching those in need and corresponding negative health consequences

DEMOGRAPHICS of the POPULATION

Reproductive Health includes:

- Safe motherhood, including emergency obstetric care
- Sexual and gender-based violence prevention & response
- Prevention and care of STDs/HIV
- Family planning

UNACCOMPANIED MINORS/ORPHANS

SOMALIA: 100,000; RWANDA: 30,000

BURKLE

BURKLE

BURKLE

Problem : Other key sectors are not adequately addressed, resulting in serious public health threats, ultimately requiring curative health response

Assessments must be multi-disciplinary

- Must consider: Access and availability to health services
- Must consider: Transportation, security, water, sanitation, electricity, etc.
- Must support: Recovery and rehabilitation of essential services

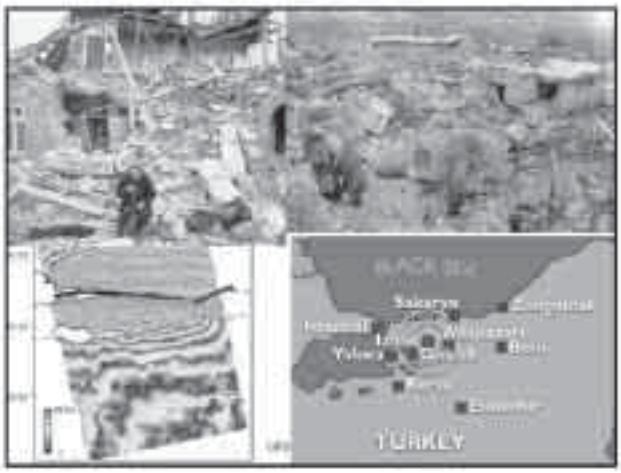
Key Health Care Guidelines:

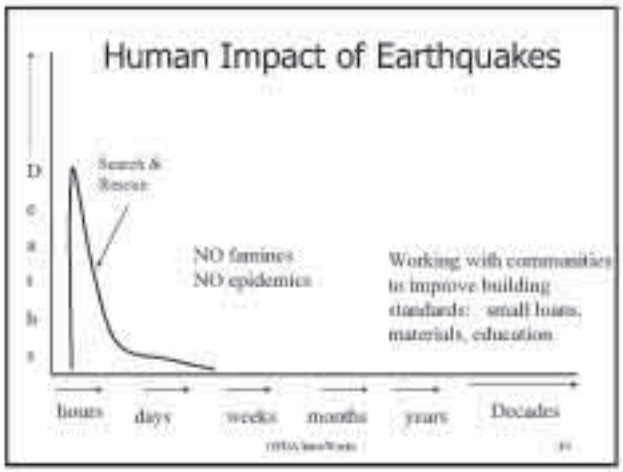
- Health services:
  - 1 clinic for every 5,000 DPs w/ 1 nurse and 2-3 national health workers
  - 1 health center for each DP settlement w/ 1 bed/5,000 people and w/ 2 doctors, 8-10 nurses/20,000 DPs

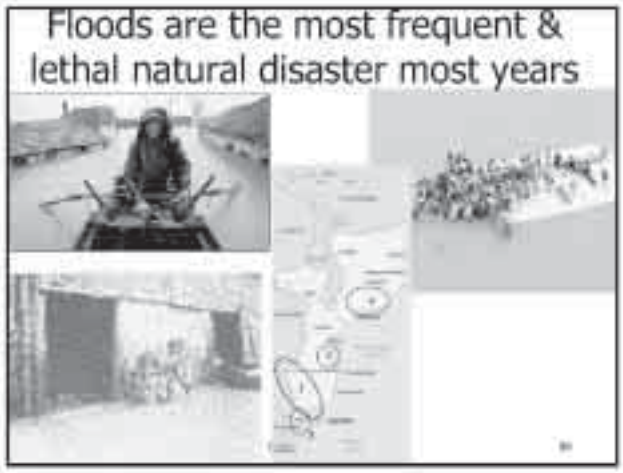
Health needs vary with the type of disaster

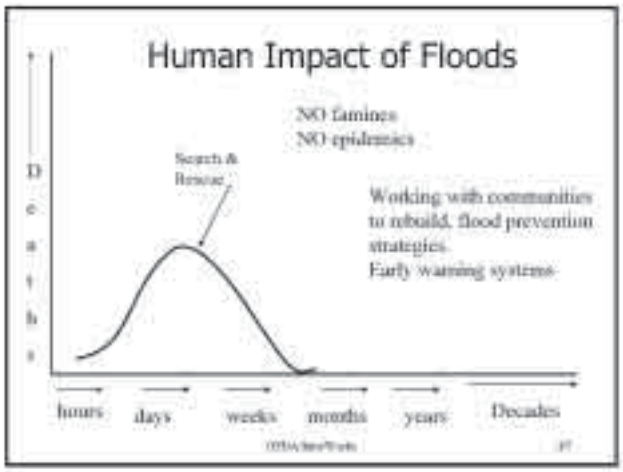
NATURAL DISASTERS

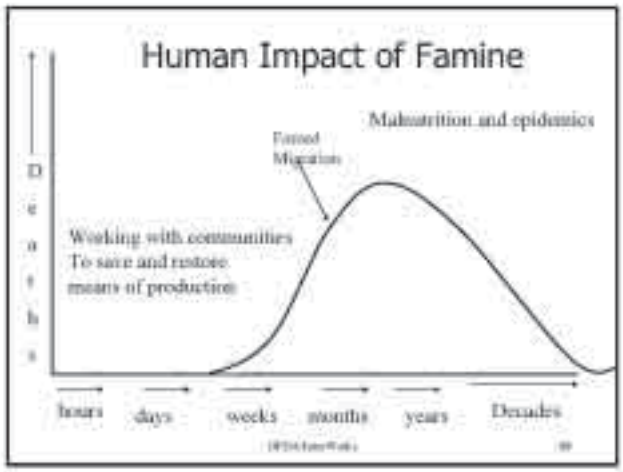
- Primarily deal with direct effects
- The greater the damage to public health infrastructure the greater the chance for indirect health effects



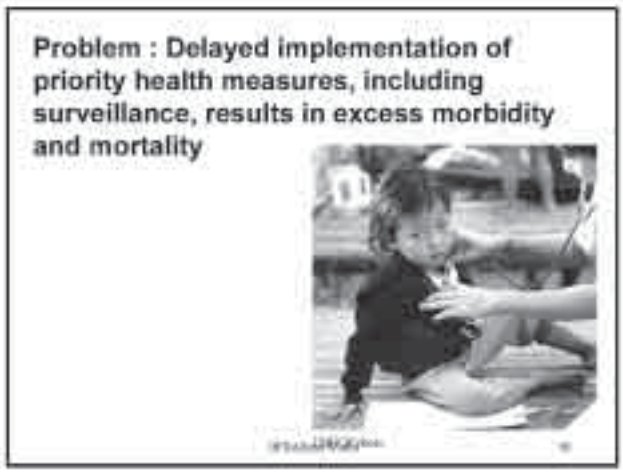

Human Impact of Earthquakes
Deaths
Search & Rescue
NO famines
NO epidemics
Working with communities to improve building standards: small loans, materials, education
hours
days
weeks
months
years
Decades


Floods are the most frequent & lethal natural disaster most years


Human Impact of Floods
NO famines
NO epidemics
Deaths
Search & Rescue
Working with communities to rebuild, flood prevention strategies.
Early warning systems
hours
days
weeks
months
years
Decades


Human Impact of Famine
Deaths
Malnutrition and epidemics
Forced Migration
Working with communities
To save and restore
means of production
hours
days
weeks
months
years
Decades


Principle:
short-onset natural disasters
do not cause famine


Problem : Delayed implementation of priority health measures, including surveillance, results in excess morbidity and mortality

Sphere recommendations

Analysis Standard #2

The health information system (HIS) *regularly collects relevant data on population, diseases, injuries, environmental conditions and health services in a standardized format in order to detect major health problems.*

RAP form for Wat/San

SAMPLE OF ASSESSMENT FORM FROM THE OFFICE OF THE COORDINATOR FOR HUMANITARIAN ASSISTANCE (OCHA)

CAN YOU PERFORM A HEALTH ASSESSMENT WITHOUT BEING A HEATHCARE PROFESSIONAL?

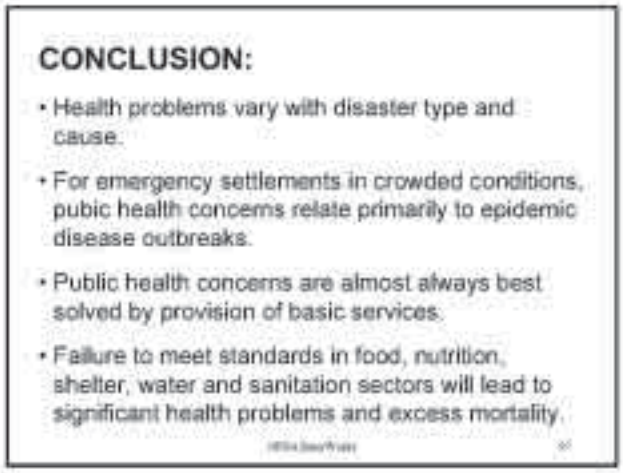
BURKLE

Epidemiological questions you will always ask

- What is the crude mortality rate?
- What is the disaggregated (for gender and age) mortality rate
- What is causing mortality and morbidity?
- What are the case fatality rates?

Review

5 major killers	Prevention measures
Malnutrition	Adequate general ration & distribution
Diarrhea	Adequate clean water/sanitation, ORT
Measles	Immunization, Vit A
Malaria	Bednets, vector control
ARI/Pneumonia	Adequate shelter, space, clothing, management of infections


CONCLUSION:
• Health problems vary with disaster type and cause.
• For emergency settlements in crowded conditions, pubic health concerns relate primarily to epidemic disease outbreaks.
• Public health concerns are almost always best solved by provision of basic services.
• Failure to meet standards in food, nutrition, shelter, water and sanitation sectors will lead to significant health problems and excess mortality.


?
QUESTIONS

Overview 3 (Fitsum Assefa)

Monitoring and Evaluation Health and Nutrition Interventions In Emergencies

JPF/MOFA Workshop
10th March, 2004

Fitsum Assefa
Nutrition Officer
UNICEF Afghanistan

Objectives

- **To illustrate how emergency Health and Nutrition Interventions are monitored and evaluated in practice and the use of Sphere standards**
  - **Overall humanitarian response**
  - **Specific Nutrition programs**

UNICEF's Core Corporate Commitments: Immediate Response

- Rapid Assessment
- Coordination
- **Program Commitments**
  - **Health and Nutrition**
  - Education
  - Child Protection
  - Water Supply and Sanitation
- Operational commitments

UNICEF's CCCs: H & N Program

- Provide essential supplies
- Provide measles vaccination and necessary critical inputs
- Provide Tetanus Toxoid and critical inputs
- Initiate and support TFPs/SFPs, based of rapid assessments
- Insure provision of H & N messages, including BF an SMP

UNICEF's role: H & N CCCs

- Policy and program guidance
- Ensuring implementation according to internationally accepted standards of good practice
- Collaboration with national/international counterparts

A commitment that entails a process of continued M & E

Case Study:Evaluation of Overall Humanitarian Response

"Malnutrition, Measles, Mortality and Humanitarian Response, During Famine In Ethiopia"

Salama, Assefa, Talley et al, JAMA, 2001, 286: 563 - 581

Ethiopia : Background

- 3 successive years of drought
- Staring 1999: Data from EWS indicated rapidly deteriorating FS and nutrition situations
- Early 2000: WFP estimated 10 million people 'at risk' of starvation in Ethiopia.
- The Somali region,was the worst affected
- Ongoing civil conflict and extremely poor health infrastructure.
- In early 2000, measles cases began to be reported by NGOs

Ethiopia : Background

- April 2000: Media attention began to focus on a town of Gode, Gode district, Somali region
- April 2000: Large scale response was triggered in Gode town, mainly food aid and feeding programs.
- Population concentrated around major site of Humanitarian response - Gode town
- May 2000: Some UN agencies reported that situation is under control, WFP claimed that famine was averted.

Ethiopia : Background

- July 2000:
  - No epidemiological data
  - no lead agency to coordinate response
- End of July 2000: SCF/US, with support from UNICEF and CDC carried out a population based assessment in Gode district.

Objectives

- **Overall:**
  - **To gather data for program planning and improving practice**
- **Specific:**
  - **To estimate famine-related mortality rates and identify causes of death**
  - **To estimate malnutrition prevalence rates**
  - **To assess underlying factors of malnutrition**

Methods

- Two-stage 30 cluster survey design, sampled across Gode district
- 1994 census as sampling frame- adjusted
- 2 villages excluded due to insecurity
- 1st stage: 30 clusters chosen by PPS
- 2nd stage: households chosen by EPI methods

Methods: Retrospective Mortality

- Household members as of December 9, 1999
- Household members classified as alive or dead
- Deaths from Dec 1999 to July 2000:
  - Cause of death
  - Month of death
  - Age at death

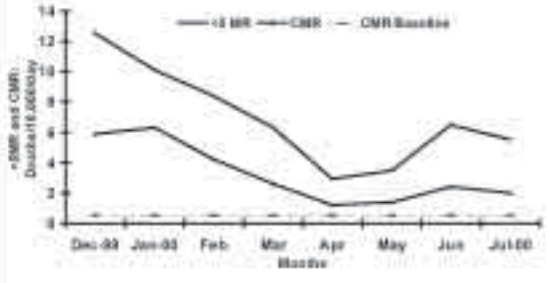
Methods: Malnutrition

- Children 6 months - 5 years
  - Classified using NCHS/WHO/CDC reference
  - Weight for height Z scores (SD)
  - Percentage of median for coverage
- Adults 18-59 years
  - Body mass index (BMI)
  - WHO classification
  - Correction for body shape using sitting height / standing height ratio

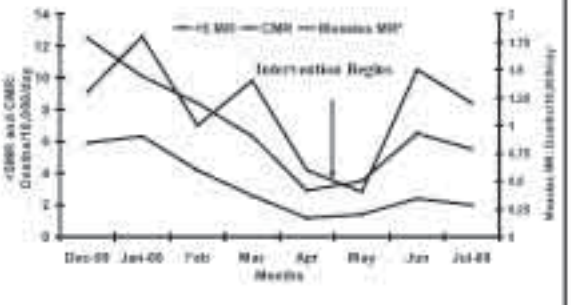
Results

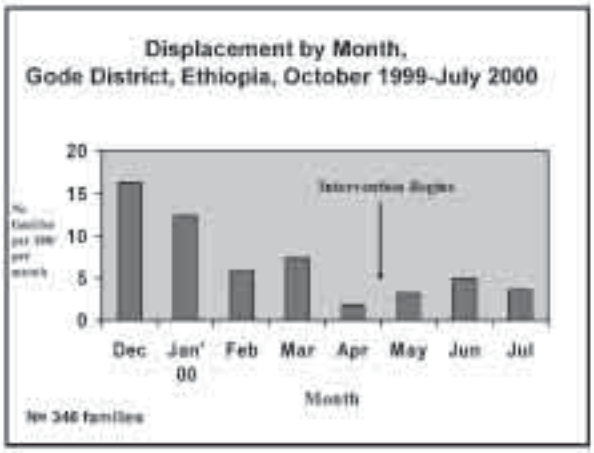
- 595 households comprising 4,032 people in 24 villages
- 346 (58.2%) households were displaced
- Mean household size: 6.4 people
- 293 deaths were recorded for the period of interest, out of which 158 (54%) were children under the age of 5 years
  - CMR: 3.2/10,000/day (95% CI: 2.4-3.8)
    - Definition of excess mortality > 1/10,000/day
  - < 5 MR: 6.8/10,000/day (95% CI: 5.4-6.2)
    - Serious situation >2/10,000/day

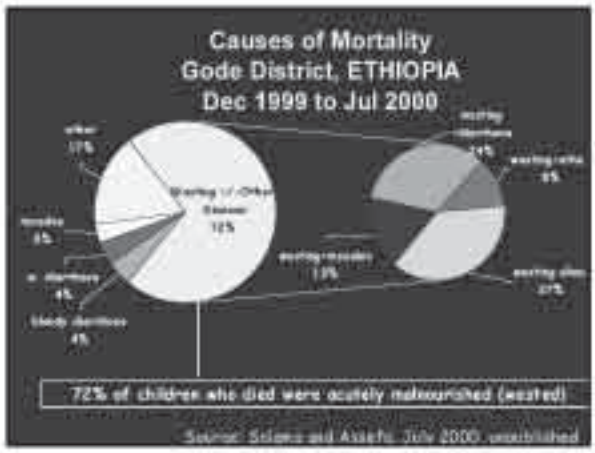
Mortality Trends, Gode District, Ethiopia, December 1999 - July 2000

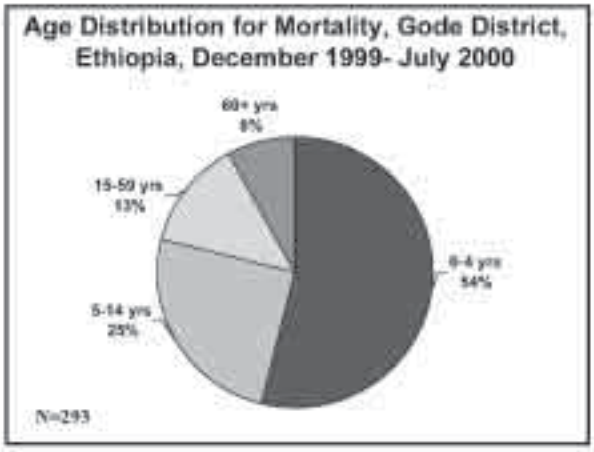


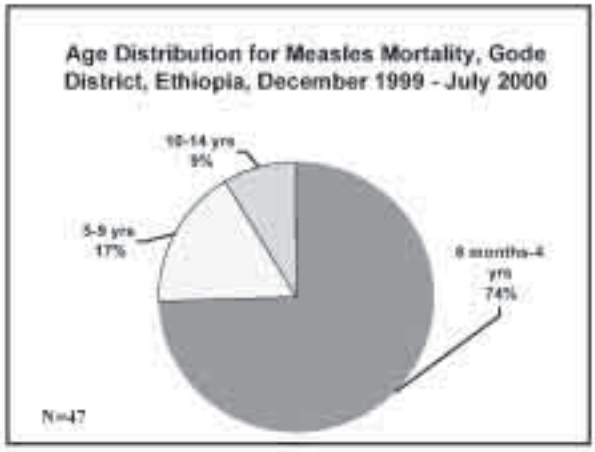
Mortality Trends, Gode District, Ethiopia, December 1999 - July 2000





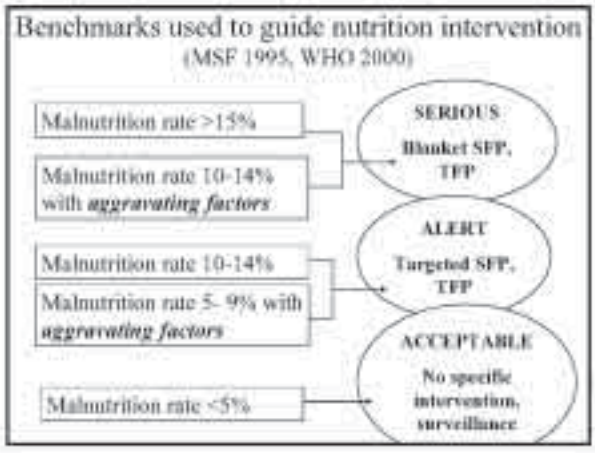






Acute Malnutrition Prevalence Rates Among Children 6 months- 4 years (N=867)

W/H Category	Prevalence (%)	95% CI
Moderate <-2 Z ≥ -3 Z scores	23.4	19.7-27.0
Severe <-3 Z scores	5.7	4.1-7.3
< -2 Z scores	29.1	24.7-33.4



Program Coverage

- –SFP Coverage: 21.5%
  - *Sphere key indicators, Nutrition, page 148, - correction of moderate malnutrition,standard 1*
- –TFC: 12.1%
  - *Sphere key indicators page 148, nutrition, correction of severe malnutrition, standard 2*
- –Measles vaccination:
  - Sphere key indicators page 275, control of communicable diseases: Standard 2- Measles

Adult Malnutrition Prevalence Rates (N=625)

BMI Category Kg/M²	Unadjusted Men % (95% CI)	Adjusted Men % (95% CI)	Unadjusted Women % (95% CI)	Adjusted Women % (95% CI)
BMI < 18.5	61.5 (53.1-69.9)	28.6 (19.8-36.7)	44.5 (38.5-50.6)	20.6 (15.8-25.4)
BMI < 16.0	14.4 (9.1-19.7)	2.9 (0.1-5.6)	11.0 (8.1-13.9)	2.7 (1.4-4.0)

- Was famine averted?
- Was situation under control?

Conclusions

- Prolonged and sever famine, mortality high and sustained, at least for 6 months
- Intervention delayed and inadequate
- No initial situation analysis, programming was not based on data
- None standardized approaches/interventions
- Lack of coordination
- No lead agency in ensuring H & N surveillance and intervention

Conclusions

- suggest negative impact of the humanitarian response (centralized intervention, communicable diseases transmission)
- Most deaths due to wasting/starvation and major preventable diseases
- Measles important in children 6 months-5 years and 5-14 years
- Coverage was low (health as well as nutrition)
- Weak GOV. capacity, limited effort for capacity building

Limitations

- **Are there any limitations of the study/evaluation?**
  - **Recall bias**
  - **Selection bias**
  - **Cause of death**

- What health **activities** would you recommend to take place in response to the situation?
- What **strategies** would you recommend to ensure that nutritional support for those suffering from malnutrition is met?

Outcome of evaluation

- UNICEF took the role in coordination/technical assistance from CDC
- Mass measles immunization in August 2002
- Change from wet to decentralized SFP
- Improvement in general food ration
- Water and health information
- Training on humanitarian principles and key technical areas
- Surveillance system, within the government system (UNICEF secondment)
- Standardization of monitoring tools and indicators according to Sphere.

Case studies - Program M & E

Nutrition Program M & E

- Therapeutic Feeding Program (TFCs)
- Supplementary feeding programs (SFPs)

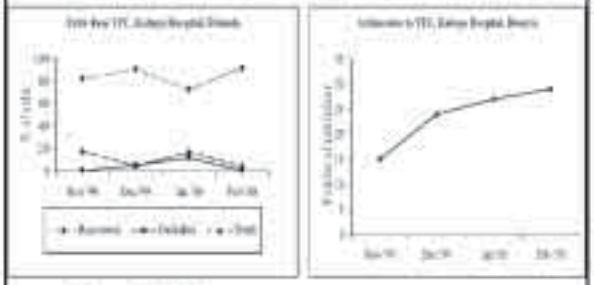
Therapeutic Feeding Programs: Progress and Challenges

"……Case fatality rates in TFCs have remained unchanged since the 1950s and are typically 20-30% and sometimes are as high as 50-60%…"

"……56% of expert practitioner experts reported that kwashiorkor was a 'protein deficiency and this was why high protein diets were prescribed……"

Schofield and Ashworth, 1996

TFC, Kabaya Hospital, Rwanda



Source: SCF/UK

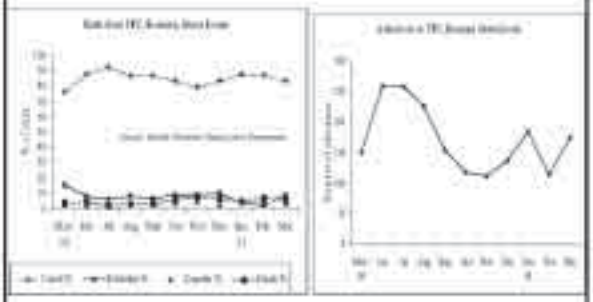
Analysis of Problems in TFPs

- In case of change in mortality rate or unusually high mortality, methods that can be applied to identify the problems include
  - Calculation of the Prudhon index
  - Cusum analysis
- Such detailed analysis and its interpretation requires specialised software, knowledge and skills.
- Invaluable for identifying where there are problems and formulating solutions to improve the effectiveness

Prudhon, C et al. A model to standardize mortality of severely malnourished children on admission to therapeutic feeding centres. European J of Clinical Nutrition 51(11): 771-777

Example of CUSUM for Hospital x

TFC, Kenema, Sierra Leone



Source: Merlins, Kenema, Sierra Leone

A success story?

- The CSFP has "*saved the lives of over a million children from certain starvation and possibly death*" (MoHCW)
  - High proportion of children registered
  - Anecdotal reports of high levels of take-up
  - Smooth deliveries of food to feeding points
- Acute malnutrition based on MUAC:

	< 12.5cm	12.5 – <13.5cm
Oct-92	2.1%	6.0%
Mar-93	2.2%	6.0%

A different view point..

	% U/Ns in feeding	No sites SFP was working
Oct-92	37.5%	15 / 21
Mar-93	80.2%	20 / 21

- Patchy coverage of programmes in Oct 92,
  - one quarter of centres not operating
- Coverage within programmes was low, but improved over time
- For those attending, regularity of feeding was high
- Little evidence children of nutritionally vulnerable HHs were more likely to be included

How would you have improved the monitoring system?

Process Indicators - *efficiency*

Coverage
Total number registered

Admissions

Re-Admissions

Average daily attendance rate
No attending in a given day/
No expected on same day x 100
(MSF Reference > 75%)

Average length of stay on discharge
Sum of length of stay of discharged/
No of discharged individuals x 100
(MSF Reference 60 days or less)

Why?

- ***High Re-admissions?***
- ***Low Attendance Rates?***
- ***Long length of stay?***

Main Outcome Indicators

Sphere, Chapter 3, page 145- 148

- Average Weight Gain (g per kg body weight)
- Recovered % - successful discharge
- Defaulter % - failed to attend
- Death % - died while still registered or after transfer
- Transfer % - referral to TFC, or transfer to another SFC

Evaluating Coverage and Average Length of Stay

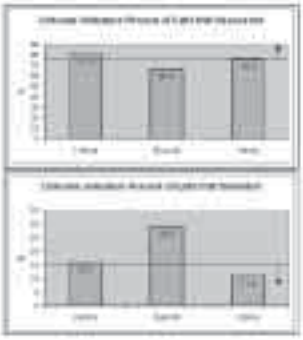
Examples based on nutritional surveys....

	Coverage	Mean Length of stay
Goma (Kibumba) Sept 94[a]	93.7%	50
Liberia (Nimba) Jan 94[a]	69.9%	50
Burundi (Ruyigy) April 94[a]	29.6%	70
Ethiopia (Gode) 2001[b]	21.5%	? (>120)

a. Vautier et al., 1999; b. Salama et al, 2001

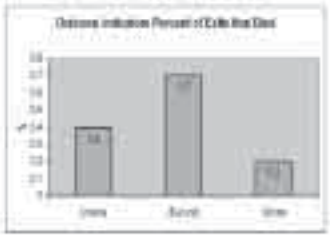
What influences coverage?

Interpreting Outcome Indicators



Reference Value for Recovered > 75%

Reference Value for Defaulters < 15%



All three programmes achieved the reference value of < 2% for deaths.

Evaluation of surveys: Ethiopia 1999-2000:

- Spigel *et al* (unpublished), evaluated 125 nutrition surveys by 14 different NGOs, conducted from Nov. 1998-Jun. 2000
  - RHA*: 16 (13%)
  - Cluster: 109 (87%)
    - 42 surveys part of early warning system with different aim and cluster methodology
    - 67 surveys were "**intended**" to provide useful data to direct programs
  - Only 5 surveys (4%) recorded measles vaccination coverage

* RHA = rapid health assessments using convenience samples

Evaluation of "Intentional" Surveys

- **Valid (i.e. representative):**
  - **≥30 clusters**
  - **PPS**

and

- **Precise:**
  - **≥10 children per cluster**

Valid and Precise Cluster Surveys
7 of 67 (10.5%)

No. of Children /Cluster	No. Acceptable	No. of Clusters <30	No. of Clusters ≥30
	<10		
	10-29		2
	≥30		5

Recommendations

- Improve training manuals
- Be wary of survey data/reports
- Technical persons review reports
- Ensure field personnel appropriately trained
- Decisions based on survey results?
- "HQ staff" to do surveys (?)
- Co-ordinate with "survey NGOs" in field

Deviations from Standards
Reasons for Performance Shortfalls

Lack of skills, knowledge and experience	Problem of Policies or Procedures	Problem of resources
Training, Coaching on-the-job	*Review, revise or amend in consultation with key stakeholders*	*Identify constraints. Remove obstacles Advocacy* *Lower Standards*

Causes of malnutrition

Thank YOU

事例紹介

HuMA-BHN-JEN Case Project

Japan Platform Iraq-Crisis Response Team (JPF-ICRT) from Jan-May 2003 in Jordan

JAPAN PLATFORM　Iraq Crisis Response Team イラク危機対応チーム

AAR JAPAN

JPF/MOFA Workshop on Evaluation of Humanitarian Assistant 2004.3.10-11

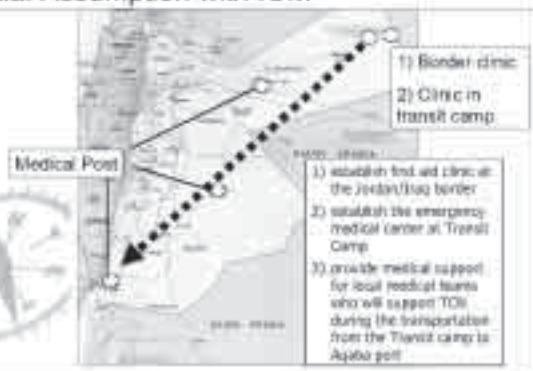
Assumption by UNHCR (January 2003)

UNHCR estimated of 20,000 Iraqi refugees and 60,000 third country nationals (TCNs) would be fleeing from Iraq Once US-led military intervention to Iraq was commenced .
The humanitarian intervention plan for those groups was coordinated by UNHCR in cooperation with Jordanian authorities.

aim

- To provide emergency medical care to the people fleeing from Iraq to Jordan to seek asylum for a temporary period.
- To assist the patients in a serious condition to receive treatment in medical facilities established in Jordan.
- To share the burden of Jordan caused by the mass influx of people from Iraq.

Initial Assumption with IOM



Initial supplies

- Equipment for 2 field clinics and ambulatory medical bags
- Medical equipment
  - Estimated of 1-150 outpatients per day
  - New Emergency Health Kit (10,000 people for 3 months)
- Foods and drugs for staff

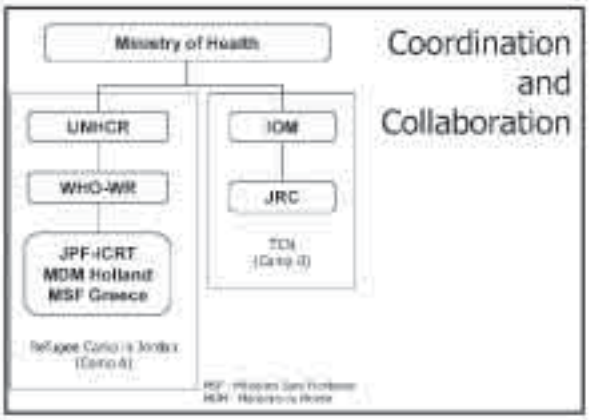
Activities by Chronology

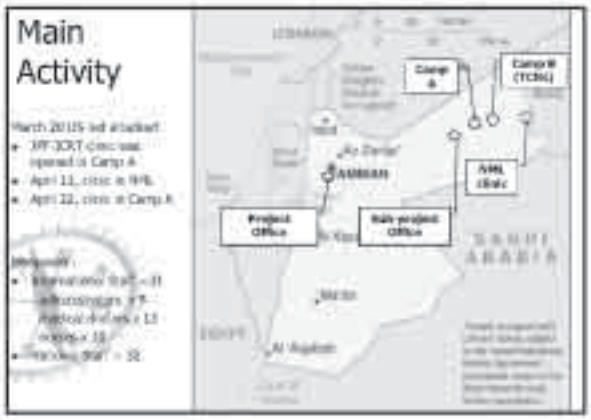
2002
- November～　JPF Assessment Team

2003
- January 24　JPF-ICRT was formed
- January 28　Project Manager & Medical Coordinator arrived in Jordan

Time for Preparation

- March 8　JPF-ICRT, MDM Holland, MSF Greece were selected in medical sector in Jordan
- March 9　NGO registration was approved
- March 20 US-led army attacked Iraq
  Clinic was established in Camp A
- April 11　Clinic started
- May 31　Takeover to 2nd team





Counter Part

- UNHCR
- Ministry of Health
- Hashimite Charity Organization
- IOM
- WHO country representative
- UNDP
- JRCS
- Jordan Doctor's Association
- JICA
- Japanese Embassy
- MDM Greece
- MSF Holland

Roles and Coordination in medical sector

- Collaboration Team
- Swift Response
- Preparation Period
- Counter Part
- Distinction of team
- Standardize and flexibility of medical system
  - Equipment, treatment methodology, monitoring
- Medical Coordination
  - Medical doctors and nurses
  - Training, basic knowledge,

Lessons learned from the mission (1)

- Coordination

Japanese medical staff should have had more knowledge of the frame for international humanitarian activity and how to coordinate in medical sector.

Lessons learned from the mission (2)

►Standardizing medical system and flexibility

management ability
- medical team
- medical equipment
- clinical methodology
- more flexible procedures for coordination

Critical Data

2003 11 Apr. – 31 May

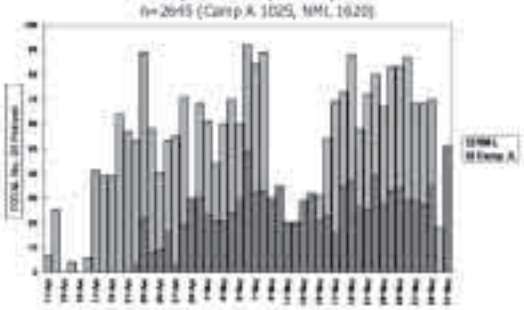
Daily number of outpatient:
►NML = 40 ～ 60
►Camp A = 20 ～40

Total number of patients:
►NML = 1,620
►Camp A = 1,025

Approximately a half of them were revisiting patients in the end of May

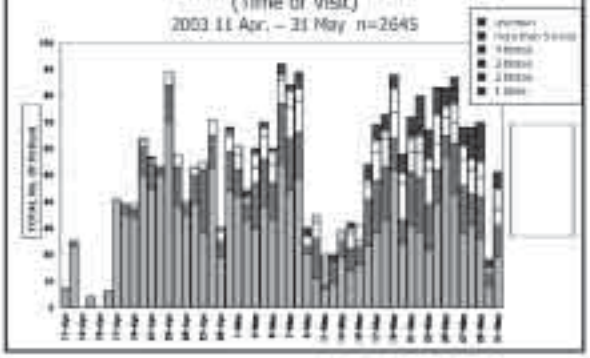
Total number of patients

2003 11 Apr. – 31 May
(inc. revisit patients)
n=2645 (Camp A 1025, NML 1620)



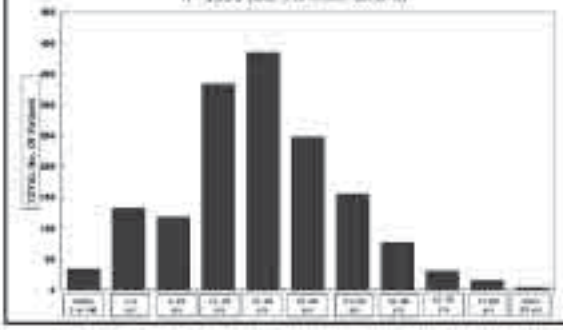
Total number of patients

(Time of Visit)
2003 11 Apr. – 31 May n=2645



Age distribution of 1st Visit-patient

2003 11 Apr. – 31 May
n=1533



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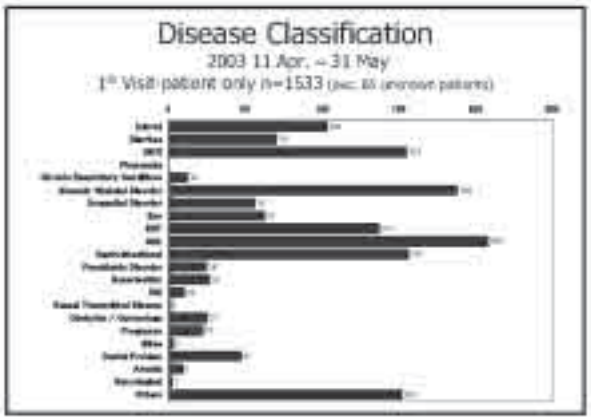

Disease Classification
2003 11 Apr. – 31 May
1st Visit patient only n=1533


Thank you very much
for your attention

PWJ Case Project

peace winds

Health Interventions in NGO's Humanitarian Assistance in Northern Iraq

Peace Winds Japan

PWJ's Activities in Response to Emergency

1. Pre-war situation in Iraq and Kurdish Autonomous Region (KAR)
2. History of PWJ's activities in KAR
3. Overview of the Iraq War
4. PWJ's emergency response – focused on medical assistance
   - 4.1. Inputs
   - 4.2. Preparedness
   - 4.3. Needs assessment
   - 4.4. Health situation of the displaced and the evacuees
   - 4.5. Health service situation
   - 4.6. Mobile clinic
   - 4.7. Coordination with non-medical sectors
   - 4.8. Coordination with other organizations
   - 4.9. Rehabilitation assistance after the emergency phase

Disease Patterns in KAR
- 80's: Transition → 90's Polarized, mixed with
- Infection + Chronic diseases : Children + Elderly people

Health Service
- Hospital&Specialist-centered > PHC (UN programs)
- Infrastructures (Electricity, water) development
- Urban-Rural discrepancy
- Intentional discrimination by Sadaam Regime

WAR ↓

Destruction of infrastructure and various systems
→health service functions ↓ , PHC ↓
Gap from the pre-war : Urban > Rural
Chances for reviving PHCs in rehabilitation phase

Goal
- To prevent increased mortality and morbidity due to the war in the Northern Iraq

(baseline Crude Mortality Rate 4.9 /1,000/ yr.
0.13 /10,000/day

Project Objectives
- To assist and facilitate alleviation of the suffering of people affected by the war

Process of the Emergency Assistance (March – May 2003)

	March	April	May
War Phase	Preparation	Break / Emergency	Ending / Rehabilitation
KAR	Provision of Medicine (to MOH)		
	Needs assessment		
	Mobile clinic		
	Provision of medicine—Assistance for hospitals—		
	Survey → Surveillance		
CG		Needs assessment	
Mosul		Mobile Clinic	
Kirkuk		Assistance for hospitals—	
Baghdad		Provision of medicine to MOH	
		Renovation of health facilities	
		Monitoring	
Coordination			

Preparedness

Seven years Experience-Mobility, Information, Trust from the local society, coordination

↓

- Medicine Provision—MOH
- Stocking of Non-Food Items(NFI), Logistics
- Staff Training
- Training for Landmine Awareness
- Preparation of Surveillance
- Chemical & Biological Weapons
- Meeting with Ministry of Health and other related organizations

Inputs

Manpower
- 160 local staff at the peak, 6-10 international staff, 8 Japanese
- Mobile clinic team
- 1 Dr, 1 Medical Assistant, 1 Ns, 1 Cast Distributer, lab tech, Social Worker

Finance--Total: $1,880,000 Fund sources: JPF $ 1,697,000, PWJ $ 2,000

Project implementation
- Medical personnel expenditures: $7,000
- Medicine & medical equipment: $840,000
- Referral cost: $000
- Non-food items: $413,000
- International staff salaries: $ 00,000

Administration, travel expenses and others
- Field offices administration (in Iraq): $00,000
- Logistics support office administration (in Tehran, Iran): $ 00,000
- Tokyo office administration: $28,000
- Travel expenses: $40,000
- Fixed assets: $141,000
- External auditing: $11,000

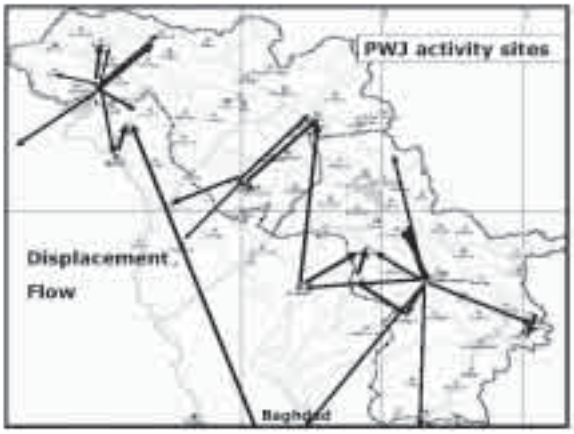
Outcomes:
- 1.Well prepared for Emergency
- 2.Priorities identified
- 3.Interventions effectively implemented
  - Timely interventions
  - Adequate Coverage
  - Targeting vulnerable groups
- 4. Activities well coordinated
- 5. Local capacity strengthened

Activities:
- 1. Preparedness
  Mobile clinic organization Medicines-stocking, Coordination
  Medicines provision
- 2.Assessment —Joint initial assessment
  Priority setting: target areas and groups
- 3-1. Mobile Clinic
- 3-2. Public Health Activities
- 3-3. Assistance to Local Health Authorities
- 4. Coordination meeting, Information sharing
- 5. Provision Medicine to Local Hospital & Health Center
- Health Education, Staff training

March 18, 2003
Evacuation just before the Iraq War

Evacuation from the central government (CG) side (cities along the border)

Empty the Major Cities



Assessment Sheet standardized inside PWJ

Date Location Distance from Office

Investigator Contacted person

Security

Original Population

Newly arrived (IDP)- Original place /State of arrival Flow

Population: Infant/ <5 y /Disabled /Pregnant/Elderly/Women headed

Agencies involved

Shelter: Public building Tent or vehicle

Food

Water / Sanitation

Heating

Economic state

Health care delivery

Health state

Joint Assessment

Local authorities Involved: MOH

Different NGOs --Targeted for specific groups
- Local Health Staff
- MAG
- HelpAge
- Save the Children
- PWJ

Assessment of the Evacuation

- Voluntary evacuation > forced displacement
- Means: by car(rich)/ foot(poor) ; Moving Distance: vary
- Flow: 500-1000 people / day / site No Chaos
- Site: Host families, Schools, Ex-army bases, Chicken farms, Outdoors; No camp
- Population:
  - Further displacement of IDPs and refugees
  - Women (especially pregnant one);
  - Elderly, Disabled Children
  - Women-headed families: few
  - the Unaccompanied: few
  - Big discrepancy among the displaced

Condition: Overcrowded, Cold
- Remaining residents; Neglected areas
- Security: KAR--moderately good, CG--unstable

Emergency Assessment

- Water: Disrupted water supply: spring, river, well →tanking
- Food: Storage for 1-2 weeks –The poor sell food
  Lack of oil and Fresh vegetables
- Heating: Lack of fuel→ blankets and firewood
- Health: ARI: (+) Overcrowded, Indoor air pollution
  No Diarrhea , Immunization Coverage >85%
  Chronic diseases deteriorated -lack of medicine
- Nutrition: MUAC<13.5cm 7% <12.5 cm 1%
  Low rate of malnutrition, Lack of vitamin B

- Health care institutions:
  Overloaded, lack of medicine, referral : ±

ex-Chicken farm: 20 families

Mobile Clinic

- 12 Teams:Doctor, Medical Assistant, Nurse, Laboratory technician, Pharmacist, Health educator
- Rural areas in KAR, Neglected areas in CG side
- Primary health care, Acute conditions & Chronic cases
- Outreach→Home visits（Disabled children,Elderly, Women）

Simple clinical tests, Health education,Water and Sanitation, Latrine construction

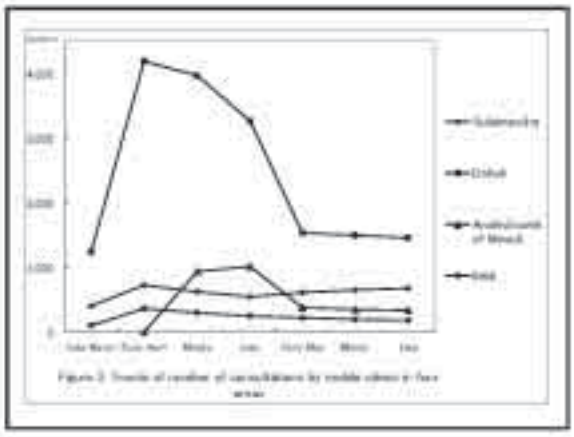
Immunization（−）→（+）contracted from UN

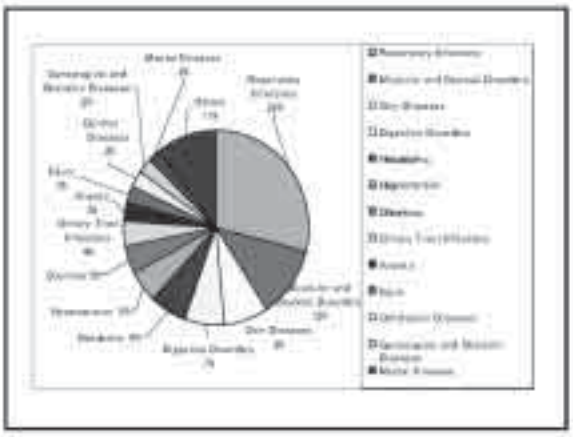
Nutrition: Feeding Center(−), Vitamin only

Surveillance: weak

Health Education

Laboratory Test





Vulnerable groups

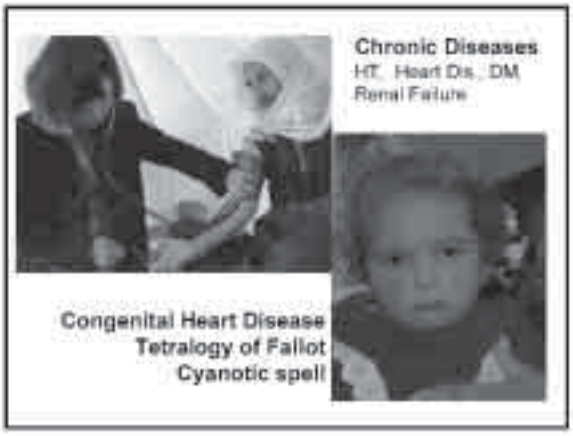
- Children < 5 yrs., infant, neonates
- Unaccompanied
- **Elderly Adults above 60 years old**
- **Disabled people and children**
- Pregnant women, Lactating women
- Women-headed households
- **Seriously ill– Malignancy**
- **Chronic diseases –HT, DM, etc.**
- Mental Health Problems Decreased !

Major Causes of Death

- Chronic Disease
  Cancer, Heart Dis. *High-level Medical*
- Neonates *care dependent*

- War related Injury
  Few for
  Acute Diseases
  Infectious diseases

Gap between Pre- and Post-Disaster



Coordination

	Good	Bad
Preparation	Items stock	Contingency plan
Assessment	Joint assessment Specialized NGOs MOH	Over-assessment Delayed intervention
Information	IDPs, facilities, security E-mail, informal meeting	Lack of information on vulnerable groups, excessive information
Activities	Coordination on the sites and contents	Medicine Donation Standardization
Overall	Demarcation	Integration

Evaluation

Preparation	Adequate, but Over ?
Timing	Early evacuation phase, after the liberation
Sites	Widespread– in response to IDPs' movements including the neglected area
Assessment	Timeliness(＋),capacity assessment (±)
Staff	Led by the local staff, experience accumulated
Logistics	Quickness, enough amount, special medication
Mobile clinic	Standardization(±), Vulnerable group targeted(+)
Coordination	See other page
Sustainability	?

Qualities of assistance:
Timeliness, Mobility, Flexibility, Diversity

Challenges for Evaluation of Health Intervention in HA in Iraq

- Developed country Model
  Low mortality but High Morbidity
  High Vaccine Coverage, Low Malnutrition
  Chronic Diseases
  Curative medicine-dependent health service
  Lack of Medicines
- Lack of Baseline Data
- Many organizations
- Many Factors
- Security　Emergency ⇔ Rehabilitation

MeRU Case Project

Project for Support and Strengthen
Reproductive Health Services
in Balkh Province

Medical Relief Unit, Japan
(MeRU)

Organization involved

- MeRU/ Japan Platform
- MoH, Afghanistan
- UNFPA
- UNICEF

Background situation (1)

- Maternal mortality rate(MMR):
  1,600/100,000 live births
  2nd highest in the world
- Infant mortality rate (IMR): 165/1000 live birth
- U5 mortality rate: 257/1000 live birth
  4th highest in the world

Background situation (2)

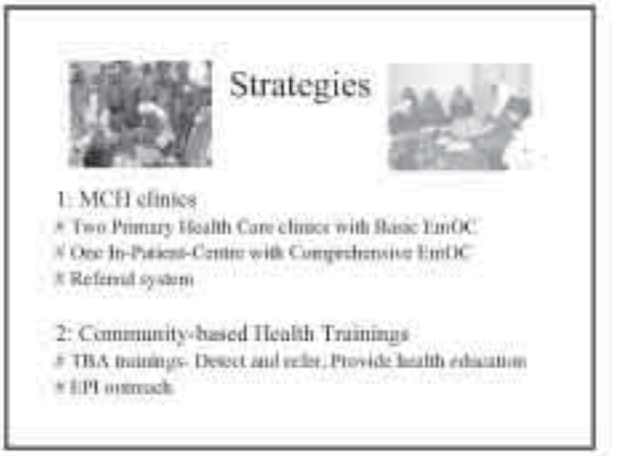
- 45/day women die from pregnancy related causes (Hemorrhage, obstracted labor, etc.)
- Diarrhea and ARI contribute to 41% of child mortality.
- Vaccine preventable diseases account for 21% of child death.
- Acute malnutrition rate 20-25% in some areas.

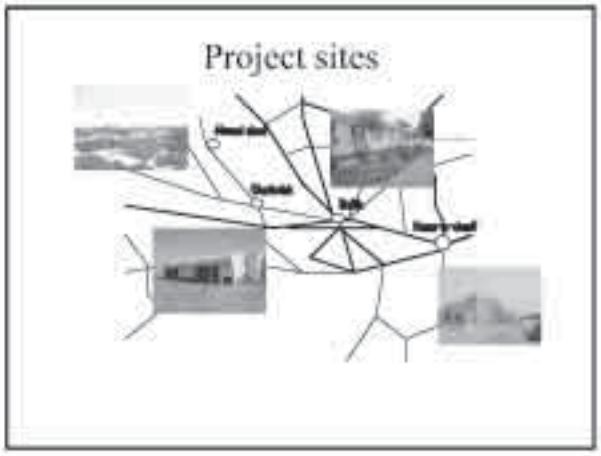
Project Objectives

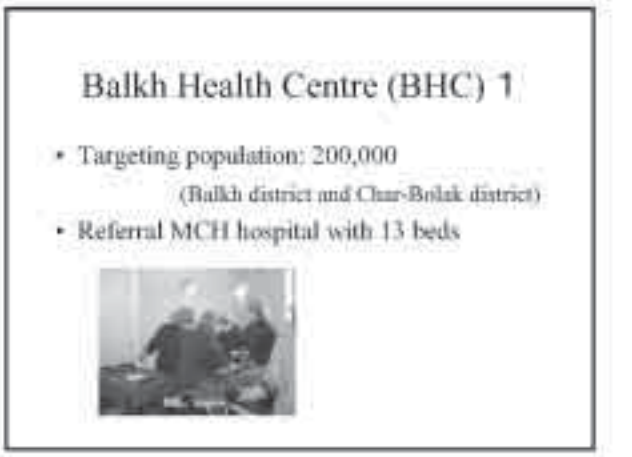
To achieve improved health status of
women at reproductive age and children under five
in Balkh province

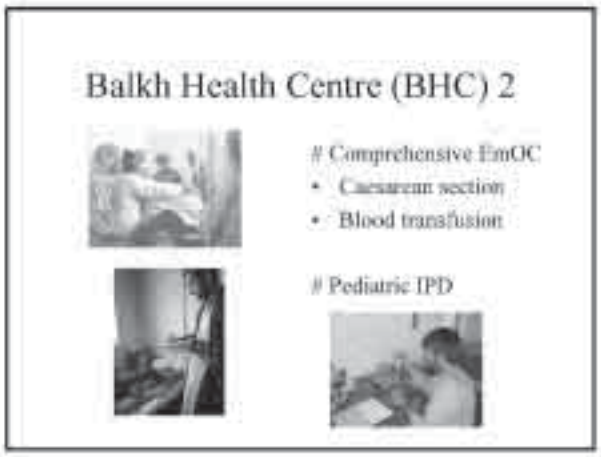
Period and Location

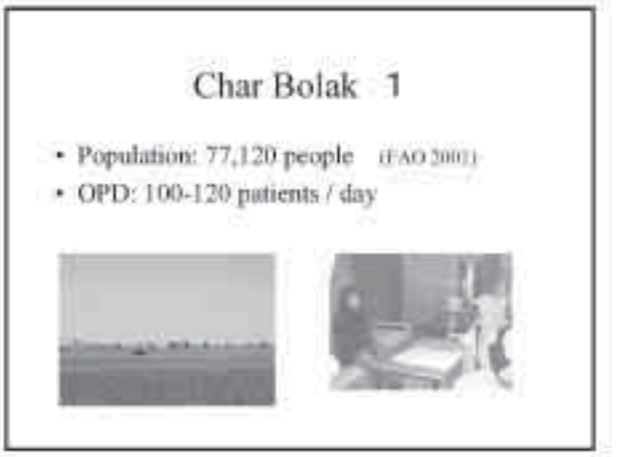
- April 2002 – March 2004
- Char Bolak and Balkh Districts, Balkh province, Northern Afghanistan
  Population: 1,405,388 (Oakridge 2000)

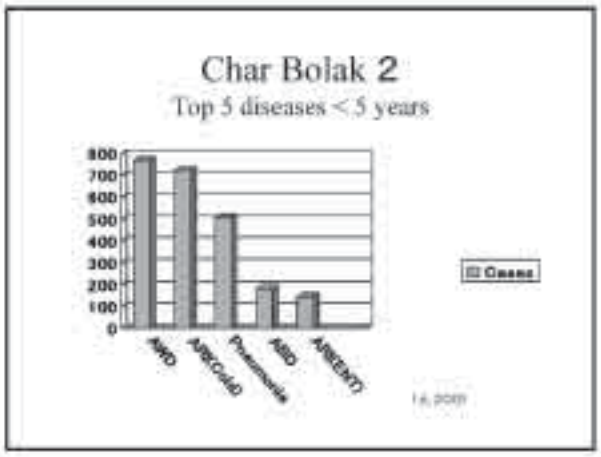

Strategies
1: MCH clinics
Two Primary Health Care clinics with Basic EmOC
One In-Patient-Centre with Comprehensive EmOC
Referral system
2: Community-based Health Trainings
TBA trainings- Detect and refer, Provide health education
EPI outreach


Project sites


Balkh Health Centre (BHC) 1
• Targeting population: 200,000
(Balkh district and Char-Bolak district)
• Referral MCH hospital with 13 beds


Balkh Health Centre (BHC) 2
Comprehensive EmOC
• Caesarean section
• Blood transfusion
Pediatric IPD


Char Bolak 1
• Population: 77,120 people (FAO 2001)
• OPD: 100-120 patients / day

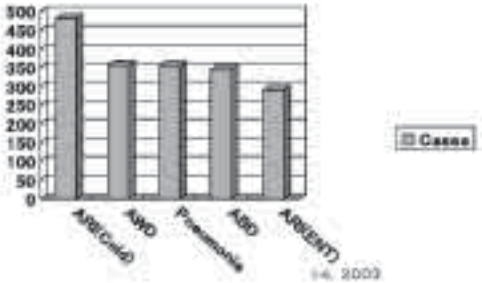

Char Bolak 2
Top 5 diseases < 5 years
800
700
600
500
400
300
200
100
0
Cases

Ahmad Abad 1

- Location: 61km from Mazar-e-Sharif
- Total number of families: 1,160
  (+1,200 in five surrounding villages)
- OPD: About 100 patients / day

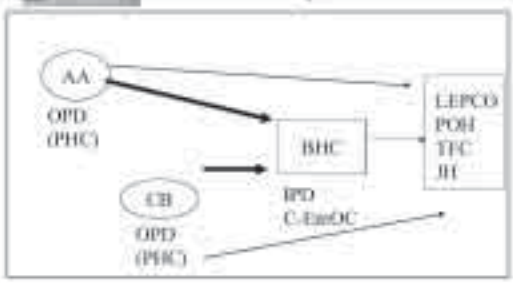

Ahmad Abad 2

Top 5 diseases < 5 years

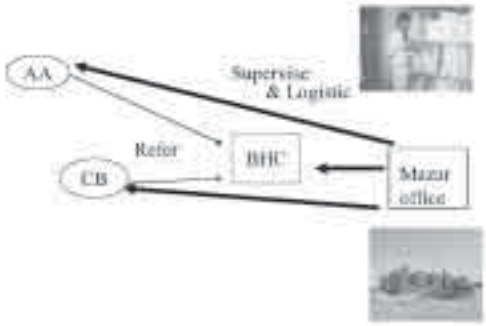


Referral

Radio network, provision of vehicles

Mazar Office and Project sites

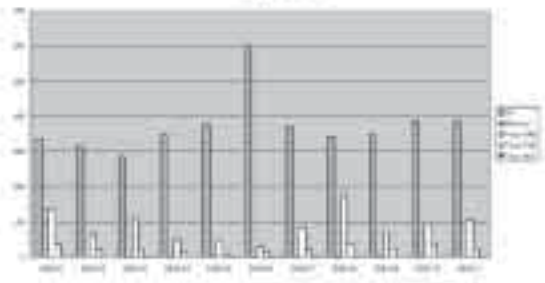


Community involvement

Village health committees

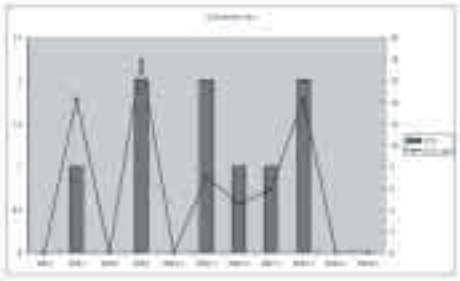

Monitoring and Outcomes （1）

Quantity



Monitoring and Outcomes （2）

Quality



Best practices

- Capacity building
  - Clinics are managed by the local staff
  - Caesarean sections are carried out by themselves
  - TBAs are promoting women at their communities
- Community involvement
  - Village health committee– Ownership
- Referral services

Constrains and difficulties

- Clinic staffing
  - # Difficulties for finding local health professionals in the village
  - # Religious/cultural constrains – Female health professionals
- Security related restriction
  - Continued rivalry between two warlords
- Poor coordination among different agencies
  - Different salary policy, clinical protocols, HIS

Thank you !

Presented by Yuki Ishihara,M.D.
MeRU Medical Advisor/ Medical Coordinator
National Cardiovascular Center, Japan

グループワークまとめ

Group A

Group A

End-user objectives of this evaluation

1. Why Evaluate??

- Lessons learned
- Was it necessary?
- How fast was decision made?
- Was forecast correct?
- Were beneficiaries covered?
- Coordination issues without others
- Was money well spent?
- Was location appropriate?
- Was treatment appropriate?
- Right prs? Right drugs?

Consideration of different groups?

For Who?

1. **Policy maker**
2. **MOFA/JPF Committee**
- To improve future emergency preparedness plans in response to warnings of imminent crises
3. **FOR ALL NGOs**
- To improve health response operations and coordination in the field.

Scope/Focus

1. Political analysis ; Was it necessary? Relevant?
2. Coordination
3. Coverage/adequacy
4. Security for staff
5. Proper treatment of cases?
6. Efficiency (How much money spent)

Evaluation Questions

1. Political analysis

WHO	What Questions
Project manager-Mr.Yamamoto and HuMA	What analysis was done? Who was consulted? Was the historical context considered? Was the 1991 event evaluation researched?
Jordan government	How closely was the Jordan government included in planning? Why did it change the policy of entery visa?
UNHCR	Why did not 80,000 people arrive?

Evaluation Question

2. Coordination

WHO	What Questions
PM, Drs	How many organizations were involved?
Drs & staff	Was there a clear coordination structure?
Drs & staff	How was information shared (by different organization)?
Drs & staff	What kind of documentation exist? i.e. coordination meeting, minutes/MOU, coordination plan

Evaluation Question

3. Coverage

WHO	What Questions
	Why was not the third country nationals targeted?
UNHCR WHO Jordan MoH	What was the total number of arrivals without disaggregated data (elderly, male/female, nationality, children) ?
	Were those who needed services received the services?

Evaluation Question

4 Security

WHO	What Questions
HuMA	What was the need for security of staff in Jordan?
	What training and equipment were provided to staff?
	What kind of security insurance was provided?
	What was the cost for insurance?
	Were there any insurance claims?
	Was security information shared?
	Was there any security incidents?
	Was there evacuation plan/security plan?
	Was there a good communication system?

Evaluation Question

5. Proper treatment of cases?

WHO	What Questions
HuMA MSF MDM	Were doctors and nurses able to correctly identify and treat the cases?
	Were their equipment and supplies correctly used?
	Did they have right equipment/medicine? Was NEHK appropriate?
	Was there any referred patients?
	Did they have right kind of staff?
	What was the assumption about medical needs?
	Was the treatment standardized?

Evaluation Question

6. Efficiency :How was the money spent?

WHO	What Questions
HuMA	How was the money spent?
	Proportion of the different task budget -percentage of administration -percentage of insurance and security issues -percentage of equipment and drugs -percentage of staff (health staff)
	Procurement procedures, logistic cost and procedure

Indicators & Method

1. Political analysis

- Key informant
- Interview
- Collection of document
- Time line
  - when the assumption was made and how long was there between the assumption plan was made and actual incident occurred.
- Meeting minutes

Indicators & Method

2. Coordination

- Sphere indicators (page 264)
- Document for regular meetings
- Interview

Indicators & Method

3. Coverage

- Interview with IOM and JRC
- Records collections

Indicators & Method

4.Security

- Report incident
- Insurance record
- Comparison evaluation of different insurance company
- Interview with staff
- Interview with UN security officer
- Comparison with other organizations'
  - Security plan
  - Equipment
  - training

Indicators & Method

5. Proper treatment of cases?

- Sphere page 40-41
- Common standard 7: aid worker competencies and responsibilities
- Common standard 8: supervision, management and support of personnel
- Written job descriptions with clear reporting lines and undergo eriodic written performance assessment

Indicators & Method

6. Efficiency :How was the money spent?

- Document and record collection
- Interview
- Expenditure data compare to the plan and budget

Thank you very much
from the very best group!!

Group B

GROUP B

THE BEST GROUP!!

END-USE:PWJ project

- To fill gap of the health care resulting from the war
- To show to national/HQ staff as well as other individuals reading this report that use of the mobile clinic for IDP either benefited or not benefited health consequences of the war

SCOPE

- Address the needs of IDP fleeing the area only during the war=emergency phase
- NOT A sustainable programme
- Is designed to measure the relevance and appropriateness of the mobile clinic during the crisis period where there is no or limited health services

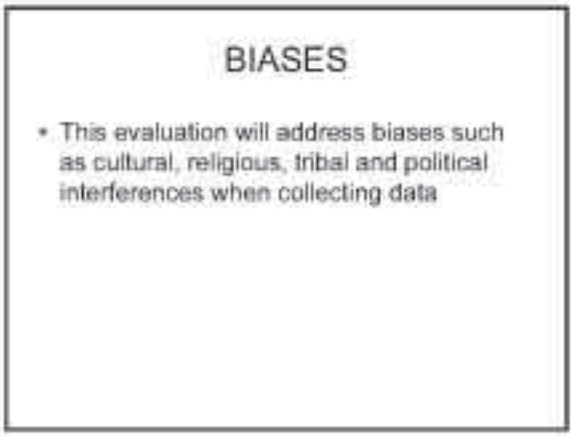
Priority question

1. Mobile clinic improve the ACCESS of the health care?
2. Mobile clinic improve the AVAILABLITY of the health care?
3. Mobile clinic improve the equity of health care?
4. Did lack of security effect access to the health care?

INDICATORS/METHODS

- Primary phase assessment will provide teams to potential areas of KAR to survey what areas are in most need
- Proxy indicators used to determine the access and availability of the health care
  - NUMBER OF health facilities
  - NUMBER OF health providers
  - Population without health care
  - MR/CMR during displacement
    - —Disaggregated for age and gender
  - Common diseases; malaria, ARI, diarrhea, malnutrition

- ONCE analyzed, this assessment determined the area needed the mobile clinics;
- and if security is confirmed, these indicators will continue throughout the length of the program
- This program will be only introduced after consultation with the need KAR authorities and local health representatives
- Additional indicators will be added such as;
  - Clinic utilization rate,
  - Access/availability of women,
  - Security indicators such as threats to staff/patients and number of patients with trauma consequence from the war and landmines


BIASES
• This evaluation will address biases such as cultural, religious, tribal and political interferences when collecting data

Group C

C Group Summary

MeRU
Support and strengthen reproductive Health Services in Balkh province

End-Use (objectives)

- At the end of the project
- For Donor, MOH/BRAC other agency working same sector
- For MeRU lessones and future activity

Scope/ criteria

1. Effectiveness
2. Coordination
3. Sustainability

Evaluation questions 1

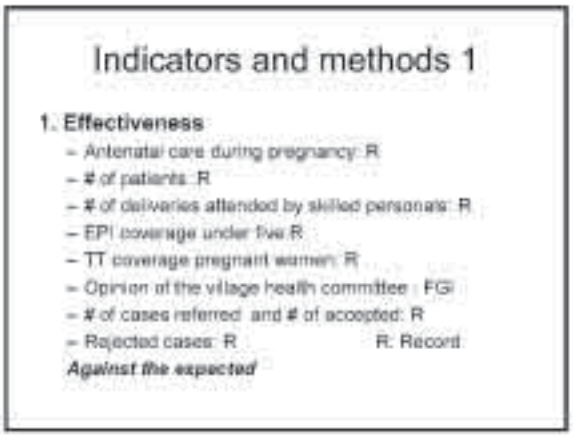
1. Effectiveness
   - Has access to MCH services expanded?
   - Is the community aware of the services?
   - Are women and children utilizing the services?
   - Are the services responding to the health needs?
   - Is the referral system functioning?

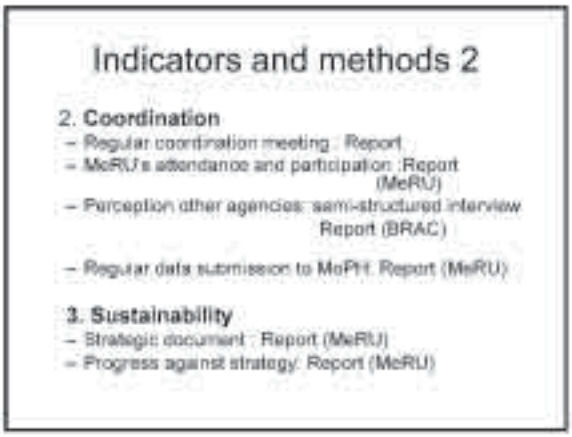
Evaluation questions 2

2. Coordination
   - Is there coordination mechanism ?
   - Is MeRU contributing to HIS?
   - Does MeRU have good working relationship with implementing partners?

Evaluation question 3

3. Sustainabiliy
   - Was there an exit strategy?


Indicators and methods 1
1. Effectiveness
– Antenatal care during pregnancy: R
– # of patients: R
– # of deliveries attended by skilled personals: R
– EPI coverage under five R
– TT coverage pregnant women: R
– Opinion of the village health committee : FGI
– # of cases referred and # of accepted: R
– Rejected cases: R
R: Record
Against the expected


Indicators and methods 2
2. Coordination
– Regular coordination meeting : Report
– MoRU's attendance and participation :Report (MoRU)
– Perception other agencies: semi-structured interview Report (BRAC)
– Regular data submission to MoPH: Report (MoRU)
3. Sustainability
– Strategic document : Report (MoRU)
– Progress against strategy: Report (MoRU)

参加者感想

（寄稿者名は匿名とし、原文のまま記載いたしました。）

A

初日
講義は、ぞれぞれ興味深かったが、一方通行の授業になると動きが少なくて、緊張感が持たなくなる傾向があった。
二日目のワークショップ
個々人が、より参加する機会があってよかったのではないだろうか。

B

ワークショップを終えて・・・
初めてのMissionが大変大きなMissionであったことは、大変であったの一言では言い表わすことができないものでした（問題が多すぎて・・・）。評価すべきこと、今後のMissionに生かすためにもやるべきという話は常に出ていますが、どこから始めようかとまとまらずにいました。これを機会に、再度、できる限りの評価をしていきたいです。ありがとうございました。大変勉強になりました。

C

二日間のワークショップに参加させて頂き誠にありがとうございました。
評価という概念をしっかりと日本のNGO活動に根付かせるための素晴らしい第一歩であったと存じます。
その初回であったにも関らず、素晴らしい講師陣を招聘して下さり嬉しく存じます。能力だけでなく、明るさやユーモアさにも富み、常に明るくこちら側も学ぶことができました。
日本の医師たちが評価されることに慣れていませんので、ちょっと大変かも知れません。
でも、資料は、両面コピーでお願いします。
日本語ですみません。

D

Comments
- まず、何のため／誰の為に評価するのかという点をクリアーにするところからはじまり、とても分かりやすかった。
- 評価について考えることは、つまりプロジェクトをどうデザインするか、ということに深くかかわってくるので非常に興味が持てた。
- 自分の団体のプロジェクトが題材になったことは非常に勉強になった。ppt資料が欲しいのですが。
- Sphereの基準は、ケースによっては使えないこともありますが、それでもやはりある程度の基準があることは必要だと感じた。

E

今回、このワークショップに参加して、今まで緊急人道援助について、体系的に学んだことも考えたこともなかったことが分かった。プロジェクトを運営する上で、あるいは、メンバー（スタッフ）の一人として、どうあるべきかとういう視点を多く得た。
それから、後半にあった問題提議によるディスカッションは、非常にためになった。
どうもありがとうございました。

F

I have able to obtain a lot of useful information from this workshop, in particular I was interested in a set up medical standard.
Some improvements, if I may suggest, it should take place during weekend so that a lot of staff members from NGO can participate. I think also there should be shorter but more frequent break time. Maybe more anthropological imput?

G

First I'm very grateful for this opportunity that was given to me to be here for two days. I have learnt a lot about not only in Evaluation of Health Sector, but many other things that are important as I work in NGO. Good hospitality and well organized, I think Everyone had very meaningful time. I hope this kind of activities will continue and be carried on. Thank you.

H

Thanks very much. I had a very good time and learned many things for evaluation. Previous, I tried to do evaluation for project. But now I know what is the proper way. It is basical and it is just a first step. But itÅfs great improvement, cause before my evaluation was done selfish and not fear way. Especially our three teachers are excellent! It is difficult to teach, but they cheer us up. I hope this kind of lecture will be continue.

I

Com. for JICA/MOF Programme
I am very honored to join this programme such as coordinated by excellent staffs. It was my first time, express and perform in front of several authorized or motivated people in English.
I really appreciated to attendance and support by JICA/MOF. Thank you very much.
P.S. One day I hope to become a good coordinator in NGO or IGO, after step by step up.

J

At first thank you very much. I learned many point regarding to evaluation. For future, I want to have the opportunity to make good todayÅfs experience.

K

Thank you for a fruitful seminar! I have experienced monitoring before, and it seemed like Pacific Ocean, too deep and huge ? endless. However, through this seminar I gained courage to actually try evaluation. Not only we learned the basic skills of evaluation, what was the best of this seminar was hearing to the wonderful lectures of their experience, decisions, attitude towards evaluation.

L

Remarks to participate in Workshop
I have already had experiences in NGO for two and half years. And also I participated Mother and Child health project for 6 months in Afghanistan. But I studied a little evaluation in humanitarian assistance projects. When I participated this workshop, I studied method of evaluations and so on. In first I'd like to continue to study evaluation. Thank you very much.

M

I was very happy to attend this workshop. It was very well-organized and facility was very comfortable. One case study, the objectives were not clear for me at the beginning, but the facilitator led us and finally we could make the best presentation. Thank you.

平成 15 年度 NGO 活動環境整備支援事業
「緊急人道支援活動における評価手法セミナー（医療セクター）」

平成 16 年 3 月

発行： 外務省経済協力局民間援助支援室
〒 100-8919　東京都千代田区霞が関 2-2-1
電話： 03-3580-3311（代表）
FAX： 03-5501-8360