



INTER-AGENCY  
HUMANITARIAN  
EVALUATION

**INTER-AGENCY EVALUATION  
OF THE COVID-19  
HUMANITARIAN RESPONSE  
INCEPTION REPORT**

15 APRIL 2022

## Management and implementation of the evaluation

The evaluation was commissioned and funded by the Inter-Agency Humanitarian Evaluation Steering Group (IAHE SG), an associated body of the Inter-Agency Standing Committee (IASC). The KonTerra Group and Itad Ltd. were contracted to conduct the evaluation.

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## Disclaimer

The contents and conclusions of this evaluation report reflect strictly the opinion of the authors, and in no way those of the IASC, United Nations or other stakeholders.

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## Acronyms

A4EP	Alliance for Empowering Partnership	QA	Quality Assurance
AAP	Accountability to Affected Populations	RC	Resident Coordinator
CBPF	Country-Based Pooled Fund	RCCE	Risk Communication & Community Engagement
CERF	Central Emergency Response Fund	RMRP	Regional Refugee & Migrant Response Plan
DAC	see OECD/DAC	RRP	Refugee Response Plan
DRC	Democratic Republic of the Congo	SCHR	Steering Committee for Humanitarian Response
EDG	Emergency Director's Group	SERP	Socio-Economic Recovery Plan
EOS	Evaluation and Oversight Section	SG	Secretary General
EQ	Evaluation Questions	SPRP	Strategic Preparedness & Response Plan
ERC	Emergency Relief Coordinator	SRF	Solidarity Response Fund
EVD	Ebola Virus Disease	SWE	System-Wide Evaluation
FAO	Food and Agricultural Organization	ToC	Theory of Change
FGD	Focus Group Discussion	ToR	Terms of Reference
FTS	Financial Tracking Service	UN	United Nations
GBV	Gender-Based Violence	UNCT	United Nations Country Team
GEAG	Global Evaluation Advisory Group	UNDSS	United Nations Department of Safety & Security
GHRP	Global Humanitarian Response Plan	UNEG	United Nations Evaluation Group
GPMB	Global Preparedness Monitoring Board	UNFPA	United Nations Population Fund
HC	Humanitarian Coordinator	UNHAS	United Nations Humanitarian Air Service
HCT	Humanitarian Country Team	UNHCR	United Nations High Commissioner for Refugees
HNO	Humanitarian Needs Overview	UNICEF	United Nations Children's Fund
HPC	Humanitarian Program Cycle	US	United States
HRP	Humanitarian Response Plan	WFP	World Food Programme
IAHE	Inter-Agency Humanitarian Evaluation	WHO	World Health Organization
IASC	Inter-Agency Standing Committee		
ICVA	International Council of Voluntary Agencies		
IDPs	Internally Displaced Persons		
IFRC	International Federation of Red Cross and Red Crescent Societies		
IOM	International Organization for Migration		
KII	Key Informant Interview		
MG	Management Group		
MPTF	Multi-Partner Trust Fund		
MRP	Migrant Response Plan		
NGO	Non-Governmental Organization		
OCHA	Office for the Coordination of Humanitarian Affairs		
OECD/DAC	Organisation for Economic Co-operation and Development / Development Assistance Committee		
OPAG	Operational Policy & Advocacy Group		
PwD	Persons with Disabilities		

## Glossary of terms

<b>COVID-19 Strategic Preparedness and Response Plan (SPRP)</b>	This strategic preparedness and response plan outlines the public health measures that the international community stands ready to provide to support all countries to prepare for and respond to COVID-19. The document takes what we have learned so far about the virus and translates that knowledge into strategic action that can guide the efforts of all national and international partners when developing context-specific national and regional operational plans. <sup>i</sup>
<b>Global Humanitarian Response Plan</b>	The COVID-19 Global Humanitarian Response Plan (HRP) is a joint effort by members of the Inter-Agency Standing Committee (IASC), including UN, other international organizations and NGOs with a humanitarian mandate, to analyze and respond to the direct public health and indirect immediate humanitarian consequences of the pandemic, particularly on people in countries already facing other crises. <sup>ii</sup>
<b>Inter-Agency Humanitarian Evaluation</b>	An Inter-Agency Humanitarian Evaluation (IAHE) is an independent assessment of results of the collective humanitarian response by member organizations of the IASC. IAHEs evaluate the extent to which planned collective results have been achieved and how humanitarian reform efforts have contributed to that achievement. <sup>iii</sup>
<b>Inter-Agency Standing Committee</b>	Created by United Nations General Assembly resolution 46/182 in 1991, the Inter-Agency Standing Committee (IASC) is the longest-standing and highest-level humanitarian coordination forum of the United Nations system. It brings together the executive heads of 18 organizations to formulate policy, set strategic priorities and mobilize resources in response to humanitarian crises. With members from within and outside the United Nations, the IASC strengthens collective humanitarian action through the implementation of a coherent, unified response. Towards that end, the IASC advocates for common humanitarian principles and makes strategic, policy and operational decisions with a direct bearing on humanitarian operations on the ground. The IASC is chaired by the Emergency Relief Coordinator (ERC). <sup>iv</sup>
<b>Secretary-General's Call for Solidarity</b>	On March 23rd, 2020, Secretary-General António Guterres issued an urgent appeal for a global ceasefire in all corners of the world to focus together on the true fight – defeating COVID-19. He repeated the call at the start of the 75th United Nations General Assembly session in September.
<b>System-wide Scale-up activation</b>	The IASC Humanitarian System-Wide Scale-Up Protocols are a set of internal measures designed to enhance the humanitarian response in view of increasing humanitarian needs and to ensure that IASC member organizations and partners can rapidly mobilize the necessary operational capacities and resources to respond to critical humanitarian needs on the ground. This exceptional measure will only be applied for a time-bound period of up to six months (which can be exceptionally extended by another three months). <sup>v</sup>
<b>The UN Framework for the Immediate Socio-Economic Response to COVID-19</b>	This report sets out the framework for the United Nations' urgent socio-economic support to countries and societies in the face of COVID-19, putting in practice the UN Secretary-General's Shared Responsibility, Global Solidarity report on the same subject. It is one of three critical components of the UN's efforts to save lives, protect people, and rebuild better, alongside the health response, led by the World Health Organization (WHO), and the humanitarian response, as detailed in the UN-led COVID19 Global Humanitarian Response Plan. <sup>vi</sup>

<sup>i</sup> <https://www.who.int/publications/i/item/strategic-preparedness-and-response-plan-for-the-new-coronavirus>.

<sup>ii</sup> United Nations (2020) *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020*, March 2020.

<sup>iii</sup> <https://interagencystandingcommittee.org/inter-agency-humanitarian-evaluations>.

<sup>iv</sup> <https://interagencystandingcommittee.org/the-inter-agency-standing-committee>.

<sup>v</sup> <https://interagencystandingcommittee.org/humanitarian-system-wide-scale-activation>.

<sup>vi</sup> United Nations (2020) *A UN Framework for the Immediate Socio-Economic Response to COVID-19*, April 2020.

# 1 Introduction and evaluation background

This section outlines the purpose of this report and describes the purpose, objectives and scope of the evaluation.

## 1.1 Purpose of the inception report

1. This inception report describes how the evaluation team will fulfil the Terms of Reference (ToR) for the inter-agency evaluation of the COVID-19 humanitarian response which is being jointly undertaken by KonTerra and Itad. This is the first output from the evaluation and lays the foundation for the remainder of the evaluation by providing a contextual analysis and key information about the proposed approach including tools, methods and timelines. A summary of the key steps of the inception and pilot phase and the evidence that was used to inform the report is outlined in Box 1.

### Box 1: Summary of the inception and pilot phases' key steps and evidence used to inform the inception report

The inception report was informed by a mix of internal and external consultations and document review.

- Members of the evaluation team participated in an initial briefing meeting with the OCHA evaluation manager and Chief of Evaluation and Oversight. This was followed by two meetings with the Management Group.
- A series of interviews were conducted with key informants drawn from across the humanitarian ecosystem, albeit with an emphasis placed on IASC forums including the Principals, Emergency Director's Group (EDG), Operational and Policy and Advocacy Group (OPAG). Members of the Global Evaluation Advisory Group were also interviewed. In total, 51 interviews were conducted during the Inception Phase, prior to the pilot case studies (see annex 2).
- The evaluation team carried out a review of key documentation which drew from a repository of 918 documents. Of these, 68 documents are referenced in this report (see annex 1). Included in this was the evaluation review which was undertaken to identify and document lessons from recent evaluations of the COVID-19 response. Forty-four evaluations and lessons papers were reviewed for this exercise.
- In addition to undertaking more general interviews and literature reviews, a focus was placed on the Global Humanitarian Response Plan (GHRP) in support of the development of the first Learning Paper which was drafted during the Inception and Pilot Phase.
- A number of internal team meetings were also held to fine-tune the analytical framework, evaluation matrix and broader approach for the evaluation.

2. The structure of the inception report is outlined below.
  - **Section 1** of the report provides an introduction and background to the evaluation. It summarizes the purpose and objectives of the evaluation and outlines the scope, based on the ToR.
  - **Section 2** of the report outlines the context in which the evaluation is being undertaken.
  - **Section 3** of the report outlines the team's overall approach to the evaluation including the design of the evaluation and analytical framework. It explores risks to the evaluation and proposes mitigation measures.
  - **Section 4** of the report provides an overview of the evaluation methodology including the data collection, synthesis and analysis tools that will be employed.
  - **Section 5** of the report highlights the evaluation process and work plan. It provides details of the different phases of the evaluation and provides a detailed timeline for the inception phase.
  - Section 6 of the report outlines the approach that the evaluation will take towards quality assurance and will provide details of KonTerra/Itad's role in addition to the roles of the Management Group (MG) and the Global Evaluation Advisory Group (GEAG).



## 1.2 Evaluation background, purpose and scope

### 1.2.1 Background to the COVID-19 pandemic and the IASC response

3. In 2020, the coronavirus disease (COVID-19) pandemic triggered an unprecedented global crisis. The World Health Organization (WHO) reports that, as of 2 March 2022, there were 437,333,859 confirmed cases of COVID-19 and over 5.9 million deaths.<sup>1</sup> In addition to the direct health impacts, the related socio-economic crisis is pushing more people into poverty and placing tremendous strain on already overburdened social and health services, and threatening to reverse hard-won development gains.
4. Almost every country in the world has reported cases, with communities large and small affected. The most vulnerable people have been particularly hard hit by the unprecedented effects of the pandemic on health systems, economies and societies.
5. These effects were particularly serious for people living in settings affected by humanitarian crises prior to and during the pandemic, where underlying vulnerabilities were already exacerbated by conflict and violence, and by the effects of climate change.
6. On 19 March 2020, the United Nations Secretary-General issued a Call for Solidarity in response to the unprecedented global health and development threat posed by the COVID-19 pandemic. The main objectives of this call were: (i) delivery of a large-scale, coordinated and comprehensive health response; (ii) adoption of policies that address the devastating socioeconomic, humanitarian and human rights aspects of the crisis; and (iii) a recovery process that builds back better.<sup>2</sup>
7. IASC member organizations have been major actors in addressing the humanitarian impacts of the crisis, ramping up an array of collective response mechanisms to meet the most urgent needs of nearly 250 million people in 63 countries (see Annex 6 for a list of the countries). The COVID-19 pandemic necessitated IASC and other humanitarian actors to adapt existing programmes, and where needed create new programming to respond to the COVID-19 pandemic.
8. To mobilize resources to meet these needs, the Secretary-General on 25 March 2020 launched the Global Humanitarian Response Plan (GHRP), a consolidated plan that brought together COVID-19 appeals and inputs from UN agencies and Non-Governmental Organizations (NGOs), and complemented other plans developed by the International Red Cross and Red Crescent Movement. The GHRP made an initial financial request of US\$2.01 billion that was increased, by the third and final iteration, to \$10.3 billion (which was then revised down to \$9.5 billion).
9. On 17 April 2020, the Emergency Relief Coordinator (ERC) declared a system-wide Scale-Up Activation to respond to COVID-19 to ensure coordinated global support to humanitarian country operations to mitigate the impact of the pandemic. The Scale-Up Activation covered all countries included in the GHRP for an initial period of six months. It was subsequently extended for another three-month period, in line with the regular procedures for a maximum duration of nine months for scaled-up measures to remain in effect.
10. The GHRP concluded as planned on 31 December 2020, at which time COVID-19 and non-COVID-19 humanitarian responses were consolidated in the Global Humanitarian Overview 2021. This also signalled the synchronization of COVID-19 and non-COVID-19 funding requirements and reporting under the regular Humanitarian Programme Cycle in regional and country plans. Meanwhile, new 'COVID only' humanitarian

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<sup>1</sup> <https://covid19.who.int/>.

<sup>2</sup> United Nations (2020) *United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better*, June 2020

plans in the remaining GHRP countries either concluded on 31 December 2020 or were integrated into other development plans or frameworks.

11. For these reasons, and in line with the Scale-Up Activation Protocol for COVID-19 that sets a maximum 9-month limit to the activation period, the ERC declared the deactivation of the IASC Scale-Up response on 17 January 2021. The IASC issued its final progress report on the GHRP on 22 February 2021.

### 1.2.2 Evaluation rationale, purpose and objectives

12. The subject of this evaluation is **the collective preparedness and response of the IASC member agencies at the global, regional, and country level** in meeting the humanitarian needs of people in the context of the COVID-19 pandemic.
13. Inter-Agency Humanitarian Evaluations (IAHEs) were introduced to strengthen system-wide learning and promote accountability towards affected people, national governments, donors, and the public, and are guided by a vision of addressing the most urgent needs of people impacted by crises through coordinated and accountable humanitarian action. IAHEs inform humanitarian reforms and help the humanitarian community to improve aid effectiveness to ultimately better assist affected people. IAHEs are not an in-depth evaluation of any one sector or of the performance of a specific organization.
14. In line with IASC protocols, an evaluation of Scale-Up responses is required within 9 to 12 months of the declaration of a Scale-Up to meet its formal learning and accountability needs. In the event of infectious disease events, the protocol states that an IAHE should be conducted '*if necessary*'. The ToR (pg. 7) outline three considerations to provide further rationale for the evaluation of the IASC's collective efforts to respond to pandemic-related humanitarian needs:
  - A documented knowledge gap pertaining to collective humanitarian response to infectious disease events.
  - Capturing learning from global, regional and local levels vis-à-vis joint analysis, planning and programming, as well as how collective systems enabled this.
  - The significant accountability obligation due to the substantial funding received from the international community through IASC mechanisms.
15. The ToR (pg. 8) identify that the intended purpose of the evaluation is for learning and accountability and the main objectives of this evaluation are threefold, namely to:
  - Determine the extent to which the IASC member agencies' collective preparedness and response actions, including its existing and adapted special measures, were relevant to addressing humanitarian needs in the context of the pandemic.
  - Assess the results achieved from these actions at the global, regional and country level in support of people, and with governments and local actors.
  - Identify best practices, opportunities and lessons learnt that will help to improve ongoing and future humanitarian responses, including through wider and accelerated adaptation of certain humanitarian policies, approaches, and practices.

### 1.2.3 Scope of the evaluation

16. The substantive, temporal and geographic scope of the evaluation are summarized in Table 1 below.

**Table 1: Scope of the evaluation**

Scope	Description
<b>Substantive</b>	The subject of the evaluation is the collective IASC preparedness and humanitarian response at the global, regional and country level to meet the humanitarian needs of people in the context of the COVID-19 pandemic. Thus, as with all IAHEs, this evaluation will focus primarily on the actions and roles of the IASC and its member organizations, in support of governments and local actors, to meet the needs of the most vulnerable people and those in hard-to-reach areas.
<b>Temporal</b>	The evaluation will cover the IASC-led humanitarian response to COVID-19 from 1 January 2020, when WHO activated its Incident Management Support Team, up until the time of the IAHE data collection phase. To assess the contribution of the Scale-Up measures to the response, the IAHE will focus on the period from 18 April when the IASC Scale-Up response was activated until 17 January 2021, when it was deactivated. To answer the evaluation questions that are specific to the GHRP, the IAHE will focus on the period covered by the plan i.e., March to December 2020, and up to February 2021 when the last GHRP progress report was published. To answer the evaluation questions related to collective preparedness to the pandemic, the evaluation will also review relevant IASC documents, decisions and actions taken prior to 1 January 2020.
<b>Geographic</b>	The IAHE is global in scope, with focus on countries included in the GHRP and its revisions, as the only countries in which collective IASC action to address pandemic related needs took place.

### 1.2.4 Intended users and use of the evaluation

17. There are several users for the evaluation as follows:

- The primary users are the ERC, IASC Principals, Operational Policy and Advocacy Group, Emergency Directors Group, and others within the IASC member organizations.
- The secondary users are donors, front-line responders, local actors, the Joint Steering Committee to Advance Humanitarian and Development Collaboration and other inter-agency mechanisms to advance the humanitarian-development-peace nexus agenda, who will also particularly benefit from the higher-level conclusions and lessons learned for the humanitarian system.

18. In doing so, the IAHE will:

- Provide the Member States and their disaster management institutions with evaluative evidence and analysis to inform their national policies and protocols for crises involving international agencies and other actors.
- Provide information to affected people on the outcomes of the response.
- Provide international organizations, donors, learning and evaluation networks and the public with evaluative evidence of collective response efforts for accountability and learning purposes.

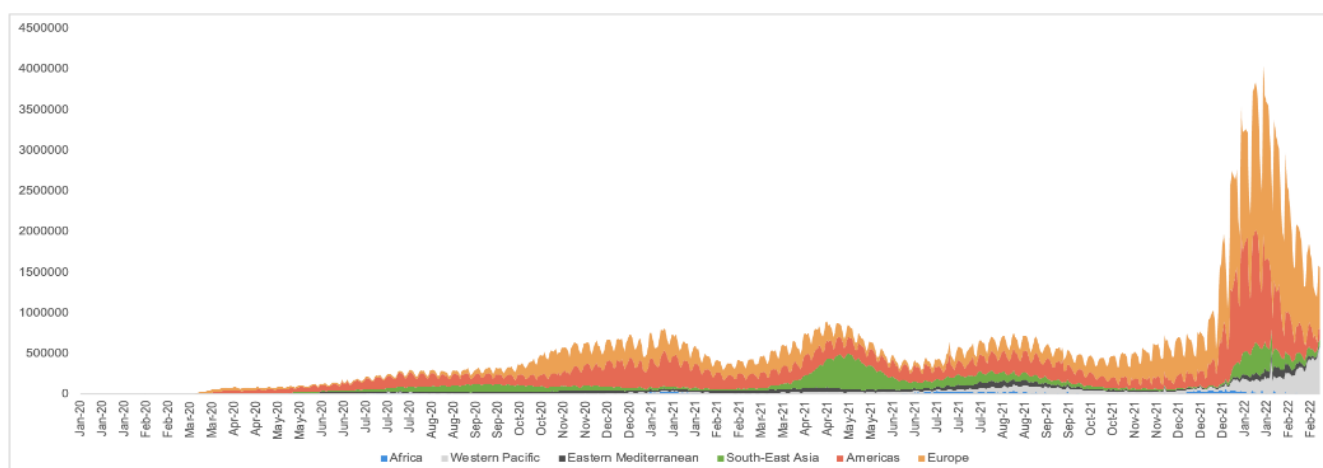
## 2 Evaluation context

This section begins with an overview of the timeline and impact of COVID-19 before outlining planning and funding for the response. It goes on to focus on key challenges that the COVID-19 pandemic posed for the humanitarian system and the implications of these for this IAHE. It concludes by situating the IAHE in the context of other evaluations of the pandemic response and previous IAHEs.

### 2.1 Timeline and impact of COVID-19

19. On 30 January 2020, WHO declared a Public Health Emergency of International Concern due to the outbreak of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). However, most countries did not take action till WHO characterized COVID-19 as a global pandemic on 11 March 2020.<sup>3</sup>
20. While almost all countries have reported cases of COVID-19, the timeline below demonstrates that countries and regions experienced waves of infection at different times. For example, South-East Asia experienced a significant wave of infections between March and June 2021 while Europe, the Americas and the Western Pacific have experienced the most significant increases in infections in late 2021-early 2022. Figure 1 below also shows that some regions have much higher numbers of reported cases than others, with Europe and America reporting the highest numbers while Africa has had a much lower number of confirmed cases, even taking into account different testing and reporting capacities.

**Figure 1: Timeline of confirmed cases of COVID-19 by WHO region**



Source: <https://covid19.who.int/> as of 5 March 2022

21. The COVID-19 pandemic is not only a health crisis, but also a disruption to long-term socio-economic development, impacting supply chains, unsettling financial markets, affecting education (particularly due to school closures) and livelihoods (particularly of low wage workers and the informal sector). A combination of these factors and measures put in place to suppress the virus have led to higher levels of food insecurity as well. The pandemic highlighted global inequalities whereby lower-income countries or specific population groups are affected disproportionately in terms of access to food and basic services, causing existing vulnerabilities to be further exacerbated. Effects on vulnerable groups include domestic violence, early child marriage and child protection risks.<sup>4</sup> Border closures had a significant impact on refugee crises, as 160 countries fully or partially closed their borders, with over half of them making no exception for refugees or

<sup>3</sup> The Independent Panel for Pandemic Preparedness and Response (2021) *COVID-19: Make it the last pandemic*.

<sup>4</sup> United Nations (2020) *Shared Responsibility, Global Solidarity: Responding to the socio-economic impacts of COVID-19*, March 2020.

asylum seekers.<sup>5</sup> This exacerbated the impact of a triple crisis (with health, socio-economic and protection dimensions) that the pandemic created for refugees, internally displaced persons (IDPs), migrants and stateless persons.<sup>6</sup>

## 2.2 Planning for the COVID-19 pandemic response

22. In response to this multi-layered global crisis, in March 2020, the United Nations (UN) Secretary-General (SG) issued a ‘Call for Solidarity’, focusing on three objectives: (i) delivering a large-scale, coordinated health response, (ii) adapting policies and programming to address the socio-economic, humanitarian, and human rights aspects of the crisis, and (iii) rebuilding better – strengthening social protection systems.<sup>7</sup> The UN’s report on a comprehensive response to COVID-19 highlights three major response plans to address different needs and aspects of the crisis.<sup>8</sup>

- *The World Health Organization (WHO) Strategic Preparedness and Response Plan (SPRP)*, published on 4 February 2020, outlines WHO’s three key pillars of response: (i) coordination and support, (ii) country preparedness and response, and (iii) priority research and innovation acceleration.<sup>9</sup> Individual countries create preparedness and response plans (PRPs) aligned with the response pillars. The initial SPRP (February – June 2020) was updated in April 2020.<sup>10</sup>
- *The IASC COVID-19 Global Humanitarian Response Plan (GHRP)* launched on 25 March 2020 and covered the period up to the end of December 2020.<sup>11</sup> It was the humanitarian community’s first ever event-specific global appeal. It aimed to: (i) contain the spread of COVID-19, (ii) decrease the deterioration of human rights, assets, and livelihoods, and (iii) protect and assist people particularly vulnerable to COVID-19, such as refugees, IDPs, and migrants.<sup>12</sup> The second iteration, published in May 2020, requested \$6.71 billion to respond to humanitarian needs in an expanded set of 63 countries (see Annex 6), with additional countries added to an ‘at risk and to watch list’.<sup>13</sup> The third and final iteration of the GHRP, issued in July 2020, requested \$10.3 billion.<sup>14</sup> Throughout its various iterations, the GHRP remained focused on the immediate humanitarian needs caused by the pandemic and related short-term responses. It did not attempt to cover the full spectrum of pre-existing needs and responses in GHRP countries, which continued to be encapsulated in existing humanitarian plans. These plans were updated during the year to incorporate COVID-19 and adjusted non-COVID-19-related needs and financial requirements.
- *The UN Framework for the Immediate Socio-Economic Response to COVID-19*, which puts the UNSG’s “Shared Responsibility, Global Solidarity” statement and report into action, including five streams of work: (i) Protecting health services and systems (ii) Social protection and basic services (iii) Protecting jobs and small and medium-sized enterprises (iv) Macroeconomic response and multilateral collaboration (v) Social cohesion and community resilience.

23. In light of the intertwined impacts of COVID-19 on communities, there was a degree of overlap between the three response plans in terms of their objectives and planned activities. The evaluation team undertook a

<sup>5</sup> <https://www.unhcr.org/news/latest/2020/10/5f7dfbc24/covid-19-crisis-underlines-need-refugee-solidarity-inclusion.html>.

<sup>6</sup> United Nations (2020) *United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better*, June 2020.

<sup>7</sup> <https://unu.edu/news/news/un-secretary-general-covid-19-pandemic-calls-for-coordinated-action-solidarity-and-hope.html>.

<sup>8</sup> United Nations (2020) *United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better*, June 2020.

<sup>9</sup> WHO (2020) *2019 Novel Coronavirus (2019-nCoV) Strategic Preparedness and Response Plan*, 4 February 2020.

<sup>10</sup> WHO (2020) *COVID-19 Strategy Update*, 14 April 2020.

<sup>11</sup> UN OCHA (2020), *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, March 2020*.

<sup>12</sup> UN OCHA (2020), *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, March 2020*.

<sup>13</sup> UN OCHA (2020), *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP May Update*.

<sup>14</sup> UN OCHA (2020), *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP July Update*.

mapping of the objectives of the three plans and planned activities below these in order to identify areas where the GHRP overlapped with the SPRP and the socio-economic response plan. Figure 2 below provides an overview of this, highlighting the range of objectives and activities that fall within the scope of this evaluation. A more detailed analysis is provided in Annex 6. This highlights the potentially very broad scope of this evaluation and section 3 on methodology outlines the team’s approach and areas of focus. A system-wide evaluation of the UN development system’s response to COVID-19 is also underway<sup>15</sup>, covering the response to socio-economic impacts. The IAHE evaluation team has liaised with the system-wide evaluation team to avoid duplication.

**Figure 2: Summary of international response plans, identifying scope of the evaluation**



Source: adapted from OCHA, 2020

### 2.3 Humanitarian funding for the response

24. As noted earlier, funding requirements within the GHRP grew from an initial ask of \$2.01 billion in March 2020 to an eventual \$10.31 billion in July 2020.<sup>16</sup> By February 2021, the date of the last progress report on the GHRP, \$3.8 billion had been contributed against the GHRP – 40 per cent of the requested amount. Total humanitarian funding received for COVID-19 was \$6.6 billion and included direct funding to governments, the Red Cross/Red Crescent Movement, and funding to UN agencies and NGOs for non-GHRP countries.<sup>17</sup> A small number of key donors provided a significant proportion of GHRP funding, with the top five donors contributing over half of the overall amount,<sup>18</sup> and the Government of the United States (US) alone providing nearly one quarter of all funds received against the appeal.<sup>19</sup>
25. Levels of funding varied significantly across the 63 countries included in the GHRP. Figure 3 below shows that, of the countries with existing appeals, Iraq and Libya requested modest levels of funding and received almost the full amount. Somalia also received 82 per cent of the funding requested. At the other end, Venezuela and Zimbabwe only received 21 and 27 per cent respectively of requested funding. Regional appeals also received minimal funding.

<sup>15</sup> Freeman, T. A. L. Esser and P. Vela (2022) *Inception Report: System-Wide Evaluation of the UNDS Response to COVID-19*, Executive office of the Secretary General of the United Nations

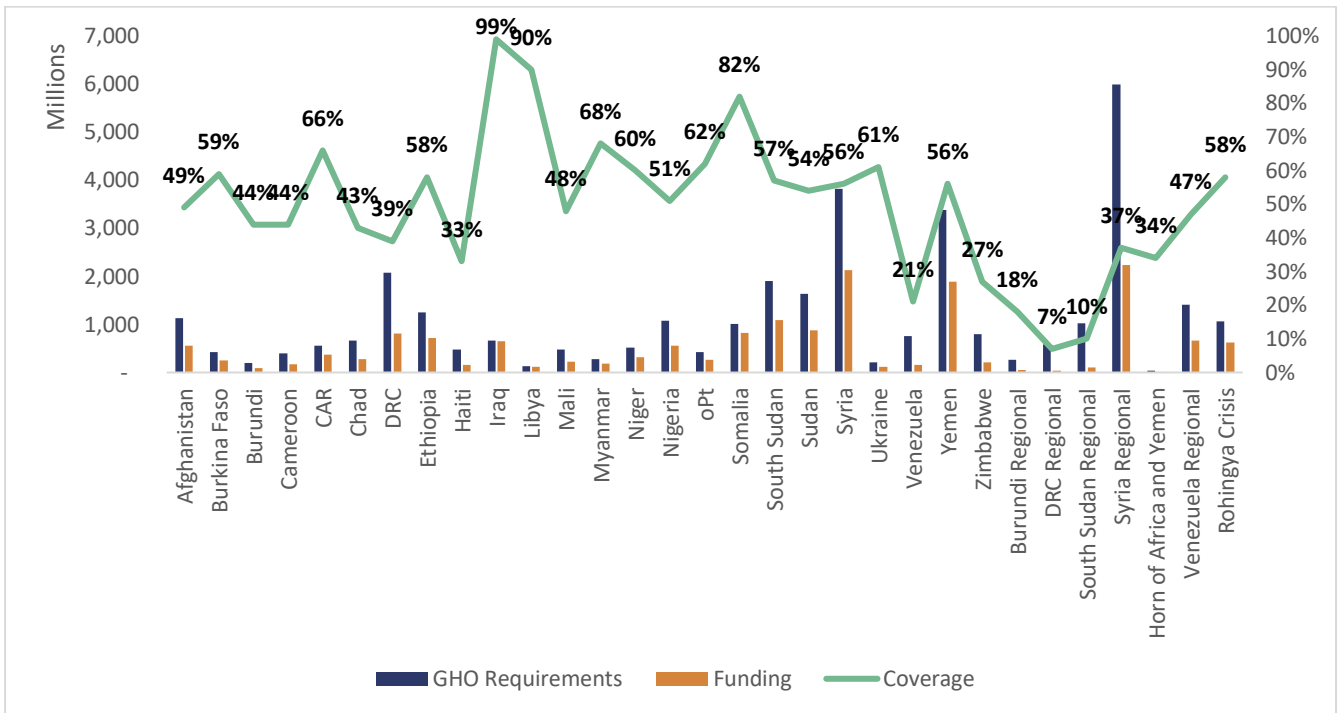
<sup>16</sup> Financial requirements for the GHRP were subsequently revised down to \$9.5 billion.

<sup>17</sup> UN OCHA (2021), Global Humanitarian Response Plan COVID-19, Final Progress Report, 22 February 2021.

<sup>18</sup> According to reporting on OCHA’s FTS, the US, Germany, the European Commission’s Humanitarian Aid and Civil Protection Department (ECHO), the United Kingdom and Japan provided a combined total of \$2.1 billion against the GHRP, representing 55 per cent of overall contributions.

<sup>19</sup> Reporting on OCHA’s FTS shows that the US contributed a total of \$919 million towards the GHRP, representing 24 per cent of overall contributions.

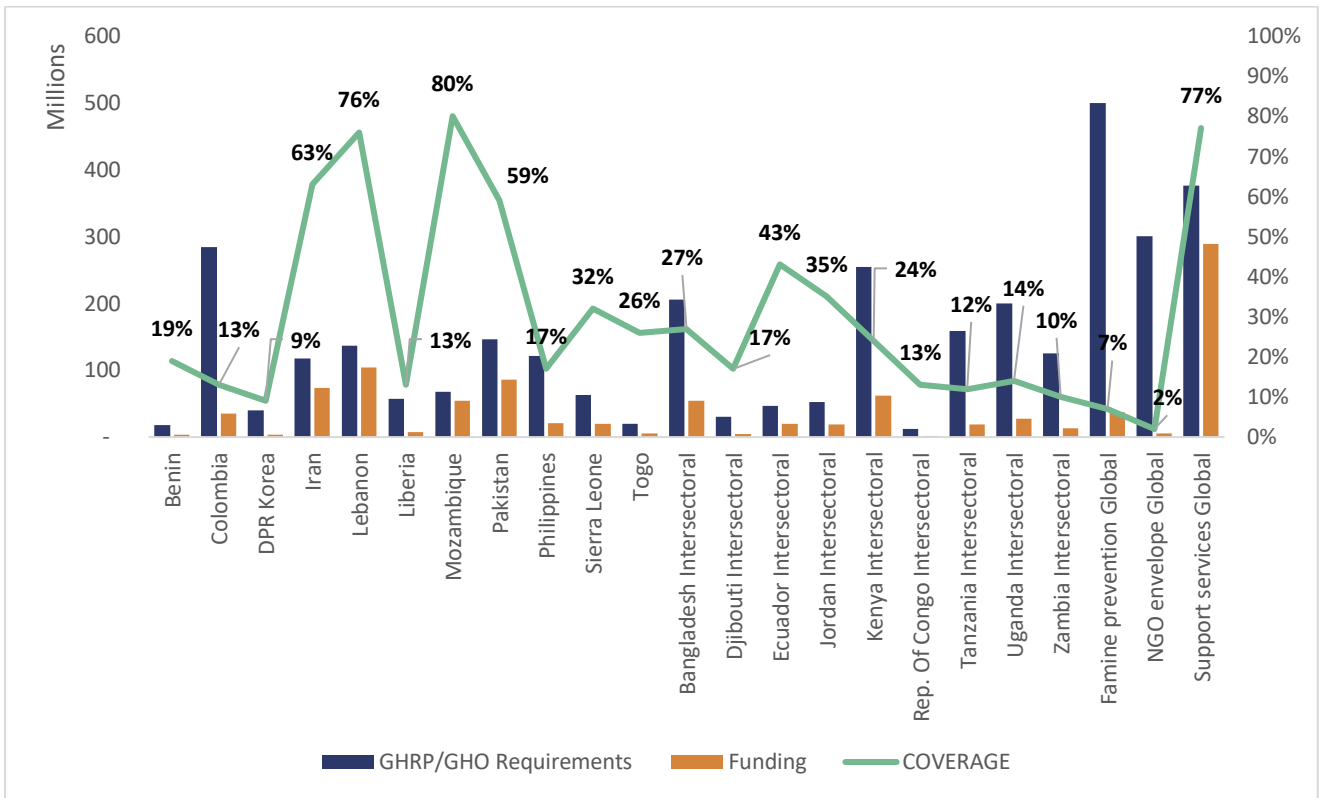
**Figure 3: Funding requested and received by GHRP country with pre-existing appeal**



Source: OCHA (2021), Global Humanitarian Response Plan COVID-19, Final Progress Report, 22 February 2021.

26. Figure 4 below shows the amount of funding received versus the amount requested by GHRP countries that launched COVID-specific appeals as well as global funding included in the GHRP. This shows that countries such as Lebanon and Mozambique were well-funded while countries such as the Democratic People’s Republic of Korea, Liberia, and Tanzania received very small percentages of requested funding.

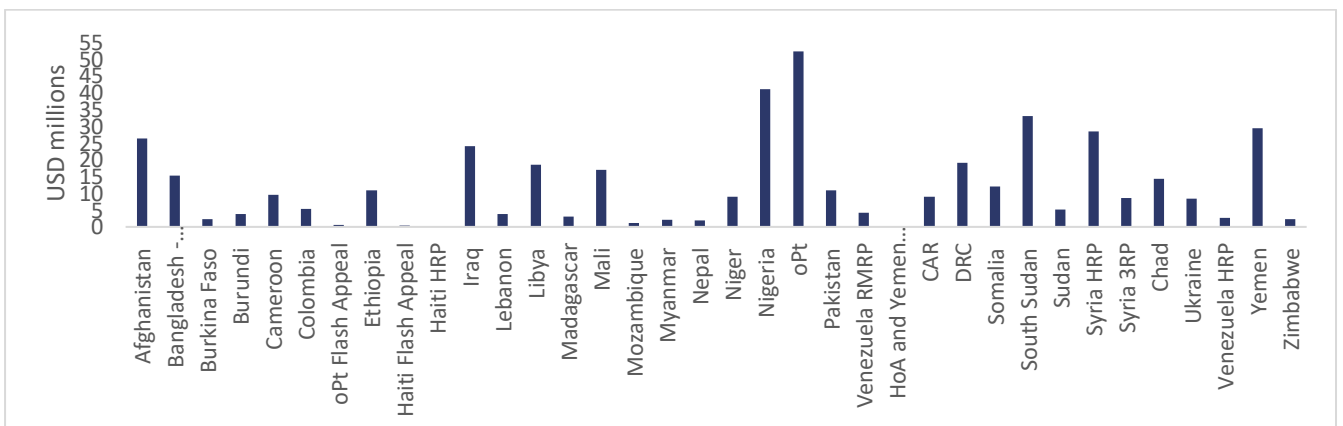
**Figure 4: Funding requested and received by GHRP country with COVID-specific appeal**



Source: OCHA (2021), Global Humanitarian Response Plan COVID-19, Final Progress Report, 22 February 2021.

27. From January 2021 onwards, once the GHRP period had ended, the IASC response to the effects of COVID-19 was integrated into country-specific HRPs, RRP and other country-level plans. Humanitarian funding for COVID-19 related needs totalled over \$1.5 billion in 2021, according to data in the Office for the Coordination of Humanitarian Affairs’ (OCHA) Financial Tracking Service (FTS). Of this, \$436 million was provided within humanitarian appeals and \$1.1 billion outside of appeals. Figure 5 below shows COVID-19 funding by appeal in 2021. This shows that oPt, Nigeria, Syria and Yemen all received significant COVID-19 funding.

**Figure 5: COVID-19 funding by appeal in 2021**



Source: OCHA Financial Tracking Service, data downloaded 8 March 2022.



### 2.3.1 Pooled funding

28. As existing humanitarian pooled funds, the Central Emergency Response Fund (CERF) and Country-Based Pooled Funds (CBPFs) responded to COVID-19 related needs with significant amounts of humanitarian funding. They began allocating funds from 27 February 2020, even before the launch of the GHRP, and had provided \$204 million by 15 May 2020 (\$95 million through CERF block-grant allocations, \$7.2 million through CERF reprogramming; \$100.2 million through CBPFs allocations and \$1.7 million through CBPF reprogramming).<sup>20</sup> Figure 6 below shows CERF and CBPF funding for COVID-19 by country. In 2020, there were CBPFs in 19 countries and so their funding is within these contexts.<sup>21</sup> As a global fund, the CERF has a wider reach, as outlined in the figure below. This shows that the CERF and CBPFs allocated over \$490 million to 50 contexts in support of the COVID-19 response.
29. A combination of a document review and inception phase interviews highlighted that the CERF introduced both innovative and flexible measures in response to COVID-19. It used an early, fast-tracked process to allocate block grants to nine UN agencies totalling \$95 million between February and May 2020, including \$40 million earmarked for logistics and humanitarian supply-chains service.<sup>22</sup> This was the first time that CERF funding went directly to UN agencies at the global level rather than through country-specific grants, with the aim of providing maximum flexibility for agencies to prioritize according to critical global and country needs within the parameters of the GHRP. The CERF also made its first ever NGO allocation in June 2020,<sup>23</sup> channelling \$25 million to twenty-four NGOs for COVID-19 response in six countries, with the International Organization for Migration (IOM) serving as the grant manager.<sup>24</sup> A review of the allocation is broadly positive, noting that the allocation demonstrated that ‘*CERF can fund front-line organizations, without following the typical UN agency-partner model, and that it can add real value in situations where a significant additional and rapid injection of funds for NGOs is required*’.<sup>25</sup> The CERF also made two special allocations dedicated to gender-based violence (GBV) programming.<sup>26</sup>

<sup>20</sup> UN OCHA (2020) *Pooled Funds: Overview of Allocations for COVID-19*, 15 May 2020.

<sup>21</sup> See <https://cbpf.data.unocha.org/> In July 2021, OCHA established the first Regionally hosted CBPF for West and Central Africa with funding to Burkina Faso and Niger (<https://reliefweb.int/sites/reliefweb.int/files/resources/210719-Press%20release%20WCA%20RHPF.pdf>). As of 2022, the Jordan and Pakistan CBPFs have closed, leaving 17 country-level funds and the Regionally hosted CBPF.

<sup>22</sup> CERF (2020), *CERF COVID-19 Allocations, CERF Advisory Group Meeting, November 2020*.

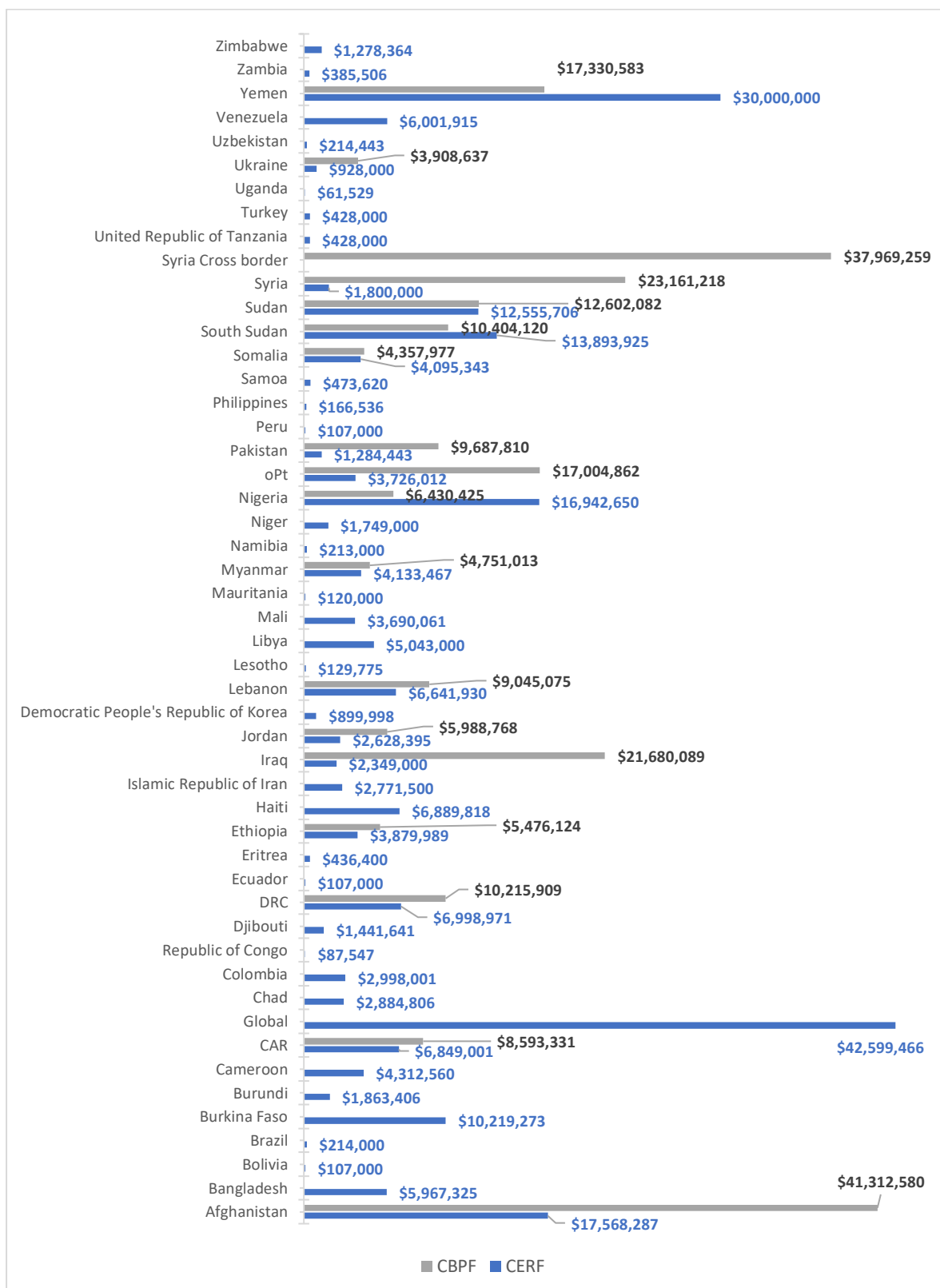
<sup>23</sup> CERF (2020), *CERF COVID-19 Allocations, CERF Advisory Group Meeting, November 2020*.

<sup>24</sup> CERF funding supported NGO COVID-19 responses in Bangladesh, the Central African Republic, Haiti, Libya, South Sudan and Sudan.

<sup>25</sup> Poole, L. (2021), *Independent review Central Emergency Response Fund (CERF) COVID-19 NGO allocation*, 11 October 2021.

<sup>26</sup> Special COVID-19 GBV CERF allocations in 2020 included \$5.5million of earmarked funding from the Underfunded Emergencies Window, and \$25 million from the Rapid Response Window to UNFPA and UN Women (of which an estimated 40 per cent is allocated to women-led organizations and women’s rights organizations): CERF (2020), *CERF COVID-19 Allocations, CERF Advisory Group Meeting, November 2020*; CERF (2020), *Protection from Gender-based Violence, CERF Special Allocations in 2020, As of July 2021*.

**Figure 6: CERF and CBPF COVID-19 funding by country**



Source: <https://pfddata.unocha.org/COVID19/> Accessed on 1 March 2022

30. A study report shows that the CBPFs introduced specific flexibility measures for the COVID-19 response in the following areas: modifying project ceilings, reprogramming projects, increasing budget flexibility, and monitoring, spot checks, audits and electronic signatures. Subsequently, based on the experience of applying these flexibility measures, the CBPF section has incorporated several measures into global guidance.<sup>27</sup> CBPFs have been an important mechanism for donors to meet their Grand Bargain commitment on funding to local actors<sup>28</sup> and the GHRP also flagged them as one of the primary ways of channelling funding to local and national humanitarian organizations. In response to COVID-19, 32 per cent (\$80 million) of CBPF funding is reported to have gone to local and national actors.<sup>29</sup>
31. The team's data collection through country case studies will provide it with the opportunity to assess how the efforts of the CERF and CBPF to provide innovative and flexible funding (as outlined above) supported the COVID-19 response. This will help to answer the evaluation question specifically on pooled funds, '*To what extent did pooled funds contribute to the provision of adequate, timely and flexible funding to meet the GHRP requirements?*' It will also contribute to the evaluation question about innovative approaches, solutions, and new ways of working that would benefit ongoing or future responses.
32. In 2020, dedicated pooled funds were set up to finance the SPRP and the socio-economic response plans. Assessing these funds is beyond the scope of this evaluation but it will be helpful to review whether the various pooled funds contributed to working in the humanitarian-development-peace nexus at case-study country level. WHO, UN Foundation and Swiss Philanthropy Foundation jointly launched the Solidarity Response Fund (SRF) on 13 March 2020. Its purpose was to facilitate direct financial contributions from companies, organizations and individuals to the COVID-19 response by WHO and its partners under the three pillars of the SPRP.<sup>30</sup> As of November 2021, the SRF had raised almost \$257 million from 676,626 donors. It ceased active fundraising at the end of 2021.<sup>31</sup> An evaluation of the SRF highlighted that the fund was able to maximize impact because it was a pooled fund with no earmarking of contributions. The SRF's main added value was its early initiation, clear targeting, the ability to quickly fund activities, and to focus on innovations and identified funding gaps. The Fund's agility was increased through funding redeployment and reallocation mechanisms.<sup>32</sup>
33. On 31 March 2020, the SG launched the UN COVID-19 Response and Recovery Fund to support low- and middle-income countries to respond to COVID-19 and its impact, particularly the socio-economic shock. The Fund's purpose is to act as an inter-agency mechanism to contribute to the three objectives of the SG's Call for Solidarity. The Fund is managed by the UN Multi-Partner Trust Fund (MPTF) Office.<sup>33</sup> To date, the Fund has raised over \$86 million and allocated funding to 80 countries.<sup>34</sup> Key messages from a lessons learning and evaluability exercise include the importance of the speed of response, the need for pre-existing coordination structures and human resources to sustain a collaborative response, the need for a participatory and inclusive approach to ensure a coherent response, the value of a global response framework with country-

<sup>27</sup> Featherstone, A. and T. Mowjee (2021) *Enhancing Programme Effectiveness of CBPFs*, unpublished.

<sup>28</sup> UN OCHA (2019) *OCHA Evaluation of Country-Based Pooled Funds: Global Synthesis Report*, November 2019. For the full set of Grand Bargain commitments, see [https://interagencystandingcommittee.org/system/files/grand\\_bargain\\_final\\_22\\_may\\_final-2\\_0.pdf](https://interagencystandingcommittee.org/system/files/grand_bargain_final_22_may_final-2_0.pdf)

<sup>29</sup> UN OCHA (2021), *Global Humanitarian Response Plan COVID-19, Final Progress Report, 22 February 2021*.

<sup>30</sup> IOD Parc (2021) *UNF-WHO COVID-19 Solidarity Response Fund: Joint Evaluation*, December 2021.

<sup>31</sup> <https://covid19responsefund.org/en/>.

<sup>32</sup> IOD Parc (2021) *UNF-WHO COVID-19 Solidarity Response Fund: Joint Evaluation*, December 2021.

<sup>33</sup> UN (2020) *The Secretary-General's UN COVID-19 Response and Recovery Fund*, April 2020.

<sup>34</sup> <https://mptf.undp.org/factsheet/fund/COV00>.

level plans, and the need for adequate levels of funding.<sup>35</sup> It will be useful for this evaluation to explore whether these lessons are equally applicable to the humanitarian response to COVID-19.

## 2.4 Key features of the COVID-19 response and implications for the evaluation

34. Two years on from the start of the pandemic, it is clear that responding to COVID-19 has posed unique challenges and every country has encountered difficulties in responding to it. For the collective humanitarian response, COVID-19 both brought to the fore issues that had been long debated and presented new challenges. While the role of local actors has been discussed extensively since before the World Humanitarian Summit in 2016, COVID-19 presented a new challenge because of the very restricted ability to deploy international staff and conduct “business as usual”. This is discussed in section 2.4.1 below. The pandemic and the response to it had a differential impact on different segments of populations - women and girls, persons with disabilities, children and youth, and older persons.<sup>36 37</sup> The ToR include gender and assistance to persons with disabilities as cross-cutting issues for the evaluation and these are discussed in sections 2.4.2 and 2.4.3 below. Other issues that are relevant for the COVID-19 response include the challenges faced by a collective system that is still organized to work in silos, both sectorally as well as across the humanitarian-development-peace nexus, and; the challenges faced in making good on the promise of a ‘*participation revolution*’.<sup>38</sup> Challenges related specifically to the pandemic response include the need to plan globally but act locally, the dilemma of access and the call for a global ceasefire, and road-testing collective pandemic preparedness and response. Inception phase interviewees compared attempts to address the challenges as ‘*building the aeroplane while flying it*’.
35. An examination of each of these issues offers an entry point to better identify implications for the evaluation and areas for further exploration during the data collection phase. COVID-19 also presented humanitarian actors with unprecedented challenges and the need to find different ways of operating. For example, international humanitarian actors are used to focusing on geographically specific emergencies (with the IASC scale-up activation protocols designed for this). However, COVID-19 was a global crisis affecting very large numbers of countries/regions at the same time. Also, governments put in place regulations to contain the spread of COVID that shaped both the secondary impacts of the pandemic and the ways in which humanitarian actors provided assistance, requiring them to find different approaches to overcome restrictions on movement and in-person contact. There are specific evaluation questions on the application of the scale-up activation protocols, the role of governments and local actors, and the adaptation of humanitarian programming that will provide evidence on these issues.

### 2.4.1 The role of local actors

36. In a natural disaster, local actors are often the first to respond. National authorities have a sovereign and primary responsibility to respond and protect their population. In fragile states or crisis contexts, organizations at the local level, such as the national Red Cross-Red Crescent National Society local branches, faith-based organizations and other civil-society groups are often at the forefront of responding to humanitarian needs in the communities. Despite the clear importance of local actors, the international

<sup>35</sup> Freeman, T., A. L. Esser, C. Chatterjee, and P. Vela (2021) *Early Lessons and Evaluability of the UN COVID-19 Response and Recovery MPTF*, April 2021.

<sup>36</sup> UN OCHA (2020), *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP May Update*

<sup>37</sup> UNICEF (2020) *Responding to COVID-19: UNICEF Annual Report 2020*, New York: United Nations Children’s Fund (UNICEF)

<sup>38</sup> <https://interagencystandingcommittee.org/a-participation-revolution-include-people-receiving-aid-in-making-the-decisions-which-affect-their-lives>

humanitarian system was built by and for international donors, multilateral organizations and international NGOs.<sup>39</sup>

37. In 2016, the High-Level Panel report to the Secretary-General highlighted the importance of direct funding to local humanitarian responders, when possible and relevant.<sup>40</sup> Commitment 2 under the Grand Bargain set a target of providing 25 per cent of humanitarian funding to local and national responders ‘as directly as possible’ by 2020. However, progress on direct funding has been limited, with donors still relying on multilateral organizations, international partners and pooled funds, particularly CBPFs, to channel funding to national and local NGOs.<sup>41</sup> Also, inception phase interviews highlighted that, despite decades of ‘capacity-building’ by international actors, national and local NGOs still receive very limited direct funding. Part of the reason for this is a perception amongst international actors that they have insufficient capacity to handle significant funding.
38. With international travel and movement restrictions impeding the ability of the international humanitarian community to deploy surge staff and transport supplies as normal, COVID-19 brought the role of local actors to the fore because they were on the ground and able to maintain and possibly scale-up humanitarian operations. In a guidance document, the IASC argued that ‘*Localization is therefore both a necessity and an opportunity for effectively meeting humanitarian needs and recovery efforts post COVID-19.*’<sup>42</sup> The Alliance for Empowering Partnership (A4EP) also highlighted the importance of localization, particularly as many international actors were struggling with operational disruptions and domestic COVID-19 crises.<sup>43</sup>
39. The IASC developed its guidance on localization in the context of the COVID-19 response relatively quickly, publishing it in May 2020.<sup>44</sup> This reflects an understanding that, with the international system paralyzed, local actors would deliver the bulk of humanitarian assistance on the ground. Through the country case studies, this evaluation will examine the extent to which local actors were able to overcome COVID-related restrictions better than international organisations to deliver humanitarian assistance. A review of documents and inception phase interviews indicated that challenges with delivering on localization commitments from before the pandemic were exacerbated by COVID-19 specific challenges. The team has identified the following issues that will need examination during the data collection and analysis phases:
- A lack of adequate channels for timely and flexible funding to local actors. This is reflected in the fact that the GHRP, as a framework for existing humanitarian operations to respond to COVID-19, did not offer an effective conduit for direct funding to local actors. As a result, IASC guidance on localization focused on responsible partnership practice.<sup>45</sup>
  - Adapting decision-making processes for situations when international staff members with decision-making authority were no longer in-country. Also, a lack of transparency in decision-making around priorities and funding.
  - Ensuring the safety and well-being of national partners given their exposure to the virus as front-line

<sup>39</sup> OECD (2017) *Localising the Response: World Humanitarian Summit Putting Policy into Practice*.

<sup>40</sup> UN (2016) *Too important to fail—addressing the humanitarian financing gap: High-Level Panel on Humanitarian Financing Report to the Secretary-General*.

<sup>41</sup> Featherstone, A. and T. Mowjee (2020) *Desk Review in Enhancing the Potential of Pooled Funds for Localisation*, Grand Bargain Workstream 2: Localisation.

<sup>42</sup> Inter-Agency Standing Committee (2020) *Localisation and the COVID-19 Response: Interim Guidance*, IFRC and UNICEF in collaboration with IASC Results Group 1 on Operational Response Sub-Group on Localisation.

<sup>43</sup> A4EP (2020) *Localised response to COVID-19 global pandemic: A4EP Position Paper*.

<sup>44</sup> Inter-Agency Standing Committee (2020) *Localisation and the COVID-19 Response: Interim Guidance*, IFRC and UNICEF in collaboration with IASC Results Group 1 on Operational Response Sub-Group on Localisation

<sup>45</sup> Inter-Agency Standing Committee (2020) *Localisation and the COVID-19 Response: Interim Guidance*, IFRC and UNICEF in collaboration with IASC Results Group 1 on Operational Response Sub-Group on Localisation.

responders, as underlined by IASC guidance.<sup>46</sup>

40. Insufficient recognition and representation of local actors in coordination, leadership and decision-making at both global and national levels.
41. The structure of partnerships with local actors, including the short duration of funding that hampers sustained support and investment in capacity-strengthening that goes beyond the provision of training or a focus on financial management.<sup>47 48 49 50 51</sup>

#### 2.4.2 The differential impact of the pandemic on women and girls

42. There was early recognition of the disproportionate effect of the COVID-19 pandemic on women and girls. Although the IASC has had a policy on gender equality and the empowerment of women and girls in humanitarian action since 2017,<sup>52</sup> it issued a gender alert specifically for COVID-19 in March 2020.<sup>53</sup> Women make up 70 per cent of the global health workforce, which put them at greater risk of infection.<sup>54</sup> Social norms (such as expectations that women and girls are responsible for nursing sick family members and might be the last to receive medical attention when they become ill) also expose women and girls to greater health risks. In addition, overwhelmed health services, movement restrictions, and diverted funding mean that women and girls are less likely to have access to specific health services such as sexual and reproductive health, GBV survivor care, HIV treatment and natal services.<sup>55</sup> Women are also likely to experience more severe economic impact because they often engage in informal, low-wage activities that were severely disrupted by measures to contain the spread of the virus. School closures due to COVID-19 are likely to have long-term effects on educational, health and economic outcomes for girls while adding to the disproportionate caregiving responsibilities of women.<sup>56 57</sup>
43. The May 2020 iteration of the GHRP recognized that COVID-19 was evolving into a protection crisis for women and girls, in particular, because social and economic stresses combined with measures to contain the spread of the virus had led to a spike in GBV. At the same time, services for GBV survivors had reduced capacity or had been repurposed for COVID-19 testing and/or treatment.<sup>58</sup> The July iteration of the GHRP reported that over 240 million women and girls aged 15-49 had experienced violence by an intimate partner in the previous 12 months and older women were also affected.<sup>59</sup>

<sup>46</sup> Inter-Agency Standing Committee (2020) *Localisation and the COVID-19 Response: Interim Guidance*, IFRC and UNICEF in collaboration with IASC Results Group 1 on Operational Response Sub-Group on Localisation.

<sup>47</sup> Charter 4 Change. (2020) Lobby Brief: Localization, COVID GHRP, and UN Country Based Pooled Funds.

<sup>48</sup> A4EP (2020) *Localised response to COVID-19 global pandemic: A4EP Position Paper*.

<sup>49</sup> ICVA (2020) *REINFORCE, REINFORCE, REINFORCE: Localization in the COVID-19 Global Humanitarian Response*.

<sup>50</sup> A4EP (2020) *Reversing the inequity – Opportunity knocks again or missed opportunity again!!?*

<sup>51</sup> Featherstone, A. and T. Mowjee (2021) *DEC Localisation Scoping Paper*, July 2021, unpublished.

<sup>52</sup> Inter-Agency Standing Committee (2017) *Gender Equality and the Empowerment of Women and Girls in Humanitarian Action: Policy*, IASC Reference Group on Gender and Humanitarian Action.

<sup>53</sup> Inter-Agency Standing Committee (2020) *Gender Alert for COVID-19 Outbreak: Interim Guidance*, IASC Reference Group for Gender in Humanitarian Action.

<sup>54</sup> UN (2020) *Shared Responsibility, Global Solidarity: Responding to the socio-economic impacts of COVID-19*, March 2020

<sup>55</sup> Inter-Agency Standing Committee (2020) *Gender Alert for COVID-19 Outbreak: Interim Guidance*, IASC Reference Group for Gender in Humanitarian Action.

<sup>56</sup> Care (2020) *Gender Implications of Covid-19 Outbreaks in Development and Humanitarian Settings*.

<sup>57</sup> UN OCHA (2020), *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP July Update*.

<sup>58</sup> UN OCHA (2020), *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP May Update*.

<sup>59</sup> UN OCHA (2020), *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP July Update*.

44. IASC guidance highlighted that the participation and leadership of women and girls is crucial for a more effective humanitarian response to COVID-19.<sup>60</sup> However, there is evidence that women's rights organizations have continued to be largely excluded from formal decision-making processes and funding opportunities during the COVID-19 response.<sup>61</sup>
45. Despite the disproportionate effect of public health emergencies on women and girls, there has been limited research on the gender implications of these emergencies that could contribute to improved response. Less than 1 per cent of published research papers on the 2014–16 West Africa Ebola virus disease (EVD) outbreak and the 2016 Zika outbreak focused on gender dimensions.<sup>62</sup> As noted in section 2.5, the evaluations of the COVID-19 response reviewed during the inception phase revealed limited evidence on gender. An evaluation of WHO's integration of gender, equality and human rights into its work concluded that in a crisis, gender, equity and human rights can become deprioritized within the emergency response, for example in relation to disaggregation of COVID-19 epidemiological data by sex and other inequity factors.<sup>63</sup> A finding from UNHCR was that, in response to increased risks of intimate partner violence, GBV and child abuse during the pandemic, it was important to provide intimate partner violence survivors and those at risk with cash support and also, where possible, safe spaces.<sup>64</sup> Some major evaluation reports have yet to be published so there is likely to be more evidence on the extent to which the humanitarian response to COVID-19 took account of gender dimensions. Nevertheless, this evaluation is an opportunity to understand to what extent the collective humanitarian response ensured attention to gender in line with commitments and for understanding how gender can be better integrated into pandemic responses. Section 4.1.8 and Annex 8 outline the team's methodological approach.

### 2.4.3 The challenge of addressing disability inclusion in the COVID-19 response

46. In June 2019, the SG launched the UN Disability Inclusion Strategy and the IASC published its guidelines on the inclusion of persons with disabilities in humanitarian action in July.<sup>65</sup> <sup>66</sup> The UN's strategy was the first system-wide approach to addressing inclusion across UN entities, bodies and mechanisms. In August 2019, the SG appointed Under-Secretary-General (USG) Ana Maria Menéndez, the Senior Advisor on Policy, to oversee implementation of the strategy across the UN system<sup>67</sup> with a coordination unit in the SG's office.
47. Persons with disabilities are likely to be disproportionately affected by COVID-19 because they are at greater risk of contracting it and also developing more severe health conditions and dying from it. Persons with disabilities are also more likely to face discrimination in accessing healthcare and life-saving procedures.<sup>68</sup> Therefore, the SG took a number of steps to ensure that the response was inclusive of persons with disabilities. This included launching a Policy Brief on a disability-inclusive response to COVID-19 on 5 May 2020<sup>69</sup>; ensuring that the COVID-19 Response and Recovery Multi-Partner Trust Fund included persons with disabilities systematically in the various pillars of the Framework and supported greater collection of data, disaggregated by disability, on the socioeconomic impact of the pandemic; and requesting entities reporting

<sup>60</sup> Inter-Agency Standing Committee (2020) *Gender Alert for COVID-19 Outbreak: Interim Guidance*, IASC Reference Group for Gender in Humanitarian Action.

<sup>61</sup> Women's Humanitarian Voices. (2022). *Covid-19 through a feminist lens – A Global Report*, p. 1).

<sup>62</sup> Care (2020). *Gender Implications of Covid-19 Outbreaks in Development and Humanitarian Settings*.

<sup>63</sup> WHO (2021) *Evaluation of the integration of gender, equity and human rights in the work of the World Health Organisation. Volume 1: Report*.

<sup>64</sup> UNHCR (2020) *Covid-19 Response: Lessons from UNHCR's Evaluation Evidence*.

<sup>65</sup> UN (2019) *United Nations Disability Inclusion Strategy*.

<sup>66</sup> Inter-Agency Standing Committee (2019) *Inclusion of Persons with Disabilities in Humanitarian Action: Guidelines*, IASC Task Team on Inclusion of Persons with Disabilities in Humanitarian Action.

<sup>67</sup> [https://www.internationaldisabilityalliance.org/sites/default/files/sg\\_response\\_letter\\_to\\_iddc\\_chair\\_-\\_signed.pdf](https://www.internationaldisabilityalliance.org/sites/default/files/sg_response_letter_to_iddc_chair_-_signed.pdf).

<sup>68</sup> UN (2020) *Policy Brief: A Disability-Inclusive Response to COVID-19*, May 2020.

<sup>69</sup> UN (2020) *Policy Brief: A Disability-Inclusive Response to COVID-19*, May 2020

on their implementation of the Disability Inclusion Strategy to provide information on disability-inclusive action taken in the COVID-19 response.<sup>70</sup> In addition, the USG has convened a time-bound Task Team, comprising 35 UN entities, with five workstreams related to the COVID-19 response. One of these is on humanitarian action and includes organizations for persons with disabilities in leadership roles. This has produced practical tip sheets and included relevant indicators in monitoring mechanisms.

48. The May iteration of the GHRP was developed in parallel with work on the Policy Brief and identifies persons with disabilities as one of the most affected population groups. It outlines the range of risks and challenges that COVID-19 poses for persons with disabilities in humanitarian settings.<sup>71</sup> The July iteration of the GHRP expanded on these risks and challenges but there is little mention of achievements in providing assistance to persons with disabilities in the final progress report on the GHRP.<sup>72</sup> A number of studies have identified practical challenges that humanitarian actors face in ensuring disability inclusion, even without the additional difficulties posed by COVID-19. These include a lack of disaggregated data, limited capacity to identify persons with disabilities (given that disabilities and the extent to which they affect a person vary widely) and then to tailor assistance to their specific needs, dealing with intersectionality (whereby an individual might be elderly, female and have a disability), institutional mandates that focus on certain ‘types’ of individuals to be assisted, a lack of mechanisms to track funding for assistance to persons with disabilities, and the limitations of addressing the long-term needs of persons with disabilities with short-term humanitarian funding. In addition, both studies identified a more fundamental issue of trade-offs between assisting the most vulnerable (the principle of impartiality) and assisting the largest number of people (the principle of humanity) and highlighted that this cannot be resolved through technical approaches to humanitarian assistance.<sup>73 74</sup>
49. An interviewee summed up the reason for limited progress as the ‘*gap between intent and the capacity to implement on the ground*’ and pointed to a lack of information about how all the guidance, tools and resources to improve the humanitarian response to the needs of persons with disabilities have been implemented during the COVID-19 response. This is a gap that the evaluation can seek to address through its country case study approach. Section 4.1.8 and Annex 8 outline the team’s methodological approach.

#### 2.4.4 Adapting the architecture to work across the humanitarian-development-peace nexus

50. It has been pointed out that ‘The pandemic is more than a health crisis; it is an economic crisis, a humanitarian crisis, a security crisis, and a human rights crisis’.<sup>75</sup> Therefore, the response to COVID-19 demanded global, regional and national-level collaboration among humanitarian, health, development, and peace and security actors to address the intertwined effects of a multi-dimensional crisis. The IASC recognized the need for humanitarian, development and peace actors to deliver assistance in a complementary, mutually reinforcing and simultaneous manner to address both immediate lifesaving needs and the longer-term impacts. It identified four areas that required a ‘nexus’ approach – the right type of financing, inclusive partnerships, knowledge and information-sharing, and responses that are conflict

<sup>70</sup> [https://www.internationaldisabilityalliance.org/sites/default/files/sg\\_response\\_letter\\_to\\_iddc\\_chair\\_-\\_signed.pdf](https://www.internationaldisabilityalliance.org/sites/default/files/sg_response_letter_to_iddc_chair_-_signed.pdf).

<sup>71</sup> UN OCHA (2020), *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP May Update*.

<sup>72</sup> OCHA (2021), *Global Humanitarian Response Plan COVID-19, Final Progress Report*, 22 February 2021.

<sup>73</sup> Mowjee, T., and A. Featherstone (2020) *Independent Review of the Four Priority Underfunded Areas for the Central Emergency Response Fund: Final Report*.

<sup>74</sup> Barbalet, V., and C. Wake (2020) *Inclusion and Exclusion in Humanitarian Action: The state of play*, HPG Working Paper, ODI.

<sup>75</sup> United Nations (2020) *United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better*, June 2020.



sensitive.<sup>76</sup> This is a useful set of areas for the evaluation to consider when gathering data against the evaluation questions related to the nexus, particularly as there is currently limited evidence on the extent to which health, humanitarian, development and peace actors were able to overcome barriers to deliver a coherent response to the pandemic.

51. While nexus discussions have focused on humanitarian, development and peace actors, in the COVID-19 pandemic, the interface between health and humanitarian actors was also crucial. This is reflected in the UN's approach to a comprehensive response to COVID-19 and the overlap between the SPRP and GHRP outlined in section 2.2.<sup>77</sup> Early evidence from inception phase interviews suggest that there is a lack of mechanisms to ensure coordination between the health and humanitarian systems at global as well as national levels.
52. The evaluation will seek to explore these inter-linked issues through a number of ways; through the comparative case study approach which includes a range of different contexts in which the profile, capacity and scope for humanitarian, development and peace actors is different. Included in the sample is a country that is provisionally listed as a case study country for the System-Wide Evaluation (SWE) which provides a unique opportunity for the evaluation teams to have an in-depth discussion of the nexus between humanitarian and development systems, but also the GHRP and the Socio-Economic Recovery Plan (SERP).

#### 2.4.5 COVID-19 and accountability for humanitarian action

53. It has long been recognized that affected people must play an active role in decisions that affect their lives, yet evaluations of humanitarian response have consistently highlighted that there has been limited progress in delivering accountability to affected populations (AAP). Moreover, where community feedback mechanisms do exist, they tend to be put in place for specific agency programmes. However, people do not live in silos and their needs and priorities regularly cut across different programmes. As a result, they are often faced with confusing and overlapping feedback and engagement systems. Collective approaches to AAP seek to address this by focusing on the overall humanitarian response and putting people rather than projects at the centre, but they tend to be the exception rather than the norm in humanitarian settings, and where they do exist, their focus is understandably on referral (to clusters, implementing agencies etc.) rather than redress. The unique challenge that COVID-19 posed for AAP was that the restrictions to limit the spread of the virus made traditional in-person engagement with communities either very difficult or even impossible. The evaluation will assess collective mechanisms for AAP where these exist in the case study countries under evaluation question 6.1 on collective response mechanisms. The team will also consult affected communities directly, as described in section 4.1.6.
54. The need to spread health messaging to protect people from the risks of COVID-19 and also to counter misinformation has meant that risk communication and community engagement (RCCE) has been a critical part of the response, cutting across health and humanitarian activities. All three iterations of the GHRP highlight the importance of RCCE for the humanitarian response and some agencies developed specific guidance on this in the context of COVID-19.<sup>78 79 80</sup>
55. The evaluation team recognises the important focus placed in the ToR on the voice of affected people and will use this as a lens to understand people's experience of the assistance they received, in addition to

<sup>76</sup> IASC (n.d.) *Commitments into Action: A holistic and coherent response to COVID-19 across the humanitarian-development-peace nexus*, IASC-INCAF discussion document.

<sup>77</sup> United Nations (2020) *United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better*, June 2020.

<sup>78</sup> IFRC, UNICEF and WHO (n.d.) *COVID-19 Preparedness and Response: RCCE Action Plan Guidance*.

<sup>79</sup> UNHCR (2020) *Risk Communication and Community Engagement – COVID-19*, 21 March 2020.

<sup>80</sup> WHO (2020) *Tips for Engaging Communities during COVID-19 in Low-Resource Settings, Remotely and In-person*, 20 April 2020.

examining the extent to which people have been able to provide feedback about the assistance they received in a way that is relevant to them. The IASC Commitments on Accountability to Affected Populations,<sup>81</sup> the Risk Communication and Community Engagement Briefing Pack<sup>82</sup> will provide important reference documents and the evaluation will draw on primary evidence with affected communities, and secondary data from agency surveys and perceptions studies.

#### 2.4.6 Planning globally, while acting locally

56. The COVID-19 pandemic was, and continues to be, an unprecedented crisis. Its global reach presented a unique situation that required a coordinated, flexible, rapid response to keep pace with the evolution of the pandemic. A joint effort by the IASC and coordinated by OCHA, the GHRP demonstrated how quickly the international community could come together to tackle a global emergency and sought to re-tool and position the collective humanitarian system in a way that would allow it to harness global support for action in the 63 countries targeted by the Appeal. Publication of the first iteration of the GHRP just two weeks after declaration of the pandemic was a remarkable achievement in and of itself. The challenges posed by the planning and coordination required to bring together an unparalleled number of actors to respond to a complex set of problems has stretched the humanitarian community further than ever, but it has also offered insights about the adaptive capacity of the system and highlighted some important limitations in how effectively the linkages from global to regional to national level work.
57. The evaluation will seek to assess the humanitarian response to the COVID-19 pandemic at different levels with a view to understanding what can be learnt about how it plans, coordinates, and delivers assistance. One input into this is the GHRP Learning Paper which will be drafted during the Inception and Pilot phase. This will be complemented by analysis from regional and country-level case studies as the evaluation moves into the data collection phase.

#### 2.4.7 COVID-19, the Global Ceasefire and the dilemma of access

58. On March 23rd, 2020, the SG issued an urgent appeal for a global ceasefire in all corners of the world to focus together on the true fight – defeating COVID-19. He repeated the call at the start of the 75th UN General Assembly session in September.<sup>83</sup> In the days after the appeal was made, a number of armed groups and governments both acknowledged and expressed a willingness to consider it, with estimates that conflict parties in eleven countries recognized the call by early April including in Cameroon, the Central African Republic, Colombia, Libya, Myanmar, the Philippines, South Sudan, Sudan, Syria, Ukraine and Yemen.<sup>84</sup> However, there were also numerous challenges, including for those that accepted the call, which meant that this was not backed up by action.<sup>85</sup>
59. The evaluation's focus is not on the politics of ceasing hostilities, but the implications of this on the access that affected people had to the humanitarian assistance they required. While reliable data is difficult to obtain, in May 2020, the Norwegian Refugee Council estimated that 660,000 people were displaced due to armed conflict in the two months following the ceasefire call. This included 480,000 people in Democratic Republic of Congo (DRC) and over 10,000 people each in Afghanistan, the Central African Republic, Syria, Somalia and Myanmar.<sup>86</sup> The implication of the 'double crisis' of conflict and COVID-19 meant that needs for

<sup>81</sup> IASC (2018) *IASC Revised Commitments on Accountability to Affected Populations and Protection from Sexual Abuse*, 13 July 2018.

<sup>82</sup> IASC Results Group on Accountability and Inclusion (2021) *COVID-19 Risk Communications and Community Engagement (RCCE) and Humanitarian System: Briefing Pack*.

<sup>83</sup> <https://www.un.org/en/globalceasefire>.

<sup>84</sup> <https://abcnews.go.com/US/wireStory/chief-cease-fire-appeal-backed-parties-11-nations-69961494>.

<sup>85</sup> <https://www.crisisgroup.org/global/whats-happened-un-secretary-generals-covid-19-ceasefire-call>.

<sup>86</sup> Norwegian Refugee Council (2020) *Crossfire and COVID-19: Double Crisis for Displaced Civilians*.

assistance were dramatically increasing at a time when the capacity of the humanitarian system was decreasing as a consequence of reduced access to countries, restricted movement within countries and increases in bureaucratic hurdles. While these were often well-intentioned and used as a means of slowing the transmission of the virus, there are also claims that some of the restrictions deliberately targeted humanitarian activities, for example, by restricting humanitarian flights or requiring local governments to distribute aid, which have raised serious concerns about humanitarian space and impartiality.<sup>87</sup>

60. The evaluation's comparative case study approach, and the inclusion of some of the countries worst affected by violent conflict offers an important opportunity for the evaluation to understand the effect of the pandemic on humanitarian access, space and principles, both from a conflict perspective, but also from a perspective of government-imposed movement restrictions and associated bureaucracy.

#### 2.4.8 Road-testing collective pandemic preparedness and response

61. Responding to infectious disease-related humanitarian crises was a known challenge before the outbreak of COVID-19.<sup>88</sup> The international community has undertaken considerable analysis and reforms after each major health crisis, with the last major effort to strengthen preparedness globally undertaken after the 2014-16 Ebola crisis in West Africa.<sup>89</sup> However, in September 2019, the Global Preparedness Monitoring Board (GPMB) warned of systemic problems in global preparedness, including in the humanitarian system, for a pandemic scenario involving a respiratory pathogen.<sup>90</sup> Despite this, the Independent Panel for Pandemic Preparedness and Response was blunt in its assessment that *“the world was not prepared and had ignored warnings which resulted in a massive failure: an outbreak of SARS-COV-2 became a devastating pandemic.”*<sup>91</sup>
62. One of the GPMB's seven urgent actions to prepare for health emergencies was for the SG, OCHA and WHO to 'strengthen coordination in different country, health and humanitarian emergency contexts, by ensuring clear United Nations systemwide roles and responsibilities; rapidly resetting preparedness and response strategies during health emergencies; and enhancing United Nations system leadership for preparedness, including through routine simulation exercises.'<sup>92</sup> Lessons from the Ebola outbreaks in the DRC also highlighted the need to address poor synergy between health and humanitarian actors and their lack of understanding of each other's systems, which had persisted since the Ebola response in West Africa in 2014-16.<sup>93</sup> This was reflected in inception phase interviews and will be an area for the evaluation to explore through the country case studies as well as global level interviews in the data collection phase.
63. The IASC put in place a Scale-Up Protocol for the Control of Infectious Disease Events in 2019.<sup>94</sup> However, the exceptional and rapidly evolving situation with COVID-19 required the IASC to adopt an agile and flexible approach and it issued a version of the Scale-Up Protocols adapted to the pandemic in April 2020.<sup>95</sup> Nevertheless, a 2021 assessment of lessons from the Ebola response in DRC recommended that the System-

<sup>87</sup> Brubaker, R., Day, A and Huve, S. (2021) *COVID-19 and Humanitarian Access: How the Pandemic Should Provoke Systemic Change in the Global Humanitarian System*, February 2021.

<sup>88</sup> These include (i) Harvey, F. et al (2019) From 'never again to the new normal': What does the 2018–2019 Ebola outbreak in the Democratic Republic of the Congo tell us about the state of global epidemic and pandemic preparedness and response? IOAC thematic report commissioned by the Global Preparedness Monitoring Board, September 2019. (ii) United Nations, (2016) Protecting humanity from future health crises: Report of the High-level Panel on the Global Response to Health Crises, GA A/70/723.

<sup>89</sup> Bezruki, A., and S. Moon (2021) *Always Fighting the Last War? Post-Ebola Reforms, Blind spots & Gaps in COVID-19*, Global Health Centre Working Paper no. 26.

<sup>90</sup> Global Preparedness Monitoring Board (2019) *A World At Risk: Annual report on global preparedness for health emergencies*.

<sup>91</sup> The Independent Panel for Pandemic Preparedness and Response (2021) *COVID-19: Make it the last pandemic*.

<sup>92</sup> Global Preparedness Monitoring Board (2019) *A World At Risk: Annual report on global preparedness for health emergencies*, pg. 10

<sup>93</sup> Humanitarian Policy Group (2021) *The Democratic Republic of Congo's 10<sup>th</sup> Ebola Response*.

<sup>94</sup> IASC (2019) *System-wide Scale-up Activation, Protocol for the Control of Infectious Disease Events*, April 2019.

<sup>95</sup> IASC (2020) *Activation of the IASC System-Wide Scale-Up Protocols: Adapted to the Global COVID-19 Pandemic*.

Wide Scale-Up Activation Protocol should be revised to ensure it is considered fully at an early stage and that its reconsideration is triggered whenever commonly agreed thresholds are reached.<sup>9697</sup> It also recommended that the Operationalization of the Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events should be improved through well-defined standby agreements – and possibly joint trainings – between WHO and key agencies with complementary capacities.

64. The evaluation includes a specific question on the extent to which the IASC’s preparedness measures in targeted GHRP countries after Scale-Up declaration contributed to a more timely and relevant humanitarian response. In addition, the GHRP Learning Paper has identified concerns about what the Scale-Up Activation meant in practice for countries included in the GHRP, including those that did not have an existing humanitarian response plan. Specifically, if resources and funding were prioritized, as per the Protocols, then what could those countries reasonably expect by way of support from headquarters in terms of additional staff, funding, access to air transport, medical evacuation, etc.? The evaluation will address these issues through the country case studies.

## 2.5 The COVID-19 IAHE in the context of other evaluations

65. There has been a huge amount of evaluative work undertaken both nationally and globally during the COVID-19 pandemic. This includes country-level assessments, real-time evaluations and learning, institutional evaluations, project and program evaluations, joint thematic evaluations and system-wide evaluations. Evidence syntheses and lessons learned reviews are another emerging area of work. As part of the inception phase, the evaluation team conducted a review of these evaluations to get a better insight into the lessons that have already emerged. Whilst this was an important exercise for understanding the landscape of evaluations, some significant reports (including from UNHCR and IFRC) are yet to be published. Therefore, there was a limit to the team’s ability to identify gaps in data through this exercise. However, the review identified the following important points for consideration:

- There were a significant number of documents highlighting lessons learned from Ebola, however documentation indicating how or if this was applied during the pandemic has not yet been identified.
- Although reviews of the evaluation landscape identify gender as a significant theme cited in the data, this is not yet apparent from the evaluation reports reviewed. This could be due to the type of documentation reviewed, but it is an important consideration for the team moving forward.
- Disability inclusion does not receive significant attention so that a broader review of the COVID-19 evaluation landscape makes no reference to it.<sup>98</sup> The team’s own review found disability identified as a gap in data and data collection.<sup>99 100</sup>

66. The evaluation team’s review, as well as other evidence, highlights that most of the evaluations of the COVID-19 response have been undertaken by individual agencies and focus on their own response.<sup>101</sup> This

<sup>96</sup> The proposed thresholds are fourfold and include (i) the deterioration of the humanitarian situation in the outbreak area, (ii) a severe deterioration in security in the affected areas, (iii) indicators suggestive of continued, uncontrolled growth of the outbreak, or insufficient response efficacy, and (iv) a simultaneous outbreak elsewhere in the country.

<sup>97</sup> Humanitarian Policy Group (2021) *The Democratic Republic of Congo’s 10<sup>th</sup> Ebola Response*.

<sup>98</sup> Johnson, L. and M. Gamarra (2021) *COVID-19 Global Evaluation Coalition, “How are the COVID-19 response and recovery efforts being evaluated? Landscape analysis of National and International evaluations and reviews of COVID-19 response and recovery efforts.”* OECD, Paris

<sup>99</sup> IEG (2021) *COVID-19 and Aging Populations*.

<sup>100</sup> Breard, P. (2021) *Evidence Summary on Covid-19 and Food Security. Main Report*.

<sup>101</sup> COVID-19 Global Evaluation Coalition (2021) *Evaluating the response - The Coalition supports independent, credible evaluation of COVID-19 response and recovery efforts*.

evaluation's focus on the humanitarian system and collective action should enable it to contribute to a broader understanding of the pandemic response.

67. One of the most notable exceptions to this is the System-Wide Evaluation (SWE) of the UN Development System, which is being undertaken concurrently with this evaluation. The SWE seeks to *'provide an overall assessment of the UNDS response, supported by an analysis of how the process of UNDS reform may have enabled and/or constrained that response. It will provide an assessment of how well the UNDS response has integrated action on the core UN values of human rights, gender equality, inclusion (including persons with disabilities) and LNOB...The evaluation [will also seek to] identify barriers and recommend changes which can better position the UNDS to contribute to the goals of Our Common Agenda.'*<sup>102</sup>
68. The SWE is a sister-evaluation to the IAHE and initial discussions between the Team Leaders have identified potential moments for joint reflection as well as opportunities to check-in. The evaluation team included Sierra Leone in its country case study sample as a potential opportunity for joint analysis.
69. It is also useful to situate this IAHE in the context of previous IAHEs. To date, with one exception, all IAHEs have focused on a single-country emergency response. These include Yemen, Ethiopia, Mozambique, South Sudan, the Central African Republic and Typhoon Haiyan in the Philippines. The only other global IAHE, published in October 2020, had a thematic focus on gender equality and the empowerment of women and girls. Therefore, this IAHE will be unique in being both global and covering a very wide range of issues, as highlighted in section 2.4. In addition, there has been no IAHE of previous responses to infectious disease outbreaks, so this evaluation offers an opportunity to distil and analyze the evidence that has emerged from the pandemic, with a view to offering guidance on how to address gaps in policies and practice.

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<sup>102</sup> Freeman, T. A. L. Esser and Vela, P. (2022) *Inception Report: System-Wide Evaluation of the UNDS Response to COVID-19*, Executive office of the Secretary General of the United Nations.

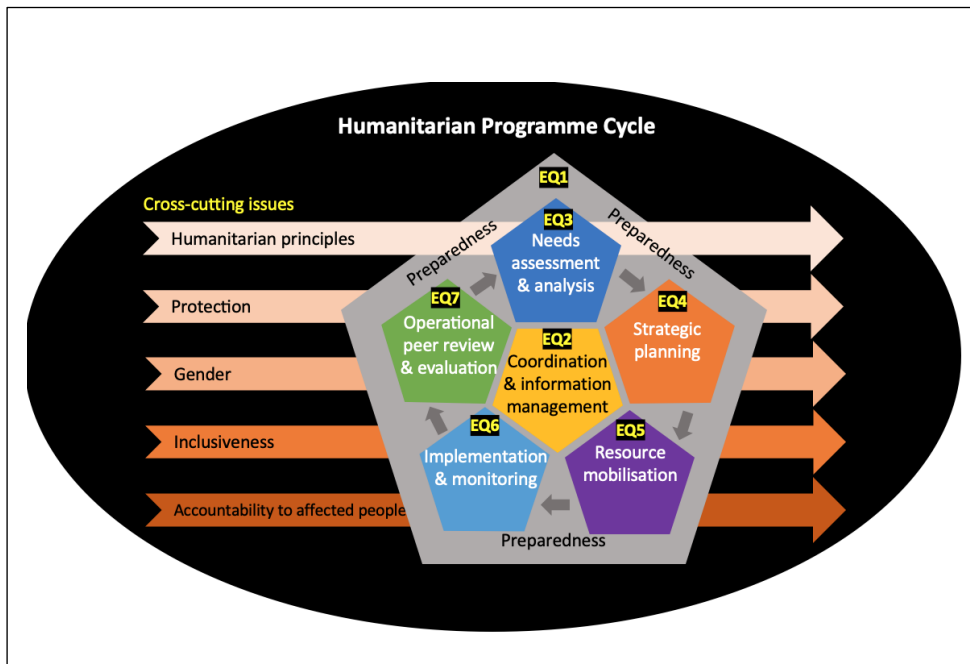
### 3 Evaluation design

This section outlines the team’s overall approach to the evaluation including the design of the evaluation and analytical and conceptual frameworks. It explores evaluability issues and where challenges are identified, mitigation measures are proposed.

#### 3.1 Conceptual framework

70. Given the focus of the evaluation on ‘the collective preparedness and response of the IASC member agencies at the global, regional and country level in meeting the humanitarian needs of people in the context of the COVID-19 pandemic’ the Humanitarian Programme Cycle (HPC) has been used as a foundation to frame the evaluation and organise the evaluation questions (see Figure 7).

**Figure 7: The HPC as a foundation for the evaluation**



71. The evaluation team has drawn on aspects of Theory of Change thinking to develop a practical conceptual framework for the evaluation (see figure 8 and Annex 4). The framework focuses on the collective IASC response to provide a pathway from inputs to activities and results. It captures the activities and anticipated results of collective action in response, both those that are specific to the GHRP in addition to those that may overlap with other response frameworks (the SPRP and SERP) The framework will be used to guide the evaluation team as it tests the core assumptions and seeks to understand how and why results have/have not been achieved.

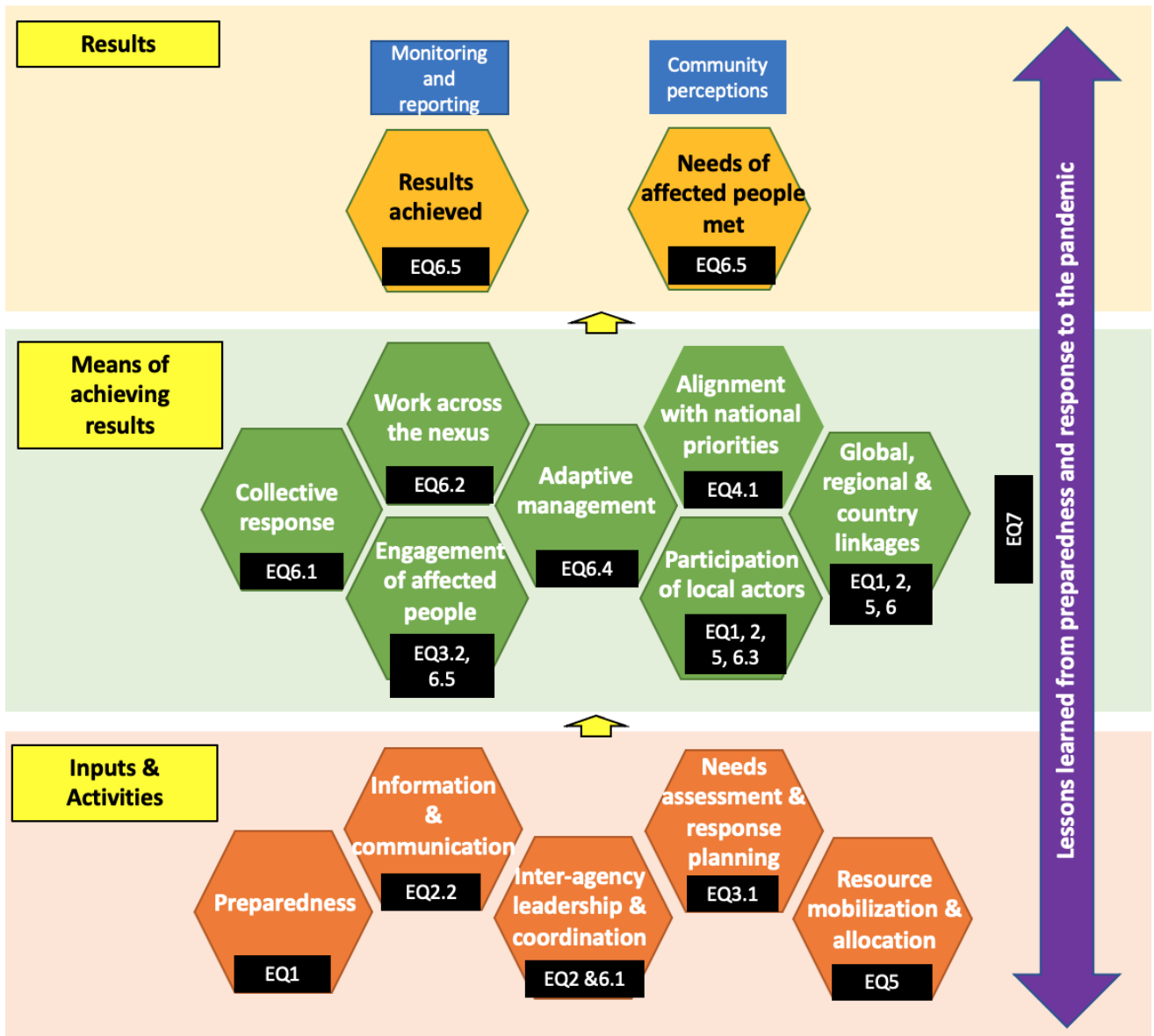
72. The conceptual framework comprises the elements outlined in Table 2 below.

**Table 2: Elements of the conceptual framework**

<b>Inputs and activities</b>	At the input level, the evaluation will examine 5 aspects that are fundamental to the delivery of collective action – contingency planning and preparedness, implementation and communication, interagency leadership and coordination, needs assessment and response planning and resource mobilisation and allocation. Emphasis will be placed on the means by which the collective humanitarian system has worked in a coordinated and coherent manner to identify needs, develop response plans and put in place efficient and transparent mechanisms to prioritize and resource programmes.
<b>Means of achieving results</b>	The ToR focuses considerable attention on the means by which the members of the humanitarian system delivered the collective COVID-19 response. These cover a broad range of policies and approaches including work across the nexus, engagement of affected people, adaptive management, alignment with national priorities, participation of local actors, and linkages between global, regional and country response. In particular, the evaluation will seek to examine the extent to which and the ways in which these approaches contributed to collective COVID-19 results.
<b>Results</b>	The team will review global and country-level monitoring data with a view to determining the results that were achieved and reported. During the data collection phase and case study visits, the evaluation team will seek to assess the availability and granularity of the monitoring data that has been collected, noting that while data on results/outputs is often available, data on the achievement of outcomes is usually scarce. As a second means of assessing results, the country case studies will offer an opportunity to elicit a snapshot of the perceptions of affected people on the COVID-19 response. This evidence will be complemented by perceptions studies conducted at the time the response was being undertaken.
<b>Cross-cutting issues</b>	Embedded in the HPC and outlined in the ToR for the evaluation are five cross-cutting issues - humanitarian principles, protection, gender, inclusiveness, and accountability to affected people - each of which is fundamental to the effective delivery of humanitarian assistance. The ToR groups these issues under a single question, but for the purpose of the evaluation they are written into relevant evaluation questions. A second cross-cutting issue are lessons that have been learnt during the COVID-19 response.
<b>Assumptions and risks</b>	The conceptual framework outlines a preliminary set of assumptions and risks. The assumptions are drawn from the GHRP results framework and will be tested during the evaluation to determine their validity and the extent to which, and ways in which, they influenced the response. During the country case studies, the team will pay attention to the approaches that were taken and effectiveness of the risk mitigation strategies that were adopted.

73. The team anticipates that this approach will lend itself well to applying an inductive approach to exploring how these building blocks for collective action have been leveraged in particular case study contexts, the extent to which these have enabled or hindered success, and in identifying good practice and innovation that could be applied elsewhere.

**Figure 8: Summary of the conceptual framework (see Annex 4 for the full framework)**



74. The conceptual framework will be used to guide the preparation of evaluation outputs including the case study country presentations and the Main Evaluation Report.

### 3.2 Evaluation matrix and questions

75. Based on the ToR for the evaluation and the conceptual framework above, the evaluation team has developed an evaluation matrix which outlines evaluation questions, indicators, sources of evidence, assumptions and how each question addresses the OECD/DAC criteria (see Annex 5). Table 3 below lists the evaluation. The matrix identifies the stakeholder groups for which each question is relevant, and this will enable the team to adapt the list of questions so that they are relevant for key informants at global and field-level.



**Table 3: List of evaluation questions and sub-questions**

<b>1. Preparedness</b>
1.1 To what extent were the collective preparedness measures put in place by the IASC prior to the pandemic relevant and adapted to the COVID-19 pandemic?
1.2 To what extent did the IASC’s preparedness measures in targeted GHRP countries after Scale-Up declaration contribute to more timely and relevant humanitarian response?
<b>2. Coordination and information management</b>
2.1 To what extent was the IASC response coherent and well-coordinated in its delivery of the response to a multi-dimensional crisis?
2.2 To what extent have inter-agency information management and communication mechanisms been able to support IASC collective decision-making?
<b>3. Needs assessment and analysis</b>
3.1 To what extent were country humanitarian plans and response strategies for the pandemic informed by a systematic and comprehensive identification of affected people’s needs?
3.2 To what extent were assessments of humanitarian needs conducted in consultation with affected populations?
<b>4. Strategic planning</b>
4.1 To what extent did the IASC’s collective global, regional and country-level humanitarian response planning and prioritization correspond to the national priorities of affected countries?
<b>5. Resource mobilization</b>
5.1 To what extent were the IASC’s efforts successful in mobilizing adequate, timely and flexible funding to meet the GHRP requirements?
5.2 To what extent did pooled funds contribute to the provision of adequate, timely and flexible funding to meet the GHRP requirements?
5.3 To what extent did IASC allocation strategies, mechanisms, and decision-making processes facilitate the efficient use of available resources to meet response objectives, including by channelling resources to frontline responders (international and local/national NGOs and civil-society organizations)?
<b>6. Implementation and monitoring</b>
6.1 Collective response mechanisms: Added value and support to country teams
6.1.1 How effectively did the IASC make use of collective mechanisms for planning and implementing the response?
6.1.2 To what extent were the global IASC strategy and Scale-Up mechanisms effective in ensuring IASC country teams’ capacity to lead, coordinate and deliver humanitarian assistance in targeted countries?
6.2 Humanitarian-development-peace nexus: Coherence and complementarity to address multiple effects of pandemic
6.2.1 To what extent were the IASC humanitarian policies, strategies, and responses to COVID- 19 consistent and complementary with the health and social economic responses by United Nations and other actors?
6.2.2 To what extent did the collective humanitarian response to the pandemic contribute to the overall objectives of the SG’s call for solidarity to address the impact of the multi-dimensional crises?
6.2.3 To what extent were there linkages and synergies in COVID-19-related responses across the humanitarian-development-peace nexus aimed at addressing the intertwined effects of the pandemic?
6.3 Localization: Ensuring complementarity and participation
6.3.1 To what extent did international humanitarian preparedness and response to COVID-19 complement and empower national and local actors in their efforts and leadership to address COVID-19-related humanitarian needs?
6.3.2 How effectively did IASC collective mechanisms for planning and implementing the response ensure local participation?
6.4 Adaptive capacity: Adaptability of decision-making and response, including through the use of monitoring data

6.4.1 To what extent did the IASC’s collective response prove relevant and adaptive in meeting the demands of the crisis and the humanitarian needs caused by it?
6.4.2 How effective was the IASC’s monitoring framework for the COVID-19 response in supporting operational and strategic decision-making?
6.5 Results: Extent to which humanitarian needs addressed
6.5.1 To what extent did the IASC’s collective response to the pandemic meet the humanitarian needs of affected people adequately and effectively, both overall and vis-à-vis specific vulnerable groups?
<b>7 Lessons learned</b>
7.1 What are the main challenges and lessons learned from preparedness and response to the pandemic?
7.2 What are the key strategic and policy challenges and opportunities for improving the IASC’s future responses to pandemics and other infectious disease events with multi-country humanitarian impacts?
7.3 What were the innovative approaches, solutions, and new ways of working that would benefit ongoing or future responses, in particular those from local actors?
7.4 What are the key lessons from COVID-19 response that can strengthen humanitarian-development-peace nexus approaches in the future?

### 3.3 Stakeholder analysis

76. Multiple stakeholders across the humanitarian community have interests in the results of the evaluation and will have influence on the outcomes of the evaluation. Meaningful engagement with, and participation of, the end users will be critical to the usability and value of this evaluation. Described in Table 4 below are the different categories of stakeholders and their interests in this evaluation.

**Table 4: Stakeholder analysis**

	<b>Stakeholder group</b>	<b>Involvement in the response</b>	<b>Interest in the evaluation</b>
<b>Primary (directly affected)</b>	Crisis-affected populations in need of humanitarian assistance.	Most impacted by the crisis, intended primary beneficiaries of the response. Share views on needs through participatory consultation processes, ensuring response is relevant to needs and timely	Perspectives on the quality, usefulness, and coverage of the response; sharing views on the response from a gender and age perspective; sharing views on how the response addressed specific vulnerabilities; potential benefit from improved assistance
<b>Primary</b>	Governments, ministries and disaster management institutions of the 63 countries targeted by the GHRP	Government institutions at national/sub-national level supporting coordination and operations. Access for humanitarian actors to areas affected by conflict and displacement to reach people in need.	Relevance, Coverage, timeliness, and results of the response; Unintended effects of the response; how HCT-coordinated response engaged with government institutions; inform national policies and protocols for crises involving international agencies and other actors.; Improved services delivery
<b>Engagement of primary stakeholders:</b> The evaluation team will engage with affected people and governments during the case studies which will offer an opportunity for input. The team will conduct key informant interviews (KIIs) with government representatives. Where governments are part of HCTs or clusters, they may participate in validation meetings. Section 4.1.6 and Annex 10 outline the methodology for community consultation.			
<b>Key stakeholders (required to achieve results)</b>	Front-line responders including national NGOs, INGOs, UN agencies, including those involved in sectoral response and cross-cutting issues	Delivery of humanitarian assistance to affected communities.  Those interested in how the international response worked	Engagement with civil society, for instance roles, communication, results for civil society (including effect on local capacities to respond); coordination; relevance, timeliness, and effectiveness of response

	(gender, inclusiveness, protection etc.)	with civil society and national NGOs	
<b>Key stakeholders</b>	Cluster leads, sector leads and partners	Coordination of response	Key challenges and achievements of the response; effectiveness of coordination and possible trade-off associated with coordination
<b>Key stakeholders</b>	Regional and country-based humanitarian leaders (RC/HC, HCT, Regional leadership)	Decision-making and planning	Key challenges and achievements of the response; influence of assistance on conflict dynamics; decision-making, including timeliness, successes, coverage; effectiveness of in-country leadership structures; adherence to humanitarian principles; evaluative evidence of collective response efforts for accountability and learning purposes.
<b>Key stakeholders</b>	Global humanitarian leaders (ERC, IASC Principals, OPAG, EDG)	Architects of the GHRP, development of global guidelines and design of strategic response strategies	Improve future humanitarian action, policy development, & reform; challenges and opportunities; decision-making, including timeliness, challenges, successes; pandemic preparedness and response; evaluative evidence of collective response efforts for accountability and learning purposes.
<b>Key stakeholders</b>	Donors (bilateral, multilateral, pooled funds, other)	Funding of operations whose decisions directly affect the choice of responders and the timeliness and relevance of the response	Relevance, coverage, efficiency, and results; challenges and opportunities; decision-making, including timeliness, challenges, successes; in-country leadership structures; pandemic preparedness and response; evaluative evidence of collective response efforts for accountability and learning purposes.
<b>Engagement of key stakeholders:</b> The team will conduct KIIs with response staff, coordination staff, leaders and donors at global and country level. Targeted members of this group will have scope to engage in discussion of the outputs either as part of country-level validation meetings, or through webinars and other dissemination activities as agreed with the MG and IAHE Steering Committee.			
<b>Secondary stakeholders</b>	IASC Results Groups	Have no direct engagement in the response but who have an influence on the assistance through their research and/or advocacy/policy work.	Improve future humanitarian action, policy development, & reform; challenges and opportunities; decision-making, including timeliness, challenges, successes; pandemic preparedness and response; evaluative evidence of collective response efforts for accountability and learning purposes.
<b>Secondary stakeholders</b>	Grand Bargain Workstreams	Have no direct engagement in the response but who have an influence on the assistance through their research and/or advocacy/policy work.	Improve future humanitarian action, policy development, & reform; challenges and opportunities; decision-making, including timeliness, challenges, successes; nexus, assistance, and the conflict
<b>Secondary stakeholders</b>	Joint Steering Committee to Advance Humanitarian and Development Collaboration/other inter-agency mechanisms	Have no direct engagement in the response but who have an influence on the assistance through their research and/or advocacy/policy work.	Improve future humanitarian action, policy development, & reform; challenges and opportunities; decision-making, including timeliness, challenges, successes; nexus, assistance, and the conflict
<b>Engagement of Secondary stakeholders:</b> Secondary stakeholders will have be informed of the outputs of the evaluation through webinars and other dissemination activities as agreed with the MG and IAHE Steering Committee.			

### 3.4 Limitations and mitigation measures

- 77. The evaluation team conducted a light-touch review of evaluability. The purpose of this was to ensure that the evaluation design and tools take account of limitations identified in the ToR and to ensure that the scope of the evaluation is appropriate to address the needs and views of key evaluation stakeholders.
- 78. The key limitations and mitigation measures are listed in Table 5 below. A full consideration of the evaluability assessment and these potential limitations and risks can be found in Annex 13.

**Table 5: Risks and mitigation measures**

Risk	Mitigation measures
<b>1. Risks associated with security, logistics, Human Resources (HR) and administration</b>	
Possible duplication and overlap between the IAHE and other system-wide evaluative and learning initiatives (see also the risk related to overlapping response frameworks below).	Both this evaluation and the SWE have been sensitized to concerns about potential overlap and are already discussing means of managing this. The ToRs for the two evaluations, do, in large part, mitigate the potential for this. The ongoing evaluation review/synthesis being undertaken by the team, has assisted in identifying areas of overlap which will be further analyzed during the inception and pilot phase of the evaluation.
Excessive burden of the ongoing Covid-19 pandemic response and other crises on humanitarian aid workers limits their engagement.	The team has a systematic methodology for reaching out to country level stakeholders and will work with focal points to identify (i) a larger number of contacts than required to ensure a minimum number of stakeholders across different categories can be reached; (ii) suggest group interviews where possible to increase the number of respondents to the evaluation; and (iii) ensure good triangulation of key informant responses with document review to validate the information provided by key informants. At global and regional level, the evaluation team will work to compile a list of contacts early on in the data collection phase to ensure there is sufficient time for stakeholders to be available for interview or to suggest alternative people for the team to interview.
Logistical, security and access challenges that are currently hard to predict due to international and national travel restrictions related to the COVID-19 pandemic.	KonTerra and Itad have built up expertise managing the risks that the pandemic presents and will bring this to bear in the evaluation. The evaluation team has proposed a 2-option approach within the evaluation, covering (i) possible in-country visits; (ii) a hybrid approach of remote data collection by evaluation core team members and working with national consultants on community consultation.
Delays to the start of data collection. For an evaluation with multiple country case studies, delays in one aspect of the process can have significant implications for other aspects, particularly when these occur at the early stages of the evaluation	The team will maintain regular liaison with the OCHA evaluation manager and will also draw on the capacity of Management Group (MG) members to facilitate aspects of the evaluation where this is required. The Team Leader will make clear requests for support where, and if, needed to help address bottlenecks. Prompt support will be a prerequisite to problem-solving.
<b>2. Risks associated with clarity about the scope and scale of the evaluation</b>	
It will be important to build trust in the independence of the evaluation and in evaluation confidentiality in order to elicit engagement from stakeholders that are representative of the diversity of the humanitarian system.	The team will utilize KonTerra’s and Itad’s safeguarding policies and ethical principles and develop culturally appropriate approaches to informed consent and/or assent, voluntary participation, right to withdraw, anonymity and confidentiality. The use of the evidence matrix and summary will ensure triangulation of all data while anonymising the sources of data which only the evaluation team will have access to.
The evaluation is broad in terms of its geographic scope and the breadth of issues under evaluation, which may make it difficult to capture and prioritize the most important findings.	The re-organization of the evaluation questions has assisted in providing greater coherence and addressing overlap within the evaluation questions. The development of an analytical and conceptual framework is also helpful in focusing the evaluation on how the humanitarian system works in practice, in addition to ensuring its focus on the ‘collective’ response. Strong validation and triangulation within and between the comparative case studies will also contribute to identifying common issues.
The overlapping response frameworks are confusing, but also complicate efforts to	The team identified and delineated the boundaries between the different response frameworks although this is a complex undertaking as it lacked clarity during the response

<p>clearly delineate the boundaries of the substantive scope of the evaluation. Moreover, these boundaries will likely be different in each of the country case studies.</p>	<p>itself (see section 2.2 and Annex 6). Good communication with the evaluation team undertaking the SWE will assist in ensuring coherence between the two exercises.</p>
<p><b>3. Risks associated with the quality and availability of data</b></p>	
<p>There is broad acknowledgement that data reliability might be problematic, particularly in terms of the results of the GHRP.</p>	<p>The evaluation will not be able to address deficiencies in the global monitoring data. Through the proposed comparative case study approach, the evaluation will have an opportunity to focus on country-level data which it can complement through its own primary data collection with affected communities. With the evaluation occurring almost two years after the launch of the GHRP, there are also likely to be gaps in evidence due to staff turnover, lack of recall and difficulty in identifying documentation.</p>
<p>Due to the dynamic nature of the COVID-19 pandemic and the speed at which decisions were taken, not all key moments in the collective response may have been documented.</p>	<p>The evaluation team will maximize key informant interviews to fill information gaps and rely on anecdotal evidence in some instances where documentation is missing.</p>
<p>Harvesting community perceptions on the COVID-19 response will be a complex undertaking and it is anticipated that it will be difficult to build a coherent analysis from the secondary data that is available.</p>	<p>The evaluation team will approach the collection of community perceptions of the humanitarian response through two complementary processes: (i) analysis of Ground Truth Solutions data collected across a number of GHRP countries, and (ii) primary data collection in each of the case study countries undertaken by national evaluation consultants.</p>
<p>It may be difficult to conduct in-person community consultations as planned in certain contexts due to COVID-19 related restrictions or access issues due to conflict, remote location, etc.</p>	<p>The evaluation team will conduct individual phone interviews with affected populations in cases where in-person focus group discussions are not possible. The team will rely on agencies responding to COVID-19 to provide the contact details for phone interviews. This will reduce the number of people consulted but will yield more detailed qualitative data.</p>
<p>While an examination of the humanitarian – development – peace nexus is an important aspect of the ToR, the evaluation will be limited in the extent to which it will be able to do this given its primary focus on one of the three response frameworks.</p>	<p>Ongoing engagement and structured discussions with the SWE will assist in mitigating this risk, although a review of the nexus is outside the scope of the SWE. Attempts by the evaluation team to have a shared case study country (Sierra Leone) may offer an opportunity to explicitly focus on the nexus between humanitarian and development interventions.</p>

### 3.5 Ethical considerations

79. The evaluation team upholds the 2020 United Nations Evaluation Group (UNEG) Code of Conduct for Evaluation and Ethical Guidelines for Evaluation; UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation, the UN System-Wide Action Plan (UN-SWAP) on gender equality and the 2017 IASC Policy on Gender Equality and the Empowerment of Women and Girls in Humanitarian Action, especially in relation to evaluations including affected populations and vulnerable groups. All team members have in-depth knowledge of humanitarian principles, human rights, social inclusion, and AAP commitments in evaluation practice.
80. KonTerra and Itad will apply ethical standards to the data collection process including the protection of rights and dignity of evaluation informants. This includes applying the principles of informed consent, voluntary participation, assurances of anonymity and confidentiality of data protection and do no harm principles in all parts of the data collection exercise. Prior to any interview event, participants are oriented to informed consent and voluntary participation. All data is treated with confidentiality. Where personal information is collected, it is removed from the questionnaires or recording transcripts and used only with the Quality Assurance (QA) manager for verification. All the activities of the evaluation team will follow and respect OCHA data protection guidelines. In interview notes and reporting, source references are framed so as to not be

traceable to a single person. Additionally, all interviewees will be informed at the start of the interview regarding confidentiality principles, and they will not be directly quoted in the report – unless they give specific consent. Knowing potential interviewees have a high workload or need their time to earn an income, the team will keep the interviews as concise and as efficient as possible.

81. Principles of inclusion are important for ensuring that vulnerable voices are not marginalized, and inclusion is considered an ethical issue. This leads to approaches in evaluations such as bringing a differential lens to stakeholder analysis to ensure that all voices are represented, creating environments where vulnerable voices are freer to speak (for example, carrying out gender-disaggregated Focus Group Discussions (FGDs) with same sex facilitators at least for consultations with women so that participants feel comfortable to speak more freely). The team will also make efforts to include persons with disabilities in FGDs or other forms of community consultation (see section 4.1.7).
82. To the extent it is available in data sets, sex-disaggregated output and outcome data and analysis as well as data on persons with disabilities will be included in the evaluation. During data analysis evaluation teams will pay special attention to ensuring that perceptions of women, girls, men, and boys are appropriately and accurately represented to ensure gender sensitivity.
83. Do no harm principles are important considerations not only for aid recipients who might feel disempowered, but also for the national consultants and evaluation team members themselves. During the inception phase, the evaluation team has been assessing the potential of harm to aid recipients or data enumerators for any evaluation process. For example, in some high-risk environments, national consultants traveling through contested regions who are stopped by anti-government forces are at risk of being killed if they are found carrying many papers such as surveys or even a computer that an NGO worker may carry. In these same environments, participants in interviews or FGDs may also be at risk if they are seen to be joining a meeting that could be potentially construed as anti-government. The team will adapt its community engagement methodology to the specificities of case study contexts as needed.
84. The COVID-19 pandemic highlighted additional risks to those participating in group meetings, which will be managed through the development of COVID-19 protection measures for FGDs and other group meetings. KonTerra's team upholds WHO and government regulations while conducting evaluations in the field. Moreover, KonTerra has issued a COVID-19 guidance for all KonTerra staff and teams, requiring full vaccination for all evaluation teams travelling to the field in an attempt to ensure the safety of teams and all stakeholders involved.
85. The principles outlined above have provided the foundation for Annex 11 which outlines ethical and safeguarding considerations for community engagement.

## 4 Evaluation approach, methodology and tools

This section provides an overview of the evaluation methodology including the data collection and analysis tools that will be employed.

### 4.1 Data collection methods and sources

86. The team will use a mixed-methods approach for data collection and analysis which has been informed by the work undertaken in the inception phase and by the conceptual framework outlined in section 3.2 above. While much of the data collected will be qualitative, the team will collect and analyze quantitative data in the form of (i) financial and funding data, (ii) data on outputs where this is available, and (iii) secondary data from household surveys and community perception studies (to the extent available).

87. The evaluation will ensure methodological rigour through i) the collection of both primary and secondary data across the evaluation period and triangulation of evidence across multiple data sources; ii) the combination of evaluation tools and multiple analytical methods; and iii) rigorous comparative qualitative analysis through the use of an evidence assessment framework.
88. The main methods for data collection will be the following:
- Document and literature review
  - Review of quantitative data
  - Aid worker survey
  - Semi-structured key informant interviews
  - Country case studies
  - FGDs and participatory tools for community engagement
  - Mainstreaming gender and disability inclusion into data collection tools and approaches
  - Learning papers

#### 4.1.1 Document and literature review

89. The evaluation team has conducted a review of key global and country-level documents relating to the COVID-19 response. The purpose of this review was to identify where there is already documented evidence relating to the key evaluation questions and sub-questions and also to identify areas for consideration during data collection (see section 2.4). The document review also helped to refine the evaluation design and tools. In addition, the team reviewed evaluations and reviews of the COVID-19 response as well as relevant lessons learned exercises (see section 2.5). The purpose of the review was to synthesize findings from other relevant evaluations and help contextualize this IAHE (see Annex 7 for a summary of the team's approach). The team has a repository of 918 documents which will inform the evaluation. Key documentation categories are listed below (Box 2) while Annex 1 has a list of the documents referenced in this report.

#### **Box 2: Key documents for the evaluation**

- Relevant RRP/HRP/HNO/RRF including monitoring and reporting data
- Relevant advocacy materials and appeal documents
- HCT meeting minutes and communications which have a bearing on decision-making for the COVID-19 response, including key correspondence with regional offices and headquarters
- HCT strategies on thematic or cross-cutting issues such as PSEA, protection, gender and localization
- Relevant needs assessment documents and reports
- Country-specific response guidelines and procedures (sectors/clusters and cross-cutting issues)
- Country-specific reports on thematic issues or cross-cutting issues (sectoral reports, nexus, localization, AAP/RCCE, protection, gender, disability, inclusion, humanitarian principles and access, and cash)
- Reporting from collective AAP platforms or other community feedback mechanisms
- Country-specific reports on pooled funding (CBPF/CERF/other)
- Sitreps and updates
- Evaluations, reviews and lessons learned

#### 4.1.2 Review of quantitative data

90. The team will undertake quantitative data analysis, focused on secondary data from GHRP monitoring reports at global level as a means of determining the results that have been achieved. It will also analyze humanitarian financing data from the FTS. This will include a review of allocations by sector compared to the severity of needs, where this data is available. In addition to undertaking global analysis, the evaluation team will conduct light country-level quantitative data analyses in advance of each country visit.
91. The team will also review and interpret secondary community perception data. Initial discussions with Ground Truth Solutions (members of the GEAG), have resulted in agreement to draw on their country-level data to respond to a discrete set of questions listed in the evaluation matrix.<sup>103</sup> Ground Truth have collected community perceptions data both prior to, and during the COVID-19, which has potential to provide a rich source of evidence for the evaluation to complement primary data collection through FGDs with communities in case study countries.<sup>104</sup>

#### 4.1.3 Aid worker survey

92. As outlined in the ToR for the evaluation, the team proposes to conduct an online survey of aid workers as a key stakeholder group. The purpose of the online survey is to gather perspectives on the COVID-19 response from a wide range of aid workers (see below) based in as wide a range of the 63 GHRP countries as is practical. Analysis of survey data will complement information gathered during the document review and interviews. It will allow the evaluation team to consider views from those involved in delivering the COVID-19 response beyond the eight countries selected for case-studies. Design of the survey and analysis of the results will take into account existing data from other surveys.
93. It is proposed to survey broadly across the IASC members and their partners and agencies with responsibility for leading and coordinating collective action. Included among these are HCTs, cluster coordinators, NGOs (local, national and international), Red Cross/Red Crescent staff and volunteers, and government representatives involved in the delivery of assistance. The survey will be conducted online and be available in four languages (English, French, Arabic, and Spanish). A list of target individuals and groups to complete the survey will be drawn up in cooperation with OCHA and the MG. The staff of OCHA, UNHCR or other agency coordinating the response at country level will be requested to support the dissemination of the survey with their networks. This, together with measures such as having the survey available in multiple languages and keeping the survey short and focused is designed to encourage a good response rate.
94. The focus of the survey is on a discrete sample of evaluation questions which include needs assessment (EQ3), inter-agency coordination and leadership (EQ2 and 6), resource mobilization (EQ5), feedback mechanisms (EQ6) and lessons learned (EQ7). Although the survey will be in multiple languages, responses will be translated and consolidated to provide one overall summary of the results in English. The length of the survey will be kept as short as possible (taking approximately 20 minutes to respond) and questions will be straightforward in order to incentivize a high response rate. Questions will be largely based around the use of a five-point Likert scale. All individual survey responses will be kept confidential. Aggregate results (organised, for example, by country and organisation type) and summaries of open-ended responses will be shared with OCHA and included in the evaluation report. The survey questions are listed in Annex 12.

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<sup>103</sup> Questions where 'FGDs with affected population' is listed in the data sources column.

<sup>104</sup> See <https://groundtruthsolutions.org/our-work/covid-19-response/>.



#### 4.1.4 Semi-structured key informant interviews

95. Based on the analysis of stakeholders in section 3.4, the team will conduct semi-structured key informant interviews (KIIs) throughout the evaluation. These will engage a range of agency staff, partners and donors at global, regional, and country level, including those outlined in the ToR. Country-level key informants are listed in Box 3 below.

#### Box 3: Country-level key informants

##### Leadership and management

RC/HC, HCT and government representatives with responsibility for leading the COVID-19 response.

##### Donors

Donors that made significant contributions to funding the COVID-19 response including bilateral, multilateral and pooled funds. Humanitarian Funding Units (for CBPFs) and IOM (for NGO CERF allocations, where relevant).

##### Coordination and cross-cutting issues

- Sector coordination: Sector/Cluster (including sub-cluster) coordinators/Inter-Cluster Coordination Group (ICCG); OCHA, UNHCR or RCO staff members tasked with inter-sector coordination, information management, and response monitoring.
- Thematic issues: Staff/agencies with coordination responsibilities for/knowledge of (i) the humanitarian-development-peace nexus (including SPRP, SERP and the SG's Call for Solidarity) (ii) localization (including local/national NGO forums).
- Cross-cutting issues: Staff/agencies with coordination/advisory support roles relating to (i) AAP/RCCE, (ii) gender (including PSEA and GBV prevention and response), disability, inclusion and diversity, (iii) humanitarian access, principles and negotiation, (iv) protection, (v) cash.

##### Implementing organizations especially front-line responders

A broadly representative mix of local, national and international NGOs and UN agencies including relevant country-based inter-agency forums (UNCT, country-based NGO consortia).

##### Affected populations

The evaluation team will conduct FGDs with affected communities receiving COVID-19-related humanitarian assistance as well as a selected number of short individual interviews (see section 4.1.6 below). Where in-person meetings are not possible due to risk or insecurity, the team will conduct phone interviews.

96. The team will conduct KIIs as part of the country case studies and will complement these with interviews with regional and global informants to triangulate findings and fill evidence gaps. The team will use the questions listed in section 3.2 as a master set of interview questions to inform the team's line of questioning during the country case studies and interviews with global stakeholders (the questions template is available in annex 14).
97. The semi-structured approach brings a number of strengths in terms of allowing the team to cover a desired range of topics relating to the overarching evaluation framework, while at the same time allowing the emergence of unexpected ideas, good practice, innovations that may not previously have been identified.

#### 4.1.5 Country case study visits

98. The evaluation team will conduct a total of six country case study visits across a range of humanitarian contexts in addition to two partially remote case studies where there will be a mix of remote interviews by international members of the evaluation team paired with community engagement undertaken by national team members.

99. For the case study visits, the evaluation team will arrive in country having discussed the ToR for the evaluation with the country focal point, agreed a draft agenda and identified key stakeholders for interviews to ensure that the time that the evaluators spend in country can be used as effectively and efficiently as possible. The first two pilot case study visits were made to (i) Somalia (country case study) and Nairobi (to conduct KIIIs to obtain the regional perspective on the COVID-19 response) (ii) Turkey (for both the refugee response and the Syria cross-border operation). The evaluation team will discuss lessons learnt from these pilots and use them to inform the refinement of the methods and tools for subsequent visits. Box 4 presents the approach to the field-based country case studies.

#### Box 4: Country visit process

- Preparation for the country visit will include carrying out a light, preliminary desk review, with a focus on reviewing evidence against the evaluation matrix to be explored in greater depth in-country. This will include an analysis of relevant data, including on the socio-economic and humanitarian context prior to COVID-19, COVID transmission rates, and humanitarian funding during the response.
- Prior to their arrival in country, the evaluation team will agree an itinerary with the HCT/evaluation focal point that includes meetings with key stakeholders (at national level and possibly sub-national level) and locations for field visits by national evaluation team members for the purposes of engaging communities.
- Each visit should commence with a kick-off meeting in country with either the evaluation focal point and/or the HCT to orient the team to the national context, provide background on the evaluation approach, methods and tools, and to enable an initial exploration of key issues.
- A series of semi-structured interviews with key in-country informants at national level (and potentially sub-national level) will follow. It is anticipated that national evaluation team members will conduct gender disaggregated FGDs with a small number of affected communities where this is possible.
- In the final days of the country visit, the evaluation team will prepare a presentation and undertake a feedback workshop with the HCT with the objectives of (i) presenting and discussing preliminary findings, (ii) filling gaps in evidence, (iii) checking the validity of the findings, (iv) promoting learning and fostering ownership.
- Based on the feedback workshop and additional analyses of country data, the evaluation team will revise the presentation and submit it to the HCT as a final output from the case study visit.
- As outlined in the ToR for the evaluation, the case study visits will serve as part of the evidence collection to support the overall findings of the global evaluation; they are not evaluations of a particular country response and will not produce recommendations for local action but will generate '*issues for consideration*'. The presentations will feed into the cross-country case study analysis and the evaluation synthesis report.

#### 4.1.6 Community engagement

100. National evaluators will conduct sex-disaggregated FGDs in the local language with community members at sub-national level in order to explore perceptions of whether and how the COVID-19 response made a difference to the lives of affected populations. If relevant for the context, the evaluators will conduct separate FGDs for certain population segments, for example displaced persons and host communities or different ethnic/religious groups. As outlined in Annex 11 on ethical and safeguarding considerations for community engagement, the team will not involve anyone under the age of 18 in FGDs or interviews.

101. Specifically, community consultations will be used to address issues of the timeliness and relevance of assistance, targeting and accountability. The team has developed a methodology, details of which can be found in Annex 10, and will use this in each of the country visits (where this is possible). Where possible, a gender-balanced team of national consultants will be used to ensure access to men and women in each of the countries as part of an approach that will seek to obtain sex-disaggregated data.
102. It will be important for the evaluation team to work closely with OCHA and the Humanitarian Country Team in the early stages of field visit planning to do as much as possible to ensure that community-level visits are feasible, relevant, and useful.
103. Box 5 below provides a short description of the complementary tools that the evaluation team will use to engage with communities.

#### **Box 5: Primary data collection tools – community perception analysis**

The evaluation team will use three complementary data collection tools during community consultations.

**1. Project timelines:** The national consultants will prepare a context-specific timeline before conducting FGDs, showing key events during the pandemic, such as the detection of the first cases, lockdowns, school closures or a significant increase in cases. This timeline will be used as the basis of discussion to identify what assistance the community received and when.

**2. Assessing quality exercise:** Once the community has agreed on what assistance was provided and when, the evaluation team will facilitate a discussion to assess the quality of the assistance provided. This will focus on 4 aspects – **timeliness and relevance** (the extent to which the assistance arrived on time, was adequate and also appropriate compared to needs, and whether relevance and timeliness were maintained over time), **effectiveness** (what difference the assistance made to people’s lives and the extent to which it helped them face the challenges that resulted from the COVID-19 pandemic), **targeting** (whether the assistance was provided to the most vulnerable and those most in need and how these recipients were identified), and **accountability** (including awareness of any collective mechanisms for reporting sexual exploitation and abuse).

**3. Stories of change:** During the project site visits, when team members identify particularly illustrative stories (for example, through discussions of the relevance questions in the FGDs), they will seek to document these in order to obtain details of what assistance was received and its effect. The aim of this will be to highlight how the COVID-19 response has contributed to making a difference to people’s lives. The evaluation team’s aim is to gather these stories in each of the eight case study countries.

104. The team has modest expectations of the extent to which affected populations will be able to provide detailed feedback on some aspects of the COVID-19 response, but it does believe that community engagement will be useful to inform country case studies. Collection of beneficiary feedback will be constrained by the duration of field visits, with teams unlikely to visit more than one or two locations within each case study country. As a result, the community consultations will only offer a snapshot of the assistance provided. When data from the case studies and global level consultations is aggregated for the synthesis report, it will highlight examples of good practice/need for lessons and offer stories of how the COVID-19 response has made a difference to people’s lives.
105. The evaluation team will comply with all relevant norms and rules (national and UN-specific) that are in place to minimize risk to key informants and communities.

#### **4.1.7 Gender and disability inclusion**

106. In line with *UNEG Guidance on Integrating Gender Equality and Human Rights in Evaluation* (2011), the evaluation will treat gender and disability inclusiveness as critical lines of inquiry that will cut across all relevant areas of investigation. The evaluation will do this in the following ways:

- Examine the extent to which collective response actions sought to ensure attention to gender and the needs of persons with disabilities in the pandemic response. This will involve looking in particular at the extent to which the pandemic response was informed by gender analyses, how mechanisms and processes facilitated or inhibited the involvement of women and persons with disabilities, and attention to gender as well as other marginalized groups, and the extent to which this affected the quality and efficacy of the response. Special attention will be paid to assessing the extent to which the collective response brought about cohesiveness in prioritization of the needs of the most vulnerable women and men, girls and boys, and paid attention to the specific needs of disadvantaged groups such as persons with disability (as per Evaluation Terms of Reference, p. 16).
- Review evidence of the ways in which women and men, boys and girls, and persons with disabilities, were (differently) targeted and engaged in interventions through analysis of statistical data.
- Identify best practices, opportunities and lessons learned to ensure stronger and more consistent attention to gender and to persons with disabilities in future pandemic responses.

107. The approach of the evaluation to mainstreaming gender and persons with disabilities is outlined in Box 6 below. See annex 8 for details of the team's approach to gender and inclusion.

### Box 6: Details of the evaluation's approach to gender and inclusiveness analysis

- Methodology: Evaluation questions and indicators in the evaluation matrix (see Annex 5) include attention to gender and inclusiveness to ensure that the evaluation produces in-depth analysis of the extent to which the collective response targeted women and girls (as well as men and boys) and persons with disabilities in the design, coordination, and implementation of the response.
- Data analysis will disaggregate information by gender to highlight numerical differences in terms of targeting, involvement, and effects of interventions. This will be done both in analyzing secondary data (for example data that will be gathered from existing surveys), and also in the evaluation's own primary data collection (through the aid worker survey, country level interviews, etc.). The team will also identify the extent to which data on persons with disabilities is available.
- Interview guidelines have been designed to reflect the focus on gender and inclusion in the evaluation matrix and include questions on gender and other cross-cutting issues.
- Draw on the knowledge of key informants with specialized expertise on system-wide accountability frameworks for gender and disability inclusion.
- Documentation review will focus on specific initiatives to enhance attention to gender and disability inclusion and examine to what extent these produced the anticipated response.
- Country studies will review the extent to which emergency preparedness and response planning was grounded in gender analysis and the extent to which this was followed through in design and implementation. Country case studies will equally systematically examine any evidence of examples of gender transformative actions and review UN Country Team scorecards for reporting on their implementation of the UN's Disability Inclusion Strategy during field visits.<sup>1</sup> The team will consult with women's rights organizations as well as Organizations of Persons with Disabilities.
- The community engagement process that is part of this evaluation (see Annex 10) will ensure that the evaluation brings out the views of beneficiaries on gender and disability inclusion. To the extent possible, the team will seek to ensure the participation of persons with disabilities in FGDs.
- Data collection by the evaluation team in the field will be done in gender sensitive ways and to facilitate the participation of persons with disabilities. Gender-balanced teams will conduct interviews and focus groups with beneficiaries, disaggregated by gender.
- Data analysis. Integration of gender, disability and other categories of exclusion will be explored via coding and analysis of data generated by this evaluation.

#### 4.1.8 Learning papers

108. As outlined in the ToR for the evaluation, the team will develop two learning papers that will inform the final evaluation report as well as the humanitarian policy and practice of the IASC and its members more broadly. These papers will serve as inputs into the final evaluation, but will also be standalone documents. Because they are separate to the main evaluation report, they will be prepared at different phases of the evaluation and will play a role in providing high-quality evaluative evidence during the process (as opposed to focusing on an evaluation report at the end of the process).
109. During initial discussions with the MG, it was agreed that the focus of the first learning paper would be the process of developing the GHRP; this paper has been prepared during the inception and pilot phase as the first substantive output of the evaluation, along with this draft inception report. The GHRP learning paper has been structured in a way that is consistent with the evaluation matrix and hence the evidence collected during its preparation will make a direct contribution to the evaluation. This will also make it possible for the

evaluation to follow-up issues from the learning paper that require additional research and/or from input from the country case studies.

110. KIs undertaken during the inception phase have suggested focusing the second Learning Paper on localization and the humanitarian response to the COVID-19 pandemic. It is considered that this would be relevant to ongoing policy discussions within the IASC and the broader humanitarian community, and consequently, would make an important contribution to the evaluation as well as future humanitarian responses. An outline of both papers is provided in Annex 9. A brief overview is provided in Box 7 below.

### Box 7: Overview of the two proposed learning papers

#### GHRP learning paper

In July 2020, the IASC Principals tasked OCHA with leading and sharing ‘*lessons learned from the GHRP process that can be applied to and strengthen the annual development of the 2021 GHO*’. Thereafter, OCHA conducted a light lesson learning exercise, which concluded in October 2020.<sup>1</sup> This learning paper will build on the OCHA-led exercise and the findings and recommendations that were documented during that process. The paper will seek to respond to two main learning areas: (i) how beneficial was the GHRP process as a new approach for collectively responding to the demands of a global crisis; and (ii) to what extent did the GHRP process facilitate an inclusive and well-coordinated response?

#### Localization learning paper (proposal for consideration by the MG)

Localization constitutes a core commitment for the humanitarian community and was identified very early in the COVID-19 response as being critical in light of the travel restrictions, and the need to move fast and quickly to mobilize capacity and respond.<sup>1</sup> Consequently it is also the subject of a specific set of questions under the IAHE. Localization has also been identified by the Grand Bargain 2.0 as a key priority<sup>1</sup> (together with participation of affected communities and more agile funding) and has been included in the IASC 2022/23 work plan as one of four enabling priorities.<sup>1</sup> This learning paper has an important potential forward looking value in that it will feed into these priorities. In addition, a specific learning paper on Localization will ensure that the evaluation brings out key lessons and gives voice to the views of local actors on the achievements and challenges of the COVID-19 response.

## 4.2 Approach to case study sampling

111. Since the GHRP included 63 countries (see Annex 6), a purposive sampling approach will allow the evaluation team to focus on a manageable number of information-rich cases to study in some depth. The aim is to identify trends and patterns between the different contexts to answer the evaluation questions. Manageable in this instance refers to the envelope of resources and the limited time-frame available for the evaluation, as well as the accompanying burden of work for host countries.

### 4.2.1 Selection criteria for a purposive sample of country case-studies

The selection of case-study countries was developed by applying the following five criteria, organized roughly in order of importance:<sup>105</sup>

- Geographic balance and coverage of all or most of the different regions affected by COVID-19.
- The nature of the humanitarian context and different vulnerability factors, including conflict, displacement, natural hazards, economic crisis, etc.
- Severity of humanitarian need. In this case, the sample is intended to only include countries ranked as very high or high during the time of the COVID-19 humanitarian response.<sup>106</sup>

<sup>105</sup> Specifically, each of the 63 countries was examined against 18 criteria which included the following: Humanitarian context; response plan; national and local leadership capacity; INFORM Severity Rating (Dec 2020); INFORM Severity rating (DEC 2021); People targeted pre-COVID-19 (GHO, 2020); People targeted (Nov 2020); volume of appeal funding; per cent of appeal funding met; CERF funding; CBPF funding; access; government travel restrictions; COVID-19 trends (cases, transmission); other considerations.

<sup>106</sup> The evaluation team used the INFORM severity index dated December 2020.

- Consideration of different response leadership and coordination modalities. In this case, this refers to countries with HRPs, RRP, COVID-specific appeals, other appeals or no appeals at all.
- Resourcing, with an emphasis on countries that received different levels of funding against their requested amount for preparedness and response to COVID-19; and a particular focus on those countries that were recipients of pooled funding, both from the CERF and CBPFs (section 2.3 provides an analysis of COVID-19 funding by appeal as well as through the CERF and CBPFs).
- The trajectory of the pandemic and the operating environment for humanitarian assistance as a consequence of rules and regulations introduced by governments.

112. While it would be desirable to achieve a balance between the criteria listed above in the selection of countries to participate in the evaluation, it is anticipated that any sampling strategy will also need to be sensitive to practical considerations such as security and access in addition to internal factors such as the availability of key staff, competing evaluative priorities, and the ability of countries to host the evaluation.

#### 4.2.2 Selected case study countries

113. Based on the criteria outlined above, the eight proposed country case-studies are listed in the table below (Table 6).

**Table 6: Countries selected for the evaluation**

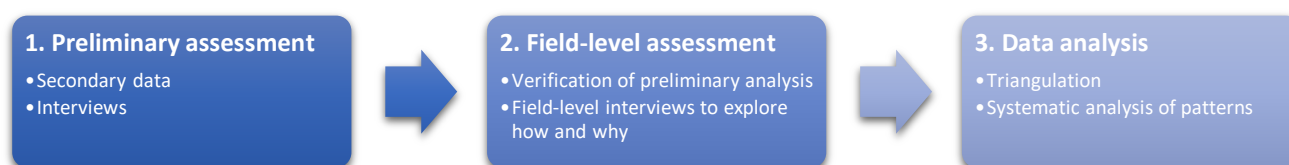
Country	Region	Type of context	INFORM Severity rating	Type of appeal	Appeal funding	Pooled funding
<b>Somalia</b>	Southern and Eastern Africa	Conflict, displacement, natural hazards	High	HRP/MRP	40%	CERF/CBPF
Rationale (pilot)	High to very high severity of need; no increase in number of people targeted pre- and post-COVID; relatively low volume of appeal funding in 2020 (\$89m); CERF and CBPF funding; mixed government capacity with significant numbers of vulnerable communities beyond the reach of assistance; relatively low CSO capacity and access; existing community feedback data from Ground Truth; potential to cover regional offices in Nairobi which will be the only opportunity for the evaluation to engage with regional stakeholders.					
<b>Turkey</b>	Middle East and North Africa	Refugee hosting, relatively stable	High	RRP	17%	CERF
Rationale (pilot)	Refugee-hosting country, high severity of need; significant increase in number of people targeted pre- and post-COVID; high volume of appeal (RRP) funding received in 2020 (\$131m); CERF and CBPF funding; the evaluation team can also examine the cross-border response into Syria (which links with the Syria remote case study); strong government and CSO capacity.					
<b>Bangladesh</b>	Asia	Refugee hosting, natural hazards	High	RRP, COVID appeal	47%, 28%	CERF
Rationale	Bangladesh is one of the countries at greatest and most immediate risk from climate change and experiences significant annual flooding with high severity on communities. The Rohingya crisis has resulted in Bangladesh experiencing very high numbers of refugees (742,000). As with other Asian nations, COVID-19 incidence has been comparatively high with the fourth wave only receding in February 2022.					
<b>DRC</b>	West and Central Africa	Conflict, displacement, disease outbreaks (Ebola)	Very high	HRP/RRP	43%, 8%	CERF/CBPF
Rationale	Very high severity of need; modest increase in number of people targeted pre- and post-COVID; one of the top-funded appeals (HRP) by volume in 2020 (\$119m); low funding for RRP (\$12m); one of the top recipients of CERF and CBPF funding for COVID-19; mixed government and CSO capacity across the country; recent experience of Ebola, albeit at sub-national level which offers links to preparedness in addition to comparative analysis.					

<b>Colombia</b>	Latin America and Caribbean	Refugee/migrant crisis, organized crime, urban violence	High	HRP/RMRP	15%, 14%	CERF
<b>Rationale</b>	High severity of need; modest increase in number of people targeted pre- and post-COVID; one of the lowest-funded appeals (HRP) in 2020 by per cent; CERF funding; significant work on humanitarian – development - peace nexus; mixed government and CSO capacity and access.					
<b>Sierra Leone</b>	West and Central Africa	COVID	N/A	Other (COVID-19)	N/A	N/A
<b>Rationale</b>	Sierra Leone is a non-HRP country (the only one included in the sample) albeit with prior experience of significant conflict/displacement/refugee/disease-related humanitarian needs. It has recent experience of the Ebola epidemic (and Lassa Fever prior to Ebola) which informed a significant quantity of preparedness planning including at an international level. The System Wide Evaluation may include the country as a case study which would offer the potential to make a detailed examination of the nexus.					
<b>Syria</b>	Middle East and North Africa	Conflict, displacement, climate change	Very high	HRP/RRP	52%, 17%	CERF, CBPF
<b>Rationale (remote)</b>	Syrians are enduring the worst economic crisis since the war began, with record levels of food insecurity and rapid inflation. At the same time, water shortages in northern Syria are creating drought-like conditions for millions and jeopardizing already compromised health and water systems. High severity, conflict and displacement context, modest increase in no. people targeted pre- and post-COVID, one of the top-funded appeals by \$, CERF funding, one of the top recipients of CBPF funding.					
<b>Myanmar</b>	Asia and Pacific	Conflict	High	HRP	70%	CERF/CBPF
<b>Rationale (remote)</b>	Conflict and civil unrest have spread throughout the country since the military took power, displacing 220,000 people during 2021 in addition to the more than 330,000 internally displaced. access to health services is severely limited or out of reach for many across the country, especially in areas affected by conflict. High severity, conflict (and previously natural disaster) context, no change in no. people targeted pre- and post-COVID, one of the top-funded appeals by per cent, CERF and CBPF funding					

### 4.3 Data collection, synthesis and analysis

114. The ToR lends itself to an inductive approach to data collection and analysis and to assessing the contribution made by the COVID-19 response to achieving results. The evaluation team will take an approach that places primacy on exploration and observation as a way of identifying patterns, and by exploring inductively and collaboratively with key stakeholders where good practice exists. In support of this, the evaluation team has designed a three-step process that will enable it, in a systematic and transparent way, to gather data so as to minimize bias, and to take a pragmatic but systematic approach to analyzing a substantial volume of qualitative and quantitative data and evidence across a range of case studies (Figure 8).

**Figure 8: Three-step process for systematic evidence gathering and analysis**



115. The different steps in the process are described in more detail below.

- Preliminary assessment: The evaluation team has conducted a preliminary analysis during the inception and pilot phase and will also undertake a context mapping prior to travel to each of the case study countries. This will enable a more focused approach to be taken during fieldwork to gathering further data and verifying the quantitative and qualitative data that has already been collected.



- Field-level assessment: Based on the preliminary assessment of evidence conducted for each country case study, the evaluation team will be able to focus down on the most relevant aspects of the ToR in order to explore the contribution made by the COVID-19 response to change, test assumptions, the relative importance of enabling and inhibiting factors, and the contributory role of key stakeholders.
- Data analysis: The analytical process brings together evidence from these different streams against the evaluation matrix as the main analytical tool. To strengthen the validity of the findings, a series of layered triangulation techniques are applied to the data collection and data analysis processes. These include triangulation of data types, triangulation of data sources, and the triangulation of data collectors (see Box 8).

**Box 8: Triangulation techniques to be used to strengthen the validity of findings**

- Data Types: The evaluation will gather information via the qualitative, quantitative and secondary data tools described earlier.
- Data Sources: The information sources come from a wide range of stakeholders at both global and country-level. The case countries are reflective of different regions, humanitarian contexts and funding levels. It is anticipated that the collection of evidence across these different sources can enhance triangulation and improve the potential for patterns to be observed.
- Data Collectors: The evaluation team contains members from diverse backgrounds, roles and experiences. The plan is to rotate responsibilities and members across the team to ensure that no single evaluator has too much influence over specific aspects of the process.
- Consistent Tools: A set of systematic tools for the evaluation will assist in ensuring that even though different data collectors and sources are engaged, the techniques are being applied in a consistent manner than can be cross-checked during quality control processes by internal team members and external agents.
- Participatory Analysis: During the evidence assessment and analysis process, the evaluation team will seek to ensure that multiple perspectives are considered. This will be supplemented by an additional consultative approach with findings presented to and validated by the key stakeholders – including debriefings at the end of each evaluation field mission and a proposed validation meeting at a global level. The purpose of this will be to engage key stakeholders in (i) a process of review and validation of the evaluation findings and conclusions, and (ii) co-creation of the recommendations.

### 4.3.1 Data analysis and synthesis

116. The evaluation team has designed a process to gather data in a systematic and transparent way that will minimize bias, and to take a pragmatic but systematic approach to analyzing a substantial volume of qualitative and quantitative data and evidence across a range of case studies (see below and Figure 9).

**Figure 9: Approach to data analysis and synthesis**



117. Step 1: For each case study country, the evaluation team will ensure that field work is preceded by a contextual mapping that will draw from the documentation and any interview evidence. This will include information on the humanitarian situation/priorities prior to the pandemic; COVID-19 response priorities as of March 2020, including most at risk populations and anticipated direct and indirect impact;

pandemic response - key events and key dates including when the pandemic hit and how it evolved; COVID-19 coordination; key achievements of, and challenges with, pandemic response.

118. Step 2: The team has developed an interview notes template organized by evaluation question. This will include interviewee details as well interview date and interviewer name. These summaries will be confidential and not be shared.

119. Step 3: A single evidence matrix, organized by evaluation question, will bring together all the evidence collected by the evaluation team (from interviews and from documentary review) at both case study and global level. The evidence will be included in the form of summary points that draw from interview notes and from documentation. Each finding will be referenced either by an interview number or a documentary source number. The evidence matrix will be used both to isolate and analyze the evidence for individual case study countries. It will also be used to support a comparative case study analysis across all of the case study countries.

120. Step 4: For each country case study, the team will develop a debriefing PowerPoint which will be shared with the HCT for purposes of validation. This will outline preliminary findings against each of the evaluation questions, and emerging areas of learning. See section 4.4.1 below for further details on dissemination.

121. Steps 5: The evaluation team will use an iterative approach to evidence analysis and sense-making. This will be important because of the volume of primary and secondary evidence that it will collect and review. In order to make sure that the evaluation draws from this evidence, the approach will focus on ‘sense-making’ by:

- **Capturing key messages from each interview.** These key messages can be compiled into a single document against the main EQs and themes of the evaluation to provide a sense of emerging findings.
- **Capturing high-level findings in the evidence matrix.** As evidence is accumulated for each EQ in the evaluation matrix, individual team members use this to begin to identify high-level key findings that summarize from the accumulated body of evidence. This will be done through a summary line in the evidence matrix under each evaluation question.

- **Discussing emerging findings in internal team meetings.** The evaluation team will meet remotely and in person at regular points during the evaluation process (such as after the pilot case studies and at the end of the data collection phase). The meetings will be used to discuss emerging findings from country studies, from the learning papers, and against specific evaluation questions and cross-cutting themes, and to identify areas that need further exploration or triangulation and where evidence may be insufficient. The synthesis of evidence from the team meetings will inform the evaluation report.
- **Discussing draft/emerging findings with external stakeholders.** This will be done informally through discussions with key stakeholders, and formally through (i) the presentation of initial/emerging findings from the inception and pilot phase, and (ii) once the draft evaluation report has been prepared. The GEAG is considered as an important forum to present and discuss the findings of the draft evaluation report.

### 4.3.2 Use of qualitative data analysis software

122. The evaluation team considered the use of MAXQDA as a qualitative data analysis software package. Whilst the software has benefits, its use still poses considerable challenges. Multiple people must work on separate projects, in order to combine these, the projects must all be merged. It is common that these files are usually too big to run on a single computer causing major crashes and delays. In addition, once projects are merged, they can often duplicate or lose data. Given the relatively short timeframe for this evaluation, the team deemed the risks of data loss and delays to the delivery schedule to be too high. The only mitigation measure against data loss would be to regularly export MAXQDA files to Excel and merge them as Excel files. This would have the same outcome as working in Excel from the start. Therefore, the team focused on developing a robust evidence assessment framework in Excel during the inception phase.

### 4.3.3 Recommendations

123. The recommendations outlined in the evaluation report will be the logical implications of the findings and conclusions and will be:
- Categorized as (i) Critical, (ii) Important, or (iii) Opportunity for learning
  - Relevant, realistic and useful, and reflect the reality of the context within which the pandemic response has been conducted
  - Clearly stated and not broad or vague
  - Realistic and reflect an understanding of the collective humanitarian system, its capacities and its potential constraints
  - Suggest where responsibility for follow-up should lie

## 4.4 Dissemination of findings

### 4.4.1 Dissemination

124. The evaluation team and OCHA will ensure that each user group has access to the findings of the evaluation including their implications for accountability and implementation. It is anticipated that dissemination will occur at two distinct levels: Country and global level.

125. *Country-level:* At the end of each case study, the evaluation team will conduct a debriefing session with a presentation of the initial findings to primary stakeholders and intended users (this will be done in-person or remotely). The presentations (PowerPoint slide decks) will be shared with the HCT.

126. *Global-level:* The evaluation team will seek to engage with key stakeholders during the preparation of the draft synthesis report. Specifically, it is proposed that a validation workshop is conducted to support the development of the recommendations to increase engagement and strengthen their relevance.
127. Upon completion of the draft synthesis report, a validation workshop will be held with a presentation of the main findings, conclusions and recommendations. Once the evaluation is completed, presentations of the main findings and recommendations will be made to humanitarian forums as outlined in the ToR.

## 5 Evaluation process and work plan

This section highlights the evaluation process and work plan. It provides details of the different phases of the evaluation and provides a detailed timeline for the inception and pilot phase.

### 5.1 Phases of the evaluation

128. The evaluation has been designed around four distinct phases, an inception and pilot phase, a data collection phase, a reporting phase and a dissemination phase. Details of the activities and outputs from each phase are given below.

#### 5.1.1 Inception and pilot phase

129. Immediately after award of the contract, the evaluation team leader and KonTerra Evaluation Manager undertook an initial videoconference call to formally kick off the evaluation and discussed and agreed next steps in beginning the key activities of the inception phase. An in-person team meeting with the core team members was held soon after to organize the team, allocate tasks, and to provide initial input into the inception report. The evaluation team commenced the design of the evaluation and data collection methods and tools for the inception report. During this phase, an initial review of documentation was undertaken in addition to remote key informant interviews for purposes of scoping and to provide initial input. During the inception and pilot phase, the final list of case study countries was finalized and the process of arranging travel dates was initiated.
130. In addition to the inception report, two other evaluation inputs will be prepared: The evaluation synthesis was undertaken with a view to harvesting evidence against each of the evaluation questions from lessons-learned, reviews and evaluations that have already been conducted. The GHRP learning paper has been undertaken in this phase of the evaluation with a draft report submitted to the MG at the same time as the Inception Report is submitted.
131. The purpose of the ‘pilots’ was to field test the approach and gather an initial set of evidence against each of the evaluation questions. Turkey and Somalia were selected as the two pilot case studies and offered an opportunity for the evaluation team to engage at regional (Nairobi) and national levels. Once the data collection instruments are validated, the team will carry out the remaining data collection in the other six selected countries in the data collection phase.
132. The pilot case studies offered an opportunity for the evaluation team to provide feedback on early/emerging findings and it is anticipated that webinars will be undertaken with key stakeholders, including the Global Evaluation Advisory Group.
133. The inception and pilot phase will be completed with the submission of this final inception report that has been revised based on feedback from the Management Group.

### 5.1.2 Data-collection phase

134. The data collection and field mission phase will be the most labour-intensive phase of the evaluation and will comprise the in-person case study visits, remote case studies, the aid worker survey and the preparation of the second learning paper.
135. For each in-person case study visit, a joint international/national evaluation teams will undertake the visit. The role of the national evaluators will be to assist with gathering beneficiary feedback and understanding of the local context.
136. The two remote case studies will also be conducted during the data collection phase albeit with the international team members engaging remotely, while the national consultants undertake FGDs with affected communities. These will be undertaken in countries which are not possible for international consultants to access (either because of the need to self-isolate or due to security or logistical constraints) and will supplement the evidence gathered from the in-person country case studies and contribute to the evidence that informs the main evaluation report.
137. The second learning paper outlined and agreed during the inception phase will be drafted. While this will draw heavily from the literature, it is anticipated that it will also be informed by the country case studies. The timing of their drafting will be dependent on the topic agreed and the schedule of the country visits.
138. In addition to the country case studies, the team will expand on the initial literature review and conduct data analyses and the online survey. During this phase, the team will conduct additional interviews with global stakeholders to gather missing data and triangulate evaluation findings. The remote interviews will be drawn from an initial list of stakeholders provided by OCHA. If possible, the Team Leader and Senior Evaluator will undertake headquarters visits to New York and Geneva. after the field missions. The full team will meet in person towards the end of the phase after the completion of all data gathering visits in order to conduct data analysis, synthesis and to plan the drafting of the main report.

### 5.1.3 Reporting phase

139. The team will prepare country presentations as agreed by the MG and based on the approach outlined above. Drafts will be shared with the HCT which will be revised based on feedback received. The team will draft the Main Evaluation Report on the basis of the findings of the country visits and the associated comparative analysis and submit it for comment. It proposes to hold a one-day validation workshop with the Global Evaluation Advisory Group (in Geneva or New York if a face-to-face meeting is possible) after which the team will prepare and submit a final report incorporating the feedback received. As outlined in the ToR, the main evaluation report will be complemented by an Evaluation Brief of no more than two pages.

### 5.1.4 Dissemination phase

140. Activities and a timeline for the dissemination phase will be informed by the MG as outlined in the ToR. The evaluation team will prepare a series of presentations in support of this which will include the following:
- For each of the field missions, the evaluation team will conduct a country-level debriefing with the UN/HCT, and relevant Government counterparts, where they are members of HCT. This will be undertaken in person or remotely. The presentation will be made available to the MG.
  - Upon completion of the draft evaluation report, the evaluation Team Leader will present the results of the IAHE to the IASC Operations, Policy and Advocacy Group and to the IASC Emergency Directors Group in Geneva and/or New York and other stakeholders. A presentation will also be made to the GEAG.
  - Once the evaluation is completed, presentations of the main findings and recommendations will be

made available to various fora as decided by the IAHE Management and Steering Groups. The evaluation team will be available to assist with these presentations.

## **5.2 Evaluation outputs and work plan**

141. Tables 7 and 8 below presents the full work plan for the first three phases of the evaluation. When reviewing this, it is important to note that at the time of submission of this report, not all of the dates for the case studies have been agreed and as a consequence, the work plan should be considered a working draft.
142. The dissemination phase has not been included as dates for this will need to be agreed in discussion with the MG and the IAHE Steering Group.







### 5.3 Agreed deliverables

143. The evaluation team will provide the following deliverables, in line with the work plan above (Table 9).

**Table 9: Agreed deliverables**

Phases	Deliverables	Timeline
<b>Inception and pilot</b>	First draft inception report	14 March 2022
	First draft of GHRP Learning Paper	14 March 2022
	Final GHRP learning paper	15 April 2022
	Final Inception report	15 April 2022
	Country-level debriefs and presentations for 2 x pilot case studies	March 2022
	Presentation of emerging findings (to MG, GEAG etc.)	w/c 18 April 2022
<b>Data collection</b>	Country level debriefs and presentations for 4 x case studies	May – Jun 2022
	Country-level debriefs and presentations for 2 x remote case studies	May – Jun 2022
<b>Reporting</b>	Validation and recommendations co-creation workshop	TBC
	Submission of draft Learning paper #2	Jul 2022
	Submission of final Learning paper #2	Aug 2022
	Submission of draft evaluation report	Aug 2022
	Presentation of draft report and findings to the MG and GEAG	Aug 2022
	Submission of final evaluation report	Sep - Oct 2022
	Presentation of final report to GEAG, MG, etc.	Sep - Oct 2022

### 5.4 Evaluation team composition and tasks

144. The composition of the team has been revised from the proposal stage, reducing the size of the core team, and redistributing some roles and responsibilities (see Annex 3 for team organogram and, roles and responsibilities).

145. The team is led by Andy Featherstone, Team Leader, a highly experienced evaluator with extensive UN agency humanitarian experience. The core evaluation team is comprised of Tasneem Mowjee and Charlotte Lattimer who bring complementary expertise in evaluation and research experience across various geographical focus areas, and a range of linguistic skills for this evaluation. Rebecca Kindler and Pierre Townsend will join the evaluation team for the Colombia case study. Betsie Lewis is in the role of senior researcher and will participate in the DRC case study. Flovia Selmani will be responsible for data analysis and visualization. The Itad Partner, David Fleming, will be responsible for providing strategic technical support and QA throughout the evaluation.<sup>113</sup> The Project Manager for this evaluation, Belén Díaz, carries out the day-to-day management of the evaluation, and she is supported in this role by Mélanie Romat, who will manage all contract administration and logistical tasks (including sub-contracting experts, workplan tracking and logistics).

146. The core team will also be supported by a team of in-country evaluation experts, the final selection of which will be made once dates for each of the countries have been finalized. The in-country evaluators will be managed and supported by the core team, establishing working relationships encompassing effective communication, capacity-building and an adaptive approach. A collaborative approach will be developed

<sup>113</sup> The approach taken to quality assurance is described more fully in section 6 of this report.

with partners, and will include capacity development through mentoring, on-the-job support and formal training.

## 5.5 Support required by the evaluation team

147. The evaluation ToR is both broad and complex and as a consequence, members of the humanitarian community globally and in each of the participating case study countries will have an important role in achieving a successful outcome. There are a number of specific areas where they may be required to provide practical support.

### 5.5.1 Support required from OCHA EOS

148. OCHA EOS will play an important role in supporting the evaluation team, in addition to facilitating their engagement with the MG and GEAG. Specific support requirements will include the following:

- Identification and collation of data that is held globally
- Identification of global key informants and facilitation of introductions to the evaluation team members
- Where regional visits are possible (e.g., Kenya), the support of OCHA EOS will be necessary to broker initial engagement and to advocate on behalf of the evaluation team
- The willingness of selected case study countries will play an important part in the success of the evaluation and the team will require support from OCHA EOS to negotiate and kindle the support of country stakeholders

### 5.5.2 Practical support for the country case studies

149. The evaluation team will contact the HCT/evaluation focal point well in advance of visiting case study countries in order to determine what practical support will be necessary for the team. All direct costs, such as for hotels, guest houses and UNHAS bookings, will be paid or reimbursed by the evaluation team and/or KonTerra.

- Early engagement is requested in order to prepare and submit visa applications and introduction letters, where needed.
- HCT/evaluation focal point to facilitate the Evaluation Team's access to in-country informants and documentation, and organize any project visits and the country-level debriefing at the end of the field mission.
- HCT to provide advice and technical guidance to the evaluation team on contextual issues and how they relate to key evaluation questions and additional areas of investigation in the country.
- Assistance may be required in identifying and booking hotel accommodation or where this is not available, UN guest houses, particularly in some of the more complex case study countries.
- Support with logistical arrangements such as in-country travel (including the provision of vehicles in some country contexts).
- While the evaluation team will include national consultants who will focus on sub-national community engagement, where there is potential also to engage affected communities at national-level, and as a strategy to increase coverage, the evaluation team may consider additional work with communities in which case a request may be made for humanitarian staff to assist with identifying relevant locations and communities for FGDs, as well as translation and/or facilitation. This will be discussed on a country-by-country basis and will only be pursued if there is a willingness by the country to provide additional support.

### 5.5.3 Specific support required for country case studies in volatile contexts

150. For case study countries that are particularly volatile, the evaluation team will need to work with the evaluation focal point to determine where assistance will be required (Box 9).

#### Box 9: Support required for country case studies in volatile contexts

- Briefings: Security briefing on arrival from UNDSS.
- Transportation: Where it is not possible to hire hard-skinned vehicles where these are required, or where the UN is afforded particular security guarantees.
- Communications: Where security information is communicated via VHF handsets, a request may be made for access to handheld radios. In these contexts, access to radio-checks and travel check-in procedures when in the field may be requested. Where procurement is difficult, requests may be made for local sim cards for evaluation team members.
- Accommodation: Where secure accommodation is in UN compounds, the evaluation team may request UN support.
- Emergency plans: While KonTerra has duty of care for the consultants, in the event of significant insecurity, it will be important to establish whether the UN will extend hibernation/evacuation procedures to the evaluation team members, particularly while they are in field locations.

## 6 Quality assurance

This section outlines means to quality assure the evaluation and associated outputs.

### 6.1 KonTerra's quality assurance approach

151. The quality assurance system put in place for this evaluation is based on United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation, OECD/ DAC Evaluation Quality Standards and ALNAP Quality Pro Forma. It builds on the following three pillars: (i) Robust evaluation teams, (ii) three-fold QA review and (iii) QA considerations:

#### 6.1.1 Robust evaluation teams

152. The outstanding technical and evaluative expertise of the Team Leader and that of the team members are the first guarantee of the quality of this evaluation. They will pay special attention to ensuring the following quality dimensions of the evaluation:

- credibility and robustness of the methods;
- adequate levels of triangulation;
- solid analysis and grounding on evidence;
- adequate application of evaluation criteria and questions;
- balanced mixed-methods;
- completeness, excellent flow and clarity of the evaluation findings;
- well articulation and internal consistency of the evaluation reports;
- preservation of ethical evaluation standards, and
- high level of engagement of evaluation stakeholders.

### 6.1.2 QA review

153. The evaluation includes three QA steps. Firstly, all evaluation deliverables as well as the intermediate methodological and content products produced to reach the evaluation deliverables will be reviewed by the evaluation team members and two KonTerra peer reviewers.
154. Secondly, Itad's QA Lead, David Fleming, and Quality Assurance reviewer, Elisa Sandri, will conduct an in-depth review of all evaluation deliverables. They will also provide regular technical and strategic inputs to the evaluation team, including methodological, and contribute to the analytical discussion. The QA Lead will make constructive and detailed comments and will ensure that the evaluation team has addressed them satisfactorily, and that the products are complete, before submission to OCHA's Evaluation Manager.
155. Thirdly, evaluation stakeholders' feedback on draft versions of deliverables will be collected in a consolidated comment matrix which will incorporate input from all reviewers. The team will address comments, make amendments and corrections to their draft products as deemed appropriate, and provide an explanation of how the comments have been considered and addressed. The QA Lead will review the comment matrix and subsequent versions of the drafts to ensure all comments have been adequately considered by the team and, that any rejections, have been duly explained in the comment matrix.

### 6.1.3 QA considerations

156. Quality assurance in evaluation function is intimately dependant on two factors:

- (i) **The level of commitment and knowledge of evaluators on evaluation principles and quality standards:** the evaluation team, under the leadership of Andy Featherstone is well-versed in the process of conducting complex and strategic evaluation. Primary and secondary data will be triangulated in different rounds, emerging themes will be assessed from different angles, and evidence will be systematised, synthesized, aggregated, and appropriately weighed in the light of the range of internal and external factors which also will be properly mapped.
- (ii) **The skills, ability, and time to craft and build excellent evaluation products:** The process of bringing together different evidence streams in a solid and consistent product requires skilful and seasoned evaluation teams whose competencies have been assessed and validated during the team composition process. It also requires sufficient time to craft the deliverables. For this reason, it is important to ensure enough time is built into the evaluation calendars to grant the foreseen two step internal QA steps of all evaluation deliverable drafts before submission to OCHA.

## 6.2 The role of the Management Group

157. The IAHE will be managed by an Inter-Agency Management Group (MG) comprised of senior-level evaluation officers representing the independent evaluation offices of IAHE SG members, including the following organizations: ALNAP, ICVA, IOM, SCHR, UNFPA, UNHCR, UNICEF, WFP, WHO, and OCHA (chair). The members of the MG are mandated by their respective Steering Group representatives within all the delegation of authority of the MG to manage IAHE deliverables as per the IAHE guidelines.
158. The independence of the evaluation process will be safeguarded by, and will reside with, the MG. The Team Leader will report to the MG through the Evaluation Manager, with all final quality control and process decisions resting with the MG in order to ensure the smooth functioning of the evaluation. Wherever necessary, the MG will work with the Team Leader to finalize individual evaluation outputs, so as to ensure the maximum quality, credibility and utility of all end products.

159. The Chair of the Management Group will be OCHA's Evaluation Manager. S/he will be the main point of contact for the evaluation and ensure day-to-day support and consistency throughout the evaluation process, from drafting the TOR to the dissemination of the report.

### **6.3 The role of the Global Evaluation Advisory Group**

160. A Global Evaluation Advisory Group (GEAG) has been formed to provide support to the IAHE. Acting in an advisory capacity, its role is to comment on draft evaluation deliverables, advise on data and evidence sources and support communication and dissemination activities, with the aim of ensuring the relevance and utility of the evaluation's findings and recommendations to the humanitarian community. The evaluation team will have three formal meetings with the GEAG during the evaluation, (i) at the end of the inception and pilot phase, (ii) once a draft evaluation report has been prepared, and (iii) to present the final report.

### **6.4 The role of the IAHE Steering Group**

161. As per IAHE Guidelines, the IAHE Steering Group approved the ToR, and will approve the final evaluation report, based on the recommendations provided by the IAHE Management Group. The Steering Group will also contribute to the development of a communications strategy for the IAHE results.

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# Annexes

## Annex 1: Key documents consulted during the inception and pilot phase

This annex outlines the texts cited in this inception report. A list of documents that were included in the COVID-19 evaluation review are also included.

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## Annex 2: Inception phase consultations

Presented below is a list of persons consulted during the inception phase.

### Non-governmental Organizations and inter-agency initiatives

Azmat Khan, Chief Executive Officer, Foundation for Rural Development  
 Delphine Pinault, Humanitarian Policy Advocacy Coordinator & UN Representative, CARE International  
 Dr Javed Ali, Emergency Response Director/Senior Medical Advisor, IMC  
 Gabriella Waaijman, Global Humanitarian Director, Save the Children  
 Gareth Price-Jones, Executive Secretary, Steering Committee for Humanitarian Response, SCHR  
 Jeremy Wellard, Head of Humanitarian Coordination, ICVA  
 Lars Peter Nissen, Director, ACAPS  
 Mary Pack, Vice President Humanitarian Leadership and Partnership, IMC  
 Michael Mosselmans, Head of Humanitarian Programme Policy, Practice and Advocacy, Christian Aid

### United Nations

Alf Ivar Blikberg, Section Chief a.i., Asia-Pacific, Europe, Latin America and Caribbean, and Asia-Pacific (ELACAP) Section, Operations and Advocacy Division, OCHA  
 Allyson Chisholm, Emergency Specialist, COVID-19 Team, UNICEF  
 Andy Wyllie, Chief, Assessment, Planning and Monitoring Branch, OCHA  
 Annika Sandlund, Head of Partnership and Coordination Service, UNHCR  
 Daniel Hass, Humanitarian Affairs Officer, CERF Secretariat, OCHA  
 David Goetghebuer, Humanitarian Affairs Officer, Monitoring, OCHA  
 Françoise Ghorayeb, Senior Adviser Data in Emergencies, UNFPA  
 Gopal Mitra, Senior Social Affairs Officer, Disability Team, Executive Office of the UN Secretary-General  
 Jeffrey Labovitz, Director for the Department of Operations and Emergencies, IOM  
 Julie Belanger, Acting Chief, Pooled Fund Management Branch, formerly Head of Regional Office, West and Central Africa, OCHA  
 Julie Thompson, Humanitarian Affairs Officer (Financing), OCHA  
 Kostas Stylianos, Associate Inter-Agency Officer, UNHCR  
 Marcy Vigoda, Senior Humanitarian Adviser, OCHA  
 Maria Lilian Barajas Calle, Humanitarian Affairs Officer, Coordination Branch, OCHA  
 Marina Skuric-Prodanovic, Chair of GCC; Chief, System-wide Approaches and Practices Section, OCHA  
 Mark Lowcock, Former Emergency Relief Coordinator, OCHA  
 Michael Jensen, Chief, CERF secretariat, OCHA  
 Mike Ryan, Executive Director, WHO Health Emergencies Programme, WHO  
 Nicolas Rost, Head of Programme Unit and Rapid Response Lead, CERF Secretariat, OCHA  
 Rachel Maher, AAP Focal Point, OCHA  
 Reena Ghelani, Chair of the EDG and Director, OCHA Operations and Advocacy Division, OCHA  
 Rein Andre Paulsen, FAO, Director, Office of Emergencies and Resilience (formerly Head, OCHA Coordination Division, GVA, OCHA)  
 Ruth Hill, Lead Economist, Global Unit of the Poverty and Equity Global Practice, World Bank  
 Sarah Telford, Lead, Centre for Humanitarian Data, OCHA  
 Stephen O'Malley, Director, Peer to Peer Support Project (formerly Head, COVID-19 Policy Team), OCHA  
 Valerie Guarnieri, Assistant Executive Director, WFP Programme and Policy Department, Co-Chair of the IASC OPAG  
 Violet Kakyoma, Resident Coordinator/Humanitarian Coordinator, Chad, UN  
 Yasser Baki, Head, COVID-19 Policy Team, OCHA (formerly ERC Chief of Staff), OCHA

### Donors

Anders Nordstrom, Ambassador for Global Health, UN Policy Department, Ministry for Foreign Affairs, Sweden

Andri-van Mens, First Secretary Humanitarian Affairs, Permanent Representation of the Netherlands to the United Nations

Dylan Winder, Humanitarian Counsellor, UK Mission to UN, FCDO

Jeremy Konyndyk, Executive Director, COVID-19 Task Force Office of the Administrator for International Development, USAID (member of the WHO high-level Independent Oversight and Advisory Committee)

Matt Sudders, Group Head, CHASE, FCDO

#### **Other**

Christian Els, Data Chief, Ground Truth Solutions

Farhad Movahed, Humanitarian Affairs Officer, IASC Secretariat, IASC

Glyn Taylor, Team Leader, Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, Humanitarian Outcomes

Joanne Liu, Professor of Medicine at the University of Montreal Clinical Medicine at McGill University

Meg Sattler, Director, Ground Truth Solutions

Meltem Aram, Founding Director, Development Analytics

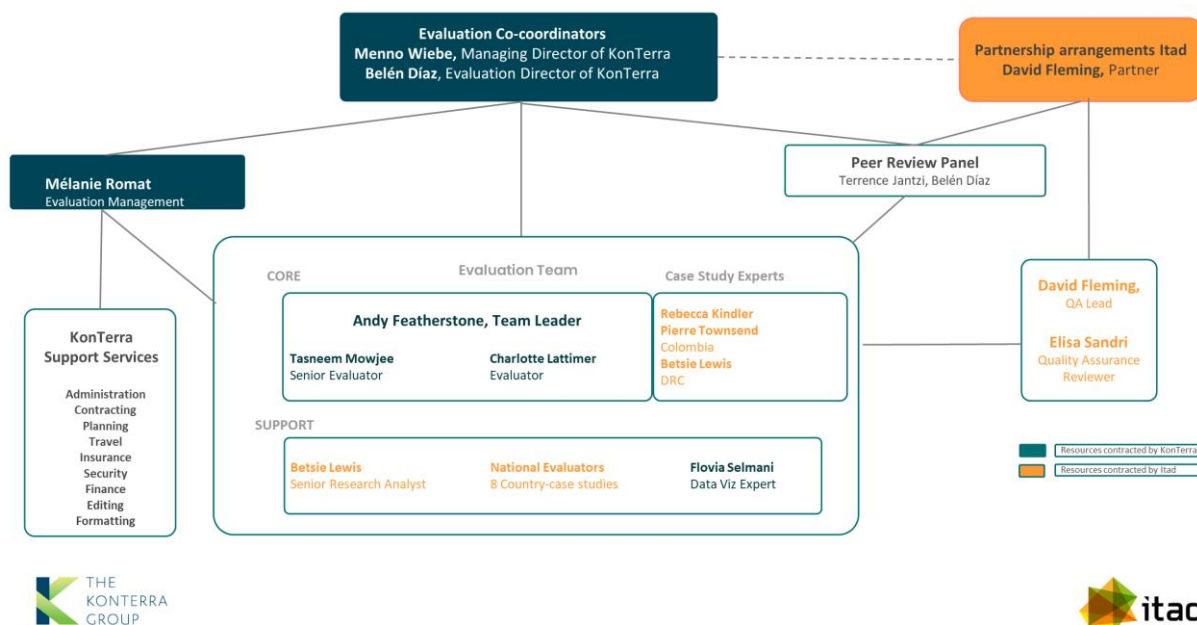
Pascale Meige, Director, Disaster and Crisis Prevention, Response and Recovery Department, IFRC

Smruti Patel, Founder, Global Mentoring Initiative

Ted Freeman, Team Leader, System Wide Evaluation, Consultant

## Annex 3: Team organogram, roles and responsibilities

This annex outlines the structure of the evaluation team and provides an overview of its roles and responsibilities



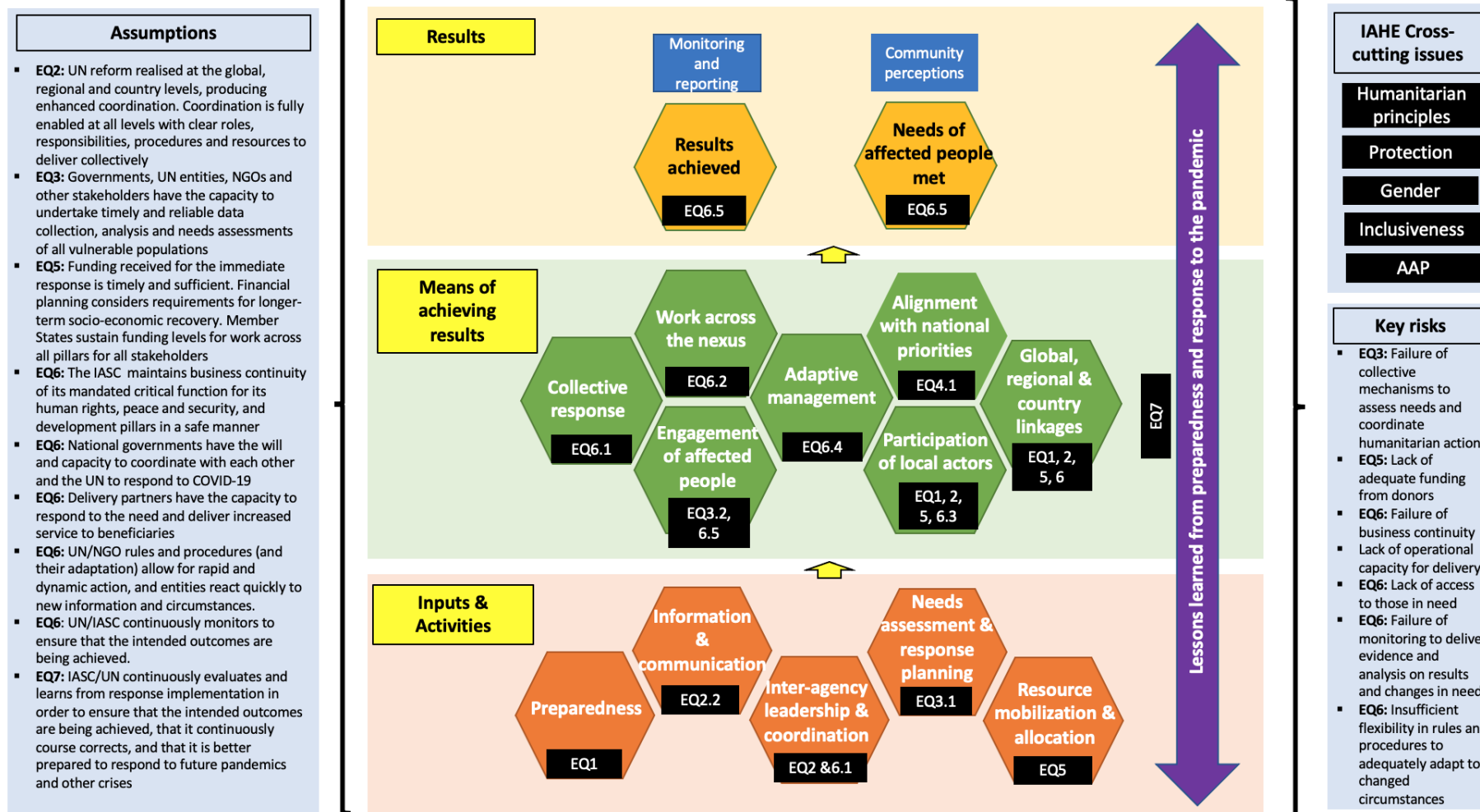
The table below describes roles and responsibilities for each team member in the evaluation team.

Team member and role	Responsibilities
Andy Featherstone [Team leader]	<ul style="list-style-type: none"> <li>Leading the detailed design of the evaluation and setting out the methodology and approach in the Inception Report.</li> <li>Allocating areas of work to team members and guiding them in implementation.</li> <li>Overseeing the data collection and analysis, and the production of the Learning Papers.</li> <li>Responsible for the end of pilot phase and data collection phase presentations.</li> <li>Participating in three country case studies.</li> <li>Leading the drafting of the report and consolidating the inputs of team members.</li> <li>Representing the evaluation team on technical matters in meetings with the evaluation MG and other forums, and leading on presenting evaluation findings.</li> <li>Coordinating and leading on all deliverables.</li> </ul>
Tasneem Mowjee [Senior evaluator]	<ul style="list-style-type: none"> <li>Supporting the team in the development of methodology and analysis.</li> <li>Technical support on methodology, data collection and analysis.</li> <li>Inputting into the development of deliverables as requested by the Team Leader.</li> <li>Participating in three country case studies.</li> <li>Providing subject matter expertise to other country case studies.</li> </ul>
Charlotte Lattimer [Evaluator]	<ul style="list-style-type: none"> <li>Supporting the team in the development of methodology and analysis.</li> <li>Technical support on methodology, data collection and analysis.</li> <li>Inputting into the development of deliverables as requested by the Team Leader.</li> <li>Leading on the GHRP Learning Paper.</li> <li>Participating in three country case studies.</li> <li>Providing subject matter expertise to other country case studies.</li> </ul>

<p>Rebecca Kindler Pierre Townsend [Case Study Experts]</p>	<p>Participating in one country case study. Input into the development of deliverables as requested by the Team Leader.</p>
<p>Betsie Lewis [Senior Researcher + Case Study Expert]</p>	<p>Supporting the team in the development of methodology and analysis. Technical support on methodology, data collection and analysis. Inputting into the development of deliverables as requested by the Team Leader. Leading on the evaluation review. Participating in one country case study. Coordinating the recruitment and support for the national consultants. Providing subject matter expertise to other country case studies as required.</p>
<p>Flovia Selmani [Data analyst]</p>	<p>Provision of data analysis for the evaluation team, including specific support for the Learning Papers, the inception report and final evaluation report. Provision of context analysis prior to country case studies and for country presentations. Support for analysis and manipulation of the data shared with the evaluation by Ground Truth Solutions. Support for analysis and data visualization for the Aid Worker Survey. Responsible for data visualization for all evaluation outputs.</p>
<p>David Fleming [QA]</p>	<p>Ensuring that evaluation deliverables meet KonTerra/Itad and UNEG quality standards. Supporting the Team Leader and Project Director with embedding quality throughout all evaluation processes. Supporting the evaluation team in inception, where needed, on finalising the evaluation approach and methodology.</p>
<p>Belén Díaz [Project director]</p>	<p>Having ultimate responsibility for the project, ensuring that it is delivered on time, on budget, and to the expected high quality. This will involve close liaison with the Team Leader to resolve any complex technical issues, in addition to acting as the client contact for the highest-level queries (and escalation) on project delivery and performance. Overseeing all contractual and scheduling matters for the evaluation, working in close coordination with the Project Manager and Team Leader. Assuring the robustness of the methodologies used and the quality of all outputs and deliverables. Working closely with the Team Leader and Project Manager to feedback any quality issues as early as possible to ensure the project progresses to the expected high quality. This will also involve ensuring quality control advice is acted upon in a timely manner.</p>
<p>Mélanie Romat [Project Manager]</p>	<p>Reporting to Itad’s Project Director to ensure the project it is delivered on time, on budget, and to the expected high quality. Leading on the day-to-day management of the project, including actively monitoring progress. Providing logistical support as required to support the Team Leader in the efficient and effective management.</p>

## Annex 4. Conceptual framework

Presented below is the conceptual framework for the evaluation. The conceptual framework will be used to guide the preparation of evaluation outputs including the case study country presentations and the Main Evaluation Report.





## Annex 5: Evaluation Matrix

Presented below is the evaluation framework, consisting of evaluation questions, indicators, data sources, key assumptions and evaluation criteria.

Evaluation questions	Indicators	Data sources	Assumptions	DAC Criteria
<b>1. Preparedness</b>				
1.1 To what extent were the collective preparedness measures put in place by the IASC prior to the pandemic relevant and adapted to the COVID-19 pandemic?	<ul style="list-style-type: none"> <li>Evidence that measures included infection disease/pandemic scenarios</li> <li>Evidence that measures were designed for a multi-country crisis</li> <li>Ways in which preparedness measures were adapted, at global and country level</li> <li>Ways in which IASC preparedness measures took account of national and local capacities and leadership for preparedness</li> <li>Extent to which measures were designed for situations of restricted movement of aid workers/access to affected populations</li> </ul>	<ul style="list-style-type: none"> <li>Document review of IASC collective preparedness measures</li> <li>Global KIIs with OPAG, EDG</li> <li>Country-level KIIs with OCHA staff, IASC member agencies, HCTs, host country governments</li> </ul>		Relevance
1.2 To what extent did the IASC's preparedness measures in targeted GHRP countries after Scale-Up declaration contribute to more timely and relevant humanitarian response?	<ul style="list-style-type: none"> <li>Evidence that IASC member agencies and partners undertook Advanced Preparedness Measures and contingency planning in response to COVID-19</li> <li>Evidence that measures contributed to a timely response</li> <li>Ways in which measures helped to design a response relevant to the needs of affected populations</li> <li>Ways in which measures helped to design a response tailored to the specific needs of vulnerable groups (women and girls, older persons, persons with disabilities)</li> <li>Evidence that measures could be adapted as the situation evolved.</li> </ul>	<ul style="list-style-type: none"> <li>Document review of global (GHRP) and country level risk analyses, contingency planning, preparedness exercise documents</li> <li>Global KIIs with GHRP stakeholders</li> <li>Country-level KIIs with RC/HCs, HCT members, OCHA staff, cluster coordinators, host country governments</li> </ul>		Effectiveness
<b>2. Coordination and information management</b>				
2.1 To what extent was the IASC response coherent and well-coordinated in its delivery of the response to a multi-dimensional crisis?	<ul style="list-style-type: none"> <li>Extent to which coordination mechanisms aligned with IASC policies</li> <li>Global and country level mechanisms for IASC members to coordinate response efforts met regularly and were consistent</li> <li>Coordination mechanisms were based on clear roles, responsibilities, procedures and adequate resources</li> <li>Evidence of national and local actor participation in coordination mechanisms</li> <li>IASC response was coordinated with development actors and government</li> </ul>	<ul style="list-style-type: none"> <li>Review of relevant IASC policies, documents on coordination mechanisms</li> <li>Global KIIs with OPAG, EDG, cluster coordinators</li> <li>Country-level KIIs with RC/HCs, HCTs, development actors, OCHA staff, cluster coordinators, government entities and national/local actors</li> <li>Aid worker survey</li> </ul>	UN reform is fully realized at the global, regional and country levels, producing enhanced coordination across the UN system. Coordination is fully enabled at all levels with clear roles, responsibilities,	Coherence, Coordination

Evaluation questions	Indicators	Data sources	Assumptions	DAC Criteria
	<ul style="list-style-type: none"> <li>• Coordination mechanisms promoted coherent response across sectors</li> <li>• Identification of factors influencing the effectiveness of coordination mechanisms</li> </ul>		procedures and resources to deliver as one	
2.2 To what extent have inter-agency information management and communication mechanisms been able to support IASC collective decision-making?	<ul style="list-style-type: none"> <li>• Types, regularity and quality of information management and communication mechanisms used by IASC decision-makers (global and country level)</li> <li>• Perception of IASC decision-makers that existing information management and communication mechanisms were appropriate and useful for the pandemic response</li> <li>• Extent to which other information management mechanisms informed IASC collective decision-making</li> </ul>	<ul style="list-style-type: none"> <li>• Document review of IASC meeting minutes, inter-agency and communication mechanisms</li> <li>• Global KIIs with IASC principals, EDG</li> <li>• Country-level KIIs with RC/HCs, HCT members, OCHA staff, information management officers</li> </ul>		Connectedness, coordination
3. Needs assessment and analysis				
3.1 To what extent were country humanitarian plans and response strategies for the pandemic informed by a systematic and comprehensive identification of affected people's needs?	<ul style="list-style-type: none"> <li>• Needs assessments conducted were timely and systematic</li> <li>• Existence of age- and gender-disaggregated data on humanitarian needs</li> <li>• Needs assessments identified specific needs of women and girls, persons with disabilities, older people, marginalized groups, displaced populations, and other potentially vulnerable population groups</li> <li>• Introduction/existence of innovative and effective approaches to needs assessment which took into account access restrictions and aligned with the (evolving) characteristics of the pandemic</li> <li>• Country humanitarian plans and response strategies based on needs assessment data and analysis</li> <li>• Country humanitarian plans and response strategies respond to different needs of segments of affected populations.</li> <li>• Country humanitarian plans identified and addressed protection risks, particularly for the most vulnerable groups</li> </ul>	<ul style="list-style-type: none"> <li>• Document review of needs assessments and country humanitarian plans</li> <li>• Country-level KIIs with IASC members, cluster coordinators, local actors, needs assessment organizations</li> </ul>	Governments, UN entities, NGOs and other stakeholders have the capacity to undertake timely and reliable data collection, analysis (including health surveillance) and needs assessments of all vulnerable populations	Relevance
3.2 To what extent were assessments of humanitarian needs conducted in consultation with affected populations?	<ul style="list-style-type: none"> <li>• Needs assessments demonstrate consideration of, and consultation with, affected people, including different segments of the affected population</li> <li>• Limitations to participation and inclusion of affected people in needs assessment were addressed</li> </ul>	<ul style="list-style-type: none"> <li>• Document review of needs assessments</li> <li>• Data from collective feedback mechanisms (where available)</li> <li>• Global KIIs with needs assessment organizations, cluster coordinators</li> </ul>		

Evaluation questions	Indicators	Data sources	Assumptions	DAC Criteria
	<ul style="list-style-type: none"> <li>Existence of procedures/processes for beneficiary feedback on changing needs and evidence that the response took account of feedback.</li> </ul>	<ul style="list-style-type: none"> <li>Country level KIIs with needs assessment organizations, IASC members, cluster coordinators</li> <li>Secondary data on community perceptions (where available)</li> <li>FGDs with affected population</li> </ul>		
4. Strategic planning				
4.1 To what extent did the IASC's collective global, regional and country-level humanitarian response planning and prioritization correspond to the national priorities of affected countries?	<ul style="list-style-type: none"> <li>Extent to which GHRP and regional and country-level humanitarian response plans reflect affected country priorities</li> <li>Types of mechanisms used in global, regional and country-level humanitarian planning and prioritization processes to include and align with national priorities</li> <li>Evidence that IASC response planning was adapted to evolving government priorities</li> </ul>	<ul style="list-style-type: none"> <li>Document review of humanitarian response plans, national plans</li> <li>Global KIIs with GHRP stakeholders, including OCHA</li> <li>Regional/country-level KIIs with OCHA, UNHCR, RC/HCs, HCT members, cluster coordinators and host country government</li> </ul>		Relevance
5. Resource mobilization and allocation				
5.1 To what extent were the IASC's efforts successful in mobilizing adequate, timely and flexible funding to meet the GHRP requirements?	<ul style="list-style-type: none"> <li>Amount of funds raised against GHRP appeal</li> <li>Level of un-earmarked funds raised</li> <li>Timing of donor commitments and disbursement to GHRP appeal</li> <li>Types of fundraising approaches used</li> <li>Use of internal IASC agency funding approaches and instruments to provide adequate and timely funding</li> <li>GHRP process and country level response plans take account of resource mobilization efforts for longer-term socio-economic recovery</li> <li>Factors influencing donor decisions to contribute to GHRP appeal</li> <li>Extent of donor engagement in GHRP planning</li> </ul>	<ul style="list-style-type: none"> <li>Financial data analysis</li> <li>Global KIIs with donors, IASC members' resource mobilization personnel, ERC</li> <li>Country-level KIIs with RC/HCs, HCTs, INGOs, national NGOs</li> </ul>	Funding received for the immediate response is timely and sufficient. Financial planning considers requirements for longer-term socio-economic recovery. Member States sustain funding levels to the UN for work across all pillars, and increased funding from a multi-stakeholder pool will be available	Efficiency
5.2 To what extent did pooled funds contribute to the provision of adequate, timely and flexible funding to meet the GHRP requirements?	<ul style="list-style-type: none"> <li>Amount of funding from CERF and CBPFs against GHRP requirements</li> <li>Level of increase in donor funding to pooled funds to support the COVID-19 response</li> <li>Timing of pooled fund allocations and disbursements to COVID-19 response</li> <li>Ways in which CERF and CBPFs provided funding flexibility to recipient organizations</li> </ul>	<ul style="list-style-type: none"> <li>Financial data analysis</li> <li>Global KIIs with CERF and CBPF staff, ERC, CERF recipient agencies</li> <li>Country-level KIIs with CBPF staff, RC/HCs, CERF and CBPF funding recipients (including local actors)</li> <li>Document review of pooled fund allocation documents and guidance</li> </ul>		Efficiency

Evaluation questions	Indicators	Data sources	Assumptions	DAC Criteria
<p>5.3 To what extent did IASC allocation strategies, mechanisms, and decision-making processes facilitate the efficient use of available resources to meet response objectives, including by channelling resources to frontline responders (international and local/national NGOs and civil-society organizations (CSOs))?</p>	<ul style="list-style-type: none"> <li>• Types of prioritization and decision-making processes in place to make efficient use of resources</li> <li>• Degree of alignment between allocation of resources and response objectives</li> <li>• Time of resource allocation, including to frontline responders</li> <li>• Efforts made to allocate resources to actors best placed to achieve response objectives</li> <li>• Extent to which IASC allocation strategies prioritized funding to frontline responders</li> <li>• Types of mechanisms in place for channelling resources to frontline responders</li> <li>• Level of funding from IASC mechanisms to I/NNGOs and CSOs</li> <li>• Level of flexibility of funding channelled to frontline responders</li> </ul>	<ul style="list-style-type: none"> <li>• Financial data analysis</li> <li>• Global KIIs with ERC, donors, UN agencies, CBPF staff, Red Cross Movement</li> <li>• Country-level KIIs with RC/HCs, donors, I/NNGOs and CSOs, Red Cross Movement, cluster coordinators, CBPF staff, government representatives</li> <li>• Review of decision-making and resource allocation documents, CBPF allocation strategies</li> </ul>		<p>Efficiency</p>
<p>6. Implementation and monitoring</p>				
<p>6.1 Collective response mechanisms</p>				
<p>6.1.1 What was the added value of collective mechanisms to the planning and implementation of the response?</p>	<ul style="list-style-type: none"> <li>• Ways in which collective needs assessments delivered benefits</li> <li>• Evidence that collective planning processes were inclusive</li> <li>• Examples of how coordination mechanisms ensured better coverage of assistance and avoided duplication</li> <li>• Ways in which collective mechanisms for accountability and PSEA delivered benefits for affected population during the COVID response</li> <li>• Ways in which collective mechanisms on risk management and access improved efficiency during the COVID response</li> </ul>	<ul style="list-style-type: none"> <li>• Review documents on IASC collective mechanisms at global and country level</li> <li>• Global KIIs with EDG, cluster coordinators, needs assessment organizations</li> <li>• Country-level KIIs with RC/HCs, HCTs, cluster coordinators, entities managing collective accountability/PSEA mechanisms, I/NNGOs</li> <li>• Data from collective feedback mechanisms (where available)</li> <li>• FGDs with affected population</li> </ul>		<p>Effectiveness</p>
<p>6.1.2 To what extent were the global IASC strategy and Scale-Up mechanisms effective in ensuring IASC country teams' capacity to lead, coordinate and deliver</p>	<ul style="list-style-type: none"> <li>• Perception of IASC country teams that global IASC strategy and Scale-Up mechanisms supported leadership of response</li> <li>• Degree of alignment between global IASC strategy and Scale-Up mechanisms and country-level humanitarian coordination and delivery mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>• Review of documents relating to IASC global strategy and Scale-Up mechanisms</li> <li>• Global KIIs with EDG</li> </ul>		<p>Effectiveness</p>

Evaluation questions	Indicators	Data sources	Assumptions	DAC Criteria
humanitarian assistance in targeted countries?	<ul style="list-style-type: none"> <li>Extent to which activation of global IASC strategy and scale-up mechanisms upheld underlying humanitarian principles, the core protection principles, the do no harm principle, as well as good practice on national/localized response, AAP, gender equality, humanitarian-peace-development collaboration, coordination, quality funding and cross-sector collaboration</li> </ul>	<ul style="list-style-type: none"> <li>Country-level KIIs with RC/HCs, HCT members, cluster coordinators</li> </ul>		
6.2 Humanitarian-development-peace nexus				
6.2.1 To what extent were the IASC humanitarian policies, strategies, and responses to COVID- 19 consistent and complementary with the health and social economic responses by United Nations and other actors?	<ul style="list-style-type: none"> <li>Alignment and complementarity between IASC humanitarian policies and strategies, and national health and social economic response plans and strategies</li> <li>Examples of consistency and complementarity between humanitarian and health and social economic programming,</li> <li>Extent to which the IASC policies, strategies and responses were aligned with the broader social and economic responses contained in the UNDAF/UNSDCF</li> <li>Factors facilitating/hindering consistency and complementarity between humanitarian, health and social economic responses</li> </ul>	<ul style="list-style-type: none"> <li>Document review of evaluations, HRP, health and social economic response plans (including UNDAF/UNSDCF), IASC policies</li> <li>Global KIIs with ERC, OPAG, EDG, donors, WHO, UNDP</li> <li>Country-level KIIs with RC/HCs, HCTs, WHO, UNDP and other UN agencies delivering social economic response, host country governments</li> </ul>	The UN/IASC is able to maintain business continuity of its mandated critical function for its human rights, peace and security, and development pillars in a safe manner	Coherence, connectedness
6.2.2 To what extent did the collective humanitarian response to the pandemic contribute to the overall objectives of the SG’s call for solidarity to address the impact of the multi-dimensional crises?	<ul style="list-style-type: none"> <li>Perceptions of the contribution of the GHRP response to the SG’s call for solidarity to address the impact of the multi-dimensional crisis</li> <li>Efforts made to provide assistance across sectors and across the humanitarian-development-peace nexus</li> <li>Factors facilitating achievement of objectives</li> <li>Challenges with achieving objectives</li> </ul>	<ul style="list-style-type: none"> <li>Review of results reporting, document review of evaluations</li> <li>Global KIIs with GHRP stakeholders, EDG, SWE evaluation team</li> <li>Country-level KIIs with RC/HCs, HCTs, cluster coordinators, development actors</li> </ul>		Effectiveness
6.2.3 To what extent were there linkages and synergies in COVID-19-related responses across the humanitarian-development-peace nexus aimed at addressing the intertwined effects of the pandemic?	<ul style="list-style-type: none"> <li>Efforts to identify intertwined effects of the pandemic</li> <li>Efforts to establish common objectives and strategies to address pandemic effects through joint planning and priority setting</li> <li>Efforts by humanitarian, development and peace actors to ensure synergies when planning the COVID-19 response</li> <li>Extent to which mechanisms for coordinating the response of humanitarian, development and peace actors existed and were used</li> <li>Examples of synergies in the humanitarian-development-peace response</li> </ul>	<ul style="list-style-type: none"> <li>Review of planning documents, evaluations, lessons learned exercises</li> <li>Global level KIIs with ERC, SWE evaluation team, UNDP, DPPA</li> <li>Country-level KIIs with RC/HCs, HCTs, host country government, development and peace actors, cluster coordinators</li> </ul>		Coherence, connectedness
6.3 Localization				

Evaluation questions	Indicators	Data sources	Assumptions	DAC Criteria
<p>6.3.1 To what extent did international humanitarian preparedness and response to COVID-19 complement and empower national and local actors in their efforts and leadership to address COVID-19-related humanitarian needs?</p>	<ul style="list-style-type: none"> <li>• Evidence that national/local actors participated in international preparedness and planning processes</li> <li>• Evidence that national/local actors led or were involved in needs assessments used to inform humanitarian response plans and priorities</li> <li>• Evidence that national/local actors were involved in (or led) response coordination mechanisms</li> <li>• Increase in amount of assistance that national/local NGOs and CBOs delivered to communities</li> <li>• Evidence that government entities led COVID-19 response (including planning)</li> <li>• Evidence that international actors identified national/local response efforts and how to complement them in planning and implementation</li> <li>• Ways in which international actors sought to enhance involvement, and build capacity, of national and local actors as part of the COVID-19 response.</li> </ul>	<ul style="list-style-type: none"> <li>• Document review of preparedness plans, HRPs, needs assessments</li> <li>• Global KIIs with INGOs and UN agencies</li> <li>• Country-level KIIs with RC/HCs, HCTs, cluster coordinators, host country government, NNGOs</li> </ul>	<p>National governments have the will and capacity to coordinate with each other and the UN to respond to COVID-19:</p> <p>Delivery partners (including community-based organizations and NGOs) have the capacity to respond to the need and deliver increased service to beneficiaries, despite COVID-19 conditions</p>	<p>Connectedness</p>
<p>6.3.2 How effectively did IASC collective mechanisms for planning and implementing the response ensure local participation?</p>	<ul style="list-style-type: none"> <li>• Level of local actor participation in clusters or other humanitarian coordination mechanisms</li> <li>• Ways in which clusters and HCTs have ensured local participation in HRPs or other planning processes</li> <li>• Ways in which clusters and HCTs have ensured local participation in coordination and decision-making fora</li> <li>• Existence of significant examples of local participation contributing to the quality of planning.</li> <li>• Extent of local participation in collective mechanisms for AAP and PSEA</li> <li>• Perception of local actors of the quality of their participation in collective mechanisms for planning and implementing the COVID-19 response</li> </ul>	<ul style="list-style-type: none"> <li>• Review of HRPs/planning documents, cluster and HCT documents</li> <li>• Country-level KIIs with HCTs, OCHA staff, cluster coordinators, entities host country government, NNGOs</li> <li>• Aid worker survey</li> </ul>		<p>Effectiveness</p>

Evaluation questions	Indicators	Data sources	Assumptions	DAC Criteria
6.4 Adaptive capacity				
6.4.1 To what extent did the IASC's collective response prove relevant and adaptive in meeting the demands of the crisis and the humanitarian needs caused by it?	<ul style="list-style-type: none"> <li>Extent and ways in which the IASC's collective decision-making, processes and methodologies adapted and evolved in response to the trajectory of the crisis</li> <li>Extent and ways in which IASC's fast-track mechanisms adapted and evolved in response to the trajectory of the crisis</li> <li>Examples of UN rules and procedures being flexible and adapted to new information and changes in context</li> <li>Ways in which IASC approaches to providing assistance adapted and evolved in response to the specific challenges posed by the pandemic</li> <li>Extent and ways in which the collective response adapted to the identified specific needs of women and girls, persons with disabilities, older people, marginalized groups, displaced populations, and other potentially vulnerable population groups</li> <li>Examples of the way in which the efficiency and effectiveness of the response improved through adaptive measures</li> </ul>	<ul style="list-style-type: none"> <li>Review of documents relating to IASC decision-making, processes and fast-tracked mechanisms</li> <li>Global KIIs with IASC Principals, EDG</li> <li>Country-level KIIs with HCTs, IASC members, CBPF staff, cluster coordinators</li> </ul>	UN rules and procedures (and their adaptation) allow for rapid and dynamic action, and entities are able to react quickly to new information and circumstances.	Relevance
6.4.2 How effective was the IASC's monitoring framework for the COVID-19 response in supporting operational and strategic decision-making?	<ul style="list-style-type: none"> <li>Availability of monitoring data against intended results</li> <li>Perceptions of operational and strategic decision-makers of the relevance of monitoring data</li> <li>Evidence that operational and strategic decision-makers had timely access to monitoring data</li> <li>Evidence that operational and strategic decision-making based on IASC monitoring data</li> <li>Availability of disaggregated monitoring data on different population groups</li> <li>Examples of monitoring data being used to adjust, improve and refine operations.</li> <li>Evidence of participation of affected people in monitoring of the COVID-19 response</li> </ul>	<ul style="list-style-type: none"> <li>Review of monitoring framework data</li> <li>Review of operational and strategic decisions made</li> <li>Global KIIs with EDG</li> <li>Country-level KIIs with RC/HCs, HCTs, IASC members, cluster coordinators</li> <li>FGDs with affected populations</li> </ul>	UN/IASC continuously monitors to ensure that the intended outcomes are being achieved.	Effectiveness
6.5 Results				
6.5.1 To what extent did the IASC's collective response to the pandemic meet the humanitarian needs of affected people adequately	<ul style="list-style-type: none"> <li>Level of assistance delivered against needs identified</li> <li>Number of people reached with assistance against number of people targeted</li> </ul>	<ul style="list-style-type: none"> <li>Review of needs assessments, results reported against GHRP/HRP/other response plans, cluster results reporting, evaluations</li> </ul>	The collective nature of the response added value in providing assistance to meet	Coverage Impact

Evaluation questions	Indicators	Data sources	Assumptions	DAC Criteria
and effectively, both overall and vis-à-vis specific vulnerable groups?	<ul style="list-style-type: none"> <li>Evidence that assistance was targeted to address the different needs of women and girls, older persons, persons with disabilities, displaced populations and other potentially vulnerable groups</li> <li>Availability of disaggregated data on assistance provided to different segments of the affected population</li> <li>Extent to which assistance provided met minimum standards and upheld humanitarian principles</li> <li>Prioritization of protection within the collective response</li> <li>Affected population views on timeliness, relevance and adequacy of assistance received</li> <li>Level of consistency of the response over time</li> <li>Evidence of that assistance provided had positive results for affected populations</li> <li>Identification of any negative consequences of the response</li> <li>Evidence that the humanitarian needs were aligned/coordinated with longer term development needs to ensure smooth transitioning of beneficiaries where necessary</li> </ul>	<ul style="list-style-type: none"> <li>Country-level KIIs with RC/HCs, cluster coordinators, OCHA staff, IASC members, frontline responders, including local actors</li> <li>FGDs with affected populations</li> <li>Secondary data on views of affected populations about COVID-19 response (where available)</li> <li>Data from collective feedback mechanisms (where available)</li> </ul>	the needs of affected population.	
<b>7. Lessons learned</b>				
7.1 What are the main challenges and lessons learned from preparedness and response to the pandemic?	<ul style="list-style-type: none"> <li>Evidence that results of evaluations and lessons learned exercises of preparedness and response used to course correct</li> <li>Identification of challenges with coordination, processes, procedures</li> <li>Factors contributing to effective preparedness activities</li> <li>Factors that hampered preparedness activities</li> <li>Challenges that IASC members faced in responding to the pandemic</li> <li>Ways in which IASC members addressed challenges with the response</li> <li>Factors contributing to effective pandemic response</li> </ul>	<ul style="list-style-type: none"> <li>Review of reports, evaluations and lessons learned exercise documents</li> <li>Global KIIs with ERC, OPAG, EDG, donors</li> <li>Country-level KIIs with RC/HCs, HCTs, IASC members, cluster coordinators, host country government, NNGOs</li> <li>Aid worker survey</li> </ul>	IASC/UN continuously evaluates and learns from response implementation in order to ensure that the intended outcomes are being achieved, that it	Lessons learned
7.2 What are the key strategic and policy challenges and opportunities for improving the IASC's future responses to pandemics and other infectious disease events with multi-country humanitarian impacts?	<ul style="list-style-type: none"> <li>Strategic and policy challenges that prevented lessons from Ebola crisis being incorporated into preparedness measures</li> <li>Evidence that lessons from pandemic response are being incorporated into IASC policies and strategies</li> <li>Identification of opportunities to improve response to future pandemics and other infectious disease events with multi-country humanitarian impacts</li> </ul>	<ul style="list-style-type: none"> <li>Document review of evaluations and lessons learned exercises</li> <li>Global KIIs with ERC, OPAG, donors</li> <li>Country-level KIIs with RC/HCs, HCTs, IASC members</li> </ul>	continuously course corrects, and that it is better prepared to respond to future pandemics and other crises	Lessons learned



Evaluation questions	Indicators	Data sources	Assumptions	DAC Criteria
	<ul style="list-style-type: none"> <li>Evidence that mechanisms and resources are in place to deliver changes at strategic and policy level</li> </ul>			
<p>7.3 What were the innovative approaches, solutions, and new ways of working that would benefit ongoing or future responses, in particular those from local actors?</p>	<ul style="list-style-type: none"> <li>International actors adopted innovative approaches and solutions and new ways of working involving local actors</li> <li>Local actors developed innovative approaches and solutions and new ways of working</li> <li>Examples of improvements brought about by innovative approaches, solutions and new ways of working</li> <li>Extent to which innovative approaches and new ways of working are relevant beyond the COVID-19 response</li> </ul>	<ul style="list-style-type: none"> <li>Document review of evaluations and reviews that identify innovative approaches and ways of working</li> <li>KIIs with EDG, CERF secretariat</li> <li>Country-level KIIs with HCTs, CBPF staff, IASC members, cluster coordinators, host country government, NNGOs</li> </ul>		<p>Lessons learned</p>
<p>7.4 What are the key lessons from COVID-19 response that can strengthen humanitarian-development-peace nexus approaches in the future?</p>	<ul style="list-style-type: none"> <li>Good practice examples of working across the humanitarian-development-peace nexus</li> <li>Challenges with existing mechanisms for collaboration across the humanitarian-development-peace nexus</li> <li>Factors contributing to the success or failure of collaboration across the humanitarian-development-peace nexus</li> </ul>	<ul style="list-style-type: none"> <li>Document review of evaluations and lessons learned exercises</li> <li>Country-level KIIs with RC/HCs, HCTs, host country government, development and peace actors, cluster coordinators, SWE evaluation team</li> </ul>		<p>Lessons learned</p>

## Annex 6: Defining the scope of the evaluation

The table below is a mapping of the three international COVID-19 frameworks and provides a nominal indication of what is within the scope of the IAHE

Outside scope of IAHE	Within the scope of the IAHE			Outside scope of IAHE
SPRP beyond scope of GHRP	SPRP	GHRP Strategic priorities/specific objectives	SERP	SERP beyond scope of GHRP
	SPRP/GHRP Objectives Overlap		SERP/GHRP Objectives Overlap	
<b>GHRP Strategic Priority 1. Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality</b>				
<b>A. Rapidly establishing international coordination and operational support</b> - Partner coordination (GOARN, technical experts/research networks, financial partners)	<b>A. Rapidly establishing international coordination and operational support</b> - Partner coordination (inc. humanitarian coordination by UN and partners) - Epidemiological analysis and forecasting - Risk communication and managing the infodemic  <b>B. Scaling up country readiness and response operations</b> - Country coordination (inc. clusters) - RCCE	<b>1.1 Prepare and be ready:</b> prepare populations for measures to decrease risks, and protect vulnerable groups, including older people and those with underlying health conditions, as well as health services and systems	<b>1. Health First: Protecting health services and systems</b> - Programme implementation and technical support (inc. capacity-building, joint programming, support for disability-inclusive response, field-based health care in some conflict settings) - Support on tracking and reaching vulnerable populations  <b>5. Social cohesion and community resilience</b> - Inclusive social dialogue, advocacy, and political engagement - Empower community resilience, participation, and equitable service delivery	
<b>A. Rapidly establishing international coordination and operational support</b> - Laboratory and diagnostics (global diagnostic capacity)	<b>A. Rapidly establishing international coordination and operational support</b> - Laboratory and diagnostics (partial overlap on WHO support for test availability in regions and countries) - Technical expertise and guidance  <b>B. Scaling up country readiness and response operations</b> - Surveillance - Points of entry - Rapid response teams - Infection prevention and control	<b>1.2 Detect and test all suspect cases:</b> detect through surveillance and laboratory testing and improve the understanding of COVID-19 epidemiology	<b>1. Health First: Protecting health services and systems</b> - Analytical and policy support, and rapid technical guidance	
	<b>A. Rapidly establishing international coordination and operational support</b>	<b>1.3 Prevent, suppress and interrupt transmission:</b> slow, suppress and stop virus transmission to reduce	<b>1. Health First: Protecting health services and systems</b>	

	<ul style="list-style-type: none"> <li>- Technical expertise and guidance</li> </ul> <p><b>B. Scaling up country readiness and response operations</b></p> <ul style="list-style-type: none"> <li>- Country coordination (inc. clusters)</li> <li>- RCCE</li> <li>- Surveillance</li> <li>- Points of entry</li> <li>- Rapid response teams</li> <li>- Infection prevention and control</li> </ul>	<p>the burden on health-care facilities, including isolation of cases, close contacts quarantine and self-monitoring, community-level social distancing, and the suspension of mass gatherings and international travel</p>	<ul style="list-style-type: none"> <li>- Analytical and policy support, and rapid technical guidance</li> </ul> <p><b>5. Social cohesion and community resilience</b></p> <ul style="list-style-type: none"> <li>- Inclusive social dialogue, advocacy, and political engagement</li> <li>- Empower community resilience, participation, and equitable service delivery</li> </ul>	
	<p><b>A. Rapidly establishing international coordination and operational support</b></p> <ul style="list-style-type: none"> <li>- Technical expertise and guidance</li> </ul> <p><b>B. Scaling up country readiness and response operations</b></p> <ul style="list-style-type: none"> <li>- Country coordination (inc. clusters)</li> <li>- RCCE</li> <li>- Rapid response teams</li> <li>- Case management and continuity of essential services</li> </ul>	<p><b>1.4 Provide safe and effective clinical care:</b> treat and care for individuals who are at the highest risk for poor outcomes and ensure that older patients, patients with comorbid conditions and other vulnerable people are prioritized, where possible</p>	<p><b>1. Health First: Protecting health services and systems</b></p> <ul style="list-style-type: none"> <li>- Programme implementation and technical support (inc. capacity-building, joint programming, support for disability-inclusive response, field-based health care in some conflict settings)</li> <li>- Support on tracking and reaching vulnerable populations</li> </ul> <p><b>5. Social cohesion and community resilience</b></p> <ul style="list-style-type: none"> <li>- Inclusive social dialogue, advocacy, and political engagement</li> <li>- Empower community resilience, participation, and equitable service delivery</li> </ul>	
<p><b>A. Rapidly establishing international coordination and operational support</b></p> <ul style="list-style-type: none"> <li>- Laboratory and diagnostics (global diagnostic capacity)</li> </ul> <p><b>C. Accelerating priority research and innovation</b></p> <ul style="list-style-type: none"> <li>- global research and innovation priority setting</li> </ul>	<p><b>A. Rapidly establishing international coordination and operational support</b></p> <ul style="list-style-type: none"> <li>- Laboratory and diagnostics (partial overlap on WHO support for test availability in regions and countries)</li> <li>- Technical expertise and guidance</li> </ul> <p><b>C. Accelerating priority research and innovation</b></p> <ul style="list-style-type: none"> <li>- global coordination of all stakeholders</li> <li>- common standards for clinical trials, specimen sharing, and data sharing</li> </ul>	<p><b>1.5 Learn, innovate and improve:</b> gain and share new knowledge about COVID-19 and develop and distribute new diagnostics, drugs and vaccines, learn from other countries, integrate new global knowledge to increase response effectiveness, and develop new diagnostics, drugs and vaccines to improve patient outcomes and survival</p>		

	<p><b>A. Rapidly establishing international coordination and operational support</b></p> <ul style="list-style-type: none"> <li>- Pandemic supply chain coordination (medical supply chain)</li> <li>- Travel and trade (advice)</li> </ul> <p><b>B. Scaling up country readiness and response operations</b></p> <ul style="list-style-type: none"> <li>- Logistics, procurement and supply management</li> </ul>	<p><b>1.6 Ensure essential health services and systems:</b> secure the continuity of the essential health services and related <b>supply chain</b> for the direct public health response to the pandemic as well as other essential health services</p>	<p><b>1. Health First: Protecting health services and systems</b></p> <ul style="list-style-type: none"> <li>- Analytical and policy support, and rapid technical guidance</li> <li>- Programme implementation and technical support (supply chain)</li> </ul>	
<p><b>GHRP Strategic Priority 2. Decrease the deterioration of human assets and rights, social cohesion and livelihoods</b></p>				
		<p><b>2.1 Preserve the ability of the most vulnerable and affected people to meet the additional food consumption and other basic needs</b> caused by the pandemic, through their productive activities and access to social safety nets and humanitarian assistance</p>	<p><b>2. Protecting people: Social protection and basic services</b></p> <ul style="list-style-type: none"> <li>- Scale up and expand resilient and pro-poor social protection systems</li> </ul> <p><b>3. Economic response and recovery</b></p> <ul style="list-style-type: none"> <li>- Integrated, country-specific policy advice and programme support (expansion of SSNs)</li> <li>- Scaling-up employment intensive programming (immediate employment schemes)</li> <li>- Support to young people and social partners in entrepreneurship and social innovation in response to COVID-19 (immediate)</li> <li>- Technical support to women micro and small entrepreneurs</li> <li>- E-commerce and digital solutions to allow secure access to services needed at the time of crisis, particularly by vulnerable groups</li> </ul> <p><b>5. Social cohesion and community resilience</b></p> <ul style="list-style-type: none"> <li>- Inclusive social dialogue, advocacy, and political engagement</li> <li>- Empower community resilience, participation, and equitable service delivery</li> </ul>	<p><b>3. Economic response and recovery</b></p> <ul style="list-style-type: none"> <li>- Integrated, country-specific policy advice and programme support (support to businesses to contain layoffs, support for boosting employment during recovery)</li> <li>- Scaling-up employment intensive programming (design gender-responsive fiscal stimulus packages)</li> <li>- Support to young people and social partners in entrepreneurship and social innovation in response to COVID-19 (longer-term)</li> <li>- Support on strategies to green fiscal stimulus packages</li> <li>- Rapid and gender-responsive socioeconomic assessments and labor market and business environment diagnostics</li> <li>- Advice on nature-based solutions for development, including for SMEs</li> <li>- Business linkages support</li> <li>- Investments to improve productivity and working conditions in micro and small firms</li> <li>- Technical support to women micro and small entrepreneurs</li> <li>- Digital payments support</li> </ul>

				- Assistance to address trade challenges and facilitating trade flows
	<p><b>B. Scaling up country readiness and response operations</b></p> <ul style="list-style-type: none"> <li>- Country coordination (inc. clusters)</li> <li>- RCCE</li> <li>- Case management and continuity of essential services (for other health services)</li> </ul>	<p><b>2.2 Ensure the continuity and safety from risks of infection of essential services</b> including health (immunization, HIV and tuberculosis care, reproductive health, psychosocial and mental health, gender-based violence services), water and sanitation, food supply, nutrition, protection, and education for the population groups most exposed and vulnerable to the pandemic</p>	<p><b>2. Protecting people: Social protection and basic services</b></p> <ul style="list-style-type: none"> <li>- Maintain essential food and nutrition services</li> <li>- Ensure continuity and quality of water and sanitation services</li> <li>- Secure sustained learning for all children, and adolescents, preferably in schools</li> <li>- Support the continuity of social services and access to shelters</li> <li>- Support victims of GBV</li> </ul> <p><b>5. Social cohesion and community resilience</b></p> <ul style="list-style-type: none"> <li>- Inclusive social dialogue, advocacy, and political engagement</li> <li>- Empower community resilience, participation, and equitable service delivery</li> </ul>	<p><b>5. Social cohesion and community resilience</b></p> <ul style="list-style-type: none"> <li>- Support to governance, fundamental freedoms and the rule of law</li> </ul>
	<p><b>A. Rapidly establishing international coordination and operational support</b></p> <ul style="list-style-type: none"> <li>- Pandemic supply chain coordination (contingency planning to mitigate disruption to non-medical supply chain)</li> <li>- Travel and trade (advice)</li> </ul>	<p><b>2.3 Secure the continuity of the supply chain for essential commodities and services</b> such as food, time-critical productive and agricultural inputs, sexual and reproductive health, and non-food items</p>		
	<p><b>GHRP Strategic Priority 3. Protect, assist and advocate for refugees, internally displaced people, migrants and host communities particularly vulnerable to the pandemic</b></p>			
	<p><b>B. Scaling up country readiness and response operations</b></p> <ul style="list-style-type: none"> <li>- Country coordination (inc. clusters)</li> <li>- RCCE</li> <li>- Case management and continuity of essential services (for other health services)</li> </ul>	<p><b>3.1 Advocate and ensure that the fundamental rights</b> of refugees, migrants, IDPs, people of concern and host population groups who are particularly vulnerable to the pandemic <b>are safeguarded, and that they have access to testing and health-care services, are included in national surveillance and response planning for COVID-19, and are receiving information and assistance</b></p>	<p><b>1. Health First: Protecting health services and systems</b></p> <ul style="list-style-type: none"> <li>- Programme implementation and technical support (inc. capacity-building, joint programming, support for disability-inclusive response, field-based health care in some conflict settings)</li> <li>- Support on tracking and reaching vulnerable populations (includes refugees and others living in camps)</li> </ul> <p><b>3. Economic response and recovery</b></p> <ul style="list-style-type: none"> <li>- E-commerce and digital solutions to allow secure access to services needed at the time of crisis, particularly by vulnerable groups</li> </ul>	<p><b>5. Social cohesion and community resilience</b></p> <ul style="list-style-type: none"> <li>- Support to governance, fundamental freedoms and the rule of law</li> </ul>

			<b>5. Social cohesion and community resilience</b> - Inclusive social dialogue, advocacy, and political engagement - Empower community resilience, participation, and equitable service delivery	
	<b>B. Scaling up country readiness and response operations</b> - RCCE	<b>3.2 Prevent, anticipate and address risks of violence, discrimination, marginalization and xenophobia towards refugees, migrants, IDPs and people of concern by enhancing awareness and understanding of the COVID-19 pandemic at community level</b>	<b>5. Social cohesion and community resilience</b> - Inclusive social dialogue, advocacy, and political engagement - Empower community resilience, participation, and equitable service delivery	<b>5. Social cohesion and community resilience</b> - Support to governance, fundamental freedoms and the rule of law

The table below lists the 63 countries included in the GHRP. These are organised by type of appeal. Countries with more than one appeal are duplicated in the list and highlighted in red to show the duplication. The evaluation team selected case studies from these countries based on the criteria outlined in section 4.2

Humanitarian Response Plan	Regional Refugee Response Plan (RRP)	Regional Refugee and Migrant Response Plan (RMRP)	Other appeals
Afghanistan	Angola	Argentina	Bangladesh (Joint Response Plan: Rohingya humanitarian crisis)
Burkina Faso	Burundi	Aruba (Netherlands)	Benin
Burundi	Cameroon	Bolivia	Congo
Cameroon	Chad	Brazil	Djibouti (Regional Migrant Response Plan - MRP)
Central African Republic	Congo	Chile	DPR Korea
Chad	Democratic Republic of Congo	Colombia	Ecuador (Intersectoral COVID-19 Response Plan 2020)
Colombia	Egypt	Costa Rica	Ethiopia (MRP)
Democratic Republic of Congo	Ethiopia	Curacao (Netherlands)	Iran
Ethiopia	Iraq	Dominican Republic	Jordan
Haiti	Jordan	Ecuador	Kenya
Iraq	Kenya	Guyana	Lebanon (Intersectoral COVID Response Plan 2020)
Libya	Lebanon	Mexico	Liberia
Mali	Niger	Panama	Mozambique

Myanmar	Rwanda	Paraguay	Pakistan
Niger	Sudan	Peru	Philippines
Nigeria	Tanzania	Trinidad & Tobago	Sierra Leone
Occupied Palestinian territory	Turkey	Uruguay	Somalia (MRP)
Somalia	Uganda		Tanzania
South Sudan	Zambia		Togo
Syria			Uganda (Intersectoral COVID-19 Response Plan 2020)
Ukraine			Yemen (MRP)
Venezuela			Zambia
Yemen			
Zimbabwe			

## Annex 7: IAHE COVID-19 Evaluation Review

This annex provides an outline of the approach for the COVID-19 evaluation synthesis.

### 1. Background

The COVID-19 pandemic has been unlike any other crisis in recent history, with humanitarian response undertaken at a global scale and traditional humanitarian action being disrupted and transformed. Evaluations of the humanitarian response to COVID-19 have documented successes and challenges in response to and recovery from the COVID-19 pandemic. The COVID-19 Global Evaluation Coalition undertook a landscape analysis of the main efforts to evaluate the response to COVID-19.<sup>i</sup> However, with the pandemic still ongoing, there remain unmet learning needs at the system level on (i) the impact of COVID-19 on humanitarian action; (ii) the flexibility and adaptiveness of humanitarian organizations to respond to the COVID-19 crisis; and (iii) the successes and challenges in delivering this response.

### 2. Purpose of the evaluation review

The purpose of the review was to harvest and analyze findings and **also to seek to reduce overlap and duplication where key issues are already being examined by other evaluations**. This is because the IAHE evaluation is one of several system-level exercises which seek to examine different aspects of the international response to COVID-19, which include:

- The evaluation of the Response and Recovery Multi-Partner Trust Fund (MPTF) established to support the UN Socio-Economic Framework for COVID-19, led by the UN Systemwide Evaluation Function under the Executive Office of the Secretary-General;
- The evaluation by the Independent Panel for Pandemic Preparedness and Responses of WHO's response to COVID-19 and WHO's other reviews of its emergency response through the work of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC) and the International Health Regulations (IHR) Review Committee; and,
- The Joint Evaluation of the Protection of the Rights and Refugees during the COVID-19 pandemic being conducted under the auspices of the COVID-19 Global Evaluation Coalition, managed by UNHCR, the Ministry of Foreign Affairs of Finland, the Governments of Colombia and Uganda, and ALNAP.

### 3. The scope of evaluation review

The synthesis focused on the **humanitarian response** to COVID-19 and a number of themes which will include lessons/recommendations that are pertinent to **preparedness, Coordination and information management, Strategic planning, Resource mobilization and allocation, Collective response mechanisms, Humanitarian-development-peace nexus, Adaptive capacity, Results and Lessons learned**. The Temporal scope of the review is from January 2020 to 25 January 2021.

The COVID-19 evaluation synthesis has taken into consideration existing collaborative and joint learning by both humanitarian and development actors, in particular ALNAPs ongoing synthesis of COVID-19 evaluations.

### 4. Approach and methodology

Data was obtained from a number of sources from a web search, from OCHA as well as from ALNAPs COVID-19 evaluation portal. This data was downloaded into a shared drive where researchers could access it. Priority was given to documents that provided explicit lessons and recommendations and all researchers followed a selection process for evaluative literature (outlined below). Using excel the evaluation synthesis has mapped recommendations and lessons against the evaluation matrix (please see Annex 5). Data has also been disaggregated by agency, date and country.

<sup>i</sup> Johnson, L. and M. Gamarra (2021) *COVID-19 Global Evaluation Coalition, "How are the COVID-19 response and recovery efforts being evaluated? Landscape analysis of National and International evaluations and reviews of COVID-19 response and recovery efforts."* OECD, Paris



## 5. Selection process for evaluative literature

In order to prioritize literature and be able to consider the strength of evidence, researchers documented whether or not data falls under the following criteria:

- Whether evaluations have been independently conducted;
- Whether the evaluation covers response delivered by IASC members for the humanitarian response for the period under evaluation;
- Whether the evaluation has a clear methodology and evidence of triangulation.

## 6. Synthesis

The output for this task is an excel sheet structured by evaluation question so that the findings can be directly imported into the team's evidence assessment framework. In this way, it will make an important contribution to the evidence that the evaluation collects. The excel sheet will also be searchable for the evaluation team. It remains a working document that can be updated as and when new evaluations are published during the data collection phase.

## 7. Limitations

Time and resources are the key limitations to the exercise. This was mitigated in part by drawing on the outputs from the broader and deeper review of evaluative evidence being undertaken by ALNAP. It is anticipated that this will be completed (at least in draft) in time for it to be reviewed and considered by the evaluation team.

## Annex 8: Approach of the evaluation to gender and disability inclusion analysis

This annex outlines the approach that will be taken by the team to ensuring that gender and disability inclusion are addressed and mainstreamed in the evaluation.

### 1. Background

Gender norms and pre-existing inequalities disproportionately impact women and girls in emergencies, including health emergencies. Gender, and other factors such as age, sexual orientation and gender identity, ethnicity, disability, education, employment, and geographical location are known to interact and compound the effects of emergencies.<sup>ii</sup> “A general lesson derived from previous crises points to the pattern that people who already face multiple forms of discrimination prior to a crisis are more likely to face higher risks and more obstacles in accessing essential services during a crisis.”<sup>iii</sup> At the same time, evaluations of previous disasters have shown that crises can also be an opportunity to include more women at leadership tables and to challenge long-standing social norms that maintain inequalities.<sup>iv</sup>

Public health emergency responses have been only very marginally guided by research of implications for vulnerable groups. Gender has received relatively little attention in pandemic emergency response research. This includes research of the ways in which pandemics affect women and girls. This is clearly illustrated by the fact that less than 1 per cent of published research papers on the 2014–16 West Africa Ebola virus disease (EVD) outbreak and the 2016 Zika outbreak focused on the gender dimensions, and earlier pandemics show even less attention to gender.<sup>v</sup>

When the pandemic struck, the normative framework for disability inclusion was relatively new, with the launch of the UN Disability Inclusion Strategy in June 2019 and the publication of IASC guidelines on the inclusion of persons with disabilities in humanitarian action in July.<sup>vi</sup> <sup>vii</sup> The UN demonstrated high-level leadership on disability inclusion from the beginning of the pandemic response. The SG took a number of steps to ensure that the response took account of the needs of persons with disabilities.<sup>viii</sup> The Emergency Relief Coordinator had made the disability inclusion a priority in the allocation of CERF funding in 2019.<sup>ix</sup> The second iteration of the GHRP was developed under his leadership at the same time as a UN policy brief on disability inclusion and identified persons with disabilities as one of the most affected population groups. It outlined the range of risks and challenges that COVID-19 poses for persons with disabilities in humanitarian settings.<sup>x</sup> The July iteration of the GHRP expanded on these risks and challenges but there was little mention of achievements in providing assistance to persons with disabilities in the final progress report on the GHRP.<sup>xi</sup>

<sup>ii</sup> IASC Reference Group for Gender in Humanitarian Action. (2020). Interim Guidance for Gender Alert for Covid-19 Outbreak (March 2020).

<sup>iii</sup> ACAPS (2020). Global Gender Analysis - COVID-19 secondary impacts on health- and protection-related issues. p. 10.

<sup>iv</sup> Covid 19 Global Evaluation Coalition. (2021). Lessons from Evaluation. Gender Equality.

<sup>v</sup> Care (2020). Gender Implications of Covid-19 Outbreaks in Development and Humanitarian Settings.

<sup>vi</sup> UN (2019) *United Nations Disability Inclusion Strategy*.

<sup>vii</sup> Inter-Agency Standing Committee (2019) *Inclusion of Persons with Disabilities in Humanitarian Action: Guidelines*, IASC Task Team on Inclusion of Persons with Disabilities in Humanitarian Action.

<sup>viii</sup> [https://www.internationaldisabilityalliance.org/sites/default/files/sg\\_response\\_letter\\_to\\_iddc\\_chair\\_-\\_signed.pdf](https://www.internationaldisabilityalliance.org/sites/default/files/sg_response_letter_to_iddc_chair_-_signed.pdf)

<sup>ix</sup> Mowjee, T., and A. Featherstone (2020) *Independent Review of the Four Priority Underfunded Areas for the Central Emergency Response Fund: Final Report*

<sup>x</sup> UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP May Update.

<sup>xi</sup> OCHA (2021), Global Humanitarian Response Plan COVID-19, Final Progress Report, 22 February 2021.

## 2. Gender and the Covid-19 pandemic response

Relatively early in the COVID-19 pandemic women and girls – and other vulnerable groups – were identified as being likely to be affected disproportionately by COVID-19.<sup>xii</sup> Expected effects for women included:

- Exacerbated burdens of unpaid care work on women and girls
- Increasing gender-based violence (GBV) and protection risks (including child marriage and pregnancy)
- Reduction of women’s economic empowerment
- Disproportionate mental health strain
- Women accounting for the majority of health and social care workers making them more exposed to COVID-19
- Interrupted access to sexual and reproductive health
- Exclusion from leadership roles<sup>xiii xiv xv</sup>

The potential severity of these effects, and their recognized likely long-term consequences were the focus of advocacy and fund-raising focussed specifically on ensuring attention to the challenges that COVID-19 would bring for girls and women.<sup>xvi xvii</sup>

In recognition of the importance of gender, the Global Humanitarian Response Plan (GHRP) guiding principles included the need for attention to “*gender equality, particularly to account for women’s and girls’ specific needs, risks and roles in the response as care providers, increased exposure to GBV with confinement measures, large numbers of front-line female health workers in the response, and key role as agents at the community level for communication on risks and community engagement.*” In addition, the meaningful participation of women in needs assessments and response was also identified as an enabling factor under Strategic Priority 2 of the GHRP. Similarly, the UN SERP underscored that “*women and girls must have a face in the response*” and identified a range of priority actions in this respect:

- Collect sex disaggregated data to ensure that the crisis does not disproportionately burden women.
- Ensure gender expertise in national, regional and global level response teams and task forces.
- Ensure that social protection plans and emergency economic schemes takes a gender perspective and takes into account unpaid care by women, specific constraints for women entrepreneurs and women in the informal sector.
- Attention to continued delivery of sexual reproductive health services, such as access to contraceptives without prescription during the crisis.
- Ensure that special services are available to prevent and respond to gender-based violence, such as special hotlines, police units and new protocols for shelters.
- Support women’s organizations on the front line and ensure women’s leadership and participation in response plans in the short and long term.<sup>xviii</sup>

<sup>xii</sup> ACAPS (2020). Global Gender Analysis - COVID-19 secondary impacts on health- and protection-related issues.

<sup>xiii</sup> Ibid.

<sup>xiv</sup> Asia-Pacific Gender in Humanitarian Action Working Group (2020) The COVID-19 Pandemic and Gender - Key Advocacy Points from Asia and the Pacific.

<sup>xv</sup> ACAPS (2020). Global Gender Analysis - COVID-19 secondary impacts on health- and protection-related issues.

<sup>xvi</sup> Ibid.

<sup>xvii</sup> This included a proposal for GHRP funding of a “Gender-Responsive Humanitarian Life-Saving Response to the COVID-19 Pandemic” by UN Women which aimed at ensuring support to 14 priority countries: Bangladesh (Cox’s Bazar), Cameroon, Haiti, Iraq, Jordan, Lebanon, Myanmar, Nigeria, occupied Palestinian Territories (oPT), Somalia, South Sudan, Turkey, Ukraine, and Yemen.

<sup>xviii</sup> United Nations (2020). Shared Responsibility, Global Solidarity: Responding to the socio-economic impacts of COVID-19.

### 3. Disability Inclusion and the COVID-19 pandemic response

The May 2020 iteration of the GHRP identified the following implications of COVID-19 for persons with disabilities:

- Greater challenges with accessing health information and implementing it
- The reduction in healthcare and specialized services, particularly for those with cognitive disabilities (including older persons with conditions such as dementia). Also, the potential loss of daily-living care due to restrictions to limit the spread of the virus
- More incidents of discrimination and violence due to stigmatization and lack of accessible information
- Greater vulnerability to financial impacts of the pandemic and also less ability to stock up on essential supplies and medication during lockdowns
- Higher support needs for children with disabilities who are out of care or schools
- Greater risk of GBV against women and girls with disabilities

It is helpful that the risks and challenges identified in the GHRP highlight issues of intersectionality, that persons with disabilities may be male or female, children or older people and that their level of vulnerability will be influenced by a combination of gender, age and other factors.

Also in May 2020, the SG published a policy brief on disability inclusion in the context of the pandemic.<sup>xix</sup> This identified four overarching actions for all those responding to the pandemic:

- Ensure mainstreaming of disability in all COVID-19 response and recovery together with targeted actions
- Ensure accessibility of information, facilities, services and programmes in the COVID-19 response and recovery
- Ensure meaningful consultation with and active participation of persons with disabilities and their representative organizations in all stages of the COVID-19 response and recovery
- Establish accountability mechanisms to ensure disability inclusion in the COVID-19 response

### 4. Evidence of the COVID-19 response to gender and disability inclusion

Some evidence has now emerged on the effects of the pandemic on girls and women as well as the extent to which their needs were explicitly taken into account. A recent report by the Feminist Humanitarian Network<sup>xx</sup> paints a bleak picture: *“Many of the findings are distressing, such as accounts of increased violence, decreasing economic opportunities, increasing poverty, and clear de-prioritization of women’s rights and lives in humanitarian planning, implementation, monitoring, evaluation, and learning. The report goes on to note that: “Despite findings that Women Rights Organizations (WRO) play a key role ... (these) were largely excluded from formal decision-making spaces in COVID-19, and their contributions to decision-making bodies ignored.”<sup>xxi</sup>*

The team’s review of evaluations and lessons learned found very limited evidence of ways in which the pandemic response has taken account of the needs of persons with disabilities. Despite the May and July iterations of the GHRP highlighting persons with disabilities as one of the groups most vulnerable to the effects of COVID-19, the final progress report on the implementation of the GHRP makes almost no mention of assistance provided to persons with disabilities (beyond UNHCR’s support to refugees with disabilities).

This evaluation presents an opportunity to understand to what extent the collective response ensured attention to both gender and disability inclusion, given the disproportionate effects of the pandemic on the basis of gender and disabilities. It also provides an opportunity for understanding how gender and disability inclusion can be better integrated into future pandemic responses.

<sup>xix</sup> UN (2020) *Policy Brief: A Disability-Inclusive Response to COVID-19*, May 2020

<sup>xx</sup> Findings drawn from eight countries – Bangladesh, Kenya, Lebanon, Liberia, Nepal, Nigeria, Palestine, and South Africa.

<sup>xxi</sup> Women’s Humanitarian Voices. (2022). *Covid-19 through a feminist lens – A Global Report*, p. 1).

## 5. Approach by this evaluation

In line with *UNEG Guidance on Integrating Gender Equality and Human Rights in Evaluation* (2011), the evaluation will treat gender and disability inclusion as critical lines of inquiry that will cut across all relevant areas of investigation. The evaluation will do this in the following ways:

- Examine the extent to which collective response actions sought to ensure attention to gender and persons with disabilities in the pandemic response. This will involve looking in particular at the extent to which the pandemic response was informed by gender analyses and data on persons with disabilities, how mechanisms and processes facilitated or inhibited the involvement of women and girls and persons with disabilities, and the extent to which this affected the quality and efficacy of the response. Special attention will be paid to assessing the extent to which the collective response brought about cohesiveness in prioritising the needs of the most vulnerable groups, paying particular attention to gender and disability inclusion (as per Evaluation Terms of Reference, p. 16).
- Review evidence of the ways in which vulnerable groups were (differently) targeted and engaged in interventions through analysis of available statistical data.
- Identifying best practices, opportunities and lessons learned to ensure stronger and more consistent attention to gender and disability inclusion in future pandemic responses.

The evaluation mainstreams gender and disability inclusion in the approach and methodology as follows.

- **Methodology:** Evaluation questions and indicators in the evaluation matrix (see Annex 5) include attention to gender and inclusiveness to ensure that the evaluation produces in-depth analysis of the extent to which the collective response targeted women and girls (as well as men and boys) and persons with disabilities in the design, coordination, and implementation of the response.
- **Data analysis** will disaggregate information by gender to highlight numerical differences in terms of targeting, involvement, and effects of interventions. This will be done both in analyzing secondary data (for example data that will be gathered from existing surveys), and also in the evaluation's own primary data collection (through the aid worker survey, country level interviews, etc.). The team will also identify the extent to which data on persons with disabilities is available.
- **Interview guidelines** have been designed to reflect the focus on gender and inclusion in the evaluation matrix and include questions on gender and other cross-cutting issues.
- **Draw on the knowledge of key informants with specialized expertise** on systemwide accountability frameworks for gender and disability inclusion.
- **Documentation review** will focus on specific initiatives to enhance attention to gender and disability inclusion and examine to what extent these produced the anticipated response.
- **Country studies** will review the extent to which emergency preparedness and response planning was grounded in gender analysis and the extent to which this was followed through in design and implementation. Country case studies will equally systematically examine any evidence of examples of gender transformative actions and review UN Country Team scorecards for reporting on their implementation of the UN's Disability Inclusion Strategy during field visits.<sup>xxii</sup> The team will consult with women's rights organizations as well as Organizations of Persons with Disabilities.
- **The community engagement process** that is part of this evaluation (see Annex 10) will ensure that the evaluation brings out the views of beneficiaries on gender and disability inclusion. To the extent possible, the team will seek to ensure the participation of persons with disabilities in FGDs.
- **Data collection** by the evaluation team in the field will be done in gender sensitive ways and to facilitate

<sup>xxii</sup> See [www.un.org/en/content/disabilitystrategy/assets/documentation/UNCT\\_Accountability\\_Scorecard\\_on\\_Disability\\_Inclusion.pdf](http://www.un.org/en/content/disabilitystrategy/assets/documentation/UNCT_Accountability_Scorecard_on_Disability_Inclusion.pdf)

the participation of persons with disabilities. Gender-balanced teams will conduct interviews and focus groups with beneficiaries, disaggregated by gender.

- **Data analysis.** Integration of gender, disability and other categories of exclusion will be explored via coding and analysis of data generated by this evaluation.

## Annex 9: Overview of Learning Papers

The purpose of this annex is to clarify the purpose, scope and structure of the proposed learning papers on the GHRP for COVID-19 (Agreed by the MG) and localization (proposed for MG consideration). Included in it are the main questions to be answered in the learning papers as well as the approach that will be followed.

### 1. GHRP Learning Paper

#### 1.1 Background

The IAHE of the COVID-19 humanitarian response includes two learning papers on themes to be determined during the inception phase of the evaluation.<sup>136</sup> Early in the inception phase, the Management Group (MG) for the evaluation agreed that the first of the two learning papers should be dedicated to the GHRP for COVID-19.<sup>137</sup>

In July 2020, the IASC Principals tasked OCHA with leading and sharing '*lessons learned from the GHRP process that can be applied to and strengthen the annual the development of the 2021 GHO*'.<sup>138</sup> Thereafter, OCHA conducted a light lesson learning exercise, which concluded in October 2020. This learning paper will build on the OCHA-led exercise and the findings and recommendations that were documented during that process.

#### 1.2 Purpose

The learning paper on the GHRP will serve as an input into the final evaluation report. It will also be used as a standalone document to inform future humanitarian policy and practice, specifically the development of subsequent GHOs and any dedicated, ad-hoc GHRPs that may be considered in response to future global emergencies.

#### 1.3. Approach

The main sources of evidence for the GHRP learning paper will be the document review – particularly documents related to the OCHA-led lessons learned process – and key informant interviews. Key stakeholders to be interviewed are mainly those with a global or regional remit; though some country-level informants may also be included (based on the advice of OCHA and the MG). Many of the interviewees will also be key informants for the evaluation more broadly; in which case, questions on the GHRP will be folded into more comprehensive inception phase interviews. Other interviews will focus specifically on the GHRP process.

#### 1.4 Scope

The paper will seek to cover the following main learning areas:

- How beneficial was the GHRP process as a new approach for collectively responding to the demands of a global crisis; and
- To what extent did the GHRP process facilitate an inclusive and well-coordinated response?

#### 1.5 Questions

In order to provide evidence on the learning areas above, and to input into the final evaluation report, the paper will seek to answer the following questions (organized according to the overall evaluation questions):

#### Preparedness

- After scale-up declaration, what preparedness measures and contingency planning were

<sup>136</sup> Learning papers have been referred to as in documentation as learning papers/evidence summaries.

<sup>137</sup> The topic of the 2<sup>nd</sup> learning paper will be determined towards the end of the inception/pilot phase of the evaluation.

<sup>138</sup> IASC Principals, 27 July 2020

undertaken in relation to COVID-19, and how were these reflected in successive iterations of the GHRP?

### Coordination and information management

- To what extent did inter-agency information management and communication mechanisms support the GHRP process?
- To what extent was the process to coordinate inputs to the GHRP effective and inclusive, both within organizations (from country and regional levels to headquarters) and between organizations?
- To what extent was there collective IASC buy-in to and ownership of the GHRP process, at all levels?
- To what extent did the GHRP process facilitate collaboration across organizations and sectors to address the multidimensional impact of the crisis?

### Needs assessment and analysis

- To what extent were country plans and response strategies within the GHRP informed by the needs and priorities of affected people, and did this change for successive iterations of the GHRP?

### Strategic planning

- To what extent did the GHRP planning process take account of and align with local, national, and regional priorities and capacities for COVID-19 preparedness and response, and did this change for successive iterations of the GHRP?
- To what extent were the contributions of individual organizations reflected in the GHRP?

### Resource mobilization

- To what extent did the financial requirements of the GHRP reflect the COVID-19-related needs and priorities of participating agencies and countries?
- Was the GHRP process successful in mobilizing additional, quality resources for the COVID-19 response?
- To what extent were donors engaged in GHRP planning?
- What factors influenced donor decisions to contribute to the GHRP appeal?
- To what extent were internal IASC member agency funding mechanisms triggered to contribute to the implementation of the GHRP?

### Collective response mechanisms

- To what extent were global IASC strategy and scale-up mechanisms and country-level humanitarian coordination and delivery mechanisms aligned?

### Humanitarian-development-peace nexus

- To what extent did the GHRP create links and synergies across the humanitarian-development-peace nexus?

### Localization

- To what extent did the GHRP process complement and empower national and local actors in their efforts and leadership to address COVID-19-related humanitarian needs, and did this change for successive iterations of the GHRP?
- To what extent did the GHRP process consult and involve national and local stakeholders, and how well did the GHRP reflect their perspectives?



### Adaptive capacity

- To what extent did the GHRP adapt and evolve in relation to the trajectory of the crisis?
- To what extent did the GHRP monitoring framework support operational and strategic decision-making, and did it provide meaningful information on the effect of collective interventions?

### Lessons Learned

- What were the main challenges and lessons learned from the GHRP process?
- Were there any innovations or new ways of working within the GHRP process that could be incorporated into future responses?
- What are the key strategic and policy challenges and opportunities for improving the IASC's future responses to pandemics or other events with multi-country humanitarian impacts?

### **1.6 Beyond the scope of the learning paper**

This learning paper, which is being developed during the inception phase of the evaluation, will emphasize the *process* of GHRP planning. It will not look in any detail at the implementation and results of the GHRP, which will be covered as part of broader data collection for the evaluation and will draw primarily on evidence from the GHRP country case-studies.

### **1.7 Structure**

The learning paper will be no more than 20 pages without annexes. It will be structured roughly as follows:

- Introduction
- Scope, approach, and methodology
- Background and context
- Findings
- Conclusions
- Areas for further consideration in the evaluation

## **2. Localization Learning Paper**

This section of the annex outlines the purpose, scope and structure of the second learning paper under the IAHE of the COVID-19 Humanitarian Response. It provides a rationale for the choice of the topic, an overview of the main questions that will be covered, and outlines the process for data collection and reporting.

### **2.1 Purpose**

The IAHE of the COVID-19 humanitarian response includes two learning papers on themes to be determined during the inception phase of the evaluation.<sup>139</sup> Early in the inception phase, the Management Group (MG) for the evaluation agreed that the first of the two learning papers should be dedicated to the GHRP for COVID-19 and that the topic of the second learning paper will be determined towards the end of the inception/pilot phase of the evaluation.

This annex sets forward the suggested topic for the second learning paper which will be focused on Localization. Localization constitutes a core commitment for the Humanitarian community, was identified very early in the Covid-19 response as being critical in light of the travel restrictions, and the

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<sup>139</sup> Learning papers have been referred to as in documentation as learning papers/evidence summaries.

need to move fast and quickly to mobilize capacity and respond,<sup>140</sup> and consequently it is also the subject of a specific set of questions under the IAHE. Localization has also been identified by the Grand Bargain 2.0 as a key priority (together with participation of affected communities and more agile funding) and has been included in the Inter-Agency Standing Committee (IASC) 2022/23 work plan as one of four enabling priorities.

This learning paper has an important potential forward looking value in that it will feed into these priorities. In addition, a specific learning paper on Localization will ensure that the evaluation brings out key lessons and gives voice to the views of local actors on the achievements and challenges. Both learning papers will serve as inputs into the final evaluation report. The learning papers will also be used as standalone documents to inform future humanitarian policy and practice.

## 2.2 Context

Early on in the Covid-19 response clear that local actors would be a critical capacity in the response and that localization would be inevitable in light of travel restrictions. It was also clear that funding would need to be redirected, scaled up and made easily available to facilitate the response, and that systems and processes needed to be adapted and made more flexible and faster, including ways of communication. The response to Covid-19 was seen as providing a concrete opportunity to respond to the Agenda for Humanity commitment 4A and Grand Bargain commitment 2 to: “reinforce rather than replace local and national capacities”, “in a spirit of partnership (...) where we all meet as equals”.

The importance of Localization was encapsulated in the summary statement of the Covid-19 global pandemic Position Paper (2020) of the Alliance for Empowering Partnership (A4EP) which stated that: “COVID-19 with its public health, economic and social impacts is a major threat. It is also a major opportunity for experiencing our shared humanity, expanding our empathy and solidarity, and -finally- investing seriously in local and national capacities.” (p. 3).

The importance of this localized response was recognized early on in the deliberations of the IASC Directors Group (DG) which guided the collective response. The IASC DG meetings as early as March 2020 identified the Covid-19 pandemic response as critical opportunity to catalyze the Grand Bargain commitments around reduced bureaucracy, flexible funding and localization.

Specific issues identified early in the covid-19 response as Localization priorities, included:

- Potential challenges to safety and well-being of national partners given their exposure to Covid-19 as front-line responders.
- Inflexibility of funding, and complexity of processes for grant applications, standing in the way of timely and effective response.
- Insufficient recognition and representation of local actors, including women led organizations, in leadership and decision-making.
- Lack of transparency in decision-making around priorities and funding.
- Nature of partnership agreements not providing space for equal voice and participation.
- Short duration of funding standing in the way of sustained support to beneficiaries and sustainability.
- Lack of visibility and recognition of the role and work of local actors as part of humanitarian

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<sup>140</sup> A4eP. (2020). Localised response to COVID-19 global pandemic A4EP Position paper.

responses.<sup>141 142 143 144</sup>

These issues informed the priorities that of the IASC Interim Guidance on Localization (further referenced below).<sup>145</sup>

### 2.3 Rationale

The IAHE as a whole focusses on understanding the collective response through three key areas of investigation around:

1. IASC member agencies' collective preparedness and response actions, including its existing and adapted special measures, and their relevance to addressing humanitarian needs in the context of the pandemic.
2. Results from these actions at the global, regional and country level in support of people, and with governments and local actors.
3. Best practices, opportunities and lessons learnt that will help to improve ongoing and future humanitarian responses, including through wider and accelerated adaptation of certain humanitarian policies, approaches, and practices.

*This Learning paper would look at the role of local actors in the collective response – and in particular at areas 1 and 3 above, from the perspective of local actors.*

The Localization would be informed by the Inter-Agency Standing Commitment (IASC) Interim Guidance on Localization and the COVID-19 response which sought to address the issue identified above.<sup>146</sup>

### 2.4 Approach

The main sources of evidence for the Localization learning paper will be a light touch document review, a selection of global and country interviews (including those drawn from the country evidence), as well as the responses that will emerge from dedicated set of questions in the global aid worker survey that is part of the broader IAHE. The paper will look across the different countries that are covered by the IAHE and identify lessons, opportunities and areas for improvement.

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<sup>141</sup> Charter 4 Change (2020) *Lobby Brief: Localization, COVID GHRP, and UN Country Based Pooled Funds.*

<sup>142</sup> A4eP (2020) *Localised response to COVID-19 global pandemic A4EP Position paper.*

<sup>143</sup> ICVA (2020) *REINFORCE, REINFORCE, REINFORCE: Localization in the COVID-19 Global Humanitarian Response.*

<sup>144</sup> A4eP (2020) *Reversing the inequity – Opportunity knocks again or missed opportunity again!?*

<sup>145</sup> IASC (2020) *interim guidance on localization.*

<sup>146</sup> IASC (2020) *interim guidance on localization.*

## 2.5 Scope

The learning paper will:

- Bring out local actor perspectives on empowerment and local leadership and the extent to which process enabled local actor involvement.
- Provide examples of good practices in local actor involvement.
- Analyze what processes facilitated involvement.
- Identify issues that stood in the way of effective engagement.
- Identify priorities in terms of systems and processes for future collective responses.

The analysis will be framed by the six key areas of the IASC interim guidance on Localization as mentioned above, and therefore seek to understand to what extent the evidence of the response supports:

- Respect for principles of duty of care.
- Responsible partnership agreements.
- Respect of humanitarian principles through partnering with responsible local humanitarian actors and proactively partnering with non-humanitarian actors (including local government).
- Promotion local leadership and participation and engagement in coordination mechanisms and decision-making processes at national and sub-national levels.
- Mechanisms for funding and how this allowed local actor to play a key role through prompt access to funding, re-programming efforts, and fast track provisions.
- Recognition and visibility of the work and role of sub-national and national responders.

The learning paper will emphasize the *processes and practices by which localization was promoted, and those that stood in the way of achieving adequate engagement*. It will highlight examples of good practice and areas of learning. It will provide an opportunity for bringing out the lessons that local actors have learned and would like to share with the collective humanitarian community to inform future responses.

The learning paper will not look in detail at the implementation and results of the involvement of local actors in the GHRP, which will be covered as part of broader data collection for the evaluation and will draw primarily on evidence from the GHRP country case-studies.

## 2.6 Structure

The learning paper will be no more than 20 pages without annexes. It will be structured roughly as follows:

- Introduction
- Scope, approach, and methodology
- Background and context
- Findings
- Conclusions
- Areas for further consideration in the evaluation

## Annex 10: Community engagement methodology

This document outlines the methodology that the evaluation team will employ to obtain community feedback on projects implemented by IASC members and their partners. It has been prepared as a stand-alone document that provides practical guidance on the community engagement methodology through Focus Group Discussions to those helping the evaluation team to set up community consultation as well as to national evaluation consultants. It should be read in conjunction with annex 11 which outlines principles linked to ethics, safeguarding and COVID-19.

### 1. The COVID-19 Inter-Agency Humanitarian Evaluation (IAHE) - introduction

This evaluation focuses on the joint humanitarian response to COVID-19 by Inter-Agency Standing Committee (IASC) members. It covers the period from the start of the pandemic response in March 2020 to date. The evaluation has a global, regional and national (country) focus and data are being collected through a combination of documentation and data review/analysis, interviews, a survey, and country case studies (remote and in-person).

As a whole, the evaluation has the following three objectives:

1. Determine the extent to which the IASC member agencies' collective preparedness and response actions, including its existing and adapted special measures, were relevant to addressing humanitarian needs in the context of the pandemic.
2. Assess the results achieved from these actions at global, regional and country level in support of people, and with governments and local actors.
3. Identify best practices, opportunities and lessons learnt that will help to improve ongoing and future humanitarian responses, including through wider and accelerated adaptation of certain humanitarian policies, approaches and practices.

### 2. Purpose of the community engagement exercise

Community engagement is an essential part of the evaluation methodology and will focus on beneficiary perceptions of whether and how the COVID-19 response has made a difference to the lives of affected populations. It is anticipated that national evaluators will conduct sex-disaggregated Focus Group Discussions (FGDs) in the local language with community members at sub-national level during field work. If relevant for the context, the evaluators will conduct separate FGDs for certain population segments, for example displaced people and host communities; or different ethnic/religious groups.

The data collected through community consultations will provide evidence against the evaluation questions and indicators outlined in the box below.

**EQ 3.2 NEEDS ASSESSMENT AND ANALYSIS:** To what extent were assessments of humanitarian needs conducted in consultation with affected populations?

Relevant indicators:

- Existence of procedures/processes for beneficiary feedback on changing needs and evidence that the response took account of feedback.

**EQ 6.1.1 IMPLEMENTATION AND MONITORING: Collective Response Mechanisms** - what was the added value of collective mechanisms to the planning and implementation of the response?

Relevant indicators:

- Ways in which collective mechanisms for accountability and PSEA delivered benefits for affected population during the COVID response.

**EQ 6.5.1: IMPLEMENTATION AND MONITORING: Results-** To what extent did the IASC’s collective response to the pandemic meet the humanitarian needs of affected people adequately and effectively, both overall and vis-à-vis specific vulnerable groups?

Relevant indicators:

- Affected population views on timeliness, relevance and adequacy of assistance received.
- Evidence of that assistance provided had positive results for affected populations.
- Identification of any negative consequences of the response.
- Evidence that the humanitarian needs were aligned/coordinated with longer term development needs to ensure smooth transitioning of beneficiaries where necessary.

While it’s important to maximize the opportunities afforded to the evaluation through its engagement with affected communities, it is also necessary to ensure that the task is manageable, particularly given that it is likely to be conducted largely by national consultants who are not core team members and hence do not have the same level of understanding about the evaluation. With this in mind, it is proposed that emphasis should be placed on EQ 6.5.1 – Results, albeit with some scope to fold in other issues linked to accountability (EQ 6.1.1: Collective response mechanisms).

### 3. Overview of community engagement methods and support requirements

This section provides a summary of the team’s approach to community engagement, focusing on aspects with which the team will require support and where national consultants will need to engage with the in-country evaluation focal point as well as agencies providing humanitarian assistance to the communities selected for FGDs.

The evaluation team will use three complementary data collection tools during community consultations to collect evidence for this evaluation. These are described in brief in the box below.

#### 1. COVID-19 timeline

Before conducting FGDs, the national consultants will prepare a context-specific timeline of key events during the COVID-19 pandemic, such as the detection of the first cases, lockdowns, school closures or significant increase in cases.

#### 2. Assessing quality exercise

The timeline will be used as the basis of the community FGD discussion to identify what assistance the community received and when. Once the community has agreed on what assistance was provided and when, the evaluation team will facilitate a discussion to assess the quality of the assistance provided. This will focus on 4 aspects:

Timeliness and relevance: The extent to which the assistance was adequate and also appropriate compared to needs and whether the relevance and timeliness were maintained over time.

Effectiveness: What difference the assistance made to people’s lives and the extent to which it helped them face the challenges that resulted from the COVID-19 pandemic.

Targeting: Whether the assistance was provided to the most vulnerable and those most in need and how these recipients were identified.

Accountability: Whether beneficiaries were informed of the support they would receive and given the option of providing feedback, including awareness of any collective mechanisms for ensuring protection and reporting sexual exploitation and abuse. And whether action was subsequently taken.

#### 3. Stories of change

During the project site visits, team members will identify particularly illustrative stories (for example, through discussions of the effectiveness questions in the FGDs), and seek to document these in order to obtain details of what assistance was received and its effect. The aim of this will be to highlight how the COVID-19 response has contributed to making a difference to individual people’s lives. The evaluation team’s aim is to gather these stories in each of the eight case study countries. Stories of change may focus in particular on women, persons with disability and the elderly.

### 3.1 Logistics/Support requirements

- The evaluation team will require the help of the country-based evaluation focal point/ Humanitarian Country Team (HCT) to identify one or two locations at sub-national level for site visits.
- The team will also need to work with responsible agencies in order to organize access to communities and to make local travel arrangements.
- It will be necessary to identify FGD participants in advance. The FGDs will be conducted in sex-disaggregated groups to ensure participants feel comfortable and safe if any sensitive topic comes up during the discussion. Each FGD should have no more than ten people (dependent on local COVID-19 regulations); be carried out in a safe space; and efforts should be made to include different categories of people, including the elderly, single-headed households and people living with disability. The discussions will last for around 1.5-2 hours.
- It will be necessary to identify a suitable location for conducting the FGDs, provide water/hot drinks and/or snacks if deemed appropriate.
- The materials required to conduct the FGDs include flip chart paper, coloured cards, and coloured pens. The national consultants conducting the FGDs will organize these materials. They will also discuss with the in-country evaluation focal point and/or relevant humanitarian agencies how best to provide hand sanitiser and masks for FGD participants.
- The FGD should be conducted in the language with which people are most comfortable, which is why the evaluation team will be working with national consultants to undertake the FGDs.
- The evaluation team will share the findings from the community consultations with the HCT as part of their country-level debriefing (assuming that the results have been processed by the time of the presentation).

### 3.2 COVID-19, do no harm and safeguarding

This section outlines how the evaluation team will ensure that FGDs are conducted in a COVID-secure manner as well as its approach to not doing harm and safeguarding.

#### COVID-secure FGDs

- FGDs should be held in a safe, well-ventilated or outdoor space and have no more than ten people attending. Hand sanitiser and masks should be provided.
- The consultants should aim to maintain appropriate distancing (at least 1.5 meters) between participants.
- The evaluation team will abide by all national and local COVID-19 guidelines and regulations.

#### Do no harm and safeguarding

Annex 1 provides a detailed description of the evaluation team's approach to safeguarding and ethical considerations. The key points are summarized below:

- No staff member, consultant, or participant will be forced into attending an FGD if they do not feel comfortable doing so. It will be made clear to participants at the beginning of the FGD that their participation is voluntary and they are free to leave at any point in time.
- No participant should be asked to travel to a location outside the community solely for the FGD; FGDs should only occur with those that are already visiting a site to receive assistance or be conducted within the community.
- The team will not conduct FGDs with those aged 18 or under to avoid child protection risks.

- Prior to the FGDs, the evaluation team will identify a mechanism through which it can report allegations of misconduct against aid workers made during the community consultations. The team will also ensure that FGD participants are made aware of how they can report any problems with the conduct of the consultants facilitating the FGDs. The team will also make efforts to identify a referral mechanism for participants in case they become distressed as a result of the discussion in the FGD.

### 3.3 Note on attribution/contribution

In any location where COVID-19 assistance was provided (either specific projects or adaptations to existing projects), it will be difficult to attribute interventions and their effects to specific IASC members with confidence. This is due to the temporal scope of the evaluation, and because communities are likely to find it difficult to isolate specific types of assistance or services and attribute them to individual duty bearers or agencies. Even in instances when this is possible, it might not be possible to determine the extent to which assistance and services contributed to specific changes or improvements in people's lives; changes take place over time and some of these may have nothing to do with the COVID-19 projects and would have happened regardless of whether or not a particular response occurred. Other changes may have a clearer link to a specific intervention, and these changes can be attributed to the project. While methods do exist to assist in understanding attribution, given the time and resource limitations of the exercise, the team will need to take a pragmatic approach to making these linkages where possible.

## 4. Detailed description of community engagement approach and methods

This section starts with a detailed description of the tools that the evaluation team will use for the FGDs (and which were summarized in the text box above). It goes on to outline the process for conducting the FGDs.

### 4.1 FGD data collection tools

#### 4.1.1 COVID-19 timeline

Prior to community visits: In advance of the visit to the project site, national evaluation consultants will draw on their knowledge of the country context and relevant sitreps and reports in order to develop an overview of important contextual shifts in the spread of the pandemic (e.g. an increase in the pace of transmission etc.), actions taken by the government (e.g. lock-downs, school closures etc.), or specific needs of the community (e.g. significant food scarcity etc.) across the two years under evaluation. The core team will be putting together information about the context, including on COVID-19 related development, and this may help to inform the work of the national consultants. This information should be summarized in a timeline on a flip chart to be used as the basis for the FGDs. It may be difficult for affected people to recall the assistance that was provided, particularly at the beginning of the pandemic. Therefore, to the extent possible, the consultants should use reports and available information to create a summary about what support was provided to the community and when. This can be used as a prompt during the FGDs to develop a consolidated picture of when shocks were experienced by the community, when they were responded to and with what assistance.

During community visits: At the start of the FGD, the consultants should work with participants to verify what assistance the community received and when in relation to the key events and information shown on the timeline. The assistance received at a certain point in time can be noted on cards that can be placed on the timeline. Cards should also be used to record any increases, decreases or changes in the assistance provided along the timeline to identify changes in the type and level of assistance provided over the evaluation period.



### 4.1.2 Assessing the quality of assistance

Once participants have provided an overview of the assistance received, the consultants can undertake an exercise to assess the quality of assistance. Using prompt questions, the consultants should facilitate a discussion to assess community perceptions of the assistance received and record the general view on cards. The discussion should focus on four aspects of the assistance.

#### Timeliness and relevance

Did the assistance arrive early, too late or on time? Specifically, what items or services arrived on time (or early or too late)? Was the assistance the right kind to meet the community’s needs? Or would other types of assistance have been more appropriate/relevant to needs (e.g., cash)? Was the assistance enough to meet the needs? Did specific needs go unmet?

#### Effectiveness

How did the assistance make a difference to people’s lives? To what extent did the assistance help beneficiaries face the challenges that resulted from the COVID-19 pandemic?

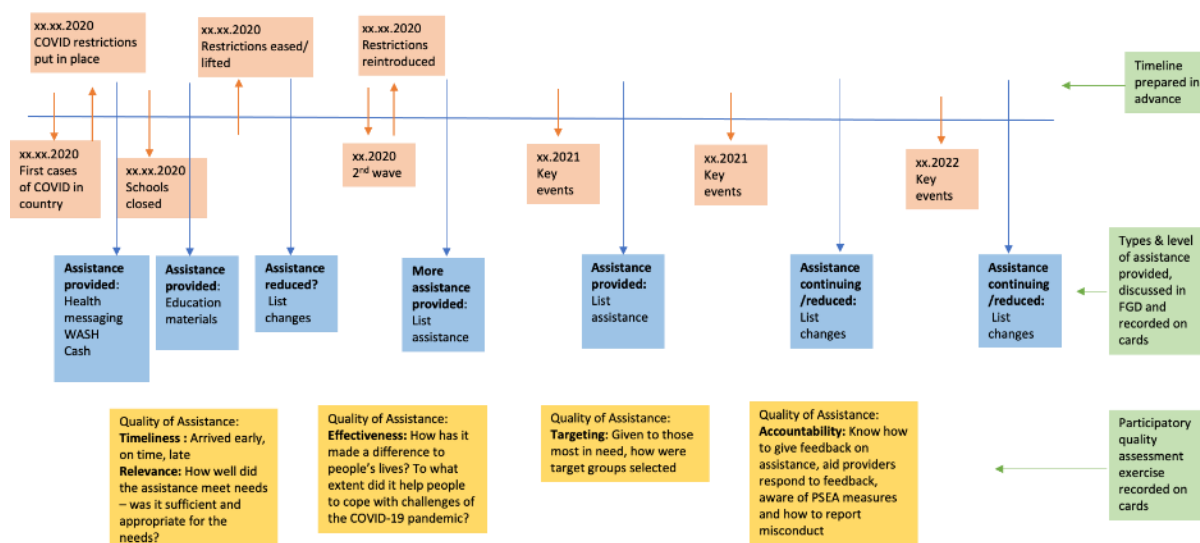
#### Targeting

How did the agencies select those who should receive assistance? Was the community involved in setting the criteria? Have those most in need (the elderly, persons with disabilities, the poorest households, other marginalized groups) received assistance? Examples? Who has not received assistance? Do you know the reasons why?

#### Accountability

If people have a complaint about the assistance given, who would they contact and how? If someone has made a complaint, did the humanitarian agency do anything about it? If an agency staff member or someone involved in providing assistance behaved inappropriately or tried to take advantage of their position to exploit someone, would participants know how to report this?

The figure below provides an indication of what a timeline combined with the quality assessment might look like.



### 4.1.3 Individual stories

As described in the previous section, as part of the assessment of quality exercise, consultants will seek to identify how the humanitarian response to COVID-19 made a difference to people's lives. If there are any particularly illustrative stories and time permits, the consultants will try to conduct a short interview with the individual(s) in order to obtain further about how the assistance received had an effect, positive or negative. The evaluation team will then use these stories to illustrate particular findings and/or to assess the contribution of the COVID-19 response. Stories of change may focus in particular on women, persons with disability and the elderly as these categories of beneficiaries are known to have been particularly affected by the COVID-19 pandemic.

## 4.2 Focus group discussion process

### Principles of conducting FGDs

- FGDs are '*semi-structured*'; the team will not read the questions as a list but use them as a guide to allow conversation to flow naturally. This is a *discussion*, not an interview, so consultants need to be flexible and ask questions out of sequence if this aids the flow of the discussion.
- Only one person should be running the FGD even if there are other people there translating or taking notes – the roles and responsibilities of all evaluation team members should be clear before the FGD starts.
- The facilitator of the FGD should seek to ensure that all participants have the chance to contribute to the discussion.
- Same polite rules as in a workshop - evaluation staff to turn off mobile phone and give full attention to the group for the duration of the FGD. Request for the community members to do the same if possible.
- Where translation is required, the translator will translate everything that everyone says (even if it is a repetition of other comments).
- The evaluation team should be fully conversant and comfortable with the FGD questions before the meeting starts. Core team members will ensure that the national consultants carrying out the FGDs are comfortable with the community engagement tools and have made the necessary preparations in advance.

At the beginning of the FGD, the FGD facilitator should:

- Make sure that local authorities and other persons (including UN/NGOs/local responders) who are associated with the provision of assistance are politely asked to let the FGD take place without their presence.
- Introduce themselves (all facilitators within the group, including any translators that are used) and a summary of the topics that will be discussed, and how the data will be used. A script will be read which will include (among other points):
- Request an introduction to the community participants and thank them for their time – inform participants that the exercise will take approximately 1.5-2 hours.
- The purpose of the evaluation and the FGD, emphasizing that this is about understanding what happened in the past, emphasizing that the evaluation is interested in understanding how assistance was provided over the full period (from the start of the pandemic and not just currently), that it is not an exercise that will result in specific assistance being provided to this community and that the purpose is to identify what can be done better in future pandemic

responses.

- The FGD is voluntary and nobody will be forced to answer any question they are uncomfortable with (although all participants will be given an opportunity to participate). Participants are free to leave at any point.
- That this exercise will not affect the assistance that participants receive in any way (i.e., positively or negatively).
- That the evaluation team member will be taking notes, the purpose of which will be to remember what people have said - but everything that is recorded will remain confidential. The information gathered will all be anonymous, which is why the evaluation team will not make a note of any names or contact details, and will be used to learn lessons about the humanitarian response to COVID-19.

For the exercise, the evaluation team should explain how the timeline and quality assessment exercise work. Then:

- Identify with participants what assistance/services the community received in response to COVID-19 over the last 2 years. The pre-prepared timeline should help participants to remember approximately when the assistance arrived in relation to key developments in the pandemic. Draw or write down the assistance received on coloured cards and place them under the timeline.
- Identify if levels of assistance changed over the two years, increasing or decreasing or ending based on developments in the pandemic and note this on separate cards placed under the timeline.
- Discuss with participants each aspect of the quality of the assistance received in turn – timeliness and relevance, effectiveness, targeting and accountability – using the prompt questions outlined in section 3.1.2. Note a summary of the views about each aspect of quality on a card, e.g., ‘*assistance arrived too late*’ or ‘*most vulnerable people received assistance*’.
- If the assessment of the quality of the assistance is different over time, place the cards at the relevant place on the timeline. For example, the assessment may be that the assistance provided at the beginning of the pandemic was too late but that later services were on time. Or that the assistance was ‘*sufficient to meet needs*’ at the beginning of the pandemic but that assistance was reduced later and ‘*not sufficient to meet needs*’.
- At the end of the exercises, take a photo of the flipchart and cards. This will make it easy to share the findings with other team members and also to compare findings across FGDs, both within the country and across case study contexts.

At the end of the FGD:

- Thank people for their time.
- Ask if anyone has any questions for us [allow those questions to be answered if even they are questions asking for more services, more help, but do not respond with any commitments].
- Once the FGD is finished, ensure that if there is a need for follow-up, that issues are referred as appropriate (see Annex 1 on safeguarding).

## 5. Recording and use of data from community consultations

Since the community consultations will be undertaken in a very limited number of locations per country, they can only provide a snapshot of the assistance provided. For this reason, the data from the community consultations will be specific to each country, but the evaluation report will use the data to triangulate or illustrate findings. Therefore, it is important that the FGD is properly documented.

## 5.1 Record-keeping

In terms of record-keeping, consultants facilitating the FGDs should keep the flipchart with the timeline and the quality assessment cards, taking a photograph at the end of the FGD and sharing this with the core team. National consultants should write up detailed notes of the discussion in the FGD and share these (preferably in English). To assist in this, the core team has developed record sheets that include the following (see Annex 2):

- A profile page-summarising information on each community.
- List of numbers of people that participated in the FGD (i.e., #women, #men, age, etc).
- Record sheet of groups consulted and any specific gaps.
- Space to record pertinent quotes from the discussion and/or record stories of change.
- Record of key issues that come up and who mentioned them (men or women) to help keep a track and to allow for a comparison across different communities.

It is proposed that the national consultants provide a remote debrief at the end of each day with a member of the core evaluation team. National consultant team members can then read through their notes from the exercise and highlight any key issues and quotes in the team meeting at the end of the day. This will also allow the team to understand any gender differences in the findings, as well as differences in perspectives according to other characteristics (e.g., age of informants) and will also make it possible to identify any issues that need follow-up in subsequent FGDs. A final debrief session at the end of the community engagement will allow discussion between the national consultants and core evaluation team members on the issues raised and methods used, and ensure that team reflections, and community discussions have been recorded fully.

## 6. Summary for national consultants

The table below summarises the tasks for national consultants at each stage of the process of community-level data collection.

Task	Engagement with
<b>Prior to site visit</b>	
Agree geographical locations for site visits for data collection and ensure that the agency facilitating site visits has understood requirements for selecting FGD participants	Evaluation team, in-country focal point for case study
Agree how consultants will travel to data collection sites, date and time of FGDs, who will be the focal point at the site, where the FGDs will be conducted (does the space comply with COVID-19 regulations), etc.	In-country focal point for case study
Discuss data collection tools and questions with evaluation team (in-person or remotely)	Evaluation team
Develop timeline of key events based on review of documents/ online resources.	Evaluation team
Identify assistance provided to communities at data collection sites, to be added to timeline	In-country focal point, agencies operating in data collection sites
Organize flip chart paper, pens, cards for participatory exercise	N/A
<b>During data collection</b>	
Follow the FGD process described in section 3.2 above and photograph the result of the participatory exercises	FGD participants
At the end of each day of data collection, do a debriefing call with the core team members undertaking the case study, as described in section 4.1	Evaluation team

<b>After data collection</b>	
Write up detailed notes of the FGD discussions in the record sheet provided and email to the core team together with photographs of the participatory exercise results	Evaluation team
Conduct a final debriefing with the core team at the end of all the FGDs, as outlined in section 4.1	Evaluation team

## **Annex 11: Ethical and safeguarding considerations for community engagement**

This annex outlines the approach that will be taken to safeguarding and ethical concerns linked to the engagement of evaluation team members with communities. It will be incorporated into the Inception Report

The evaluation team, including national consultants, will abide by the following ethical principles for this Inter-Agency Humanitarian Evaluation (IAHE).

### **Principle 1: Independence and impartiality of the evaluation team members**

The evaluation team members are independent and impartial and, while the participatory approach to community engagement may involve consultants engaging with IASC member/partner and project-related staff, as well as community elders to access communities, identify beneficiaries and/or obtain project-specific information, they will maintain impartiality and independence strictly.

### **Principle 2: Avoiding harm**

The evaluators will ensure that the basic human rights of individuals and groups with whom they interact are protected. This is particularly important with regard to vulnerable people and children. Any data collection involving community members will follow the principle of Do No Harm. Any in-country consultant contracted to conduct engagement with communities will receive full safeguarding training before undertaking any work.

The evaluation team will seek to ensure that key informant questions are modified to sensitivities of each particular country context and to avoid risks around triggering trauma. To mitigate these risks, the approach will adopt culturally meaningful approaches to ensure that the norms and traditions of the study population are respected. The questions will be carefully reviewed to ensure that they do not trigger trauma or force disclosure.

It is essential that robust safeguarding mechanisms are in place to protect the safety of participants and that of team members. Therefore, in each case study country, the evaluation team will identify a mechanism through which it can report allegations of misconduct against aid workers made during the community consultations. The team will also ensure that FGD participants are made aware of how they can report any problems with, or misconduct by, the consultants conducting the FGDs. The team will also make efforts to identify a referral mechanism for participants in case they become distressed after the FGD, including a trusted person external to the data collection.

### **Principle 3: Child protection**

To avoid any risks to children, the evaluation team will not conduct FGDs or interviews with anyone aged below 18.

### **Principle 4: Treatment of participants**

The evaluation team is aware of differences in culture, local customs, religious beliefs and practices, personal interaction and gender roles, disability, age and ethnicity, and will be mindful of the potential implications of these differences when planning, carrying out and reporting on evaluations. This particular principle informs the approach to the FGDs with beneficiaries in this evaluation.

### **Principle 5: Voluntary participation**

Participation in research and evaluation should be voluntary and free from external pressure. Information should not be withheld from prospective participants that may affect their willingness to participate. All participants have a right to withdraw from research/evaluation and withdraw any data concerning them at any point without fear of penalty. The team will make it clear to FGD participants from the beginning that their participation is entirely voluntary and they can leave at any time.

### **Principle 6: Informed consent**

Evaluation team members will inform participants how information and data obtained will be used, processed, shared and disposed of, prior to obtaining consent. First, informed consent of stakeholders will always be sought. Stakeholders will be informed of why we are collecting data and how we intend to use it, and will be offered the opportunity to withdraw from the process at any time. Second, all data will be collected under the guarantee of confidentiality. If it is decided that we want to attribute evidence to a particular stakeholder, we will seek their consent first.

### **Principle 7: Ensuring confidentiality**

It is anticipated that some of the main ethical concerns of this evaluation will relate to risks around confidentiality, anonymity and privacy. The evaluators will respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. They will also inform participants about the scope and limits of confidentiality. We are clear that confidentiality and data protection are critical, and therefore will ensure this remains a priority throughout the evaluation process. For example, respondents will be asked for permission prior to recording interviews, only evaluation team members will have access to recordings and transcripts and respondents will not be individually identified at any point. Data will be anonymized, and any identifying information will be stored separately from interview responses.

It will be important to ensure that sampling participants for the evaluation will not inadvertently put them at risk of being identified by others in the community or by authorities. During FGDs, the team will not collect any personal data from participants. They may note characteristics of a participant if this is relevant for their experience of receiving assistance, for example, specific challenges experienced by an older person or a person with disability.

### **Principle 8: Data security**

The evaluation team will guard confidential material and personal information through the proper use of passwords and other security measures. Evaluators have an obligation to protect data and systems by following up-to-date recommendations to avoid damage from viruses and other malicious programs.

In addition to the principles outlined above, the approach to engaging with communities will take account of (i) the COVID-19 situation in the locations where the FGDs are planned (ii) any national protocols that are in place, (iii) any additional United Nations (UN)/ Non-Governmental (NGO) guidance or advice as to how much movement within countries is feasible and (iv) vaccination status.

## Annex 12: Humanitarian aid worker survey

This annex outlines the approach that will be taken by the evaluation team to engaging frontline and headquarters-based humanitarian aid workers the evaluation process through the use of an online survey.

### 1. Purpose

As outlined in the ToR for the evaluation, the team proposes to conduct an online stakeholder survey. The purpose of the online survey is to gather perspectives on the COVID-19 response from a wide range of stakeholders based in as wide a range of the GHRP countries as is practical. Analysis of survey data will complement information gathered during the document review, interviews and community-level consultations. It will allow the evaluation team to consider views from stakeholders beyond the eight countries selected for case-studies. Design of the survey and analysis of the results will take into account existing data from other surveys.

### 2. Target audience and dissemination

It is proposed to survey broadly across the IASC members and their partners and agencies with responsibility for leading and coordinating collective action. Included among these are UN agencies, cluster leads, NGOs (local, national and international), Red Cross/Red Crescent staff and volunteers, and government representatives. The survey will be conducted online and be available in four languages (English, French, Arabic, and Spanish). A list of target individuals and groups to complete the survey will be drawn up in cooperation with OCHA and the MG. OCHA staff at country level will be requested to support the dissemination of the survey with their networks to encourage a good response rate.

### 3. Survey parameters

The focus of the survey is on a discrete sample of evaluation questions which include inter-agency coordination and leadership (EQ2 and 6), resource mobilization (EQ5), feedback mechanisms (EQ6) and lessons learned (EQ7). Responses will be consolidated to provide one overall summary of the results in English. The length of the survey will be kept as short as possible (taking approximately 10 minutes to respond) and questions will be straightforward in order to incentivize a high response rate. Questions will be based mainly around a five-point Likert scale. The survey will not collect data that could lead to the identification of individual respondents and all individual survey responses will be kept confidential. Only aggregate results and summaries of open-ended responses will be shared with OCHA and included in the evaluation report.

### 4. Draft Survey

#### Introduction

This survey is for those delivering humanitarian assistance in response to COVID-19 at country level during 2020 and 2021. It is part of an independent, inter-agency evaluation of the humanitarian response to the COVID-19 response which has been commissioned by the Inter-Agency Standing Committee (IASC). The evaluation does not focus on the work of any one organisation or type of organisation but will assess the extent to which the overall humanitarian response met the COVID-19 related needs of affected populations. The evaluation timeframe is January 2020 to the present time. Lessons from the evaluation should help to improve future humanitarian responses to a global, multi-dimensional crisis.

The survey should take approximately 10 minutes to complete. Please aim to answer all of the questions. The survey will not collect any personal data that would enable the evaluation team to identify individual respondents. Responses are confidential and will only be seen by members of the evaluation team.

Thank you for participating.



## 1. Introductory questions

1.1 In which country are you based?

- Drop-down list of 63 GHRP countries

1.2 In what type of organisation do you work?

- Government
- United Nations
- International NGO
- National/local NGO
- Red Cross

1.3 What role did you/do you play in the COVID-19 response?

- National (office based)
- Sub-national (office based)
- Sub-national (delivering assistance directly to people)
- I haven't been involved in the COVID-19 response

1.4

1.5 Gender

- Female
- Male
- Non-binary

## 2. Inter-agency coordination and leadership

2.1 How effectively did the inter-agency coordination mechanisms that you participated in support a coherent response to COVID-19?

**Effectiveness of sector/cluster coordination mechanisms**

Excellent      Good    Fair    Poor    Very poor

3.2 To what extent were national/local actors adequately represented in sector/cluster coordination mechanisms in which you participated?

**Representation of government in sectors/clusters**

Excellent      Good    Fair    Poor    Very poor

**Representation of national/local organisations in sectors/clusters**

Excellent      Good    Fair    Poor    Very poor

3.3 To what extent were the views of national/local actors taken into account in the coordination and decision-making mechanisms in which you participated? (please score the inter-agency coordination mechanisms you participated in at global/regional/national/sub-national level on a scale of 1-5 with 5 being excellent and 1 being poor)?

**Quality of participation by local/national actors**

Always Often Sometimes Rarely Never

3.4 How much of a decision-making or leadership role did national/local actors have in the humanitarian response?

**Government decision-making/leadership**

Very important Important Moderately important Slightly Important Unimportant

**National/local organisation decision-making/leadership**

Very important Important Moderately important Slightly Important Unimportant

**3. Resource mobilization**

3.1 Did your organisation receive additional funding for the COVID-19 response?

In 2020 Yes No

In 2021 Yes No

In 2022 Yes No

3.2 How timely was any additional funding for the COVID-19 response?

**Timeliness of funding received by organisations**

Excellent Good Fair Poor Very poor

3.3 How much flexibility did your organisation have to reprogramme funding to meet changed needs due to COVID-19?

**Flexibility of the funding received by organizations**

Excellent Good Fair Poor Very poor

**5. Feedback mechanisms**

5.1 Were affected people able to give feedback on/complain about the humanitarian assistance that they received during the COVID-19?

**Availability of feedback mechanisms**

Always Often Sometimes Rarely Never

5.2 How effectively did feedback/complaints mechanisms capture the views of affected people during the COVID-19 response?

**Effectiveness of feedback mechanisms**

Excellent      Good    Fair    Poor    Very poor

**5. Lessons learned**

5.1 What are the most important challenges with the COVID-19 response that should be addressed to improve future responses? (Please rank the list below with the most significant challenge first and the least significant challenge last)

- Ensuring national/local actors can play a leading role in humanitarian coordination/decision-making
- Ensuring adequate and timely funding for frontline responders
- Delivering a timely response to those in greatest need
- Working effectively across the humanitarian – development – peace nexus
- Ensuring affected people can give feedback on the assistance they received and receive a response
- Meeting the different needs of affected men, women, people with disabilities, elderly and other particularly vulnerable groups
- Having better preparedness measures in place to respond to a global crisis
- Other (please specify)

5.2 What innovative approaches or solutions did your organisation develop in response to the challenges posed by COVID-19 that would be useful for other humanitarian responses (current or future)?

## Annex 13: Evaluability, limitations and mitigation measures

This annex provides the results of the light-touch evaluability assessment that was conducted. It outlines the risks to the evaluation and proposes a series of mitigation measures to address them.

### 1. Evaluability questions

The evaluation team conducted a light-touch review of evaluability. The purpose of this was to ensure that the evaluation design and tools take account of limitations identified in, for example, the availability and quality of data, and to ensure that the scope of the evaluation is appropriate to address the needs and views of key evaluation stakeholders. Key questions used by the evaluation team to assess evaluability are listed in the box below.<sup>147</sup>

#### Clarity about the purpose and scope of the evaluation

- Is the purpose of the evaluation clear?
- Is there a common understanding of the scope of the evaluation?

#### Data quality and availability

- Is there relevant information available to answer the evaluation questions (including policy and strategy documentation, baselines, and reports)?
- Is there capacity to collect, organize and provide this information to the evaluation team, and is the information reliable?

#### Monitoring and evaluation tools and systems

- To what extent are there clearly defined theories of change, monitoring systems or implementation strategy documentation in place for complex humanitarian programmes?
- To what extent are there results frameworks with well-defined indicators and baselines in place?

#### Conduciveness of context to evaluation

- Are evaluation stakeholders accessible, available and in agreement on the evaluation objectives?

### 1.1 Clarity about the purpose and scope of the evaluation

The purpose of the evaluation is clear although the scope is very broad and different stakeholders have different interests within the broad (substantive) scope of the evaluation. Some aspects of the evaluation lack clarity as a consequence of the use of the three different frameworks that were used to guide and fund the response (being the SPRP, the GHRP and the SERP). The implication of this is that it is not always possible to clearly distinguish which aspects of the response are within scope. Reference in the impact evaluation question in the ToR, to the ‘*humanitarian needs of affected people*’<sup>148</sup> offers a potentially helpful lens that focuses the evaluation on the assistance that was required by affected communities (as opposed to the frameworks that guided the response). However, it is important to acknowledge an expectation that community needs will have varied considerably both within and between different communities.

The ToR emphasizes that the evaluation will focus on the ‘*collective response of the IASC member organizations in support of people, and in coordination with government and local actors*’. It also clarifies that it ‘*will not focus on agency-specific responses*’. However, interviews have highlighted some dissonance about the implications of this and the extent to which an IAHE should seek to hold individual agencies accountable for their responsibilities for leading or coordinating collective action

<sup>147</sup> The approach taken builds on guidance developed by Department for International Development and UNIFEM; DFID (2013), *Planning Evaluability Assessments: a synthesis of the literature with recommendations*; UNIFEM (2009), *Guidance Note on Carrying Out an Evaluability Assessment*.

<sup>148</sup> This reference is made under the impact criterion which is worded in the ToR as follows, ‘*To what extent is there evidence that the IASC’s collective response to the pandemic was able to meet the humanitarian needs of affected people, including the most vulnerable groups?*’.

(for example, cluster lead agencies). It will be important that clarity is provided to the evaluation team given the sensitivities that exist regarding this issue.

The temporal scope of the evaluation is clearly outlined in the ToR, and hence there is very limited potential for misunderstanding. Again, it is the breadth of the of the task (i.e., evaluating an appeal in which 63 countries participated) that will offer the greatest challenge; despite the focus on primary data collection from eight countries which makes it far larger than any previous IAHE, the sample size remains comparatively modest. Given that the context of the COVID-19 response in each country will be different in terms of the number of cases, transmission of the virus, patterns of vulnerability, context of the government response, capacity of the humanitarian system, it may be a challenge to identify, analyze and distil findings that are generalisable.

## 1.2 Data quality and availability

The ToR outlines a set of 6 evaluation questions and 24 sub-questions which are disaggregated according to the OECD/DAC criteria. During inception, these were re-framed by the evaluation team around the HPC, which offers a more relevant (and practical) lens for the IAHE as this is the framework that IASC members and their partners use to organize their collective response. It is anticipated that this will assist in ensuring that the findings and recommendations are similarly useful and practical.

Despite the re-organization, there are challenges both with the quality of the data and the quantity of data that is available; there are some evaluation questions and aspects of the COVID-19 response for which limited information is available and some gaps in the evidence. In particular, some of the initial decision-making during the Scale-Up activation were not recorded and interviews highlight the existence of differing perceptions among different stakeholders.

Linked to the issue of perceptions about the response, the inception and pilot phase has highlighted a number of sensitivities that exist; the COVID-19 response was complex, and this required that the humanitarian system *'build the plane while it was flying'*, but this also meant that there were shortcomings, gaps and deficiencies. This underlines the importance of the evaluation being independent of any one agency, but also the need to ensure confidentiality.

By focusing the *'impact'* evaluation question in the ToR on people's own experiences of the assistance they received, the ToR is shifting the locus of power to the intended beneficiaries of assistance which is laudable. At the same time, doing justice to this in the evaluation will be challenging. It is important to recognize that the primary evidence collected by the evaluation will only offer a limited snapshot of peoples' perceptions, and that much time has passed since the early response in 2020. Moreover, while the evaluation team has proposed an approach to harvest secondary data, an initial examination of the data reveals a lack of relevant or consistent household-level evidence. Where the data does exist, it tends to be quite specific to projects or agencies and there is little that is consistent within or between countries. Discussions with key stakeholders and members of the Global Evaluation Advisory Group reveal an acknowledgement of this finding, and the associated challenges that it will present to the evaluation.

The question that the ToR poses on the humanitarian – development – peace nexus is an important one, but it is also one that the evaluation will not be able to answer in its entirety due to its breadth that necessarily goes beyond the scope of its humanitarian focus. A thorough examination would require that all three of the existing response frameworks and the results of the SGs Call for Solidarity be analyzed which goes beyond the resources that are available. The focus by this evaluation on the humanitarian response is being complemented by an evaluation of the development system and efforts will be made to explore common issues such as the nexus between the two; in the case study countries, an examination of the nexus will necessarily be undertaken from a humanitarian perspective.

### 1.3 Monitoring and evaluation tools and systems

The ToR proposed that the evaluation team develops a theory of change (ToC) of the broader inter-agency effort to guide the evaluation during the inception phase and a top-level ToC for the response was developed and is attached to the ToR which uses the preliminary results framework as a basis.<sup>149</sup> However, ToCs of this nature are most useful when they are able to speak to how change happens in particular contexts, alongside context-specific assumptions (often through the development of nested ToC) which would necessitate, at a minimum, a separate ToC for each country. Instead, the evaluation has sought to draw on aspects of ToC thinking to develop analytical and conceptual frameworks for the evaluation.

While the GHRP offers a global chapeau for the response, as outlined earlier in this section, it overlaps with other response frameworks and is too high-level to inform the case studies. At a country-level, interviews have highlighted that a range of approaches were adopted for planning, with little consistency between countries; approaches included the application of unit-based vs project-based country in the same country at the same time (i.e., one method for COVID-19 responses, one for non-COVID) as well as by a hybrid approach of having some countries integrate their COVID-19 components into existing humanitarian plans while others kept them separate).

While a monitoring system was agreed and put in place, interviews suggest that it has proven challenging to implement this effectively both because of flaws in the design, but also because of limitations in organizational engagement and take-up.<sup>150</sup> The pilot case studies will offer an opportunity for the evaluation team to explore issues of access to, and the reliability of country-level monitoring data.

In a similar way, there was a lack of clarity about COVID-19 '*boundaries*' and what activity could be classed as COVID-19 if it straddled some elements of non-COVID-19 responses. This confusion has been replicated in financial tracking and there has been a lack of clarity about how to attribute funding in FTS resulting in a lack of consistency.

These monitoring and classification challenges that were faced during the COVID-19 response will also have an effect on the ability of the evaluation to draw on coherent/consistent evidence, both in terms of having confidence in the results that have been reported, but also in terms of the data that is available to the evaluation.

### 1.4 Conduciveness of the context to the evaluation

Interviews undertaken during the inception phase reveal an appetite for the evaluation and an interest in its findings which provides a helpful platform on which the evaluation team can build interest and engagement. However, with the significant increases in global vulnerability, and with little improvement in the challenging context in which so many IASC members continue to work, it is also a very difficult time to conduct such a complex evaluation. The escalating food-security crisis in Afghanistan, the ongoing conflict in Ethiopia and the invasion of Ukraine and growing regional refugee crisis are all receiving the urgent attention they deserve, but the general busyness of IASC members will be a potential limitation for the evaluation.<sup>151</sup>

From an operational perspective, a field-focused evaluation runs considerable risk of being negatively affected by the challenges posed by COVID-19 which has the potential to cause delays and pose

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<sup>149</sup> In the 'Evaluation Approach and Methodology section' of the ToR, it is proposed that 'a ToC will be developed at the outset of the evaluation' and that 'the selected evaluation team will work with this to ensure it encapsulates what has been targeted through the inter-agency effort, under what assumptions, through what pathways, and how these pathways are interrelated.'

<sup>150</sup> The GHRP learning paper will examine and report on issues of monitoring and reporting in greater detail.

<sup>151</sup> In the last two weeks of the inception phase, the majority of interviews with senior humanitarian staff have been cancelled due to competing operational priorities, mostly linked to the escalating Ukraine crisis.

challenges in delivering outputs on time. Linked to this, it is important to recognize that should the pandemic preclude field work, while the evaluation team have contingencies in place, the quality of the analysis and the outputs will be adversely affected. For this reason, the ongoing support and engagement of OCHA and the members of the MG is considered essential in trying to facilitate field visits, to the extent possible.

## 2. Risk matrix

The table below provides details of some foreseen risks in implementing this evaluation and lists mitigation measures that the evaluation team intend to follow to reduce these risks.

Risk	Risk	Mitigation	Residual risk
<b>Risks associated with security, logistics, HR and administration</b>			
Possible duplication and overlap between the IAHE and other system-wide evaluative and learning initiatives.	Medium	Both this evaluation and the SWE have been sensitized to concerns about potential overlap and are already discussing means of managing this. The ToRs for the two evaluations, do, in large part, mitigate the potential for this. The ongoing evaluation review/synthesis being undertaken by the team, has assisted in identifying areas of overlap which will be further analyzed during the inception and pilot phase of the evaluation.	Low
Excessive burden of the ongoing Covid-19 pandemic response and other crises on humanitarian aid workers limits their engagement.	Medium	The team have a systematic methodology for reaching out to country level stakeholders and will work with focal points to identify (i) a larger number of contacts than required to ensure a minimum number of stakeholders across different categories can be reached; (ii) suggest group interviews where possible to increase the number of respondents to the evaluation; and (iii) ensure good triangulation of key informant responses with document review to validate the information provided by key informants. At global and regional level, the evaluation team will work to compile a list of contacts early on in the data collection phase to ensure there is sufficient time for stakeholders to be available for interview.	Low
Logistical, security and access challenges that are currently hard to predict due to international and national travel restrictions related to the COVID-19 pandemic.	Medium	KonTerra has built up expertise managing the risks the pandemic presents and will bring this to bear in the evaluation. The evaluation team has proposed a 2-option approach within the evaluation, covering (i) possible in-country visits; (ii) a hybrid approach of remote data collection by evaluation team member and working with national consultants for FGDs with communities.	Low
Delays to the start of data collection. For a multi-country evaluation, delays in one aspect of the process can have significant implications for other aspects, particularly when these occur at the early stages of the evaluation	Medium	The team will maintain regular liaison with the OCHA evaluation manager and will also draw on the capacity of MG members to facilitate aspects of the evaluation where this is required. The Team Leader will make clear requests for support where, and if, needed to help address bottlenecks. Prompt support will be a prerequisite to problem-solving.	Low
<b>Risks associated with clarity about the scope and scale of the evaluation</b>			
It will be important to build trust in the independence of the evaluation and in evaluation confidentiality in order to elicit engagement from stakeholders that are representative of the diversity of the humanitarian system.	Medium	The team will utilize KonTerra's and Itad's safeguarding policies and ethical principles and develop culturally appropriate approaches to informed consent and/or assent, voluntary participation, right to withdraw, anonymity and confidentiality. The use of the evidence matrix and summary will ensure triangulation of all data while anonymising the sources of data which only the evaluation team will have access to.	Low
The evaluation is broad in terms of its geographic scope and the breadth of issues under evaluation, which may make it difficult to capture and prioritize the most important findings.	Medium	The re-organization of the evaluation questions has assisted in providing greater coherence and addressing overlap within the evaluation questions. The development of an analytical and conceptual framework is also helpful in focusing the evaluation on how the humanitarian system works in practice, in addition to ensuring its focus on the 'collective' response. Strong validation and triangulation within and between the	Medium

		comparative case studies will also contribute to identifying common issues.	
The overlapping response frameworks are confusing, but also complicate efforts to clearly delineate the boundaries of the substantive scope of the evaluation. Moreover, these boundaries will likely be different in each of the country case studies.	High	The team has started a process to identify and delineate the boundaries between the different response frameworks although this is a complex undertaking as it lacked clarity during the response itself. Good communication with the evaluation team undertaking the SWE will assist in ensuring coherence between the two exercises.	Medium
<b>Risks associated with the quality and availability of data</b>			
There is broad acknowledgement that data reliability might be problematic, particularly in terms of the results of the GHRP.	High	The evaluation will not be able to address deficiencies in the global monitoring data. Through the comparative case study approach that has been proposed, the evaluation will have an opportunity to focus on country-level data which it can complement through its own primary data collection during its FGD with affected communities. With the evaluation occurring almost two years after the launch of the GHRP, there is also likely to be gaps in evidence due to staff turnover, lack of recall and difficulty in identifying documentation.	Medium
Due to the dynamic nature of the COVID-19 pandemic and the speed at which decisions were taken, not all key moments in the collective response may have been documented.	Medium	The evaluation team will maximize key informant interviews to fill information gaps and rely on anecdotal evidence in some instances where documentation is missing.	Medium
Harvesting community perceptions on the COVID-19 response will be a complex undertaking and it is anticipated that it will be difficult to build a coherent analysis from the secondary data that is available.	High	The evaluation team will approach the collection of community perceptions of the humanitarian response through two complementary processes: (i) analysis of Ground Truth Solutions data collected across a number of GHRP countries, and (ii) primary data collection in each of the case study countries undertaken by national evaluation consultants	Medium
It may be difficult to conduct in-person community consultations as planned in certain contexts due to COVID-19 related restrictions or access issues due to conflict, remote location, etc.	Medium	The evaluation team will conduct individual phone interviews with affected populations in cases where in-person focus group discussions are not possible. The team will rely on agencies responding to COVID-19 to provide the contact details for phone interviews. This will reduce the number of people consulted but will yield more detailed qualitative data.	Low
While an examination of the humanitarian – development – peace nexus is an important aspect of the ToR, the evaluation will be limited in the extent to which it will be able to do this given its primary focus on one of the three response frameworks.	Medium	Ongoing engagement and structured discussions with the SWE will assist in mitigating this risk, although a review of the nexus is outside the scope of the SWE. Attempts by the evaluation team to have a shared case study country (Sierra Leone) may offer an opportunity to explicitly focus on the nexus between humanitarian and development interventions.	Medium



## Annex 14: Interview question template

This annex outlines the interview questions which were developed from the EQs and indicators listed in the Evaluation Matrix.

### 1. Preparedness

1.1 To what extent were the collective preparedness measures put in place by the IASC prior to the pandemic relevant and adapted to the COVID-19 pandemic?

- Did IASC preparedness measures include infection disease/pandemic scenarios?
- Were they designed for and relevant to a multi-country crisis?
- Did they take adequate account of national and local capacities and leadership for preparedness?
- Did they take account of situations of restricted movement of aid workers/access to affected populations?
- In what ways were the preparedness measures adapted, at both global and country level?

1.2 To what extent did the IASC's preparedness measures in targeted GHRP countries after Scale-Up declaration contribute to more timely and relevant humanitarian response?

- To what extent did IASC member agencies/partners undertake Advanced Preparedness Measures and contingency planning in response to COVID-19?
- To what extent did the measures contribute to a timely response?
- Did the measures assist in the design of a response that was relevant to the needs of affected populations, particularly vulnerable groups (women and girls, older persons, persons with disabilities)?
- Were member agencies/partners able to adapt the measures as the situation evolved?

### 2. Coordination and information management

2.1 To what extent was the IASC response coherent and well-coordinated in its delivery of the response to a multi-dimensional crisis?

- To what extent were coordination mechanisms aligned with IASC policies?
- What mechanisms were in place for IASC members to coordinate their response efforts at global and country levels? Did they have clear roles, responsibilities, procedures and adequate resources?
- What was the regularity of, and consistency in, coordination efforts?
- To what extent - and in what ways - did coordination mechanisms include national and local actors?
- How effectively was the IASC response coordinated with development actors and government?
- To what extent and in what ways did coordination mechanisms promote coherent response across sectors?
- To what extent to which existing or new coordination mechanisms for CCIs e.g., Gender Working Groups, Disability Working Groups, etc helped draw attention to and address the needs of particularly vulnerable groups (both in existing clusters and in newly established Task Forces).

- What factors influenced the effectiveness of coordination mechanisms?

#### 2.2 To what extent have inter-agency information management and communication mechanisms been able to support IASC collective decision-making?

- What types, regularity and quality of information management and communication mechanisms were used by IASC decision-makers (at global and country level)?
- To what extent do IASC decision-makers perceive that existing information management and communication mechanisms were appropriate and useful for the pandemic response?
- What other information management mechanisms were used to inform IASC collective decision-making?

### 3. Needs assessment and analysis

#### 3.1 To what extent were country humanitarian plans and response strategies for the pandemic informed by a systematic and comprehensive identification of affected people's needs?

- To what extent were needs assessments conducted in a timely and systematic way?
- Is age- and sex-disaggregated data on humanitarian needs being collected?
- To what extent did needs assessments identify the specific needs of women and girls, persons with disabilities, older people, marginalised groups, displaced populations, and other potentially vulnerable population groups?
- Were there any examples of innovative and effective approaches to needs assessment which took into account access restrictions and aligned with the (evolving) characteristics of the pandemic?
- To what extent did country humanitarian plans and response strategies based on needs assessment data and analysis and take account of the different needs of segments of affected populations?
- Did country humanitarian plans identify and address protection risks, particularly for the most vulnerable groups?
- To what extent did country humanitarian plans demonstrate that protection issues and risks were mainstreamed within context-based needs and risk analysis?

#### 3.2 To what extent were assessments of humanitarian needs conducted in consultation with affected populations?

- Did needs assessments include consideration of, and consultation with, affected people, including different segments of the affected population?
- What challenges were encountered for the inclusion and participation of affected people in needs assessment, and how were these addressed?
- Is there evidence of procedures/processes for beneficiary feedback and evidence that the response took account of feedback?

### 4. Strategic planning

#### 4.1 To what extent did the IASC's collective global, regional and country-level humanitarian response planning and prioritisation correspond to the national priorities of affected countries?

- Were national priorities for the pandemic response clearly articulated?

- If so, what mechanisms did global, regional and country-level humanitarian planning and prioritisation processes have to ensure that IASC response planning was in alignment with national priorities?
- Is there evidence to show that IASC response planning was adapted to better align it with evolving government priorities?
- Were affected country priorities adequately reflected in the GHRP and regional and country-level humanitarian response plans?

## 5. Resource mobilization

### 5.1 To what extent were the IASC's efforts successful in mobilizing adequate, timely and flexible funding to meet the GHRP requirements?

- What quantity of funds were raised against GHRP appeal?
- What level of un-earmarked funding was raised?
- What was the timing of donor commitments and disbursement to the GHRP appeal?
- What types of fundraising approaches were used?
- Did the GHRP process and country level response plans take account of resource mobilisation efforts for longer-term socio-economic recovery?
- Were internal IASC agency funding approaches and instruments used to provide adequate and timely funding?
- What factors influenced donor decisions to contribute to GHRP appeal?
- To what extent did donors engage in GHRP planning?
- To what extent was adequate funding made available for CCIs during the COVID-19 response (e.g., protection, disability, GBV, women's empowerment etc.).

### 5.2 To what extent did pooled funds contribute to the provision of adequate, timely and flexible funding to meet the GHRP requirements?

- What level of funding was made from CERF and CBPFs against GHRP requirements?
- Is there evidence of donors increasing their funding to pooled funds to support the COVID-19 response? If yes, what were their reasons?
- What was the timing of pooled fund allocations and disbursements to COVID-19 response?
- What measures were taken to ensure flexibility of CERF and CBPF funding?

### 5.3 To what extent did IASC allocation strategies, mechanisms, and decision-making processes facilitate the efficient use of available resources to meet response objectives, including by channeling resources to frontline responders (international and local/national NGOs and civil society organisations (CSOs))?

- Were there clear processes of prioritisation and decision-making in place to make efficient use of resources?
- What degree of alignment existed between the allocation of resources and response objectives?
- To what extent were resources allocated in a timely way, including to frontline responders?

- To what extent, and in what ways, were resources allocated to actors best placed to achieve response objectives?
- To what extent did IASC allocation strategies prioritise funding to frontline responders?
- What mechanisms were in place for channelling resources to frontline responders?
- What was the level of funding from IASC mechanisms to I/NGOs and CSOs?
- How flexible was the funding channelled to frontline responders?

## 6. Implementation and monitoring

### 6.1 Collective response mechanisms

#### 6.1.1 What was the added value of collective mechanisms to the planning and implementation of the response?

- What were the benefits of collective needs assessments?
- How inclusive were collective planning processes?
- In what ways did coordination mechanisms ensure better coverage of assistance and avoid duplication?
- To what extent did IASC members use collective mechanisms for accountability and PSEA during the COVID response and what benefits did these deliver for affected populations?
- To what extent did IASC members use collective mechanisms on risk management and access during the COVID response to ensure presence and proximity to those in need? What were the implications for affected people who were out of reach?

#### 6.1.2 To what extent were the global IASC strategy and Scale-Up mechanisms effective in ensuring IASC country teams' capacity to lead, coordinate and deliver humanitarian assistance in targeted countries?

- To what extent did IASC country teams consider that global IASC strategy and Scale-Up mechanisms supported the leadership of the response?
- To what extent were the Global IASC strategy and Scale-Up mechanisms and country-level humanitarian coordination and delivery mechanisms aligned?
- To what extent did the activation of global IASC strategy and scale-up mechanisms uphold underlying humanitarian principles, the core protection principle, the do no harm principle, as well as good practice on national/localized response, AAP, humanitarian-peace-development collaboration, coordination, quality funding and cross-sector collaboration?

### 6.2 Humanitarian-development-peace nexus

#### 6.2.1 To what extent were the IASC humanitarian policies, strategies, and responses to COVID-19 consistent and complementary with the health and social economic responses by United Nations and other actors?

- What alignment and complementarity existed between IASC humanitarian policies and strategies with national health and social economic response plans and strategies?
- What examples exist of consistency and complementarity between humanitarian and health and social economic programming?
- To what extent were IASC policies, strategies and responses aligned with the broader social and economic responses contained in the UNDAF/UNSDCF?

- What factors helped/hindered the consistency and complementarity of the humanitarian, health and social economic responses?

**6.2.2 To what extent did the collective humanitarian response to the pandemic contribute to the overall objectives of the SG's call for solidarity to address the impact of the multi-dimensional crises?**

- What perceptions/evidence exists of the contribution made by the GHRP response to the SG's call for solidarity to address the impact of the multi-dimensional crisis?
- What specific initiatives were taken to provide assistance across sectors and across the humanitarian-development-peace nexus?
- What factors helped/hindered the achievement of these objectives?

**6.2.3 To what extent were there linkages and synergies in COVID-19-related responses across the humanitarian-development-peace nexus aimed at addressing the intertwined effects of the pandemic?**

- What efforts were made to identify the intertwined effects of the pandemic and establish common objectives and strategies to address them as reflected in joint plans and priority setting?
- To what extent did humanitarian, development and peace actors make efforts to ensure synergies when planning the COVID-19 response?
- What mechanisms were existed or were established to coordinate the response of humanitarian, development and peace actors?
- What examples exist of synergies in the humanitarian-development-peace response?

**6.3 Localization**

**6.3.1 To what extent did international humanitarian preparedness and response to COVID-19 complement and empower national and local actors in their efforts to lead and respond to COVID-19-related humanitarian needs?**

- To what extent were international preparedness planning processes participatory and include national/local actors?
- To what extent did national/local actors lead and/or participate in needs assessments? Were their contributions reflected in the planning processes and priorities?
- To what extent and in what ways were national/local actors involved in (or lead) response coordination mechanisms?
- Did national/local NGOs and CBOs deliver an increased amount of assistance to communities?
- To what extent did government entities lead national COVID-19 responses (including planning)?
- To what extent did international actors seek to identify national/local response efforts and adopt strategies to complement their planning and implementation?
- What efforts were made to enhance involvement, and build capacity, of national and local actors as part of the COVID-19 response?

**6.3.2 How effectively did IASC collective mechanisms for planning and implementing the response ensure local participation?**

- What was the level of local actor participation in clusters or other humanitarian coordination mechanisms?

- What initiatives were taken by clusters and HCTs to ensure local participation in HRPs or other planning processes?
- What initiatives were taken by clusters and HCTs to ensure local participation in coordination and decision-making fora?
- What examples exist of local participation contributing to the quality and consistency of planning?
- What examples exist of collective mechanisms for AAP and PSEA with local participation?
- What perception do local actors have of the quality of their participation in collective mechanisms for planning and implementing the COVID-19 response?

#### 6.4 Adaptive capacity

##### 6.4.1 To what extent did the IASC's collective response prove relevant and adaptive in meeting the demands of the crisis and the humanitarian needs caused by it?

- To what extent and in what ways did the IASC's collective decision-making processes and methodologies adapt and evolve in response to the trajectory of the crisis?
- To what extent and in what ways did the IASC's fast-tracked mechanisms adapt and evolve in response to the trajectory of the crisis?
- What examples exist of UN rules and procedures being flexible and adapted to new information and changes in context?
- In what ways did IASC approaches to providing assistance adapt and evolve in response to the specific challenges posed by the pandemic?
- To what extent and in what ways did the collective response adapt to the identified specific needs of women and girls, persons with disabilities, older people, marginalised groups, displaced populations, and other potentially vulnerable population groups?
- What examples exist of the way in which the efficiency and effectiveness of the response improved as a result of adaptive measures?
- What effect did adapted ways of working, particularly the shift to remote modalities, have on inclusion e.g., were women, older people, PwD harder to consult with because of greater use of phones and social media; or did certain groups of children miss out on education because they weren't able to access remote learning approaches, etc.? What steps were taken to prevent exclusion?

##### 6.4.2 How effective was the IASC's monitoring framework for the COVID-19 response in supporting operational and strategic decision-making?

- What mechanisms were put in place to collect monitoring data against intended results?
- To what extent was the monitoring data relevant for operational and strategic decision-making?
- Was the monitoring data available to operational and strategic decision-makers in a timely way?
- What evidence exists to show that operational and strategic decision-making was based on IASC monitoring data?

- Was disaggregated monitoring data on different population groups available?
- To what extent and in what ways did affected people participate in monitoring the COVID-19 response?
- What perceptions exist of the usefulness of the monitoring data to inform operational and strategic decision-making?
- What examples exist of monitoring data being used to adjust, improve and refine operations?

### **6.5 Results**

**6.5.1 To what extent did the IASC's collective response to the pandemic meet the humanitarian needs of affected people adequately and effectively, both overall and vis-à-vis specific vulnerable groups?**

- What level of assistance was provided against the needs that were identified?
- What number of people were reached with assistance against the number of people that were targeted?
- What evidence exists to show that assistance was targeted in a way that addressed the different needs of women and girls, the elderly, persons with disabilities, displaced populations, and other potentially vulnerable groups?
- What disaggregated data is available on assistance provided to different segments of the affected population and what does it show?
- To what extent did the assistance provided meet minimum standards and uphold humanitarian principles?
- To what extent was protection prioritised within the collective response?
- What are the views of the affected population on issues of timeliness, relevance and adequacy of the assistance they received?
- What evidence exists of the consistency of the response over time?
- What positive results or negative consequences did the assistance provided have for affected populations?
- What evidence is there that the humanitarian needs were aligned/coordinated with longer-term development needs to ensure smooth transitioning of beneficiaries where necessary?

### **7 Lessons learned**

**7.1 What are the main challenges and lessons learned from preparedness and response to the pandemic?**

- What evaluations and lessons learned exercises have been conducted on preparedness and response? To what extent have they been used to course correct?
- What factors helped/hindered pandemic preparedness?
- What factors helped/hindered coordination, processes and procedures?
- What challenges did IASC members face in responding to the pandemic and how did they seek to address them?
- What factors contributed to the effectiveness of the pandemic response?

**7.2 What are the key strategic and policy challenges and opportunities for improving the IASC's future responses to pandemics and other infectious disease events with multi-country humanitarian impacts?**

- What were the key strategic and policy challenges with the IASC response?
- What opportunities exist to improve the response to future pandemics and other infectious disease events with multi-country humanitarian impacts?
- What mechanisms and resources are in place or are required to deliver necessary changes at a strategic and policy level?

**7.3 What were the innovative approaches, solutions, and new ways of working that would benefit ongoing or future responses, in particular those from local actors?**

- What examples exist of international actors adopting innovative approaches and solutions and new ways of working that involved local actors?
- What examples exist of local actors developing innovative approaches and solutions and new ways of working?
- What improvements did these changes bring about and what relevance do they have beyond the COVID-19 response?

**7.4 What are the key lessons from COVID-19 response that can strengthen humanitarian-development-peace nexus approaches in the future?**

- What good practice examples exist of working across the humanitarian-development-peace nexus?
- What are the key challenges with existing mechanisms for collaboration across the humanitarian-development-peace nexus?
- What factors contributed to the success or failure of collaboration across the humanitarian-development-peace nexus?





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