



# Guidelines for Implementing Interagency Health and Nutrition Evaluations in Humanitarian Crises

**Version 1.0**

Interagency Health and Nutrition  
Evaluations in  
Humanitarian Crises (IHE) Initiative

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This is the first version of these guidelines. Comments are welcome, and can be sent to [olga.bornemisza@lshtm.ac.uk](mailto:olga.bornemisza@lshtm.ac.uk). A second version is envisaged after more inter-agency health and nutrition evaluations are conducted, as further experience will inform improvements in how such evaluations can be done.

## List of Acronyms

ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
AR	Attack Rate
BPRM	Bureau for Population, Refugees and Migration of the US Department of State
CAP	Consolidated Appeal Process
CDC	Centers for Disease Control and Prevention
CHAP	Common Humanitarian Action Plan
CMR	Crude Mortality Rate
ECBP	Emergency Capacity Building Project
ECHO	European Commission Humanitarian aid Office
HIS	Health Information Systems
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IHE	Interagency Health and Nutrition Evaluation
IHE SC	Interagency Health and Nutrition Evaluation Steering Committee
IDPs	Internally Displaced Persons
LSHTM	London School of Hygiene and Tropical Medicine
MoH	Ministry of Health
MSF	Médécins sans Frontières
NAF	Needs Analysis Framework
NGO	Non Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
ODI	Overseas Development Institute
OECD-DAC	Organisation for Economic Cooperation and Development - Development Assistance Committee
RTE	Real-Time Evaluation
SCF	Save the Children
TEC	Tsunami Evaluation Coalition
ToR	Terms of Reference
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization

## Preface

Every year, over US\$100 million dollars is spent in support of health and nutrition programmes for refugees, internally displaced persons (IDPs), and other populations affected by humanitarian crises.<sup>1</sup> The complexity of the health and nutrition sector, and the scarcity of evaluative efforts at the sector level led to the creation of the Inter-agency Health and Nutrition Evaluation (IHE) Initiative. Created in 2003 by a group of UN agencies, NGOs and other institutions involved in humanitarian assistance, it aimed to fill the gap by commissioning inter-agency evaluations focused on the health and nutrition sector. It was guided by a Core Working Group that includes: Action Contre la Faim-France/Action Against Hunger-UK, Centre for Disease Control and Prevention (CDC), Epicentre, the London School of Hygiene and Tropical Medicine, Merlin, Médecins sans Frontières (MSF)-Holland, Save the Children UK, UNFPA, UNHCR, UNICEF, WFP and WHO-HAC.<sup>2</sup>

The IHE Initiative commissioned six evaluations in Nepal (September 2003), Zambia (November 2003), Pakistan (December 2003), Burundi (April 2005), Liberia (September 2005) and Chad (February 2006). These evaluations traversed agency and national boundaries to examine the impact of health and nutrition interventions on populations affected by a humanitarian crisis. They analysed the overall performance of the health and nutrition sector, and identified gaps and overlaps in programming. They provided the evidence base for re-orientation and improvement of the health and nutrition response, and became part of the on-going planning process. The ultimate aim of these evaluations was to improve the performance of the health and nutrition sector, to decrease threats to the lives and health of affected populations, and to enhance the collective accountability of the health and nutrition sector.

Based on the experience of the IHE initiative to date, the IHE core working group has developed practical guidelines for conducting inter-agency health and nutrition evaluations (IHEs). There are two parts to these guidelines. Part I describes the nature of IHEs and outlines an evaluation framework and methods that can be used to design and conduct IHEs. Part II describes how to manage an IHE evaluation, disseminate the findings and develop an action plan for follow-up.

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<sup>1</sup> In the period between 2000 and 2005, US\$781 million was committed by donors to the health sector via the consolidated appeals. Development Initiatives. 2006. Global Humanitarian Assistance 2006. <http://www.humanitarianreform.org/humanitarianreform/Portals/1/H%20Coordinators/HC%20retreat/Day%201/Global%20HumanitarianAssistance2006Chapter29.pdf>

<sup>2</sup> United Nations Population Fund; United Nations High Commissioner for Refugees; United Nations Children's Fund; World Food Programme; World Health Organization-Health Action in Crises.

## Key Elements of Inter-agency Health and Nutrition Evaluations (IHEs)

<p><b>Evaluation of collective action</b></p>	<p>IHEs evaluate collective performance of health and nutrition programming in a specific geographic area where a humanitarian crisis is occurring.</p>
<p><b>Interagency in nature</b></p>	<p>IHEs are inter-agency evaluations in which all health and nutrition agencies (UN, NGO, donor, national health authorities) that work in a specific geographic area take part. A local IHE steering committee manages the process, sometimes with external assistance.</p>
<p><b>Lesson learning and accountability</b></p>	<p>IHEs can be done to inform on-going activities so that action can be taken to improve the response. They can also be done to encourage broader lesson learning and accountability in the humanitarian system.</p>
<p><b>Common framework and indicators</b></p>	<p>IHEs use a common evaluative framework that details the topics for evaluation, as well as performance indicators for the health and nutrition sector.</p>
<p><b>Action planning</b></p>	<p>Agency managers formulate a point-by-point management response to the recommendations and/or main findings of the IHE.</p>



# Part I –The Nature of IHEs

## Introduction

The majority of deaths in conflict settings are due to preventable communicable diseases and malnutrition, not violence.<sup>3</sup> Health service provision makes an essential contribution to the reduction of avoidable morbidity and mortality resulting from a crisis, and alleviates the suffering of people by providing curative and preventive care. Nutritional interventions are crucial in preventing and treating malnutrition, and complement livelihoods support, food aid and health care provision. Together, health and nutrition form an important sector in humanitarian aid.

In the humanitarian field, evaluations of activities in the health and nutrition sector tend to be limited to single-agency project evaluations. Historically there has been a lack of sector-wide evaluations even though only sector-wide evaluations can examine issues such as coverage and the appropriateness of the choices of, and the balance between, various health and nutrition services. To address this need, the IHE initiative was set up in 2003 to facilitate more frequent health and nutrition sector inter-agency evaluations. This initiative complements other recent attempts to perform inter-agency evaluations in the humanitarian field (Box 1).

Box 1: Inter-agency, or joint evaluations are becoming increasingly common. One reason for this is the recommendation for more sector-wide, inter-agency evaluations in the recent Humanitarian Response Review<sup>4</sup> commissioned by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) on behalf of the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator. The tsunami of December 2004 also led to a rapid expansion of inter-agency evaluations; in order to maximize evaluative resources and do fewer single-agency evaluations, a Tsunami Evaluation Coalition (TEC) was formed under the auspices of ALNAP (the Active Learning Network for Accountability and Performance in Humanitarian Action) and five joint thematic evaluations were done.<sup>5</sup> The UK Disasters Emergency Committee (DEC), representing a group of UK humanitarian agencies, also does regular inter-agency evaluations to support its role in eliciting and channelling public funding for emergencies.<sup>6</sup>

<sup>3</sup> Salama, P, Spiegel P, *et al.* 2004. Lessons learned from complex emergencies over past decade. *Lancet* 364: 1801-13. And Coghlan, B., R. Brennan, *et al.* 2006. Mortality in the Democratic Republic of Congo: a nationwide survey. *Lancet* 367: 44-51.

<sup>4</sup> <http://www.reliefweb.int/library/documents/2005/ocha-gen-02sep.pdf>

<sup>5</sup> [http://www.alnap.org/tec/joint\\_evaluations.htm#themes](http://www.alnap.org/tec/joint_evaluations.htm#themes)

<sup>6</sup> <http://www.dec.org.uk/>



The most recent inter-agency initiative is the Emergency Capacity Building Project (ECBP), a coalition of seven US-based humanitarian NGOs funded by the Gates Foundation and Microsoft.<sup>7</sup> The ECBP aims to measure impact and improve accountability to local people by involving beneficiaries in the monitoring and evaluation of humanitarian programming. Finally, recent developments on Real Time Evaluations (RTEs) within the IASC are examples of joint evaluation.<sup>8</sup> Guidelines on how to do inter-agency evaluations more generally have been recently developed by the OECD-DAC<sup>9</sup>, however, sector-specific guidelines have not yet been developed.

Evaluation of the health and nutrition sector is complicated, as there are many elements to be examined, such as the presence and capability of trained staff, drug supply systems, financing and health and nutrition information systems. Moreover, a health and nutrition response consists of a variety of interventions, ranging from direct life-saving interventions to comprehensive nutrition and health services (such as reproductive and mental health services). Services are provided in dynamic situations with fluctuating insecurity and population movements. Outcomes are difficult and expensive to measure, and it can be problematic to attribute outcomes to health and nutrition activities.

IHEs are complex as they involve a myriad of agencies, including the United Nations (UN), non-governmental organisations (NGO), national health authorities and donor agencies, all of which have varying mandates, policy interests, timeframes, target populations, activities and exit strategies. In addition, national health systems and local capacities need to be taken into account. These complexities lead to methodological and coordination difficulties that need to be overcome. The purpose of these guidelines is to describe how to commission and implement IHEs, based on experience gained from conducting the six IHEs that have been done to date.

## Purpose of IHEs

The purpose of IHEs is to improve the collective humanitarian response of agencies and other stakeholders in the health and nutrition sector. This is done by assessing collective strengths and weaknesses, gaps and overlaps, and plausible impacts on health and

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<sup>7</sup> <http://www.ecbproject.org>

<sup>8</sup> UNICEF, OCHA. 2007. *Agency experience with Real-Time Evaluation (RTE); Towards an approach for inter-agency RTE*. A joint UNICEF/OCHA paper, in close collaboration with ALNAP membership. December 2007.

<sup>9</sup> OECD-DAC. 2005. *Joint Evaluations: Recent Experiences, Lessons Learned and Options for the Future*. DAC Evaluation Network Working Paper. [http://www.oecd.org/document/17/0,2340,en\\_21571361\\_34047972\\_33655569\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/17/0,2340,en_21571361_34047972_33655569_1_1_1_1,00.html)

nutrition trends. This information feeds into and improves decision-making processes at the field level, enabling decision-makers to make more informed judgements, recommend priorities for change, and stimulate joint planning. IHEs are thus formative evaluations, which are defined as evaluations “intended to improve performance, most often conducted during the implementation phase of projects or programs”.<sup>10</sup>

IHEs can also function as summative evaluations<sup>11</sup> by encouraging broader lesson learning in the humanitarian system. To fully serve this function, a number of IHEs would need to be analysed for common trends, problems and lessons learned. While the focus of IHEs is to improve learning and performance, they can also function as a form of collective accountability, reflecting the combined response of key stakeholders.

## **Commissioners and Users of IHEs**

It is important to make sure that the right people representing the right agencies are involved in commissioning IHEs as decision-making is as much a political process as it is a technical one. This will help optimize commitment to follow-up on recommendations, as well as ensure that recommendations attract the attention of decision-makers and stimulate change where needed at higher policy levels.

IHEs can be commissioned at the national or international level. IHEs can be commissioned by national level agencies to inform the country level response, as well as to advocate for change at higher levels in the system. A coordinating mechanism is required that is able to commission, organize and finance an IHE. This could be an existing health and nutrition sectoral coordination mechanism, such as an in-country Inter-Agency Standing Committee (IASC) Health or Nutrition Cluster.

IHEs can also be commissioned, organized and financed through an inter-agency committee with a designated lead agency at the global level. Currently, the most appropriate commissioning agencies are the IASC health and nutrition clusters as they have the mandate to conduct sector-wide health and nutrition evaluations.

Whether they are commissioned locally or globally, it is necessary to set up a local IHE steering committee of key stakeholders. This can be linked to, or emerge from already

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<sup>10</sup> OECD-DAC. 2002. Glossary of key terms in evaluation and results based management. OECD-DAC Working Party on Aid Evaluation report 6.

[http://www.oecd.org/findDocument/0,2350,en\\_2649\\_34435\\_1\\_119678\\_1\\_1\\_1,00.html](http://www.oecd.org/findDocument/0,2350,en_2649_34435_1_119678_1_1_1,00.html)

<sup>11</sup> OECD-DAC. 2002. Ibid. Summative evaluations are also defined as a study conducted at the end of an intervention to determine the extent to which anticipated outcomes were produced

existing health and nutrition coordination mechanisms. IHE steering committees are necessary to ensure in-country ownership and relevance, and to conduct joint action planning at the end of the evaluation process. They are also important in terms of managing the evaluation, drafting the Terms of Reference (ToR), and prioritizing key questions to be asked by the evaluators.

The primary users of IHEs should be decision-makers at the country level. These include heads of mission and health coordinators of NGOs, and policy-makers within the MoH and their counterparts in the UN system. IHEs can also be used by donors at both the national and international level, as the evaluation can detail both the sector-wide response as well as resource requirements.

## Timing of IHEs

IHEs can be initiated at different times, depending on the type of crisis and/or its evolution over time. Factors that could trigger the commissioning of an IHE could be a substantial change in the humanitarian context (i.e. a renewed outbreak of the conflict or a new transitional peace process) or the humanitarian response (for example, decreased funding flows). IHEs could also be triggered when a situation has stagnated in terms of the humanitarian context and/or the humanitarian response (for example neglected emergencies). IHEs can be conducted within three to six months in an acute crisis (allowing sufficient time for response development, but early enough to influence improvements in response) and/or after 12-24 months in a chronic situation. The timing of an IHE may also be influenced by whether a RTE (Box 2)<sup>12</sup> has taken place. For all of the above mentioned triggers, it is vital to identify key decision-making processes to ensure that the report is ready in time to influence these (for example a new Consolidated Appeal planning cycle, or a major donor conference on funding).

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<sup>12</sup> UNICEF. 2006. RTE Concept Note. And Jamal A and Crisp J. 2002. *Real-time humanitarian evaluations: some frequently asked questions*. UNHCR Evaluation and Policy Analysis Unit EPAU/2002/05.

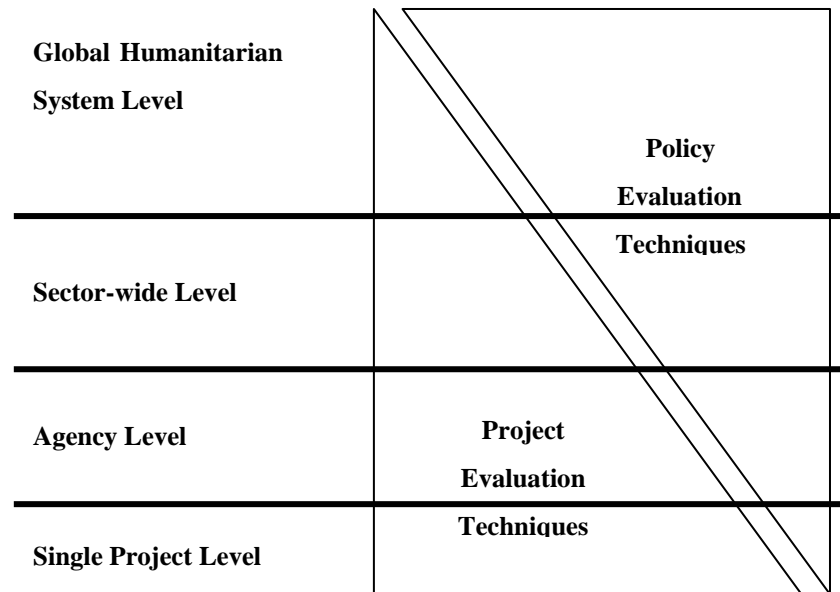
Box 2: A recent development in crisis response evaluation is the Real Time Evaluation (RTE), conducted within eight – twelve weeks after the sudden onset of a crisis or rapid deterioration of the situation in a complex emergency. RTEs are done either jointly or individually by various NGOs and UN agencies. They are meant to provide quick and practical evaluative feedback to country teams and other levels of humanitarian organizations during the early stages of an emergency response. They are conducted over a short period of time (usually less than a month) by a small team of highly qualified evaluators. Evaluative judgements are based on a rapid analysis of epidemiological trends and qualitative information on the provision of services, funding flows and implementation capacity. RTE reports are action-focused and quickly disseminated to prompt immediate response from national program managers. There are no commonly agreed triggers or methods for doing RTEs, however UNICEF, OCHA and other UN agencies are working to develop definitions and guidelines.

## The evaluative approach

Evaluations can happen at four levels – global, sector-wide, agency and single project level (Figure 1). IHEs are sector-wide evaluations of the health and nutrition sector in humanitarian settings. The health sector for the purposes of these guidelines is defined as the part of the humanitarian response responding to the health and nutrition needs of a crisis-affected population with the aim of improving the population’s health and nutritional status, or to prevent its deterioration. IHE’s focus on the processes and mechanisms that manage and deliver preventive and curative services in response to health demands and needs. They may also identify significant issues from other sectors (water and sanitation, agriculture, etc) that cause high levels of morbidity, mortality and malnutrition, and make recommendations on how to improve multi-sectoral actions to improve health outcomes.

Sector-wide evaluations require ‘big-picture’ analysis because the scale of the problem and interventions are different than single project or agency level evaluations. Thus, IHEs take the perspective of the entire affected population. A sector-wide perspective is also needed to assess population coverage, and the overall appropriateness and proportionality of the response in relation to need. For example, humanitarian policies and funding mechanisms should be examined to see how they interact at a sector-wide level, rather than how they impact on a particular project. Single agency and project-level evaluations can feed into sector-wide evaluations if the information within them is synthesized and placed in a broader context.

Figure 1. Levels of Evaluation and Mix of Policy and Project Evaluation Techniques<sup>13</sup>



As sector-wide evaluations, IHEs use a mix of project-level and policy-level techniques, with a focus on policy-level analysis (Figure 1). Project-level techniques consist of a mix of quantitative (epidemiological surveys, surveillance and monitoring) and qualitative techniques that aim to shed light on project performance, including input, output, and outcome indicators, such as health and nutrition trends. Policy-level techniques are used to analyse policies that impact on the humanitarian response. Techniques include interviews (focus groups, key informant interviews) complemented by systematic analysis of documentary evidence (both qualitative and quantitative). Policy analysis focuses on what happened and why, and usually assesses four aspects; 1) the context, describing the environment within which policy decisions take place, 2) the process, which includes problem identification, policy formulation, implementation and evaluation, 3) policy actors, describing the stakeholders whose interests are affected by the consequences of policies, and 4) the content, related to the technical aspects. It can be used to make judgments about events and processes, and through stakeholder analyses, explain why actors did what they did and to what effect, drawing practical lessons from this experience.<sup>14</sup>

<sup>13</sup> Adapted from Hallam A, September 1998. *Evaluating Humanitarian Assistance Programmes in Complex Emergencies*, Relief and Rehabilitation Network, Overseas Development Institute, London.

<sup>14</sup> Hallam 1998. *Ibid.*

## Defining the scope of an IHE

As IHEs have the potential to address almost any topic within the health and nutrition sector, it is important to focus the evaluation and to define its scope (i.e. the specific topics that should be examined during the evaluation). These topics should be listed in order of priority by defined criteria (such as public health importance). Prioritization is crucial as evaluations are restricted in terms of resources and time available; based on experience to date, IHEs are likely to be conducted by a team of two to three health and nutrition experts over a period of three to four weeks.

When defining the scope of an IHE within a ToR, the **geographic area and target population** should be defined. The geographic area could either be a region where an emergency is occurring and where humanitarian actors are present (for example, eastern and southern Chad) or it could be the whole country (for e.g. Liberia). IHEs aim to include all people affected by the humanitarian crisis, however they could focus on those more vulnerable or deliberately excluded (i.e. internally displaced people, refugees, elderly, children, handicapped, gender perspectives, ethnic or religious groups, etc) or give special attention to areas that are more affected than others within a specific humanitarian context.

In addition, the ToR should be explicit about the **time period** to be evaluated (i.e. the evaluation will examine the overall humanitarian response during the last three years). Adding an explicit request for an historic perspective may add value in terms of learning from what worked in the past, and/or what the pre-existing health system looked like (as some crises have existed for decades, information about the pre-existing health system may or may not be relevant).

Finally, the **key topics** that should be answered by the evaluation should be defined. All IHEs should analyse the following aspects of the humanitarian response in health and nutrition and the relationships between them:

1. **Health and nutrition outcomes**, such as mortality and malnutrition rates.
2. **Performance of health and nutrition services**, including provision (availability, accessibility and quality), utilisation and coverage of services.
3. **Health and nutrition sector policy and strategic planning**, including leadership, health information systems, medical products and technologies, health workforce, health financing and humanitarian funding are cross-cutting health system issues that influence the delivery of, and/or access to, adequate services.

4. **Risks** to health and nutrition, such as environmental risks related to water and sanitation, food security, forced migration, the potential for outbreaks of communicable diseases and risk of natural hazards.
5. **The humanitarian context**, such as the security and human rights situation of the affected population, protection issues and the humanitarian space.

Within this broad set of topics, stakeholders must prioritize their key questions and concerns. Care must be taken not to overload the remit of the evaluation. ToRs are often over-ambitious, with the risk that people become disappointed when the results do not match the (unrealistic) expectations that were raised.

To optimize the usefulness of the IHE approach, each evaluation will need to be adapted to its context. Some distinction in the types of scenarios (e.g. camp situation, acute conflict, transition) may be helpful when determining key questions. For example, in camp situations, it may be appropriate to evaluate health service provision for refugees and other displaced populations in the camps and its dynamic with locally available health services. In transition contexts, issues may include health and repatriation of refugees and other displaced populations, transitional funding, and upcoming plans for health system planning and service delivery at national level.

It is important to find an optimal balance between the need to adapt each evaluation to its specific context, and the need to compare IHEs. It may be useful to compare between different crises for numerous reasons, including relative needs, the effectiveness of response, and differences in funding allocation. To this end, an evaluation framework is presented in the next section which outlines a set of issues and indicators that should be examined in each evaluation.

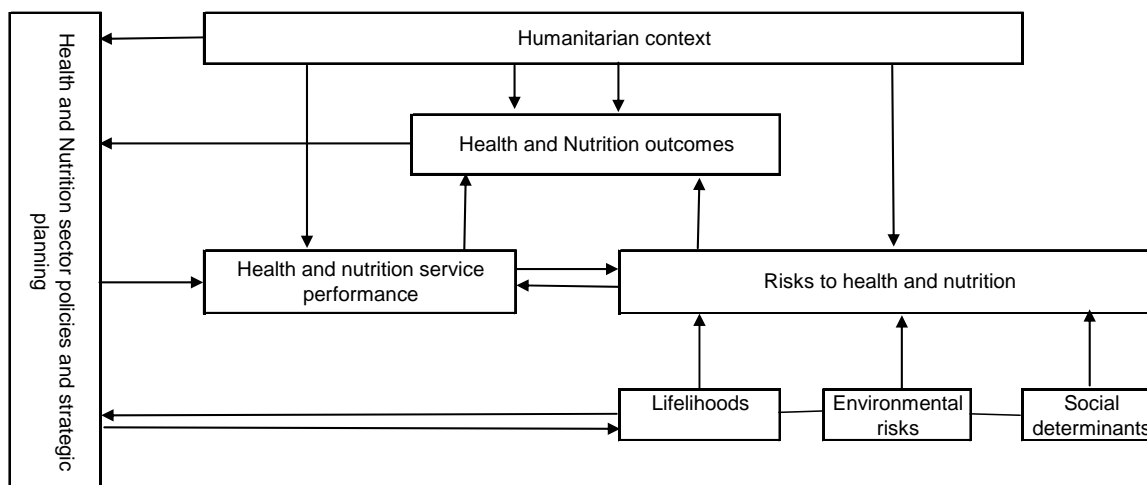
## The evaluation framework

The figure below reflects the different elements of the health and nutrition sector and indicates the interaction that may exist between them (Figure 2). It is not only vital to examine the content and performance of the different elements, but also how they influence each other.<sup>15</sup>

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<sup>15</sup> This diagram is compatible with the framework for the Needs Analysis Framework (NAF). For the purpose of this guideline, health and nutrition services are the centre of analysis. The issues to look at are similar to those in the annexes of the NAF, and one can feed into the other. Psycho-social services are seen as part of health sector, and are not mentioned separately. IASC CAP Subworking Group. 2005. *Needs analysis framework: Strengthening the process and analysis and presentation of humanitarian*

Figure 2. *Interactions between health determinants and health outcomes in conflict settings*



Key questions under each of the five topics outlined in the section above -- health and nutrition outcomes, provision of health and nutrition services, risks to health and nutrition, health and nutrition sector policy and strategic planning, humanitarian context – are detailed in the evaluation framework presented in Table 1 below. Each of the five topics is then expanded upon in the sections below. More guidance on what type of information needs to be collected, details on indicators, and references to assist in the analysis of ‘performance’<sup>16</sup> are presented in the methods section and in the annexes.

It is important to note that comparison with international references, indicators and standards of performance (some of which reflect entitlements based on human rights such as documented by the Sphere Project)<sup>17</sup> remains a challenge for evaluators. First, it is difficult to evaluate the collective response in the absence of collectively agreed benchmarks. For example, there is often more than one technical guideline on a specific health topic, and indicators and standards are not always consistent. While Sphere comes closest to consensual benchmarking, it is not agreed upon by all agencies, and is not applicable to all settings. There is also a lack of agreement on such topics as health financing (i.e. use of user fees), aid mechanisms and funding flows which are fundamental to how the health sector performs. There is a need for benchmarking of the health and nutrition response in each specific setting, but this remains a gap in most humanitarian responses.

needs in the CAP.

[http://www.reliefweb.int/cap/Policy/Needs\\_Assessment/2005/NAF.htm](http://www.reliefweb.int/cap/Policy/Needs_Assessment/2005/NAF.htm)

<sup>16</sup> Performance is defined as the degree to which a development intervention or a development partner operates according to specific criteria/standards/ guidelines OECD-DAC. 2002. Ibid.

<sup>17</sup> The Sphere Project, 2004. *Humanitarian Charter and Minimum Standards in Disaster Response*. The Sphere Project: Geneva. <http://www.sphereproject.org>.



Second, there are different interpretations of what humanitarian needs are, how to address them, and where responsibilities lie. For example, the ambition of the humanitarian community is to move towards the Sphere standards, applying the concept of ‘progressive realization’ of rights. This concept, however, does not relieve states from the obligation to urgently, promptly and effectively address acute health crises and needs. Given this, the evaluators should not evaluate against the standards *per se*, but rather evaluate the degree to which affected populations' needs are covered, and the progress the humanitarian community has made in trying to meet the standards, given the constraints of the situation.

**Table 1 – Evaluation Framework for Assessing the Health and Nutrition Sector**

<b>1. HEALTH AND NUTRITION OUTCOMES</b>			
<p><b>Mortality, morbidity and malnutrition rates:</b> What are the trends in crude mortality and under 5 mortality rates, moderate and severe malnutrition prevalence? What are the most important causes of mortality, morbidity and malnutrition, and other important public health issues? What are trends in disease patterns (proportionate morbidity/incidence/prevalence rates) and malnutrition rates?</p>			
<b>2. PERFORMANCE OF HEALTH AND NUTRITION SERVICES</b>			
	<b>Nutrition</b>	<b>Control of communicable diseases</b>	<b>Control of non-communicable diseases</b>
<b>Services</b>	General nutritional support (all groups/at risk) Correction of malnutrition (moderate/severe/micronutrient)	Prevention activities Measles vaccination Diagnosis and case management of comm. diseases (including HIV/AIDS, STIs, malaria, diarrhoea, ARI) Outbreak detection, investigation and response	Prevention activities Injuries/trauma Reproductive health services, (including emergency obstetric care) Psychosocial services Chronic diseases
<b>Provision</b>	Describe the types, levels and distribution of health facilities, referral capacity between the levels. What services and health programmes are available?		
	Are they accessible?		
	Is the quality adequate?		
<b>Utilization</b>	Are services being used?		
<b>Coverage</b>	Is the target population being reached? What are the coverage rates of the respective programmes?		

### 3. HEALTH AND NUTRITION SECTOR POLICIES AND STRATEGIC PLANNING

**Health sector leadership:** How good are strategic planning and prioritization processes? How well are coordination mechanisms and communication systems working? What is the relationship between humanitarian services and the national health system? Are there gaps and overlaps in the response (geographic or in terms of types of services)? Is there effective inter-sectoral collaboration? How are health services managed? **Health information systems:** What are the gaps in the functioning of the health information systems and disease surveillance? Is there monitoring of programmes? Have benchmarks been agreed and followed? **Medical products and technologies:** Is there appropriate management and policies regarding pharmaceuticals? Are good quality products available and accessible? **Health workforce:** What are the human resource issues (numbers, incentives, salaries etc)? Are there constraints due to human resources? **Health financing:** What (national) systems are in place for the financing of health and nutrition services; how do these affect access to services? What is the magnitude and role of out-of-pocket payments, and do they limit access? **Humanitarian funding:** Is there adequate resource mobilization and funding? (an assumption of Sphere) to deliver adequate services? What is funding *per capita*? Is there efficient and appropriate use of resources? Are there linkages between humanitarian and development funding, and how does funding compare?

### 4. RISKS TO HEALTH AND NUTRITION

**Health and nutrition risks** – What is the humanitarian response to reduce exposure to risk factors such as inadequate water and sanitation, livelihoods, and what are the strengths and weaknesses? What are other threats to health, such as the potential for outbreaks or natural disasters, and how well is preparedness organised by the health and nutrition community? How do risk factors such as forced migration, age, gender, disabilities, ethnicity, religion, and other social determinants, contribute to vulnerabilities and or make people target to violence, or lead to exclusion for accessing services?

### 5. HUMANITARIAN CONTEXT

What is the **political context** of the crisis? What are the human rights violations and what is being done to ensure protection of the affected population? How is the overall security situation, and how does this affect humanitarian space and access to services? What percentage of the affected population can be reached by humanitarian agencies?

## 1. Health and nutrition outcomes

Measuring health and nutrition outcomes (mortality, morbidity and malnutrition rates) through epidemiological surveys and surveillance systems is a significant part of the health and nutrition sector's humanitarian response.<sup>18</sup> IHE evaluators should analyse available indicators on health and nutrition outcomes, including mortality data, to

<sup>18</sup> Checchi F, Roberts L (2005). Interpreting and using mortality data in humanitarian emergencies: a primer for non-epidemiologists. HPN Network Paper 52. London: Overseas Development Institute, and CEDAT: A Database on the Human Impact of Complex Emergencies. <http://www.cred.be/cedat/index.htm>

identify trends and gaps in knowledge.<sup>19</sup> This information should be assessed in relation to the other four areas indicated in the framework. For example, if trends in malaria morbidity and mortality are a problem, a more thorough examination of malaria control (curative and diagnostic services for malaria, outbreak control, stewardship and funding) should be done.<sup>20</sup> Specific morbidity and mortality indicators that should be examined are listed in Annex 1, however other indicators may be used if the ones in Annex 1 are not available.

## **2. Health and Nutrition Service Performance**

Health and nutrition service provision can be divided into three sub-sectors: nutrition, control of communicable diseases and control of non-communicable diseases. Three aspects of performance of these sub-sectors can be evaluated: provision, utilization, and coverage.<sup>21</sup> Provision consists of three components: availability, accessibility and quality of services. Evaluations can examine whether quality services are provided and made available in an accessible and timely manner. One aspect of availability is infrastructure; evaluators should give an overview of the different types that exist, their geographic location, and referral systems. Services also need to be financially and culturally accessible. Utilization, which results in a certain population coverage, can be estimated, and gaps in coverage should be highlighted. Indicators that cover the performance of services are listed in Annex 1.

## **3. Health and nutrition sector policies and strategic planning**

To understand the dynamics of service provision and health and nutrition trends, cross cutting issues that affect all services - including leadership, health information systems, medical products and technologies, health workforce, health financing and humanitarian funding flows - need to be analysed.<sup>22</sup>

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<sup>19</sup> By identifying major gaps in data collection, IHEs can feed into ongoing initiatives such as the SMART programme, which is attempting to systematize the collection and analysis of mortality data across emergencies. Technical information on conducting and interpreting mortality surveys can be found on [www.smartindicators.org](http://www.smartindicators.org).

<sup>20</sup> Some more examples are given in the CAP IASC Needs Analysis Framework. IASC. 2007. *Needs analysis framework: Strengthening the analysis and presentation of humanitarian needs in the CAP*. Prepared by the IASC CAP Subworking group.

<http://ochaonline.un.org/humanitarianappeal/DocView.asp?DocID=1891>

<sup>21</sup> Habicht J, Victora C and J Vaughan. 1999. Evaluation designs for adequacy, plausibility and probability of public health programme performance and impact. *International Journal of Epidemiology* 28:10-18.

<sup>22</sup> For more guidance see WHO. 2006. *Analysing Disrupted Health Systems*. [http://www.who.int/hac/techguidance/tools/disrupted\\_sectors/en/index.html](http://www.who.int/hac/techguidance/tools/disrupted_sectors/en/index.html)

In the humanitarian context, it is rare that a single agency exerts leadership functions in terms of setting health policy and strategic planning. Rather, policy and strategy is the outcome of actions by numerous agencies, with various degrees of coordination between them. The first step is a stakeholder analysis, where responsibilities, strength of influence, and barriers to provision of adequate services can be explored. A good starting point is to analyze "who does what where?" This may reveal major gaps or duplications in the system that need to be addressed. Evaluators should assess coordination and communication amongst agencies, between agencies and the health authorities, and with, and between donors. Prioritization processes and strategic decision-making should also be scrutinized. There are many mechanisms in use to prioritize activities, including Transitional Results Frameworks and Common Humanitarian Action Plans (CHAPs), amongst others. For example, the quality of the CHAP with regards to health sector should be assessed. If there is no CHAP in place, or the health section is weak, evaluators should examine why this is the case, and assess how the IHE evaluation could both feed into further CHAP processes, and be used to develop a common strategy for health.

The development and functioning of health information systems (HIS) that track trends in morbidity and mortality, measure critical performance indicators of the health system, and that detect and respond to outbreaks and/or natural disasters, also needs to be analysed. For instance, evaluators should be able to assess whether key indicators are being collected, identify gaps in collection, and make recommendations on how to fill these gaps. In this regard, IHEs can support ongoing initiatives such as the SMART<sup>23</sup> programme and recent work on the establishment of a global Health and Nutrition Tracking System.<sup>24</sup>

Issues including procurement of essential drugs and medical products, human resource development and health financing need to be analysed to see how they influence the quality of services or pose common constraints in service delivery or barriers for access. Under health financing, for example, evaluators should assess any information available on out-of-pocket payments, and highlight the need for more discussion on the role of user-fees if there are concerns that user-fees are a major barrier to access.

The absolute amounts of humanitarian funding available, on a *per capita* basis, will affect the provision and coverage of services, and needs to be assessed. Issues such as

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<sup>23</sup> [www.smartindicators.org](http://www.smartindicators.org)

<sup>24</sup> Humanitarian health and nutrition tracking system: a proposal submitted to the forthcoming meeting of the IASC working group, Geneva, 5-7 July 2006.  
[http://www.who.int/hac/network/interagency/healthcluster/6\\_HNTS\\_project\\_document.pdf](http://www.who.int/hac/network/interagency/healthcluster/6_HNTS_project_document.pdf)

temporary funding gaps, or chronic under-funding of the entire emergency response, or the presence of funding gaps due to the lack of appropriate budget lines (as happens during the 'transition' from relief to development) need to be explored. Estimates of efficiency can also be made, such as how well available funding is being used.

#### **4. Risks to Health and Nutrition**

Major health and nutrition determinants in humanitarian crises include livelihoods, migration, shelter and water and sanitation. Although they are not the primary focus of this type of evaluation, which focuses on the health and nutrition sector, it is important to have an understanding of how these determinants impact on the health and nutrition of the affected population, and what is being done to address them, as they can have a significant impact on health outcomes. For instance, issues of cross-border and internal population movements may be of interest, such as the impact of migration on health and nutritional trends, and how health and nutrition services affect migration (i.e. repatriation). The significance of health determinants can be identified through morbidity patterns, and if identified, they should be briefly highlighted in the report. For example, high rates of diarrhoea might indicate that water and sanitation problems need to be addressed. Multi-sectoral action may be required to deal with possible threats to health, and as such, opportunities should be identified for possible inter-agency coordination. Health data can be used to both advocate for change and to give feedback on any changes.

In addition there are also social determinants to be considered that could lead to increased vulnerability. These usually include gender, age, people living with HIV/AIDS, poverty, ethnicity, religion and disabilities. Using disaggregated data, analyses can be made to see if there are any significant differences between and within groups and/or locations. At the same time, existing capacities, which could provide insight in coping capacity of affected populations and groups, should be analysed.<sup>25</sup> Assessing the extent to which these types of analyses are done by the health and nutrition actors in the field could be included in the remit of the evaluation.

#### **5. Humanitarian context**

The humanitarian context is the reason why agencies are present in a particular setting. It also determines their ability to 'reduce mortality, alleviate suffering and restore a life with dignity'. Operating in such environments creates specific challenges. For example,

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<sup>25</sup> See for example the Capacity and Vulnerability Analysis as part of the Common Humanitarian Action Plan: [www.reliefweb.int/cap/ToTBinder/CAP\\_Training\\_Toolkit/CapacityVulnerabilitiesAnalysis.doc](http://www.reliefweb.int/cap/ToTBinder/CAP_Training_Toolkit/CapacityVulnerabilitiesAnalysis.doc)

what is the overall security situation, and how does this affect humanitarian space? What percentage of the affected population can be reached by humanitarian agencies? A general understanding of how the security context directly impacts on service delivery is imperative as it sets the context for the evaluation's finding.

In addition, the mandates of many humanitarian agencies include witnessing human rights violations, and advocating for protection of these human rights. Evaluators can assess the role of protection and *témoignage* (witnessing and protection) by health agencies, and the use of epidemiological data in this regard. The evaluators can also gain an understanding of the political context of the crisis, including who gains and loses from the conflict, and how this impacts on health service delivery. Finally, an examination into whether humanitarian actors have thought about if, and how their collective actions may lead to prolongation of the conflict, or the reinforcement of harmful power relationships, could be included in the remit of the evaluation.<sup>26</sup>

## Methods and analysis

To conduct an IHE, evaluators must use their skills, knowledge, experience and judgement to quickly assess many different parameters. This requires analysis of various kinds of information, including secondary epidemiological data and written reports, as well as interviews with key informants (technical specialists, managers and local people) about their perceptions about the collective health and nutrition performance and impact.<sup>27</sup> The job of the evaluator is to triangulate this information, and then, using judgement based on experience, make logical and plausible arguments about the performance and possible impact of service provision. Some pointers on how to do this are included in Annex 2. Evaluation guidelines for a variety of sub-sectors, such as reproductive health, communicable diseases and health information systems, are listed in Annex 3.

### *Epidemiological indicators*

Indicators, where available, are useful to guide data collection and analysis. In Annex 1, there is a proposed minimal set of key indicators related to performance of services that should be examined in every IHE. These are based on the ones proposed for the 'health

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<sup>26</sup> Anderson, MB. 1999. *Do No Harm: How Aid Can Support Peace or War*. Boulder, Colorado: Lynne Rienner Publishers.

<sup>27</sup> For a discussion on social research tools, please see Pope C. 2000. *Qualitative Research in Health Care*. Second Edition ed. London: BMJ Books.

and nutrition tracking system'.<sup>28</sup> <sup>29</sup> Additional indicators can be selected depending on the context and relevance for the specific ToR. These can be taken from the Sphere Handbook and/or programme specific technical guidelines (Annex 3); these guidelines can also be used as references against which to analyse data, as benchmarks are set for certain indicators.

As IHE evaluations are done in a short period of time, epidemiological indicators should be assessed using existing secondary data. Evaluators should check the validity of this data by reviewing methodology and primary documentation (for example, see the notes on mortality surveys in Annex 1). They should also assess whether data has been analysed and disaggregated by gender, age and socio-economic status or other factors that represent risk factors, and ascertain if this analysis has informed the humanitarian health and nutrition response. Dis-aggregation allows for an analysis of benefits (or lack thereof) to different groups, which has a bearing on the principle of equity, or health care according to need.

In many situations, data on these indicators will not have been systematically collected or adequately analysed at an aggregated sector-wide level. There has been some recent progress to standardise collection and analysis methods, for instance, by SMART<sup>30</sup> for crude mortality rate and under-five nutritional indicators; by UNHCR through their recent standardised health information system initiative;<sup>31</sup> and by the recent establishment a group to develop a health and nutrition tracking system.<sup>32</sup> If sector-wide, aggregated analyses are available from routine monitoring systems, then they should be reported in an IHE evaluation. However, until humanitarian agencies collectively decide on groups of indicators (as has started with the Sphere) and standardize collection and analysis methods, data collection and analysis at aggregated level is likely to be sub-optimal, and evaluation teams will have to make the best use of available data. Shortcoming in data collection and analysis should be reported and recommendations should be made on how to strengthen the overall performance of the health information system.

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<sup>28</sup> Humanitarian health and nutrition tracking system: a proposal submitted to the forthcoming meeting of the IASC working group, Geneva, 5-7 July 2006.

[http://www.who.int/hac/network/interagency/healthcluster/6\\_HNTS\\_project\\_document.pdf](http://www.who.int/hac/network/interagency/healthcluster/6_HNTS_project_document.pdf)

<sup>29</sup> Griekspoor, A. Loretto, S and A Colombo. 2005. Tracking the performance of essential health and nutrition services in humanitarian responses.

[http://www.who.int/hac/events/summary%20performance%2028%2011%20\\_2\\_.pdf](http://www.who.int/hac/events/summary%20performance%2028%2011%20_2_.pdf)

<sup>30</sup> Standardized monitoring and assessment of relief and transitions (SMART) initiative. For more information, see <http://www.smartindicators.org/about.htm>

<sup>31</sup> UNHCR June 2006. Standardised Health Information Systems (HIS) Standards and Indicators Guide; and Training Manual for Implementing Partners to Support Adaptation and Deployment in Refugee Operations.

<sup>32</sup> [http://www.who.int/hac/network/interagency/healthcluster/6\\_HNTS\\_project\\_document.pdf](http://www.who.int/hac/network/interagency/healthcluster/6_HNTS_project_document.pdf)

### *The use of the OECD-DAC evaluation criteria*

The OECD-DAC evaluation criteria help analyse findings and organize conclusions (Annex 4). These consist of relevance, appropriateness, connectedness, coherence, coverage, effectiveness, efficiency and impact. They can be used as a point of reference to ask key questions on whether or not the right things are done (relevance, appropriateness), if they are done in the right way (connectedness, coherence, coverage, effectiveness, impact), and at the right costs (efficiency).

These criteria are useful in two ways: to group key questions in a logical manner, and to summarize overall findings and draw conclusions. First, they allow evaluators to make a logical list of questions, ensuring that pertinent questions are asked. For example, the criteria of connectedness, which is ‘the need to ensure that activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account’ includes a key question around the interaction between the humanitarian health services and the national health system.

Second, the OECD-DAC criteria provide a systematic way to make conclusions about the overall response. They can be used to synthesize knowledge regarding whether the combined health and nutrition response was relevant and appropriate to the needs of the affected population (and why or why not); how it was connected to the national health system; its overall coverage of the population; and why it may not be as effective as it could have been.

### *A Note on Impact Evaluation*

IHEs mainly focus on evaluating the performance of the health and nutrition sector. However, IHE evaluators can make plausible arguments about the impact of the humanitarian sector based on their evaluation of the performance of the humanitarian sector, and trends in mortality and morbidity (Annex 5). While it is beyond the scope of an IHE to attribute trends in mortality and morbidity to the performance of humanitarian activities using epidemiological techniques, it is possible for the evaluators to make judgments about the adequacy of the humanitarian response, and argue that humanitarian activities may have led to changes in health and behaviour outcomes, given certain contextual indicators. This level of argumentation meets the needs of most types of decision-makers in humanitarian crises as most individual health and nutrition interventions are evidence-based (at least in stable settings). More rigorous types of evaluative study designs (such as randomized controlled trials) are generally not possible or ethical in humanitarian settings.



## Conclusions

Together, the evaluation framework, the section on methods, and the supporting annexes should be used to guide the questions asked by IHE evaluators, and the methods that they use. Part II of these guidelines outline in much more detail the process of managing IHE evaluations.

While the focus of each IHE will be determined by context, there is scope to compare IHEs across different settings in order to inform key humanitarian actors about the strengths and weaknesses of the health and nutrition response globally. The use of a consistent evaluation framework and evaluation methods will facilitate such comparisons.

Finally, IHEs should be seen in a continuum from assessment to planning and evaluation. There should be consistency between what is examined during needs assessments, what is addressed in terms of strategy development and planning, what is monitored in terms of inputs, performance, outputs and outcomes, and finally what is analysed in the evaluation. For example, in a needs assessment, agencies would examine the availability of health facilities, and in the planning they would set targets if shortages have been identified. Through the monitoring system, they would track progress in making the new facilities functional, and in the evaluation, they would assess their activities in terms of relevance, effectiveness, etc. The indicators and/or data types required would need to be consistent throughout the process. While such a continuum does not yet exist, the evaluation framework presented is compatible with, for example, the Needs Analysis Framework<sup>33</sup> as developed for the Common Humanitarian Action Plan, and with progress that is being made in monitoring systems developed under the IASC health and nutrition clusters.

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<sup>33</sup> IASC. 2007. *Needs analysis framework: Strengthening the analysis and presentation of humanitarian needs in the CAP*. Prepared by the IASC CAP Subworking group. <http://ochaonline.un.org/humanitarianappeal/DocView.asp?DocID=1891>

## Part II - Managing the IHE Process

Part II of these guidelines are primarily directed to people responsible for commissioning, coordinating and managing IHEs. For the purpose of Part II, it is assumed that stakeholders at either the national or global level have identified the opportunity to do an IHE in a specific context. For more information on commissioning an IHE, see Part I, 'Purpose' and 'Users and Commissioners of an IHE'.

Once an IHE has been commissioned, there are three main steps to conducting an IHE:

Step 1) Plan and prepare the IHE

Step 2) Implement the IHE

Step 3) Report, disseminate and follow-up on IHE findings

Specific tasks are described in detail, followed by a checklist summarising the tasks from a practical “how-to” perspective.

### **Step 1: Plan and Prepare the Interagency Health Evaluation**

#### **Task 1.1 Set up the IHE Steering Committee**

The nature of an IHE demands that a broad group of stakeholders (including the various UN, NGO, national health authorities and donor agencies) participate in, and contribute to the evaluation process. No single agency can or should drive an IHE as this would undermine its essence. However for pragmatic reasons, it is necessary that a limited number of agencies manage the evaluation. This should be done by a smaller group of agencies that together represent the different stakeholders. It is expected that such a group is formed within the normal coordination mechanisms at country level, or at global level under the guidance of the IASC health cluster.

Whoever initiates or manages the IHE should ensure that the IHE gets broad buy-in by discussing the IHE with all relevant national actors. If a proposed IHE was initiated at the global level, a pre-visit to the selected country should be arranged to discuss the proposed purpose with the stakeholders in that country to ensure that their interests are taken into account. The IHE should also be presented to UN and NGO representatives through in-country health and nutrition coordination bodies. There must be general agreement within the health coordination body that there is a need for an IHE, and that

the timing for an IHE is appropriate (i.e. it can inform the common humanitarian action plan in the consolidated appeals process, and/or inform any other decision making process).

If the idea to do an IHE is accepted, interested representatives from the health coordination body should form an IHE steering committee (IHE SC) to take the process forward. This IHE SC should remain formally linked to the in-country health and nutrition coordination bodies for the duration of the IHE process.

The IHE SC offers stakeholders a means to participate actively in the evaluation process while creating a workable management structure to organize and implement the IHE. Within the IHE SC, decisions about roles and responsibilities, such as who will host and organize the logistics and security for the evaluators, need to be made.

#### **CHECKLIST for Task 1.1 Commission an IHE and set up an IHE steering committee**

- Initiate an IHE through normal coordinating mechanism, and/or based on certain triggers as explained in Part I, Timing.
- If initiated globally (for example through the health cluster), carry out a pre-visit to establish ownership by in-country stakeholders, and agreement on the purpose and added value of the IHE to national stakeholders. If initiated by national actors, ensure that broad buy-in is obtained via existing coordination mechanisms.
- Form an IHE Steering Committee (a smaller group of agencies formed from within the existing health coordination body), who together will manage the IHE and be able to represent the various stakeholders' interests.
- Discuss the various roles of the IHE SC, and decide how different stakeholders will contribute (staff, funds, hosting of the team, logistics, security, etc).
- Establish practical arrangements for communication between the IHE SC and the existing health and nutrition coordination bodies to ensure meaningful dialogue and adequate information sharing.

#### **Task 1.2 Develop the Terms of Reference**

The IHE Steering Committee is responsible for managing the process of designing the Terms of Reference (ToR). If needed, it can receive support from the agencies who may have initiated the IHE at the global level. Sufficient time must be allocated for preparing the ToR, allowing for dialogue between, and input from all concerned stakeholders. The key issue is to achieve shared understanding about the purpose of the IHE, the users of

the evaluation, and its value for stakeholders. Several rounds of consultations must often be held before these have been agreed upon. The purpose will influence the timing of the IHE, and the deadline for the report. Different stakeholders will have different time frames, priorities and deadlines that will need to be taken into account. It is recommended that IHE's be timed so that they feed into ongoing planning and decision-making processes, such as the Consolidated Appeals Process (CAP) or donor-funding conferences.

Once the purpose and users of the evaluation have been agreed upon, the scope (key questions, timeframe, geographic area and target population) should be defined. The IHE should address topics and questions outlined in Part I, Table 1, and make reference to the OECD-DAC evaluation criteria outlined in Annex 4. In addition, it is essential to be explicit about the time period to be evaluated: for example, the evaluation will examine the overall humanitarian response over the last three years.

The geographic area for the IHE also needs to be determined – for example, will an entire country or a limited geographic location be covered by the evaluation. This decision will be influenced by the nature of the humanitarian health interventions, and their geographic scope. IHEs should aim to include all people affected by the humanitarian crisis, and where necessary give specific attention to vulnerable or excluded groups, such as internally displaced persons, refugees, women, and religious or ethnic groups.

The purpose and scope all influence the type of information that needs to be collected and the methods required. These methods (such as the types of stakeholder to interview, and types and quantity of information to collect), should be outlined in the ToR.

Finally, the ToR should contain a work-plan for the evaluators. A schedule of organized field visits should be provided. The hosting field agency should arrange transportation and lodging, assure security arrangements, set up appointments for interviews with informants, and organize site visits. The timeline for drafting and finalizing the report should also be laid out. For more information on the format and content of a ToR, see Annex 6.

#### **Checklist for Task 1.2 Develop the Terms of Reference**

- The IHE SC ensures that the purpose of the IHE is defined through a participatory process that engages all interested users of the evaluation.
- Identify possible users of the IHE, i.e. those groups that are expected to make use of the evaluation process and its results, and how the information will be used.

- ☑ Determine the most appropriate timing for carrying out the IHE, taking into consideration the purpose/s of the IHE, the phase of the humanitarian crisis to be evaluated, and the varying timeframes and deadlines of stakeholders for planning and decision making.
- ☑ Decide on the scope of the IHE including key topics and questions, time period geographical area/s and target population/s and to be evaluated.
- ☑ Formulate the evaluation questions and methods used to collect data in key areas (see Part I of these guidelines, and Annex 4)
- ☑ Devise a work plan for the evaluators

### **Task 1.3 Estimate IHE Costs and Recruit Evaluators**

The complexity of the humanitarian crisis to be evaluated and the specific purposes of the IHE will dictate the timeframe of the evaluation, the number of evaluators needed, and the overall cost of the exercise. Ideally, resources for an IHE should be secured early in the process but this will depend on the situation. A sample budget is presented in Annex 7 which includes a pre-visit, and a 30 day evaluation done by three evaluators. Additional costs will be incurred for an action-planning workshop, and if external support is needed to manage the evaluation process.

The evaluation team members usually spend two to three weeks conducting field work. This time frame is a compromise between allowing enough time given the complexity of the topics to be evaluated during an IHE, and the need to come up with pragmatic and actionable findings within a reasonable time. Information needed to answer complex evaluation questions must be collected by evaluators through interviews with a wide range of stakeholders and the time-consuming analyses of secondary information. In order to estimate the time required for an IHE, the SC should consult with local and external evaluation experts, and realistically assess factors affecting access to intervention sites such as weather, poor roads and insecurity. If it is difficult to predict the amount of time needed for the study, flexible contracts for evaluators should be considered.

The most expensive item in an IHE budget is the cost of evaluators, including consultancy fees, transport, daily subsistence allowance, and other related costs. The IHE SC can establish a budget limit by estimating the total number of person-days/weeks required for the IHE and multiplying the figure by a competitive fee and accepted subsistence allowance rates. To the extent possible, the IHE SC should identify locally available expertise, which would also reduce overseas travel costs.

The success of the IHE is largely dependent on the choice of evaluators. The IHE SC is responsible for developing the ToR for evaluators, clarifying needed skills and expertise in relation to the scope and key questions in the TOR, and for identifying and recruiting the evaluation team members. As necessary, the recruitment process could be supported by the headquarters of the participating agencies, or for example through the health cluster. While the skills and other qualifications of evaluators vary, the following basic criteria should be considered when recruiting evaluators.

**Evaluation expertise and experience** is required, as well as strong conceptual and methodological skills. Evaluators need to have had considerable field experience to enable them to assess humanitarian relief assistance, health outcomes, and issues around transition and development. Gender balance is also important as the results of the evaluation can be enhanced by having a mix of men and women on the team.

**Subject matter expertise** is imperative, depending on the scope of the IHE. However, in order to cover the large number of health issues as laid out in Part I of the guidelines, evaluators should be generalists, and able to cover several domains of health and nutrition. Familiarity with UN, NGO and/or donor policy making processes is also important.

**Local knowledge**, including an understanding of the national context, the functioning of national health authorities, local social conditions and cultures, and ideally, some knowledge of the local language, are all needed to accurately assess the health and nutrition sector. Use of local evaluators can help to ensure adequate local knowledge.

**Independence and detachment** from the object of evaluation are essential. Whether evaluators are internal or external, all must be independent and objective and not pushing specific mandates or interests. This will avoid compromising the credibility and acceptability of the IHE exercise.

Recruitment of the evaluators should take place well before the planned dates for the IHE implementation, since the supply of qualified, experienced evaluators is very limited and the recruitment process generally time consuming. Recruiting evaluators at the last minute may considerably reduce prospects for obtaining a good evaluation. Once candidates are identified, a team leader needs to be chosen. The role of each of the evaluators needs to be outlined in each person's contract.

Care should be taken to consider the mix of evaluators. External international evaluators may be seen to be objective and professional, but may lack knowledge about the country and its specific circumstances. Local evaluators may have good knowledge of the local context and languages, but must be seen to be objective and not involved in national humanitarian health and nutrition programming. A mixed team of external consultants (both international and local), together with in-country staff has the advantage of insider knowledge as well as objectivity. As each context is different, the pros and cons of having purely external evaluators versus mixed teams must be assessed when putting together the evaluation team.

#### **CHECKLIST for Task 1.3 Estimating IHE Costs and Recruiting Evaluators**

- Set a budget limit for the IHE by estimating costs from competitive consultancy fees and required number of person-days/weeks, and other budget lines as in Annex 7.
- Identify and recruit evaluators with the required evaluation and subject matter expertise, experience, local knowledge and independence, as per the ToR.
- Initiate the recruitment process as early a possible in order to obtain the best possible services in a timely manner.

### **Task 1.4 Finalise the Terms of Reference**

Once the evaluation team has been selected, it is the responsibility of the IHE SC to finalise the ToR, as outlined in Annex 6. The evaluators should be consulted in terms of the final objectives and workplan. Other key agencies, such as those who may be supporting the IHE at the international level, and those involved in national health and nutrition coordination bodies, should also give feedback.

#### **CHECKLIST for Task 1.4 Finalising the ToR**

- Encourage feedback from a broad group of stakeholders before finalising the ToR.
- Check that the ToR follows the sample format and guidelines found in Annex 6.

## **Step 2: Implement the IHE**

### **Task 2.1 Brief the Evaluators and Finalise the IHE Work plan**

Before the evaluators leave for the field, they should be briefed, ensuring that there is a common vision of the evaluation and that the purpose of the evaluation is clear. This is particularly significant as most evaluators are likely to have never been involved in this

type of evaluation before. They should understand the sector wide nature of the IHE. Team roles and feedback mechanisms should also be decided, and ethical codes of conduct should be checked.

The IHE SC members and evaluators should develop an effective working relationship. The SC could consider giving the team leader a couple of extra days in the field at the beginning of the mission to meet key people, schedule meetings and start collecting documentation. Once the entire team has been deployed to the field, the IHE SC should introduce its members to the team, brief the team members on the humanitarian crisis and the health and nutrition sector, and make final adjustments to the work plan.

Both parties at the planning stage should have a clear understanding of how the IHE is to be carried out, who is to do what, what is to be produced and when. If unexpected developments occur, the ToR and the other documents governing the evaluation process may be open to conflicting interpretations that can only be resolved through discussion. Both parties must maintain an open and flexible attitude throughout the implementation of the IHE.

IHE team members should also be introduced to agency managers (including the UN Country Team/Heads of Agencies/NGO directors,) and officials, including national health authorities and donors, as soon as possible after arrival. The evaluators should be asked to participate in the earliest health and nutrition coordination meeting to introduce themselves and the IHE evaluation, and to ensure that a broad range of stakeholders are engaged. It may also be necessary to invite all stakeholders to a special coordination meeting to ensure that key stakeholders who may not necessarily attend the normal health/nutrition coordination meetings are aware of the upcoming IHE.

**CHECKLIST for Task 2.1 Brief Evaluators and Finalise the IHE Work plan**

- Conduct a briefing for the evaluators before they leave for the field, organised by those agencies that support the IHE at global level.
- Once in the field, the IHE SC should introduce the evaluators to its members, agency managers and other officials, and provide an overview of the humanitarian health and nutrition sector. The IHE evaluation team should attend the earliest health and nutrition coordination meeting to ensure engagement with a broad range of stakeholders.
- Decide on necessary changes in the ToR and make final adjustments to the work plan. Ensure open communication between the IHE SC and the evaluation team and allow for flexible attitude and adjustments during the process.



## **Task 2.2 Support Evaluators during the IHE**

The IHE SC should identify a host agency amongst them responsible for providing logistical support and office space during the evaluation. Appropriate security measures must also be taken to ensure the safety of evaluators during field visits. IHE SC members can share responsibility for providing support to the evaluators, and contingency plans can be drawn up for addressing unexpected needs of the evaluators during the IHE. These include communication equipment, becoming part of security protocols, and (medical) evacuation plans. Establishing a reliable, regular means of communication between the IHE SC and the evaluation team is crucial, and plans should be made for periodic consultations both prior to and during field visits.

The various stakeholders in-country should provide the necessary background documents and essential reports to the evaluation team, and help them identify key informants. Agencies should inform their staff of the IHE (for example when site visits are made) and encourage their staff to engage openly with the evaluation team, to share their knowledge, concerns, plans for the future, etc. Evaluators should ensure that they talk to local people and community leaders about their experiences and perceptions of the health and nutrition response using informal interviews and meetings, or more formal interview techniques such as exit interviews.

Evaluators should use, and refer to guidelines and references as necessary, according to the topics that they are focusing on. Annex 3 lists references on health and nutrition in emergencies, as well guidelines on evaluation methods, including exit interviews and facility assessments.

### **CHECKLIST for Task 2.2 Supporting Evaluators during the IHE**

- Identify a host agency responsible for the logistics and security of the IHE team.
- Establish a reliable means of communication between IHE SC members and the evaluation team members throughout the IHE.
- Ensure that all strategic decisions (including any changes to the ToR and IHE Work plan) during implementation of the IHE are taken jointly by the IHE SC and the evaluators.
- Provide the evaluators with adequate support, including access to documents and data, logistical support to prepare and carry out site visits and interviews, and appropriate security measures.

## **Step 3: Report, Disseminate and Follow-up on IHE Results**

In Step Three, the commissioning agencies and the IHE SC review the draft IHE report, finalise and disseminate it to key stakeholders, and make plans to follow up on recommendations.

### **Task 3.1 Review IHE Results and Prepare the Draft IHE Report**

At the end of the evaluation, and before the evaluators leave the country, the IHE SC should organise a meeting where the evaluation team presents preliminary findings and obtains stakeholders' feedback. This will provide an opportunity to clarify and validate some of the evaluators' initial findings, and identify critical issues that need to be addressed immediately. This is also the first opportunity to discuss with a broad range of stakeholders potential action points for improving performance and/or outcomes.

Once preliminary findings and recommendations have been presented to stakeholders and feedback has been given to the evaluators, the draft IHE report should be prepared. A sample format for the IHE Report is included in Annex 8, and a glossary of terms is included in Annex 9. The IHE SC should review the draft report to ensure that information presented is accurate and that the quality of the report is adequate. They should also verify that the draft report conforms to the ToR.

IHE SC members should then share the draft report with the broader group of stakeholders in order to obtain feedback on both the factual content and the appropriateness of the recommendations. This allows it to confirm that information provided to the evaluators was correctly interpreted, and that the results and recommendations have been presented in a manner that corresponds to the information needs of the intended users.

The IHE report should aim to stimulate the readers' interest, reflect their decision-making and learning requirements, and be concise and to the point. The executive summary should be written to serve as a stand-alone document, targeting stakeholders that may not read the full report. For effective reporting, evaluators should make sure to:

- Present main findings and conclusions in an executive summary, using the rest of the report for more detailed analyses and presentation of findings
- Focus on readers' expectations with regard to the objectives of the IHE. When learning is the purpose, the unexpected and the problematic should be

highlighted, while issues of limited value to the end-users should be avoided.

- Ensure that the overall structure of the report is clear and easy to understand.
- Present negative findings constructively and frankly. Shortcomings and mistakes should be mentioned, but 'blaming and shaming' should be avoided.
- Avoid jargon and difficult technical terms, keeping in mind the broad range of stakeholders who will use the report.
- Use a consistent and conventional system for footnotes and references.
- List abbreviations in a separate annex.
- Use photos, tables and figures to facilitate understanding.
- Follow a recommended model format for evaluation reports (Annex 8) in order to standardise the structure and contents of the report. The proposed format is intended both to facilitate writing reports by evaluators and checking reports by IHE SC members and others.

Members of the IHE SC should review the draft report to ensure that it is organised as agreed and that no required sections or information are missing. They should also verify that all questions raised in the ToR have been covered, and that the text is clear and succinct. The checklist below can be helpful for the review process.

- Is there a clear statement of the evaluation questions? The report should contain a clear restatement of the questions raised in the ToR so that readers will understand how the information in the report should be interpreted. Revisions of the original questions made in the course of the IHE should be noted.
- Have criteria and standards of performance been presented? Evaluation criteria and standards of performance should be presented. The basis for value judgments made in the report should be explicitly stated.
- Is there a transparent account of information gathering methods? The report should describe sources of data and methods of data collection to help readers assess the likely accuracy of facts and figures.
- Are the conclusions justified? Readers should be able to follow each step of the argument in the report, leading from question to answer. Supporting evidence should be clearly presented and alternative explanations of findings explicitly considered and eliminated.
- Has reporting been impartial? The report should reflect the perspectives of all major stakeholder groups. The report should not give precedence to any particular point of view, and cover strengths and weaknesses of opposing views.
- Is there a clear statement of limitations? All evaluations have limitations either with regard to scope and coverage, or with the depth of the analysis. An account of major limitations to the IHE should be included in the IHE report to ensure

that they are clear to the readers.

Feedback from stakeholders on the draft IHE report should be gathered quickly by the IHE SC and provided to evaluators in written format in a timely fashion so that the report can be edited accordingly and finalised promptly. At the same time, the IHE SC should also check the report according to criteria such as coverage, legibility and accessibility.<sup>34</sup> Feedback from stakeholders should be communicated immediately to the evaluators, and the report should be finalized. In quickly changing contexts, a short briefing note outlining the main conclusions can also be written and quickly disseminated to ensure that the findings are used while still relevant.

#### **CHECKLIST for Task 3.1 Reviewing IHE Results and Drafting the IHE Report**

- At the end of their mission, the IHE SC should organize a larger stakeholders meeting where the IHE evaluation team presents their preliminary findings and proposed recommendation for follow up.
- Use such a meeting to solicit comments on the accuracy of findings and adequacy of recommendations from intended users and other key stakeholder.
- Verify that the draft IHE report meets the requirements outlined in the ToR and any contractual agreements with the evaluators.
- Ensure that the draft report conforms to the format for the structure, language and style, and main contents as agreed in the IHE ToR.
- Check that the report is well written, easy to read, and that it provides a high quality response to the evaluation questions.
- Circulate the draft report to all stakeholders, and incorporate feedback into the report.
- Where appropriate, circulate the executive summary or a short briefing note outlining the key points as a stand alone document to ensure that the findings are used when still relevant in quickly changing contexts.

#### **Task 3.2 Disseminate the IHE Report**

Once the draft report has been finalised by the evaluators, and accepted by the IHE SC and the commissioning agencies, it should be reproduced and disseminated as widely as possible. The SC should develop a mailing list of people and institutions that should receive the report, and ensure that electronic files and hard copies of the report are dispatched as soon as possible after the IHE has been completed. Different formats of

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<sup>34</sup> see ALNAP Quality Proforma, Section 6: Guidelines for Assessing the Final Report and Presentation [http://www.odi.org.uk/alnap/AR2002/AR2002%20Q\\_Proforma.pdf](http://www.odi.org.uk/alnap/AR2002/AR2002%20Q_Proforma.pdf)

the final report may be developed by the evaluators for various audiences and media formats including the following:

- Electronic version of the full report for public access (on CD/DVD Rom and websites)
- Full and shortened printed/published versions (i.e. Executive summary) of the report for international agencies, local NGOs, national health authorities and the donor community. The IHE SC and commissioning agencies should also decide if the IHE report should be translated into other languages, and arrange and pay for any translation required.
- Power-point presentation of the IHE process (purpose, methodology, key findings, results and recommendations) for use in formal briefings, informal meetings and participatory workshops, making sure that the means selected is tailored to the specific interests and information needs of the intended audience.

#### **CHECKLIST for Task 3.2 Finalising the IHE Report and Disseminating Results.**

- Ensure that the evaluators edit, finalise and submit the final IHE report to the IHE SC as agreed (See Annex 8 for sample format).
- Check that the final IHE report received from the evaluators is ready for publication.
- Discuss with relevant stakeholders to whom, when and how the results of the IHE should be disseminated, and implement the dissemination plan accordingly.
- Translate the IHE report into relevant languages, as required.
- Compile a list of people and institutions that should receive the IHE report, and dispatch printed or electronic copies as soon as possible after completion.

### **Task 3.3 Make effective use of the IHE Findings**

Once the report and recommendations for follow up is approved, stakeholders in the health and nutrition sector can make use of the IHE findings by ensuring that these influence their future planning, programming, monitoring and evaluation decisions.

The IHE SC, in collaboration with the existing health coordination body, should oversee the process of following up on the IHE recommendations. They should assess the IHE, facilitate agency managers to complete an individual management response, and guide the development and implementation of a joint IHE Action Plan, as follows:

- 1) **An overall assessment of the relevance, accuracy and usefulness of the IHE and its findings.** The assessment should include feedback from a wide variety of stakeholders who have been involved in the IHE, and have been given an

opportunity to reflect upon its results and recommendations.

- 2) **A point-by-point Management Response to the recommendations and/or main findings by agency managers.** The managers' response to the IHE should include answers to the following questions: Are the recommendations accepted or rejected? Will they prompt action? If so, which actions? What support will be needed? Do the findings and conclusions of the IHE have any practical implications beyond those raised in the recommendations, and if so, which ones? If recommendations are rejected, why and what alternatives are proposed?
- 3) **A joint written IHE Action Plan with specific tasks, completion dates and assigned responsibilities for each identified action.** The IHE SC oversees the process to develop an IHE Action Plan together with the relevant stakeholders. The Action Plan should consist of clear, practical steps that are time bound, and presented in order of priority. The responsibilities of each agency/individuals should be assigned for each action, especially in a humanitarian intervention where a large number of health agencies will be involved in implementing the plan. Action Plans should be as realistic as possible, taking into consideration available human, financial and organisational resources, so that outlined tasks are realistic and feasible. Accordingly, the IHE Action Plan should be accompanied by a budget and list of other required and available resources.

Once the Action Plan has been approved, the IHE SC should put it on the agenda of the normal coordination meetings at three- and six-months intervals, to monitor progress of proposed activities, and to review the items remaining in the Action Plan for possible adjustments. A brief summary for agency managers regarding actions taken and results obtained should be completed at the end of the process.

**CHECKLIST for Task 3.3 Developing and Implementing Follow up to IHE Results and Recommendations**

- Each stakeholder can already use the findings and recommendations in their programming, policy decision-making and advocacy.
- In consultation with stakeholders and agency managers, the IHE SC should draft a plan for following up the IHE, including an assessment of the IHE; a management response to the findings and recommendations, and an Action Plan.
- Conduct IHE meetings at three and six-months following the IHE to review, and if necessary, adjust the Action Plan.
- Upon completion of the Action Plan, report on the IHE process, summarising the follow-up actions taken and results attained.



## Annex 1 – Key Indicators

Key indicators that measure various aspects of health and nutrition performance are outlined below. They were selected to give a sample measure of provision (availability, accessibility, quality), utilization, and coverage at both the primary and secondary health care level, as outlined in the evaluation framework proposed in Table 1 in Part I of the guidelines. They are based on discussions around needs assessments and tracking systems, so ensure consistency between assessment, monitoring and evaluation initiatives.<sup>35 36</sup>

Area of investigation	Indicator
1. Provision of primary and secondary health services	1.1 Availability and types of health facilities 1.2 Outpatient utilisation rates 1.3 Percentage of pregnant women who receive complete (3+ visits) antenatal care 1.4 Coverage (# facilities and met need) of emergency obstetric care 1.5 Prevalence of drug stock-outs in the clinics 1.6 Proportion of primary (and secondary) health facilities providing free care, or with working waiver systems 1.7 Provision of micronutrient programs (vitamin A and iodine)
2. Measles vaccination	2.1 Measles vaccination coverage
3. Selective feeding programs	3.1 Coverage of supplementary and therapeutic feeding programmes for U5 3.2 Recovery rates for U5 for severe malnutrition
4. Health information systems (HIS): surveillance and outbreak alert system	4.1 Timeliness of submission of outbreak surveillance reports and response 4.2 Attack rates and case fatality rates of epidemic diseases 4.3 Analysis of proportionate morbidity patterns
5. Mortality rates and malnutrition prevalence	5.1 Crude Mortality Rate (CMR) 5.2 Under 5 Mortality Rate (U5MR) 5.3 Cause specific mortality 5.4 Moderate and severe malnutrition prevalence

<sup>35</sup> Humanitarian health and nutrition tracking system: a proposal submitted to the forthcoming meeting of the IASC working group, Geneva, 5-7 July 2006.

[http://www.who.int/hac/network/interagency/healthcluster/6\\_HNTS\\_project\\_document.pdf](http://www.who.int/hac/network/interagency/healthcluster/6_HNTS_project_document.pdf)

IASC. 2007. Ibid.

<sup>36</sup> Adapted from Griekspoor A, Loretta A and S Colombo. *Tracking the performance of essential health and nutrition services in humanitarian responses*. Background paper prepared for the WHO workshop: "Tracking Health Performance and Humanitarian Outcomes" 1-2 December 2005, CCV, Geneva; and Checchi F. 2006. *Epidemiological guideline for Health and Nutrition Clusters Bulletin*. DRAFT. WHO Geneva.



One aim of using a select set of indicators is to ensure some consistency between IHEs, allowing them to be compared if required. However, other indicators may be available that could be used to inform the evaluation, and should be used. To assist with the interpretation of these indicators, notes are included below each indicator regarding what the indicator means, and how it should be interpreted.

## **1. Performance of Primary and Secondary Care**

It is important to assess the performance of primary and secondary health services. To do this, four indicators have been selected that measure various aspect of primary and secondary care: availability and types of health facilities (*availability of care*), outpatient utilization rates (*utilisation of care*), percentage of pregnant women who receive complete (3+ visits) antenatal care (*utilization of reproductive health services at primary level*); and coverage of emergency obstetric care (*availability, accessibility and coverage of RH services at primary and secondary level*).

### **1.1 Numbers and types of health facilities**

To achieve adequate provision of care, there should be a certain number and type of health facilities, as outlined in the Sphere standards:<sup>37</sup>

- One community health worker per 500-1000 people; one skilled birth attendant per 2000 population; one supervisor per 10 home visitors; one senior supervisor.
- One peripheral health facility for approximately 10,000 people, comprising of 2-5 qualified staff.
- One central health facility for approximately 50,000 people, comprising of five qualified health workers, including one doctor, pharmacist and laboratory technician.
- One referral hospital, including one doctor with surgical skills.

### **1.2 Outpatient utilization rate**

The total outpatient consultation rate is a measurement of utilisation of care. Total outpatient consultations can be compared to the population living in the catchment areas of the health facilities reporting data, so as to calculate the outpatient utilisation rate. According to the Sphere standards, utilisation rates are about 0.5-1.0 new consultations per person per year among stable populations, but can be up to 4 or more in situations

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<sup>37</sup> The Sphere Project, 2004. *Humanitarian Charter and Minimum Standards in Disaster Response*, 2004 edition. The Sphere Project, Geneva, 2004. <http://www.sphereproject.org>. See health systems and infrastructure standard 5: clinical services.

with where health facilities are within reasonable reach of the affected population.<sup>38</sup>

$$\text{Outpatient utilisation rate} = \frac{\text{total consultations during period}}{\text{population in catchment area} \times \text{duration of period}} \times \text{conversion factor}^{39}$$

### 1.3 Proportion of women receiving complete antenatal care<sup>40</sup>

The proportion of women who had three or more antenatal care (ANC) contacts during their last pregnancy in a defined period of time indicates the availability and accessibility of reproductive health services for women at the primary care level. If rates are low, then access might be restrained because such services are not available, not promoted or associated with high out-of-pocket expenditures (limiting the access to low-income households). All women (100%) should receive complete ANC care, particularly in stable situations. Approximately 4% of the total population will be pregnant at a given time (with a crude birth rate of 4%).<sup>41</sup> The proportion of ANC mothers who made at least 3 antenatal visits during pregnancy can be calculated as follows:

$$\frac{\text{number of pregnant women who had made at least 3 antenatal visits at the time of delivery}}{\text{total number of live births}} \times 100$$

### 1.4 Coverage of emergency obstetric care

Coverage of emergency obstetric care (EmOC) can be used as a proxy for access to secondary health services, and as a proxy indicator for maternal mortality. Approximately 15% of pregnant women will develop complications that require essential obstetric care, up to 5% will require some type of surgery, including caesarean section, and 100% of obstetric complications should be treated. Two indicators that relate to coverage of EmOC are:<sup>42</sup>

<sup>38</sup> This is one of the assumptions for the New Emergency health Kit, 1998.

[http://www.who.int/hac/techguidance/ems/new\\_health\\_kit\\_content/en/index.html](http://www.who.int/hac/techguidance/ems/new_health_kit_content/en/index.html)

<sup>39</sup> The conversion factor is simply to express the indicator in the desired units. Utilisation rate is usually expressed as consultations per person per year. If the period of reporting is in days, the conversion factor would thus be (x 365 days)

<sup>40</sup> UNHCR, UNFPA and WHO. 1999. *Reproductive health in refugee situations: an interagency field manual*. UNHCR: Geneva.

[http://www.reliefweb.int/rw/lib.nsf/db900SID/LGEL-5JHKQF/\\$FILE/hcr-repr-1999.pdf?OpenElement](http://www.reliefweb.int/rw/lib.nsf/db900SID/LGEL-5JHKQF/$FILE/hcr-repr-1999.pdf?OpenElement)

<sup>41</sup> Women's Commission for Refugee Women and Children. 2006. *Minimal Initial Service package (MISP) for reproductive health in Crisis Situations. A distance learning module*. 2006. pages 39 and 40. <http://www.rhrc.org/resources/misp/>

<sup>42</sup> UNICEF, WHO, UNFPA, 1997. Guidelines for Monitoring the availability and use of obstetric services. In RHRC consortium. July 2005. *Field friendly guide to integrate emergency obstetric cases in humanitarian programs*. Women's commission for refugee women and children on behalf of the reproductive health response in conflict consortium.

- For every 500,000 population, there should be at least one comprehensive and four basic EmOC facilities. This can be calculated as follows:

$$\frac{\text{Number of either basic or comprehensive EmOC facilities in the catchment areas} \times 500,000}{\text{catchment area population}}$$

A basic EmOC facility is usually set up in a health center and run by competent midwives or nurses with midwifery skills. A comprehensive EmOC facility is run by doctors or clinical officers who are able to perform a caesarean section and transfuse blood.

- Met need can be calculated as follows:

$$\frac{\text{number of direct obstetric complications treated in EmOC facilities in the catchment area}}{\text{number of expected direct obstetric complications in a population}}$$

The denominator (number of expected direct obstetric complications annually) is calculated as follows: Crude birth rate (number of live births/year/1000 people) x total population = expected annual births, is equal to the percentage of pregnant women at any given time, estimated at 4%. Of these pregnant women, 15% will experience an unpredicted obstetric complication. 5-15% will require a C-section.<sup>43</sup>

### 1.5 Availability of drugs in health clinics

Availability of drugs in health clinics is a proxy for the performance of health service delivery, and in particular the performance of the drug procurement system.<sup>44</sup> Stock-outs of four essential groups of drugs (antimalarials, antibiotics, analgesics/antipyretics, antihelminths) should be routinely monitored by agencies in their health clinics. (Agencies could consider choosing one drug from each category as a sentinel drug). Evaluators can use stock-out rates across a range of agencies to assess whether drug stock-outs are a systematic problem in a region.<sup>45</sup> The target range for drug stock-outs is less than five days per month. One indicator for drug stock-outs is:

- Average number of days out of stock per month at health facility level for the four sentinel drugs (aggregated, all health facilities supported).

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<sup>43</sup> Women's Commission for Refugee Women and Children. 2006. Ibid.

<sup>44</sup> For more information, see Management Sciences for Health. 1997. *Managing Drug Supplies*. Second Edition.

<sup>45</sup> WHO. 1999. *Operational principles for good pharmaceutical procurement*. WHO: Geneva. <http://www.who.int/3by5/en/who-edm-par-99-5.pdf>

## 1.6 Financial barriers to accessing care

In most camps, health services for refugees and internally displaced are provided for free, however in many other settings, formal or informal user fees are charged. It has been demonstrated that user fees, or out-of-pocket payments, often lead to many in the population being excluded from care.<sup>46</sup> However, there is no consensus that user fees should be abolished in all acute and chronic humanitarian settings. An assessment will need to be made by the evaluators (i.e. by examining health seeking behaviour surveys, or thru interviews with the population) regarding whether there are likely to be undue financial barriers to care. A possible indicator of absence of financial barrier is:

- Proportion of primary (and secondary) health facilities providing free care (no formal user fees), or with waiver systems that are ‘proven’ to work.

## 1.7 Micronutrient deficiencies

Agencies should identify and address the four main causes of epidemic micronutrient deficiencies in emergencies- scurvy (vitamin C), pellagra (niacin), beri-beri (thiamine) and riboflavin deficiencies. Efforts should be made to identify cases (for e.g. in outpatient consultations), and to address the issue both for the individual, as well as for the population at risk; there should be no cases of these conditions as they are preventable.

The three most common endemic micronutrient deficiencies are iron deficiency, xerophthalmia (vitamin A deficiency), and goitre (iodine), which can also worsen during an emergency. The latter two are easily diagnosed in the field, and can be dealt with through vitamin A supplementation for children and pregnant women, salt iodisation and public awareness campaigns.<sup>47</sup> Iron deficiency should also be monitored, especially if it was endemic before the emergency. Indicators of micronutrient interventions include:

- 95% of vulnerable children aged 6-59 months receive an adequate dose of vitamin A with measles vaccination.<sup>48</sup>
- At least 90% of households are using salt with an iodine content of 15 parts per million or more where total goitre rate and median urinary iodine content indicate a public health problem.<sup>49</sup>

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<sup>46</sup> WHO. 2005. *Policy brief three: Access to care and financial protection for all*. Prepared as part of the World Health Report, 2005. <http://www.who.int/whr/en/>

<sup>47</sup> Sphere 2004, Ibid and WHO. 2000. *The management of nutrition in major emergencies*. WHO: Geneva. <http://whqlibdoc.who.int/publications/2000/9241545208.pdf>

<sup>48</sup> Sphere 2004, Ibid.

<sup>49</sup> World Health Organization. 2001. *Assessment of iodine deficiency disorders and monitoring their*

## 2. Measles vaccination

### 2.1 Measles Vaccination Coverage Rate for Children 6 months – 15 years

Measles is considered to be a priority prevention program, and as one of the proxies for the overall provision of health services. Measles should mostly be considered an epidemic disease and notified. The Sphere standard of a vaccination coverage rate of 95% of children aged 6 months – 15 years should be obtained to ensure herd immunity threshold is reached. The percentage of children between 6 months and 15 years who are fully immunized against measles is calculated as:

$$\frac{\text{Number of children who finished antigen course}}{\text{Total number of children}} \times 100$$

## 3. Selective feeding programs

### 3.1 Coverage of Targeted Supplementary and Therapeutic Feeding Programs for Under-5s

This is a measure of the coverage of the humanitarian nutrition response. The percentage of expected number of moderately malnourished children U5 who are enrolled in a targeted supplementary feeding program can be calculated as follows:<sup>50</sup>

$$\frac{\text{Number of U5 enrolled at end of the month}}{\text{Estimated moderate acute malnutrition rate} \times \text{population U5}} \times 100$$

Coverage of targeted supplementary feeding programs should be >50% in rural areas, >70% in urban areas and >90% in camp situations according to the Sphere standards. It is calculated according to the target population, and can be estimated as part of an anthropometric survey. Coverage can be maximized by an optimal mix of facility and community-based treatment of malnourished children.<sup>51</sup>

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*elimination*. Geneva. WHO/NHD/01.1. [http://www.who.int/reproductive-health/docs/iodine\\_deficiency.pdf](http://www.who.int/reproductive-health/docs/iodine_deficiency.pdf) and Sphere 2004, Ibid.

<sup>50</sup> UNHCR. 2006. *Health and nutrition indicators*. UNHCR: Geneva.  
For more technical guidance on nutrition see:

<http://www.who.int/topics/nutrition/publications/emergencies/en/>

<sup>51</sup> WHO, WFP, UNSSCN and UNICEF, 2007. Joint statement: Community based management of severe acute malnutrition.

[http://www.who.int/nutrition/topics/Statement\\_community\\_based\\_man\\_sev\\_acute\\_mal\\_eng.pdf](http://www.who.int/nutrition/topics/Statement_community_based_man_sev_acute_mal_eng.pdf)

### 3.2 Recovery rates for severe malnutrition for U5

This is a measure of the quality of the humanitarian nutrition response. The Sphere standard is that >90% of U5 should recover in a therapeutic feeding centre. This can only be applied to therapeutic feeding centres. New standards for performance will need to be developed for the new approaches through community based management of severe malnutrition. The proportion of U5 who recover and could be discharged from a therapeutic feeding programme can be calculated as follows:<sup>52</sup>

$$\frac{\text{Number of U5 recovered}}{\text{Total number of U5 exits}} \times 100$$

## 4. Health information systems

### 4.1 Functioning outbreak detection system

The presence of a functioning outbreak detection system (epidemic warnings, verification and reports) is a proxy for provision of quality health and nutrition related information services. Some epidemics can be predicted and epidemic warnings should be based on epidemiological evidence. For example, strong rainy seasons are correlated with malaria peaks about two months after the peak precipitation. Meningitis occurs seasonally, and reports from neighbouring regions can raise the alert. Any epidemic preparedness actions should be described.

Suggested indicators for monitoring an outbreak detection system are drawn from recent WHO guidelines on monitoring and evaluating a disease surveillance system.<sup>53</sup>

- Timeliness of submission of surveillance reports, defined as: proportion of surveillance units that submitted surveillance reports (immediate, weekly, monthly) to the next higher level on time.<sup>54</sup>
- Timeliness of response to suspected outbreaks, defined as: proportion of suspected outbreaks that were verified within 48 hours of detection.<sup>55</sup>

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<sup>52</sup> UNHCR, 2006. Ibid.

<sup>53</sup> For more information on the monitoring and evaluation of HIS systems, see WHO. 2006. *Communicable disease surveillance and response systems: guide to monitoring and evaluation*. WHO: Geneva. WHO/CDS/EPR/LYO/2006.2

[http://www.who.int/csr/resources/publications/surveillance/WHO\\_CDS\\_EPR\\_LYO\\_2006\\_2.pdf](http://www.who.int/csr/resources/publications/surveillance/WHO_CDS_EPR_LYO_2006_2.pdf)

<sup>54</sup> Indicator 84 in WHO. 2006. Ibid.

<sup>55</sup> Indicator 87 in WHO. 2006. Ibid

Whenever reporting new or ongoing epidemics:<sup>56</sup>

- Time, place and person should be specified explicitly (for example: over the last 3 weeks, 12,000 IDPs in camp X in Country Y were affected by high rates of a communicable disease).
- Incident cases should be reported, both as totals and, if possible, as epidemic curves. Epidemic curve graphs should, if possible, go back in time to the pre-epidemic period: time (x axis) should be broken down into the smallest available units (ideally days for cholera, weeks for measles and meningitis), and the scale should be such as to enable visualisation of the curve.
- Epidemic response actions should be listed.
- It is suggested to have a systematic list of epidemic-prone diseases, such as follows (the list needs to be adapted to local surveillance approaches and epidemic profile):
  - o Malaria - Notify only if a malaria epidemic occurs. Specify causative species, bednet or indoor residual spraying coverage, first-line treatment, access to severe malaria treatment.
  - o Measles - should mostly be considered an epidemic disease and notified.
  - o Meningitis - Specify causative organism if identified, type of treatment available.
  - o Bloody diarrhoea - Specify causative organism if identified, type of treatment available, antibiotic susceptibility findings. CFR for shigellosis should be <1% according to the Sphere standards.
  - o Acute watery diarrhoea - Specify causative organism if identified. CFR for cholera should be <1% according to the Sphere standards
  - o Polio - AFB cases reported if any.
  - o Others - These could include visceral leishmaniasis (kala azar), relapsing fever, typhoid, yellow fever or other hemorrhagic fevers, etc.

#### **4.2 Attack rates and case fatality rates of epidemic diseases**

Attack rates (AR) should be provided if available. They are useful to give an idea of the proportion of the population that has been affected by the disease. Attack rates are usually expressed as a percentage.

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<sup>56</sup> Adapted from Checchi F. 2006. *Epidemiological guideline for Health and Nutrition Clusters Bulletin*. DRAFT. WHO Geneva.

$$\text{Attack rate} = \frac{\text{number of incident cases since the beginning of the epidemic}}{\text{population at risk}} \times 100$$

Case fatality rates (CFR) should be reported whenever available, with a note of the patients it refers to (hospitalised, outpatients, or whole community). Health facility-based CFRs can be calculated for each specific disease, as they are good indicators of barriers to timely health care access, severity of clinical presentation, as well as quality of care.<sup>57</sup>

$$\text{CFR} = \frac{\text{number of people who die from a disease during time period}}{\text{number of people who have the disease during time period}} \times 100$$

### 4.3 Proportionate morbidity patterns

The (top ten) most common causes of morbidity should be identified and used to inform collective humanitarian health and nutrition programming. This is done through analysis of proportionate morbidity patterns by region and period in a given population at risk. This is a useful indicator of the relative burden of each disease. Proportionate morbidity indicators should also be compared over time to determine trends. Proportion of illness attributable to a particular cause among the total population is calculated by:<sup>58</sup>

$$\frac{\text{Number of cases of a particular disease or health event}}{\text{Total number of cases}} \times 100$$

Not more than 25% of proportional morbidity should be in the ‘others’ column. It should also be disaggregated by crude and under 5 morbidity. As data on morbidity is almost always health facility based data (i.e. the most common causes of outpatient consultations, hospitalization or death), it should be recognized that this always underestimates the true disease burden in a community.

## 5. Mortality rates and malnutrition prevalence

The Crude Mortality Rate (CMR) and the under 5 mortality rate (U5MR) are indicators of severity of a humanitarian crisis, and if trend data is available, of possible impact. Judgements must be made about possible confounding factors that may affect trends in

<sup>57</sup> Checchi F. 2006. *Epidemiological guideline for Health and Nutrition Clusters Bulletin*. DRAFT. WHO Geneva.

<sup>58</sup> UNHCR 2006, Ibid.



mortality data, as well as the quality of the data.<sup>59</sup> Mortality data are likely to come into three forms:

- Raw figures such as (i) absolute numbers of deaths counted by an agency in a specific location over a given time based on local key informant interviews or other community method (sometimes very short, as during a rapid assessment), or (ii) total deaths recorded by an agency in a given number of health facilities.
- Reports from prospective surveillance systems, in which deaths in the community (and not merely in health facilities) are monitored systematically;
- Reports from retrospective surveys (usually employing a cluster sampling design).

### **5.1 Crude Mortality Rate (CMR)**

Crude mortality rate (CMR) measures the rate of deaths in the total population and is expressed during emergencies as number of deaths per 10,000 per day. The threshold above which an emergency is declared is a doubling of the baseline rate. For example, the normal baseline CMR among stable populations in sub-Saharan Africa is 0.5 deaths/10,000 people/day, and an emergency is declared when the rate is >1 deaths /10,000 people/day. The situation is deemed critical at > 2/10,000/day.<sup>60</sup>

### **5.2 Under 5 Mortality Rate (U5MR)**

The under 5 mortality rate (U5MR) measures the rate of deaths among children under five. It is expressed as number of deaths among children U5 per 10,000 U5 per day. The expected baseline rate amongst stable populations in sub-Saharan Africa is 1 deaths/10,000 children/day. When this rate doubles to > at 2 deaths /10,000 U5 children/day, an emergency is declared. The situation is deemed critical at > 4/10,000/day.<sup>61</sup>

### **5.3 Cause Specific Mortality**

More detailed information on the causes of death allows agencies to target their interventions and optimize their effect on reducing crude mortality rates. The cause specific mortality rate is expressed as # deaths caused by x/10,000/day. Together, the cumulative cause specific mortality rates are equal to the CMR, and can also be

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<sup>59</sup> For proposed criteria to judge the validity of mortality studies, see Checchi F and L Roberts. 2005. *Interpreting and using mortality data in humanitarian emergencies: a primer for non-epidemiologists*. Network Paper 52. HPN/ODI: London, Overseas Development Institute.

<sup>60</sup> World Health Organization. 2005. *Communicable disease control in emergencies: a field manual*. Geneva: WHO: Geneva. WHO/CDS/EPR/LYO/2005.27.  
<http://www.who.int/infectious-disease-news/IDdocs/whocds200527/whocds200527chapters/index.htm>

<sup>61</sup> World Health Organization. 2005. *Ibid*.

expressed as a percentage of the CMR.

When conducting surveys, one can obtain causes of death through post-mortem interviews<sup>62</sup> with family members based on symptoms such as fever or diarrhoea. In the case of real time registration of deaths, as is sometimes done in camp situations, one can register the most likely cause of death. Note that all cause of death data should be interpreted with caution as bias is a problem; for example, in identifying childhood febrile illnesses where fever can be caused by any one of a number of diseases.<sup>63</sup>

#### **5.4 Moderate and severe malnutrition prevalence in U5s**

Moderate and severe malnutrition prevalence is a measure of the severity of food-insecurity and possible impact if trend data is available.<sup>64</sup> Moderate malnutrition is measured as <2 Z scores of weight for height or below 80% of the median weight for height and/or nutritional oedema in children aged 6.0 – 59.0 months. Severe malnutrition is measured as <3 Z scores of weight for height or below 70% of the median weight for height and/or nutritional oedema in children aged 6.0 – 59.0 months. An emergency is declared when Global Acute Malnutrition (moderate plus severe malnutrition i.e. < 2 z-scores) is >20%, or Severe Malnutrition is >5%.

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<sup>62</sup> Myntti, C, Abdul-Aziz S, Aqlan G and S Al-Rubayh. 1991. Using post-mortem interviews at the community level: an example from Yemen. *Health Policy and Planning* 6(3): 282-286.

<sup>63</sup> Brown V, Checchi F, and E Depoortere. 2007. Wanted: studies on mortality estimation methods for humanitarian emergencies, suggestions for future research. *Emerging Themes in Epidemiology* 4:9. <http://www.ete-online.com/content/4/1/9/abstract>

<sup>64</sup> WHO. 2000. *The management of nutrition in major emergencies*. WHO: Geneva. <http://whqlibdoc.who.int/publications/2000/9241545208.pdf>.

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## Annex 2 - Methods for the evaluation of humanitarian action: pointers for good practice

The following points have been adapted from Alnap, 2006.<sup>65</sup>

- **Ensure that the method to be used is adequately described**, and in particular the reasons for the choice of geographical locations and projects visited; who was interviewed, why, and in what setting; and any constraints faced.
- **Use a multi-method approach, and cross-check wherever possible.** Use a variety of methods, and cross-check the information obtained, for example, secondary data available in government or agency reports with interviews with agency staff and primary stakeholders.
- **Assess against appropriate international standards and law.** Standards such as UN Conventions, the Sphere and the Red Cross/Red Crescent Code of Conduct should be routinely used as part of the evaluation methodology.
- **Talk to primary stakeholders.** First, there is an ethical requirement that evaluators do their best to talk to as many primary stakeholders as possible to ensure that the interests of this group are adequately represented in the evaluation. This also ensures accountability of evaluators to primary stakeholders. Second, to make the evaluation as comprehensive and representative as possible, elicit the views of men, women and children from different ethnic and socio-economic groups.
- **Disaggregate.** Evaluations are stronger where information is broken down by sex, socioeconomic group and ethnicity, so try to disaggregate data where possible.
- **Ensure a focus on social process and causality**, concentrating on why things happened, not just what happened. What were the reasons why the humanitarian response succeeded or failed? It is important to ask this question to support understanding of social process and lesson-learning.
- **Make clear any evaluator bias.** All evaluators have personal biases. If these biases are made clear, either within the report, or at least amongst the team members, then the evaluation team can try to ameliorate any bias. Mixed teams of evaluators (internal and external, men and women), and crosschecking multiple sources of information can help to reduce evaluator bias.
- **Integrate the DAC criteria**, or provide the rationale for not using the criteria.

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<sup>65</sup> Alnap, 2006. *Evaluating humanitarian action using the OECD-DAC criteria: An ALNAP guide for humanitarian agencies.* [www.alnap.org](http://www.alnap.org)

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## Annex 4 – Key health and nutrition questions using the OECD-DAC Criteria

The following seven OECD-DAC evaluation criteria should be covered by every IHE evaluation: relevance/appropriateness, connectedness, coherence, coverage, efficiency, effectiveness (and its sub-criteria coordination), and impact.<sup>66</sup> The key-questions listed beneath them are example questions. These need to be adapted to reflect the specific evaluation context as not all are appropriate to every context. Certain topic areas and questions need to be prioritized according to the aims of the evaluation as described in the ToR. This should be done when writing the ToR in the country with the local steering committee.

**RELEVANCE** - is concerned with assessing whether the project is in line with local needs and priorities (as well as with specific policies). **APPROPRIATENESS** is the tailoring of humanitarian activities to local needs, increasing ownership, accountability and cost-effectiveness accordingly.

- What are the major vulnerabilities, health risks and determinants of health, and have they been adequately identified?
- Do existing health and nutrition interventions address the most important health and nutrition needs? Are those that contribute most to the burden of disease adequately prioritised and addressed through the humanitarian interventions and the range of services in the PHC programs?
- Have correct and timely adaptations been made in response to changes in context?
- Are the humanitarian interventions appropriate (culturally, socially, and addressing their demands) from the perspective of the affected population?
- To what degree does the affected population participate in identifying health priorities, proposing interventions and health care delivery? Is this done in a way that increases feelings of ownership and accountability?

**CONNECTEDNESS** - refers to the need to ensure that activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account.

- Do humanitarian health and nutrition interventions take longer-term issues into account, such as chronic vulnerabilities due to poverty and livelihood insecurity?

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<sup>66</sup> Alnap 2006. *Evaluating humanitarian action using the OECD-DAC criteria. An ALNAP guide for humanitarian agencies*. ODI: London. Pg. 80.



- How appropriate are the ways in which humanitarian health and nutrition interventions integrate with livelihoods programming in a particular context?
- Is there adequate attention to reducing vulnerabilities and strengthening local capacities?
- Are health and nutrition policies and guidelines in line with national health policies and guidelines?
- How are interventions being conducted with relationship to the health system (supportive or done in parallel)?
- Are there ways for humanitarian actors to align with existing government services (for example, using national boundaries, procurement systems) to facilitate the future sustainability of services (particularly important in countries in transition to post-conflict)?
- In transition contexts, are there opportunities to link humanitarian interventions with the implementation of the national health policy, and to contribute to the transition process by building capacity of national health authorities, particularly at decentralised levels?
- Regarding integration efforts in settlements and in camps, is there potential to hand-over to District Health Management Teams in the long-run?
- Are there linkages of refugee/IDP health and nutrition programmes to national institutions, and collaboration with national institutions for the control of diseases in the camps and in refugee hosting areas?
- What is the participation of refugee/community health workers in national continuing education? What is the relationship between community health workers working with refugees and national programmes?

**COHERENCE** - The need to assess security, developmental, trade and military policies as well as humanitarian policies, to ensure that there is consistency and, in particular, that all policies take into account humanitarian and human-rights considerations.

- Is the health and nutrition sector part of a ‘coherent’ humanitarian agenda? How does this impact on the health and nutrition sector? For example, is health linked to military policies, and is health for health and human rights subordinated to a policy of hearts and minds and/or security?
- Is health provision consistent with security, trade and military policies? How does it affect the health and nutrition sector – is health undermined or is it better supported by being part of a ‘coherence’ agenda.<sup>67</sup> For example, is health, as a

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<sup>67</sup> See Centre for Humanitarian Dialogue. 2003. *Politics and Humanitarianism: coherence in crisis?* <http://www.reliefweb.int/rw/lib.nsf/db900SID/RURI->

basic service, seen as part of the stabilization process?

- If the coherence agenda exists, does it affect how the health and nutrition sector is positioned in terms of funding and other resources compared to other sectors?
- Is there alignment between the humanitarian health strategies and national health policies?

**COVERAGE** - The need to reach major population groups facing life-threatening suffering wherever they are.

- To what extent do the interventions reach the intended target population? For example:

Potential humanitarian coverage =  $\frac{\text{affected population that can be reached by humanitarian aid}}{\text{total affected population}}$

Operational humanitarian coverage =  $\frac{\text{affected population reached by humanitarian aid}}{\text{total affected population that can be reached}}$

Overall humanitarian coverage =  $\frac{\text{affected population reached by humanitarian aid}}{\text{total affected population}}$

- Are health services geographically and socio-culturally accessible and financially affordable to those most in need?
- Who is excluded from services or are there any differences in access within or between different populations?
- In refugee situations, does the host population have access to refugee services, and why or why not? What are the implications of this for these populations and the health and nutrition service providers?

**EFFICIENCY** measures the outputs – qualitative and quantitative – achieved as a result of inputs. This generally requires comparing alternative approaches to achieving an output, to see whether the most efficient approach has been used. Economists define efficiency as obtaining the best possible value for the resources used (or using the least resources to obtain a certain outcome). The two commonly used notions of efficiency are allocative and technical efficiency. Allocative efficiency means allocating resources in a way that ensures obtaining the maximum possible overall benefit. In other words,

once allocative efficiency is reached, it is impossible to change the allocation and make someone better-off without making someone else worse-off. Technical efficiency (also referred to as productive efficiency) means producing the maximum possible sustained output from a given set of inputs.<sup>68</sup>

- What is the total in-country budget for health and nutrition from all donors, including UNHCR and other contributions? Are there opportunities for improving the results within these available budgets?
- How do per capita budgets compare to national and international indicators? What percent of spending is going to public health (allocative efficiency)?
- What proportion of available resources is targeting priority public health issues and what is your assessment of wastage? Are resources in-country adequate to support required interventions to have adequate impact of prioritised programs (looking at coverage and quality aspects for these programs)? For example, how integrated are health and nutrition services, and how good is continuity of care? What percent of first contacts take place at primary care level? What is the number of contacts per full time equivalent per staff (technical efficiency)?

**EFFECTIVENESS** measures the extent to which an activity achieves its purpose, or whether this can be expected to happen on the basis of the outputs. Implicit within the criterion of effectiveness is timeliness.

- Are humanitarian health and nutrition interventions adequately prioritised across service providers to address the most important needs of the affected populations as identified above. For example, will they reach the objectives as formulated in the current CHAP?
- Are the appropriate health and nutrition services provided at all levels, primary and secondary, are these services provided according to international or nationally appropriate and agreed upon standards?
- With regards to the repatriation, are cross border health issues (malaria, HIV, etc) properly taken into account?
- How do interventions and programs compare against quality standards, as defined in national and/or international guidelines (WHO, Sphere, etc.)?

#### *Nutritional Programs*

- Are community based nutrition surveys done, and what is their quality? Are recommendations followed up on?

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<sup>68</sup> Islam M. (ed). 2007. *Health Systems Assessment Approach: A How-To Manual*.  
[http://www.phrplus.org/Pubs/Tool021\\_fin.pdf](http://www.phrplus.org/Pubs/Tool021_fin.pdf).

- Is there any system in place for detection of micronutrient deficiency? What is the prevalence of diseases associated with micronutrient deficiency: anaemia, malaria, intestinal infestation, measles, and what are the measures taken to address them? What possible interventions could be suggested?.
- Is there regular distribution for Vitamin A supplementation, if yes what is the coverage rate?
- Are the supplementary and therapeutic feeding programs effective in terms of meeting needs, coverage and adequacy of interventions? What are possible improvement that can be made?
- Is there a food distribution monitoring system in place that ensures adequate supply and fair distribution (e.g. food basket surveys, post distribution monitoring etc)? For more guidance, refer to references in Annex 3.

#### *Health Systems and Primary Health Care*

- What is the overall standard of primary health care and nutrition services? What are the strengths, weaknesses, gaps and possible corrective measures that could be taken?
- How effective are control and treatment of communicable and non-communicable diseases and how could they be better linked to each other, and to the primary health care, and national health system?
- How do refugee/IDP PHC programmes compare to national PHC programmes? How do the characteristics of the context affect provision of care: protracted, emergency, repatriation, consistency/differences among service providers (i.e. NGO or NGO/MOH) and infrastructure and level of care provided, staffing, skills, use of international, national and refugee staff, gender balance etc.
- What is access to secondary and tertiary institutions?
- What is the availability of referral guidelines, and are they used?
- How are critically ill cases transported?
- What are the gaps and weaknesses in the referral system? Analysis of critical incidents such as patients who suffer severe complications can be used to identify these.
- What is the capacity of secondary/tertiary institutions to cope/accept referrals?
- How well is the health information system (HIS) reporting system working? How well does the HIS data capture a significant proportion of the total number of deaths among the general and under-5 population groups? Is the HIS used to direct planning and resources allocation to meet the needs of the beneficiaries? For more guidance, refer to references regarding how to evaluate HIS in Annex 3.

### *Control of communicable diseases*

- How effective is control and treatment of communicable diseases and how could things be improved?
- How well are outbreak detection, investigation and response mechanisms functioning? What are the strengths and the gaps?
- Are ‘best practices’ or innovative approaches being used for disease control? (Apply the Sphere handbook of indicators and/or the UNHCR indicators where appropriate. There are also specific guidelines that should be referred to, as laid out in Annex 3).
- What are staffing patterns and training?
- What are the vaccination rates for key communicable diseases, including measles? How well are the vaccination programs working? Refer to the communicable disease control guidelines listed in Annex 3 for guidance on how to assess this.
- What is the childhood vaccination coverage rate? Use existing data bases and other channels such as focus group discussions to gain insight about factors that may hinder EPI uptake.
- What are the existing STI/HIV/AIDS prevention, promotion, and care and treatments programmes, and what interventions would be appropriate (using the IASC matrix as a reference point)? For more guidance, refer to the specific guidelines on reproductive health in Annex 3.

### *Control of non-communicable diseases*

- What is the capacity of reproductive and child health services? Are maternal and child health, family planning, sexual and gender-based violence services being provided, with adequate coverage and quality, for the population affected? Refer to the reproductive health guidelines listed in Annex 3 for guidance.
- What are staffing patterns and training?
- What is the coverage of services: CPR, ANC and PNC coverage, TT coverage, proportion delivered by trained health workers, etc?
- What are the factors that hinder provision of reproductive and child health services?
- What do critical incidents such as maternal death, tell you about that gaps in the system, and what are possible corrective measures?
- What is the capacity of mental health services? Are appropriate mental health services being provided, with adequate coverage and quality, for the population affected? Refer to the mental health guidelines listed in Annex 3 for guidance on how to assess this.
- What is the capacity of the health services to respond to injuries and trauma? Are appropriate services being provided, with adequate coverage and quality, for the population affected? Refer to the injury guidelines in Annex 3.

**COORDINATION** - While not a ‘formal’ DAC criterion, coordination is included under the heading of effectiveness. Coordination is an important consideration in the evaluation of humanitarian action. It has been defined as: ‘the systematic use of policy instruments to deliver humanitarian assistance in a cohesive and effective manner. Such instruments include strategic planning, gathering data and managing information, mobilising resources and ensuring accountability, orchestrating a functional division of labour, negotiating and maintaining a serviceable framework with host political authorities and providing leadership’ (Minear et al, 1992). It focuses on the practical effects of actions of governments and agencies – for example, whether they participate in the Consolidated Appeals Process or the cluster groups, whether they discuss geographical targeting, and the extent to which information is shared.

- Is there an overall humanitarian strategy and/or a health and nutrition sector specific strategy? Do humanitarian agencies use these to guide their interventions to ensure complementarity?
- Are health and nutrition sector priorities adequately shared by all stakeholders?
- Are interventions adequately coordinated between all relevant stakeholders to avoid overlap and identify gaps? What are the coordination mechanisms? Do donors and other actors share information on who is doing what to avoid duplication of efforts? Are there overviews of who does what where?
- Do donors implement standardized systems and procedures (harmonization)?
- What is the role of the national health authorities in coordination?
- Are there shared and/or joint assessments, planning monitoring and evaluations done?
- Are there special task forces to deal with specific issues?
- Is there adequate coordination between sectors, and development organizations e.g. in HIV/AIDS and livelihood programs?
- Is there an attempt at cross-border coordination in the case of refugees? Is there evidence of joint strategic programme monitoring and evaluation?

A donor mapping tool may be useful to analyse gaps and redundancies in donor activities. For example, the table below could be filled out to enable the evaluator to spot the gaps in service provision.

Donor	Field of intervention/ Activities	Timeline/ duration	Amount/ Commitments	Project location	Counterpart
ECHO					
USAID- OFDA					
World Bank					
DfID					
Global fund					

**IMPACT** looks at the wider effects of the project – social, economic, technical, environmental – on individuals, gender- and age-groups, communities and institutions. Impacts can be intended and unintended, positive and negative, macro (sector) and micro (household).

- Are humanitarian interventions having impact in reducing mortality and malnutrition rates to below acceptable levels? What is the baseline demographic data concerning the refugee population, and what are the trends? Review data collection, submission, collation, analysis and dissemination of monthly and annual reports, including mortality and malnutrition data collection systems. Reference should be made to the indicators outlined in Annex 1.
- Did the overall humanitarian intervention achieve acceptable health status and protection of the refugee/host/IDP population? How do indicators compare to international and national benchmarks?
- Can a contribution to the changes in the health status of the target population be plausibly attributed to the humanitarian interventions? What proportion can be attributed to national and/or community effort?
- Are there any unforeseen negative impacts of the humanitarian health and nutrition interventions?

## Annex 5 – Measuring Impact

To measure impact in a statistically valid way would require ongoing monitoring of project implementation of interventions that have a strong evidence-base, and/or a separate research exercise which uses operational research and surveys (ideally with randomization and control groups). Field epidemiology tools more commonly used in early warning systems or needs assessment would be required. Agencies would have to collect impact indicators, rather than the performance indicator that they more commonly collect. Performance indicators may provide sufficient evidence about the likely impact of interventions if they are seen as a strong proxy of impact (for example, measles immunization can be used as a proxy for impact on mortality). More commonly, however, performance indicators require more research on the link between the intervention and the health outcome before they can said to proxy impact. Table 3 illustrates some commonly used indicators with regard to their strength of association to health outcomes and the ease with which they can be monitored.<sup>69</sup>

Table 3 – Characteristics of Indicators commonly used to justify health programs

Established validity as measure of health impact	Indicator	General ease of acquiring data to show health effects
Highest	<ul style="list-style-type: none"> <li>• Crude Mortality, &lt;5 mortality</li> <li>• Case fatality rate</li> </ul>	Difficult in rural/diffuse settings, easier in camps
High	<ul style="list-style-type: none"> <li>• Nutritional status of children</li> <li>• Disease rates</li> <li>• Immunisation status of children</li> <li>• Patient-specific mental health evaluations</li> </ul>	Easy at the clinic data level, difficult but more valid with population surveys
Moderate	<ul style="list-style-type: none"> <li>• Safety of blood supply</li> <li>• Food-basket evaluations</li> <li>• Water and sanitation availability</li> <li>• Reduction in measles, mumps and rubella through reproductive health services</li> <li>• Improved patient outcomes via referrals</li> <li>• Impregnated bednets distributed</li> <li>• Comprehensive, timely health information system</li> </ul>	Logistically easy, requires skill on part of evaluator Easy in camps, more difficult in more diffuse populations Very difficult to measure even though benefits are likely to be occurring
Low	<ul style="list-style-type: none"> <li>• Good coordination between sectors</li> <li>• Knowledge &amp; attitudes about services available</li> <li>• Population practices</li> <li>• People given seeds and tools, shelter, or other materials</li> <li>• Drainage, fly control activities or tasks</li> <li>• Number of clinic visits</li> <li>• Distance to facilities, health workers per capita</li> <li>• Trainings conducted, numbers trained</li> <li>• Change in knowledge without documented change in behaviour</li> <li>• Messages/curricula developed</li> </ul>	Nearly impossible. These are difficult to measure, and all require a series of events to induce a health benefit Easy to measure. Links to health are likely to be mediated via many steps. Easy to measure. May produce no effects on health.

<sup>69</sup> Roberts L and C Hofmann. 2004. Assessing the impact of humanitarian assistance in the health sector. *Emerging Themes in Epidemiology* 1:3 <http://www.ete-online.com/content/1/1/3>



## Annex 6 - Sample Format for an IHE Terms of Reference

The format below is intended to help guide the structure and contents of the IHE Terms of Reference (ToR).<sup>70 71 72</sup>

**Humanitarian Crisis, Health and nutrition sector Background and Humanitarian Response** – Describe the humanitarian crisis, challenges and issues in the health and nutrition sector, and the structure and substance of the humanitarian health activities being carried out.

**Evaluation Purpose and Objectives** – Describe what an inter-agency evaluation is, and the context in which its being done. Describe the purpose of the evaluation, and its objectives, including its intended use in a particular context, and operational decisions the evaluation is expected to feed into. Describe the intended users of the IHE and those responsible for drafting a follow up action plan. It is also essential that the ToR is explicit about the time periods, geographic areas, and affected populations that the IHE should focus on.

**Stakeholder Involvement** – Explain how stakeholders are expected to participate in the research, reporting and dissemination activities of the evaluation. Describe the role of the IHE steering committee in country. The ToR should also specify how the evaluators are expected to interact and communicate with different groups of stakeholders during the IHE.

**Evaluation Scope and Questions** - List the key IHE questions, based on the framework and Annex 1 of these guidelines. Questions should be clustered under key headings using the OECD-DAC evaluation criteria, and should be those that are most important for a particular context. IHEs should permit both the examination of technical aspects of health and nutrition interventions and of broader strategic and policy issues. Given the diverse contexts of humanitarian crises, the specific ToR for each IHE must be developed in close collaboration with agencies and other stakeholders in the field.

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<sup>70</sup> Adapted from: *UNDP Handbook on monitoring and evaluating for Results*. UNDP Evaluation Office, New York, November 2002.

<sup>71</sup> UNICEF evaluation technical notes, Issue No. 2, December 2003. Annex 5: what goes in a TOR. [http://www.unicef.org/ceecis/New\\_trends\\_Dev\\_EVALuation.pdf](http://www.unicef.org/ceecis/New_trends_Dev_EVALuation.pdf)

<sup>72</sup> *Planning and Organizing Useful Evaluations*. UNHCR Inspection and Evaluation Service, January 1998.

**Methodology** – Outline the proposed methods and sources of data for the evaluation. These commonly include document reviews, interviews with key stakeholders, informal interview with regional and local actors, attendance at interagency planning meetings, analysis of epidemiological trends using secondary data and spot checks of health facilities.

**Evaluation team** - In relation to the scope and methodology for the IHE, this section defines the necessary qualifications of the evaluation team and individual team members in terms of evaluation skills, country and health and nutrition sector experience, social and cultural competencies, and gender balance. Assign responsibilities within the team, including a team-leader. The ToR should specify that the evaluators must be independent of the evaluated activities and have no stake in the outcome of the evaluation.

**Work Plan, Schedule and logistics** – The work plan should identify start and end dates, and outline the field sites to be visited. It should give an overview of the division of time between collection of locally available documents, briefing and debriefing health and nutrition sector coordination bodies, trips to field sites, and writing and reporting. Sometimes it may be appropriate to involve the evaluators in the follow-up phase, such as action-planning workshops to facilitate management follow-up on recommendations, and/or the assessment of the IHE by the in-country steering committee. Clarify who will be responsible for the logistics and security of the evaluation team.

**Expected Outputs** – The ToR should specify what reports should be delivered and when, as well as the format and length of the reports. The process of drafting the report, giving feedback, and finalization of the report should be described. Translation of the ToR and the final report should be considered. The evaluators should adhere to the terminology used in the OECD/DAC Glossary on Evaluation and Results-Based Management. This section may also specify the evaluators' role in follow up activities such as action-planning workshops .

**Follow up and action plan** - make reference to the development of an action plan to follow up on the recommendations, including the attribution of responsibilities for this follow up (usually to the IHE SC). Progress should be reported regularly in the ongoing coordination meetings.

## Annex 7 – Sample Budget

<b>SAMPLE IHE BUDGET</b>	
1. Pre-visit	Consultancy fees (one consultant for 6 days) Per diems + communications Travel (to and within the country) Visas and insurance
	<i>Subtotal</i>
2. IHE evaluation	Consultancy fees (3 evaluators x 30 days) Per diems + communications (20 days) Travel (to and within the country) Visas and insurance
	<i>Subtotal</i>
3. Production of Evaluation Report	Printing + mailout CD + mailout
	<i>Subtotal</i>
<b>TOTAL</b>	

<b>Additional costs</b>	
4. In-country action planning workshop	Consultancy fees (one consultant for 6 days) Per diems + communications Travel (to and within the country) Visas and insurance Meeting venue and catering
	<i>Subtotal</i>
5. External support for the evaluation	Consultant or staff person's time and expenses
	<i>Subtotal</i>
<b>TOTAL</b>	

## Annex 8 - Sample Format for IHE Reports

The model format below may be used to guide evaluators when preparing the IHE report.<sup>73</sup> Further guidance on assessing the quality of humanitarian evaluation reports can be found in ALNAP's quality proforma.<sup>74</sup>

**EXECUTIVE SUMMARY:** Summary of the IHE, with particular emphasis on main findings, conclusions, lessons learned and recommendations.

**INTRODUCTION:** Description of the history, purpose, key questions and organization of the evaluation.

**EVALUATED HEALTH AND NUTRITION SECTOR AND THE CONTEXT OF THE HUMANITARIAN CRISIS:** Description of the health system of the country, health trends and issues, and the overall humanitarian response.

**FINDINGS:** Factual evidence relevant to the questions asked by the IHE and interpretations of such evidence. These should be divided up following the evaluation framework as outlined in Part I of these guidelines.

**ANALYSIS AND CONCLUSIONS:** Assessments of intervention results and performance against given standards of performance. Discussion on the overall performance against the evaluation criteria

**LESSONS LEARNED:** General conclusions with a potential for wider application and use.

**RECOMMENDATIONS:** Proposed recommendations (practical, realistic actions) regarding improvements of policy or management addressed to the client of the IHE or other intended users. Note that findings, lessons learned and recommendations can be grouped together under each issue or topic area, followed by a final chapter on over-all conclusions and major recommendations.

**ANNEXES:** ToR, methodology for data collection and analysis, references, schedule of the IHE, persons met, etc.

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<sup>73</sup> Adapted from: *UNDP Handbook on Monitoring and Evaluating for Results*. UNDP Evaluation Office, New York, November 2002.

<sup>74</sup> <http://www.odi.org.uk/alnap/pdfs/QualityProforma05.pdf>

## Annex 9 – Abbreviated Glossary

**Accountability:** “Obligation to demonstrate that work has been conducted in compliance with agreed rules and standards or to report fairly and accurately on performance results vis-à-vis mandated roles and/or plans. This may require a careful, even legally defensible, demonstration that the work is consistent with the contract terms. Accountability in development may refer to the obligations of partners to act according to clearly defined responsibilities, roles and performance expectations, often with respect to the prudent use of resources. For evaluators, it connotes the responsibility to provide accurate, fair and credible monitoring reports and performance assessments. For public sector managers and policy makers, accountability is to taxpayers/citizens.”<sup>75</sup>

“Accountability involves two principles and mechanisms: (i) those by which individuals and organizations and States account for their actions and are held accountable for them, and (ii) those by which they may safely and legitimately report concerns, complaints and get redress where appropriate. Humanitarian accountability is concerned with ethics, rights and responsibilities ... and agreed standards and benchmarks. Men, women and children affected by disasters have a right to information, to participation, to be heard, and to redress.”<sup>76</sup>

**Benchmark:** “Reference point or standard against which performance or achievement can be assessed. Note: A benchmark refers to the performance that has been achieved in the recent past by other comparable organizations, or what can be reasonably inferred to have been achieved in the circumstances.”<sup>77</sup>

**Evaluation:** “systematic and objective assessment of an ongoing or completed project, programme or policy, its design implementation and results. The aim is to determine the relevance and fulfilment of objectives, development efficiency, effectiveness, impact and sustainability. An evaluation should provide information that is credible and useful. Enabling the incorporation of lessons learned into the decision-making process of both recipients and donors.”<sup>78</sup>

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<sup>75</sup> OECD-DAC. 2002. *Glossary of key terms in evaluation and results based management*. OECD-DAC Working Party on Aid Evaluation Report 6.

[http://www.oecd.org/findDocument/0,2350,en\\_2649\\_34435\\_1\\_119678\\_1\\_1\\_1,00.html](http://www.oecd.org/findDocument/0,2350,en_2649_34435_1_119678_1_1_1,00.html).

<sup>76</sup> Humanitarian Accountability Project.

<http://www.hapinternational.org/en/page.php?IDpage=64&IDcat=10>

<sup>77</sup> OECD-DAC 2002, Ibid.

<sup>78</sup> OECD-DAC 2002, Ibid.

- Evaluation of humanitarian action: systematic and impartial examination of humanitarian action intended to draw lessons to improve policy and practice and enhance accountability. It has the following characteristics:<sup>79</sup>

- It is commissioned by, or in cooperation with the organisation(s) whose performance is being evaluated.
- It is undertaken either by a team of non-employees (external) or by a mixed team of non-employees (external) and employees (internal) from the commissioning organization and/or the organisation being evaluated.
- It assesses policy and/or practice against recognised criteria: e.g. efficiency, effectiveness, timeliness, coordination, impact, connectedness, relevance, appropriateness, coverage, coherence and, as appropriate, protection.
- It articulates findings, draws conclusions and makes recommendations.

**Impact:** “Positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended.”<sup>80</sup>

**Health impact:** Change in the primary health objective measure that occurred because of an intervention. Because variations in health measures occur over time, a change in the primary health objective measure concurrent with the intervention cannot be assumed to be the result of the intervention without additional supportive evidence.

**Indicator:** “qualitative or a quantitative factor or variable that provides a simple and reliable means to measure achievement, to reflect the changes connected to an interventions, or to help assess the performance of a development actor.”<sup>81</sup> Some indicators relate to the process of implementing an intervention (input, process and output indicators) whilst other describe their effects (outcome and impact indicators).

**Outcome:** “likely or achieved short-term or medium-term effects of an intervention’s outputs.”<sup>82</sup> Outcomes may not become apparent for sometime after the end of an intervention is finished. Impacts are the long-term effects of an intervention and may not become apparent until months or years after an intervention has been completed.

**Outputs:** “products, capital goods and services that result from a development intervention; may also include changes resulting from the intervention which are

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<sup>79</sup> ALNAP, <http://www.odi.org.uk/alnap/>

<sup>80</sup> OECD-DAC, 2002, Ibid

<sup>81</sup> OECD-DAC, 2002, Ibid

<sup>82</sup> OECD-DAC, 2002, Ibid

relevant to the achievement of outcomes.”<sup>83</sup> Outputs can be measured immediately after an intervention has been completed.

**Performance:** “The degree to which a development intervention or a development partner operates according to specific criteria/standards/guidelines or achieves results in accordance with stated goals or plans.”<sup>84</sup>

**Performance measurement:** “A system for assessing performance of development interventions against stated goals.”<sup>85</sup>

**Triangulation:** “The use of three or more theories, sources or types of information, or types of analysis to verify and substantiate an assessment. Note: by combining multiple data-sources, methods analyses or theories evaluators seek to overcome the bias that comes from single informants, single-methods, single observer or single theory studies.”<sup>86</sup>

**Validity:** “The extent to which the data collection strategies and instruments measure what they purport to measure.”<sup>87</sup>

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<sup>83</sup> OECD-DAC, 2002, Ibid

<sup>84</sup> OECD-DAC, 2002, Ibid

<sup>85</sup> OECD-DAC, 2002, Ibid

<sup>86</sup> OECD-DAC, 2002, Ibid

<sup>87</sup> OECD-DAC, 2002, Ibid