EUROPEAN COMMISSION
DIRECTION GENERALE POUR L'AIDE HUMANITAIRE & LA PROTECTION CIVILE
Regional Support Office for East and Southern Africa (Nairobi)

RAPPORT DE MISSION

Subject: **SOMALIA WASH RO Mission (Mogadishu IDP's sites))**
Auteur: **Jerome BURLOT (WASH Adviser/RO Nairobi)**
Date: **03rd of March. 2016**

Main partners and visited sites list:

- PAH: Justyna Bajer (Head of Mission) and her team: area manager and engineer (consultant), the WASH PM was in leave during our visit.
- CARE: Muhumed Dubow (Emergency Coordinator) and his team: sanitation and water officer, water quality officer, hygiene promotion officer; and representative from their local partner
- UNICEF: Ferdinand NJUE (Head of WASH Specialist – based in Mogadishu)

Appendices list:

- 1: Fact sheet Kaxda site
- 2: UNHCR tracking population sheet
- 3: Fact sheet Hodan site

Table of Content

1. EXECUTIVE SUMMARY:

The mission took place on the 3rd of March (arriving at Mogadishu at 9am and departure time at 3pm the same day). The mission was shortened from a planned two day mission to a one day mission due to increased security incidents that occurred in Mogadishu the previous week-end (26-28th February).

The mission aimed to monitor PAH and CARE WASH activities in two different IDP sites. d. The mission included Heather Blackwell (CO TA), Abdullahi Abdisalan (CO PO) and Jerome Burlot (RO WASH Advisor). After the field site visits each partner had a one hour debrief with RO WASH advisor. Finally a very rushed meeting was taken with UNICEF Head of WASH for introduction and understanding of UNICEF WASH programme priorities.

Two field visits have been organized: one with PAH in Kaxda IDP's site (1500pp in the section where PAH intervenes through water supply; approximately 12 000 pp serviced) at KM 13; and one in Zona K IDP's site (*see fact sheet in appendix*) with CARE (50 000pp serviced).

As mentioned in the report, it is important to take into account the length of the mission (one day) and also the allowable monitoring time at each site due to security constraints (10 – 20 minutes) when analyzing the findings. Given the timing of the mission it was not possible to monitor the latrine activity (PAH).

In general the main issues/needs highlighted by the mission are:

- A problem of strategic thinking in terms of community approach and capacity building
- A need of harmonization in terms of incentive payment
- A mid or long term vision (especially for PAH) to Operation and Maintenance (O&M) the equipment provided (in particular regarding water supply and desludging). Also to reduce over time the dependency on humanitarian relief and build in parallel capacity of the communities The vision/plan will have to be regularly reviewed and adapt to the level of achievement and changing situation of the country. However this will provide some benchmark(s) to ensure better coherence of the action and targeting of the relief provided.
- A clear and relevant technical framework and modalities of design and implementation is required. Especiallyfor the capacity building and training components to ensure efficiency and sustainability of action.
- Improvement of the hygiene promotion strategy to ensure improved targeting (the action should be based on issues practically noticed on the field which can be different from one area to another and not based on an holistic approach), more dynamic (activities cannot be always the same otherwise you loose interest of people) and interactive (especially for CARE as apparently their promoter spend 5 to 10 minutes per house which does not enable to interact properly with people).
- Formalization of approaches/methods used in the project implementation to ensure coherency in the action and to mitigate potential confusion coming from turnover of staff.

- PAH water quality monitoring has to be urgently and seriously enhanced immediately. PAH cannot ensure the water they provide is permanently safe. PAH should also ensure ground water monitoring.

The overall partners' level of performance as far as it could be observed during the mission seems to be more or less acceptable. Although, some aspects of the action require urgent correction and improvement. There are also some positive outputs considering the context.

Recommendations of improvement have been listed at the end of the report in designated section.

2. MISCELLANEOUS / INTRODUCTION:

All the information's made within report are based on a very short mission and it has to be taken into account when it comes to statements about the situation and the action led by our partners.

The mission has been held in Mogadishu to monitor especially WASH activities of PAH and CARE (the CARE project is closed and liquated now) in two IDP settlements.

The mission took place on the 3rd of March. After the field site visits a debrief was undertake with each partner (1h each). . The mission has been shortening from initial plan due the last security incident which happened in Mogadishu the week before the mission.

Note regarding incentive approach:

PAH: 16 hygiene promoter got 10USD/day, 20days/month, which means 200USD/month. Nobody got specific incentive for garbage collection (*good point*).

CARE: 50 hygiene promoter got 20USD/month; 1300pp employed through USAID funded cash for work project to collect garbage get 140USD/month to work 20 days /month (means 7USD/day).

The approach should be harmonized to ensure no conflict or pulling factor and also to control the level of dependency from the relief, etc…

3. PAH:

3.1 Capacity of the partners and level of performance:

The head of mission has been quite relevant in providing information during the visit, especially given the fact that she is new (1 month in the field only). The national area manager was quite confused in his answers; however the language barrier could contribute to explain partly this level of confusion.

The technical consultant in charge of, training and the most technical aspect of the work was more or less ok in his answers. He was struggling sometime to go straight to the point, but he seems more or less appropriate in terms of knowledge to achieve his task.

The water testing equipment is pretty basic and could be a bit enhanced to at least monitor specific parameter such as salinity and conductivity. In addition, the monitoring of the ground water is not formalized and documented for further analysis and therefore not leading to full capitalization of the action.

The level of performance of the partner in the context is more or less ok. Hygiene promotion seems to be a strength activity of PAH with an inclusive communityapproach while capacity building especially for the water supply component is a weakness. The management of the water supply system needs *urgent* improvement.

3.2. Quality of achievement:

As far as it was possible to observe during the mission, it seems that in terms of infra-structure achievement (latrine and water supply system), the completion is ok, as well as the set-up of the water access. The problem is more related to the sustainability and the capacity building component.

In the meantime, the site visited was new for PAH. PAH has commissioned the water supply system in January 2016. It remains that the level of organization to ensure operating and maintenance of the water supply system should be clearly improved as a priority.

The mission met community leaders who seemed quite excited about the training he received on hygiene promotion. However he was barely able to mention what he learnt and what he did with the knowledge acquired. Given the training was only one month ago this is worrying and there is no refresher training/activities planned.

3.3. Main findings and discussion held:

- *Capacity building:*

The training activities undertaken by PAH have been implemented as ad hoc training for few days. The hygiene promotion component at least hasbeen quite (maybe too?) ambitious to be achieved through only one training. The sustainability and efficiency of the trainings can be put into question. The good point is the integration of a component within the hygiene promotion on how to interact and influence (facilitate process of thinking of the target population) people.

As already mentioned, there is no refreshing mechanism. For adult learning the approach should ensure continuous training for instance planned refresher, coaching or mentoring system. In addition, the attendee's selection is not very clear and should be better formalized. Especially as the hygiene promoters have a paid an incentive of 10$ per day therefore it is extremely important that the selection is fair and community wide. According the type of training pre requirements should be clearly established to ensure harmonized and relevant training. As a good point, it seems that the training methodology was practiccal rather than a theoretical course using heavy power point presentation.

- *Community approach and incentive:*

The community approach seems to be the weakest aspect of the PAH intervention together with capacity building.

For instance, the water supply system commissioned last January 2016, PAH signed a MoU with the private owner of the BH to use the supply. The MoU mentioned that PAH will upgrade the BH equipment and clean/disinfect the BH to ensure that the performance of hydro mechanical equipment and yield of the BH match the needs, and then the private owner of the BH is supposed to provide water free of charge during one year.

The problem is that during the visit PAH had no clue about how it is going to be organized after the 1 year. To shift from one strategy/approach to another needs time for the people to understand the impact. It also needs a clear plan and communication as soon as possible to avoid generating too much expectation and thus disappointment rom the targeted population.

So farthere is no clear vision on what involvement and reduction of the humanitarian relief dependency could be expected over time. At this stage the vision would be only assumptions. However at least it would give some direction to the action that could be regularly reviewed according the achievement made and the evolving of the local situation. Inclusion of this analysis in the initiatives could enable to better clarity and ensure the coherency of the project.

Host communities living around the IDP's settlement are supposed to access some of the services such as water supply but it is not possible to estimate the number of host communities' members benefitting from it. This is the case for CARE also as IDP sites are situated within non-IDP communities.

- *Hygiene promotion:*

This activity seems to be the sector in which PA perform better Although, the few awareness materials observed along the road did not reflect the capacity of the targeted populationfor example xxxxxxx . In addition the training materials/handout are mainly in written form but the level of literacy of the attendees is reported as low.

In addition, an issue is coming from the fact that within the hygiene promotion messages they mentioned and foster use of aqua tab, PUR, etcwhen PAH do not ensure any water treatment (no chlorination performed)), and do not provide any aqua tabs. CARE has carried out water testing of the BH and has found some contamination in some of the BH but still within standard. However it is important to regularly monitor at the different levels for a change in quality.

This type of approach would be useful only if there is a clear risk of outbreak due to water borne disease and then in this case aquatab would be distributed. The messages related to the use of aquatab could then enable a better uptake of the population about the use of such product. Again the refresher training would be important on components of hygiene promotion that are not performed regularly.

In the meantime and following the ECHO WASH policy, first of all partners should identify the water treatment HH product already available on the market and subsidy it in case of outbreak instead of to

import a new product to avoid too much confusion for the targeted population. The strategic thinking for this activity could be improved.

- *Water supply*

The water supplied by PAH is not treated and no information about the bacteriological quality of the BH water has been provided. Thus, we cannot ensure that PAH is providing safe water. The proposal mentioned safe water but did not mentioned chlorination. The strategy of PAH is to ensure safe water access only through hygiene promotion messages fostering people to treat their water. This relies on behavior changes which usually take time and without providing (fully or subsidized) the product to be used in order to promote it (*boiling water: wood harvesting potential is very limited in the area visited and in Urban areas generally*). So, as a first phase it is a bit risky to ensure safe water access in this way, especially with non-clear water quality monitoring plan.

The level of involvement of the communities in the O&M of the system is also pretty limited to mainly manipulation of the valves (the project propose to have 15 community members trained for all intervention areas and able to perform small reparation of the system, such as leaks reparation, changes of fitting etc). The system in Kaxda is new (Jan 2-16), and therefore no such operation have been performed by the community members. As no refresher training is envisaged there is a clear and high risk that the trainees might have forgot the initial training when they will need it.

60m3 per day in average is supplied to the site, which means about 40L/pp/day (far over the standard?). However this is a rough estimate based on usage vs. target population but there is no actual monitoring of host community usage at distribution point.

- *Solid waste management:*

The activity is based on paid hygiene promoter mobilizing on ad hoc manner the community to clean the site. PAH provide all the tools and collected wastes are burn and then buried.

3.4. Recommendation and issue to follow up:

- Water quality monitoring should be performed regularly at BH location, water point and HH level. Bacteriological test at least should be performed since there is no chlorination system, as well as salinity test.
- Improve mid and long term vision notably in terms of O&M of the equipment implemented and community approach.
- Improve the capacity building and training component of the project notably regarding the sustainability aspect. Continuous capacity building to include refresher training,, coaching or mentoring system should be ensured. Identification of the various capacities of the community members and enhancement of it should be improved. Then, those capacities should be used in management and supervision of ongoing and regular activities especially.
- Ground water monitoring should be ensured with record on static level and dynamic as well as recovery time of the BH.

- Harmonized number of hygiene promoter and standard in general. As in Kaxda, it seems that we have 16 hygiene promoters for about 1500pp, meaning about one per 100 people, when in others camp PAH have one for 1000pp. The same for water, the level of access in Kaxda is much higher than in others sites (40L/pp/day vs more usual 15L/pp/day. This will have an impact when the water or the O&M cost will have to be paid.
  If approach/logic of intervention is different, as what is relevant in one site can be not relevant in another, justification should be provided. In the meantime, whether the PAH strategy seems to provide more incentive for the hygiene promotion at the end it might be more cost efficient that others partners as PAH does not gives incentive for garbage collection directly but to mobilize people to do it… of course, the final quality of the result should also be taken into account.

4. CARE

4.1. Capacity of the partners and level of performance:

The CARE staff meet demonstrated their knowledge about their project with what seems to be an appropriate technical understanding of the activities led. The action related to the "treatment" of sludge seems to be the one where CARE has less control. For example they assume that some processing of the sludge is happening by the sun exposure but there is no design and they are not able to describe the level of performance of the process). Most of questions asked to them have been quite properly answered however we couldn't go deeply into the discussion due to time constraints.

Most of the documentation and information inquiries requested during the visit have been timely provided.

The knowledge regarding the efficiency of the hydraulic network (quantity of leakage) could be further investigated.

Based on the very short visit and discussion with CARE staff, the level of performance seems to be quite acceptable, especially given the context.

The local partners of CARE did not demonstrate the same level of control on the project. The representatives meet on the field were a bit confused with the question(s). Their capacity could be maybe be enhanced.

4.2. Quality of work:

Based on field observation and interviews, it seems that the quality of the achievement of CARE is more or less okadequateAlthough, there is need to improve several aspects. The storage tanks visited were located on the top of a small sand hill which already present some sign of erosion. The storage tank location has to be protected against erosion in good time to ensure stability of the equipment.

The main areas that lack quality and achievement seem to be in the hygiene promotion and the community approach component. The hygiene promotion approach is quite directive with little room to interact with people. Basically, the hygiene promoters are doing mainly door by door visit and do not spent more than 5 or 10 minutes per household. This prevents time and space to interact with and learn from the target population about their practices and the ways to improve.

Most of the time the knowledge of people regarding the hygienic messages is adequate, but the practices do not change. People need some support to translate a message into a practice, some improvement do not require financial needs but just organization inside the house.

4.3. Main findings and discussion held:

- *Contingency:*

CARE had developed a contingency plan in case of AWD outbreak, mainly based on implementation of a post chlorination system at water point which seem to be relevant.

- *Cost recovery*

CARE start to envisage the implementation of cost recovery system to ensure contribution from the beneficiaries communities to the water supply. The water is sold by the private owner of the BH and used to supply the IDP settlement. The private owners are in charge of the main maintenance needs: pump, generator, BH. The fees are paid by CARE for the time being. To ensure sustainability and reduce dependency on humanitarian relief CARE has started discussion with IPD committees and representatives to establish a cost recovery system. The targeted populations since 2011 have accessed water for free. Therefore the establishment of the cost recovery system should be progressive. The first stage should aim to at least to cover the operating cost/cost of water paid to the owners of the BH. In the long term CARE can progressively engage the BH owner to also invest in the nt hydraulic network which would also enable him to continue selling water.. An economic analyze should be performed by CARE together with the private owners of the BH.

CARE has negotiated a “good” price for water with the private owner and pays currently 0,8USD/m3 when normal price is about 1,5USD/m3. The negotiation went well given the volume purchased by CARE per day: 680m3/day from 4 BH, to supply about 50 000pp.

The cost of water is between 15 000 to 20 000 USD/month according current demands.

The level of access to water is about 12L/pp/day taking into account some leakage on the network especially occurring on the pressure line between the BH and the storage tanks.

- *Solid waste management*

CARE is providing incentive to garbage collector. The disposal is organize in such manner: the householder dispose their garbage in several located disposal point from which the garbage collector take it to others sites spread around the camps to incinerate the refuse and buried the one that cannot

be incinerated as well as the ashes. This aspect is not very clear in terms of environmental risk and sustainability (notably in terms of space). CARE mention that they have paid attention to the wind direction and the risk of fire when implementation the incineration sites.

There is so far not vision on mid or long term on this activity.

The garbage collectors are paid through cash for work project funded by USAID. Each of them got about 140USD/month, which is a large sum of money. There are widely different practices between organizations.

- *Desludging and disposal*

For a sake of space availability, there is apparently no others option than regular desludging of the latrine pit. To reduce the needs in time of desludging, CARE latrine design has been adapted to include a huge collection pit serving two latrine stances each. In the meantime, it seems that some people are reluctant to use two stances latrine for the sake of privacy. Both designs exist in the camp single and double stances latrine. The volume of the pit is about 16m3 for a double stances (according CARE) which means according the number of users a need of desludging about every 10 to 12 months. Depending on the number of users and the volume of the pit for single stance these would require desludging after 8 months..

The price of desludging for one latrine pit is about 73USD.

The desludging is undertaken by a private contractor using sewage pump and cittern truck to dispose the sludge 20km from the town limit in a desert area.

On the disposal site, the sludge is dried by the sun to ensure a bit of stabilization, and then compacted and buried. The process is very basic and the level of control is very limited. Although in such a context the attempt to process the sludge is appreciated. More investigation should be made to ensure that there is no risk of contamination of the ground water or others type of risks which could harm the environment and people.

- *Hygiene promotion (see quality of achievement section)*

The capacity building in terms of hygiene promotion focus only on ad hoc training, in which there is no component related *to how to interact and influence people facilitating their own process of thinking*.

- *Community approach and capacity building*

The aspect of community approach and increasing involvement of communities in the achievement of activities still need to be enhanced. CARE has already started reflection and consultation with IDP communities about it. So far, the level of dependency is pretty high with very few inputs from the communities. CARE has started consultation with IDP committees and various other representatives of the communities targeted to ensure financial contribution of the beneficiaries to the cost of water supply.

For the time being most of the operating and small maintenance activities for the water supply system notably are handled by the local partners of CARE with very low inputs from the beneficiaries communities. Activities such as chlorination, opening valve, care taker at water point etc should progressively be performed by the communities. An appropriate strategy in terms of incentive payments should be planned with decreasing payments , or/and in-kind, etc.

The capacity building aspect is also quite weak so far, mainly ad hoc training without regular refresher training or coaching/mentoring mechanisms. No clear added value from this activity for the time being. Technical training can barely be called technical or training; rather it is a briefing limited to very basic operations on the water supply system, such as manipulating valve etc.

According a survey made by CARE, 70% of the income of the IDP is from casual work and is about 50 to 100USD/month.

4.4. Recommendation and issue to follow up specific to CARE:

- Increase the involvement of the IDP community in the O&M of the water supply system and solid waste management. For example chlorination, water quality monitoring and the small maintenance needs could be handled by the community with appropriate training. The heavy maintenance remains a concern, but in the meantime most of the electrical and hydro mechanical part should be performed by the owners of the water source. The private owners maintain the equipment at this level. A mentoring or coaching approach could contribute efficiently to build such capacity within the targeted IDP communities
- Improve the level of organization of the communities to not only have committee to coordinate but also perform tasks e.g. ensure maintenance, communication of strategy and follow-up etc
- Develop a strategy to progressively decrease the level /type of incentive and the dependency.
- Improve the hygiene promotion component to make it more targeted, dynamic and practical
- Improve the capacity building component to make it more sustainable and efficient. Develop a clear plan with what is expected to be done or undertake by the community with related timeline.
- Develop a transparent fees collection mechanism to foster contributing to the cost of water with a progressive decreasing of the level of subsidy from the partner. In the meantime, a mechanism should be implemented to ensure access to water for the most vulnerable.
- Ensure protection against erosion at the Zona K storage tank.

5. GENERAL RECOMMENDATIONS AND ISSUE TO FOLLOW UP:

- The incentive strategy is not harmonized between partners with also high difference of payment for the same job/tasks.

- The partners struggle to have a mid or long term vision on what they do. Even, it is tricky to make any plan in such environment, it is still necessary to have some direction and decrease in

time the dependency to the humanitarian relief. For sure mid or long term plan should be reviewed and updated regularly to adapt it to the evolving of the situation in the country.

- The hygiene promotion approach is too static and needs to be more targeted, more dynamic and more practical. The hygiene promotion materials should be better adapted to the context (e.g. the features of the people in the posters are not matching the local population).

- The capacity building and in particular the training component need to be enhanced. There is no continuous training approach in the training strategy implemented. The training is focused on practice elements but it is ad hoc with no follow up, refreshing or coaching/mentoring component. This is important to ensure sustainability and quality of the outcomes. In many cases the sustainability of training is put into question for example people who received training are trying to use those new skills acquired to get a better job somewhere else. The mentoring approach would somewhat mitigate again this risk as every trainee should transfer the skill and knowledge acquired through the training to an apprentice by working in binomial all the time.

- There is a need to formalize and document more on the approach implemented to ensure coherence despite of staff turnover/changes in NGOs.

- Identification of the stronger trainees during the training to promote them as training focal point for the other attendees. This will locate the knowledge and capacity of continuous training and supervision as close as possible to the population. In the meantime, the training should be defined with different level of proficiency targeted. This will allow the stronger trainees to develop further skills and in turn increase and stimulate their involvement in the initiative. .

- To ensure a minimum of turn over for the hygiene promoter as all together they get quite an amount of money (PAH: 16pp*20 days/month*10USD = 3200USD/month). The turnover will mitigate the risk of vested interested of power individuals and clan linkages; and enable more people to get the capacity and to benefit from the incentive.

- To ensure an efficient and coherent training pre requirement should be established for the attendees.

- The selection of people benefiting from incentive should be clearer and ensure transparency. Including validation process independent of the community leadership.

- Especially in case of the partners who are not chlorinating water, bacteriological test should regularly performed at the BH location, water point and HH level.

- Monitoring of water quality should be regularly performed and in particular: conductivity and TDS of water to ensure appropriate and sustainable exploitation yield and avoid risk of brackish intrusion in the fresh ground water lenses.

6. CONCLUSION

The mission was too short to have a clear and relevant analyze of the situation, as well as the strategy and the action led by our partners on the ground. Although, several issues, added value from the project and some strategic gaps can be raised as a result of the mission.

In general and given the context of the mission, partners seem to have a level of performance more or less acceptable, though numerous improvements should be made.

CARE seem to better perform than PAH notably in terms of water supply management as well as in trying to have a mid -long term vision related to the O&M of the equipment provided through the project.

PAH seem to better perform in terms of hygiene promotion with real interaction with the communities and in some aspects of the community approach. Additionally the level of incentive reported by PAH is lower than for CARE, and yet there is more inputs from the communities in PAH project (garbage collection). This is an important learning for future action re: community engagement.

In general, there is a strong need to build harmonized incentive and community approach strategy. Integrated into any action is the development of a plan aiming to reduce the dependency from the humanitarian relief with more efficient, concrete and sustainable capacity building actions.

The total payment for water and/or incentives is large (not only ECHO funding) and therefore appropriate and robust follow up of all stages of the project is required including selection, right person receiving the payment, retaining payments, etc. is required. This links with partners communicating a clear towards sustainability with various donors.