FY21 COVID-19 PERFORMANCE EVALUATION

SUPPLEMENTARY ANNEX

September 2024

This document serves as a stand-alone compilation of reference materials for all performance evaluation deliverables associated with the USAID/BHA FY21 COVID-19 Performance Evaluation. It provides comprehensive supporting information and detailed data to complement the main evaluation report.

The annexes are organized into two main categories:

1. Overall Background Annexes: These annexes provide foundational information relevant to the entire evaluation: A. Methods, Data Sources, and Limitations; B. Interview Lists; C. Funding Overview; G. Case Study Findings; H. References
2. Brief-Specific Annexes: These annexes contain supporting information for each specific brief and evaluation question: D. Brief 1: Internal Brief for BHA; E. Brief 2: Includes separate sections for each objective; F. Brief 3

Each annex is designed to offer in-depth information, methodological details, additional data, and context to support the findings, conclusions, and recommendations presented in the main evaluation briefs. Readers are encouraged to refer to these annexes for a more comprehensive understanding of the evaluation process and outcomes.

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ACRONYMS AND ABBREVIATIONS

Acronym	Definition
ALAC	Asia, Latin America, and the Caribbean
AFR	Africa
AOR	Agreement Officer's Representative
ARP	American Rescue Plan
ART	Award Reporting Tool
ASEAN	Association of Southeast Asian Nations
BET	Budget Evaluation Team
BGH	Bureau of Global Health
BHA	Bureau of Humanitarian Assistance
CARE	Cooperative for Assistance and Relief Everywhere, formerly Cooperative for American Remittances to Europe
CDC	Centers for Disease Control and Prevention
CHPs	Community Health Promoters
CHW	Community Health Worker
CRS	Catholic Relief Services
CSI	Coping Strategy Index
CU5	Children Under Five
CO	Country Office
COVID-19	SARS-CoV-2
CVA	Cash and Voucher Assistance
DD	Disaster Declarations
DDAIM	Disaster Data, Assessments, and Information Management Team
DDI	Development, Democracy, and Innovation
EQ	Evaluation Questions
ERMS	Economic Recovery and Market Systems
ESF	Economic Security Funds
ET	Evaluation Team
FCS	Food Consumption Score
FGD	Focus Group Discussion
FSL	Food Security and Livelihoods
FY	Fiscal Year
GASI	Gender, age, and social inclusion
GBV	Gender-based Violence
GoS	Government of Syria

G3PC	Office of Global Policy, Partnerships, Programs, and Communications
HCIMA	Humanitarian Coordination, Information Management, & Assessments
HCW	Health Care Worker
HF	Health Facility
HH	Households
HHS	Household Hunger Scale
HW	Health Worker
HPSAA	Humanitarian Policy, Studies, Analysis, or Application
HQ	Headquarters
IASC	Interagency Standing Committee
IDA	International Disaster Assistance
IDP	Internally Displaced Person
IFRC	International Federation of Red Cross and Red Crescent Societies
IMC	International Medical Corps
iMMAP	Information Management and Mine Action Programs
IOM	International Organization for Migration
IP	Implementing Partner
IPC	Infection Prevention and Control
KII	Key Informant Interview
LASER PULSE	Long-term Assistance and Services for Research Partners for University-Led Solutions Engine
LOA	Life of Award
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual
MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MCH	Maternal Child Health
MDD	Minimum Dietary Diversity
MENAE	Middle East, North Africa, and Europe
M&E	Monitoring and Evaluation
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
MPCA	Multipurpose Cash Assistance
MUAC	Median Upper Arm Circumference
NFI	Non-Food Item
NGO	Non-Governmental Organizations
NS	North of Syria
NTR	Northern Triangle Region

OA	Office of Africa
Objective	Obj
OCHA	Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
PFA	Psychological First Aid
PHC	Primary Health Care
PHN	Public Health Nutrition
PIO	Public International Organization
PLW	Pregnant and Lactating Women
PSEA	Prevention of Sexual Exploitation and Abuse
PSS	Psychosocial Support
RCCE	Risk Communication and Community Engagement
RMT	Response Management Team
SOP	Standard Operating Procedure
S&S	Shelter and Settlements
SAM	Severe Acute Malnutrition
SGBV	Sexual and Gender-based Violence
SRH	Sexual and Reproductive Health
TANGO	Technical Assistance to Non-Governmental Organizations International
TPQ	Technical and Program Quality
TX	Treatment
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WFP	World Food Programme

A. METHODS, DATA SOURCES, AND LIMITATIONS

METHODS

The briefs were informed by triangulating multiple data sources, including reviews of award data and documents, scoping interviews, a scoping e-survey, Key Informant Interviews (KIIs) with United States Agency for International Development (USAID)/Bureau of Humanitarian Assistance (BHA) and Implementing Partners (IPs), and case study fieldwork, which included in-person KIIs, Focus Groups Discussions (FGDs) with project participants, and a Health Worker Survey. Each method is detailed below, with further description of the case studies in Annex G. See Annex B for interview lists.

Scoping interviews

During the Inception Phase of this evaluation, twenty-five semi-structured qualitative scoping interviews, guided by topical outlines, were conducted with BHA (36 respondents) and select Public International Organization (PIOs) (28 respondents) via Zoom, Google Meets, and Microsoft Teams. The outlines were validated and revised through BHA feedback and based on qualitative topical outlines that were extensively utilized during the Fiscal Year (FY) 2020 COVID-19 Evaluation. Individuals were purposively selected in discussion with BHA from either a pool of pre-identified individuals listed in award documents or in a contact list provided by BHA. Subsequent interviewees were identified using snowball sampling.

Interviews with BHA Key Informants focused on all aspects of the funding, including strategic, design, technical, and programming perspectives. Interviews included members of the BHA COVID-19 Task Force, COVID Council, COVID Working Group, Budget Evaluation Team (BET), and members of the Technical and Program Quality (TPQ) unit, Geo teams, and the Office of Global Policy, Partnerships, Programs, and Communication (G3PC).

Interviews with PIOs were primarily held to understand how the Supplemental was used, if monitoring and evaluation procedures were in place during the award period, and to determine if secondary data could be shared with the Evaluation Team (ET).

Scoping IP e-survey

Simultaneously, during the Inception Phase, the ET conducted an online survey using KoBo Toolbox to gather primary data from IPs that received the Supplemental (February 8-24, 2023). The brief questionnaire (available online and as a Word document in English) consisted of closed- and open-ended questions designed to inform the evaluation design. The survey included questions related to the selection of thematic areas of interest and provided initial information specific to the evaluation questions. IP staff involved in the implementation of the awards were contacted by email and asked to complete the e-survey. Multiple responses from one award were permitted (for example, a response from the prime and another from a sub-awardee). The e-survey responses included 91 unique, completed questionnaires from approximately 72 awards, covering 37 countries and five global awards.

Descriptive analysis of the closed-ended questions was done using Microsoft Excel and SPSS. Each of the open-ended questions was reviewed by a member of the ET. Responses were summarized and, where applicable, categorized to allow responses to be tallied to identify the most salient themes. Illustrative quotes were extracted to support the findings. These data were utilized to revise evaluation questions and were integrated into findings reported across the three evaluation briefs.

KIIs

During the Performance Evaluation, 82 semi-structured, qualitative KIIs (n=155) were conducted with IPs, local partners, BHA Agreement Officers Representatives (AORs), Activity Managers, and the Front Office via Microsoft Teams or Zoom. Over half of the interviews (62 percent) conducted were with PIOs. Interview guides were co-created with BHA and pre-tested in May/June 2023. Most of the interviews were conducted between September to November 2023 and lasted approximately 60 to 90 minutes. Interviews were recorded with respondents' permission and were transcribed by the ET. Transcripts were not returned to respondents for comment or correction. Informed consent was obtained from all interviewees.

Interviewees were purposively selected to maximize heterogeneity of IP type, region, disaster declaration type, sectors, size of awards (i.e., larger awards were a key focal point), and awards with activities that were novel or of interest to BHA. Consideration was also given to IPs who had completed the e-survey (i.e., convenience sampling). The sample size target was 12 Key Informants per objective based on guidance from the qualitative literature, and the ET largely met that threshold.

Qualitative analysis was conducted using the software *Dedoose*. Prior to qualitative coding, the ET deductively developed a hierarchical coding framework using the evaluation questions/matrix. Salient sub-themes (i.e., "child" and "grandchild" codes) were added inductively under primary (i.e., "parent") codes. Analysis was conducted by evaluating salience around themes of effectiveness, relevance, efficiency/timeliness, and levels of coordination and coherence of the funded awards. To ensure the reliability of qualitative data analysis, inter-coder reliability checks were conducted among team members, and any discrepancies were resolved through consensus. Additionally, debriefing sessions were held initially to validate interpretations of the coding framework and code application.

Case study fieldwork

See Annex G for the case study methods by country. In-person case study KIIs and FGDs were used to confirm preliminary findings and Qualitative Impact Protocol (QuIP) outcomes. Five case study countries were selected purposively with BHA based on varied geographic regions, funding levels, sectors, and partner types: Honduras, Syria, South Sudan, Jordan, and Kenya. This fieldwork included a total of 119 KIIs (198 respondents), 85 FGDs (890 male and female participants), and 129 Health Worker Surveys.

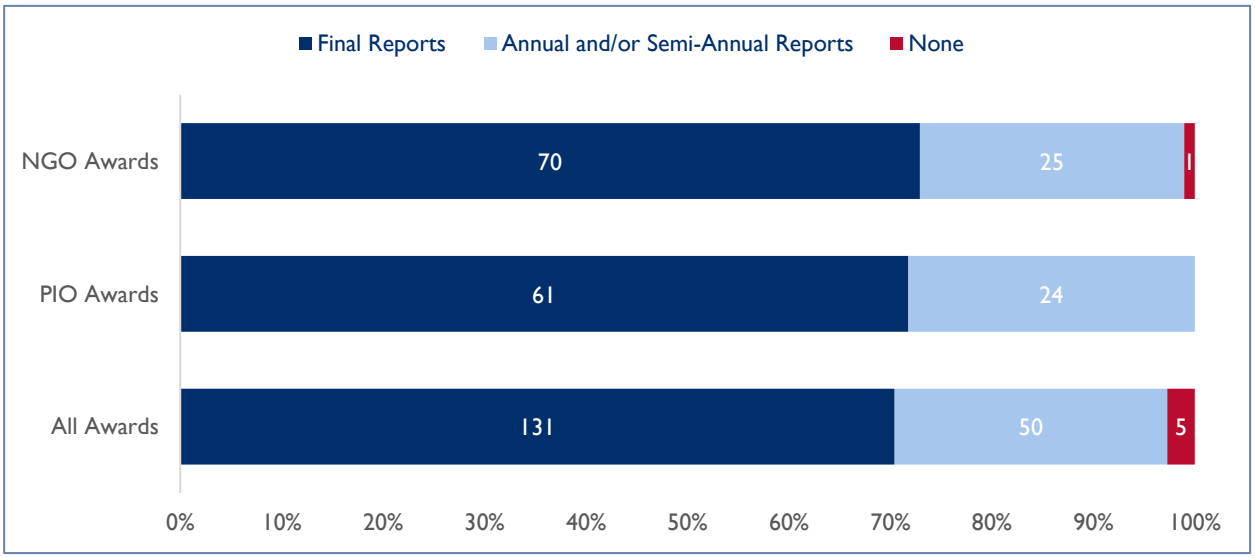
The Health Worker Survey was a cross-sectional, retrospective design including COVID-19 trained community/ primary health care level health workers in Honduras, South Sudan, and Syria. While the survey focused on the training and capacity building support from BHA-funded partners, the health workers may have participated in other types of training by this partner or other organizations in the area. The modules covered approaches for maintaining essential services, satisfaction with the project and trainings, training characteristics and outcomes (self-rated knowledge, skills, and confidence), and future pandemic capacities. Data collection occurred March-April 2024 across 40 health project facility sites of Honduras, South Sudan, Syria. The sample size followed the calculation for continuous outcome for observational, descriptive cross-sectional survey (using knowledge, skills, confidence outcomes five-point scale): For the continuous variable, the commonly used margin of error is 5% (i.e., d=5*0.05=0.252=0.0625), and the estimated standard deviation of the scale is 1.25 (i.e., SD=5/4=1.25). At the 5% Type I error rate or two-sided significance level /alpha of 95% confidence (i.e., α =100-.95=0.05. The minimum sample size of the survey is 95. Final sample: n=129 (Honduras=32, Government of Syria (GOS) controlled areas=36, Northern Syria (NS)=39, South Sudan=22).

Award report review

Award reports were compiled from reports provided from BHA that were available in ABACUS, reports provided by Award AORs, and reports provided by IPs during KIIs. During the inception phase, the ET conducted a review of documents provided by BHA and catalogued which award reports were available and which award reports were missing. The ET provided the list of missing award reports to BHA for a second review of ABACUS. The remaining award reports were compiled via requesting reports from AORs and requesting additional reports from Abacus when enough time had passed for additional final reports to become available. Additionally, some reports were provided by IPs during KIIs. Out of 186* awards, 131 had final reports, 50 had Annual and/or Semi-Annual Reports, and five had no reports. All awards with only annual or semi-annual reports conclude(d) after February 15th, 2023. The five awards with no reports came from masked awards and USAID Research/Development, Democracy, and Innovation (DDI) awards.

** Out of 186 unique awards: an award for the Association of Southeast Asian Nations (ASEAN) was excluded from the document review gap analysis, as it was an FY 2020 funding modification, and the ET did not anticipate an award report for this award.*

Figure 1. Highest Available IP Award Report



Secondary data analysis: Non-Governmental Organization (NGO)/Award Reporting Tool (ART) Indicator Dataset Analysis

Data gap analysis and data verification process

Verifying completeness of the ART Indicator Dataset: After consulting with BHA's Budget and Management Office, the ET was able to verify that the ABACUS Award Dataset contained all the unique Non-Governmental Organization (NGO) award numbers that received FY21/22 Supplemental funds. The ABACUS Award Dataset and the ART Indicator Dataset were then compared against one another to determine the completeness of the ART Indicator Dataset. The process involved filtering for unique NGO award numbers from both datasets, and then comparing these lists of unique NGO award numbers to determine if any NGO award numbers in the ABACUS Award Dataset were missing from the ART Indicator Dataset. The list of award numbers with missing indicator data was periodically shared with BHA, so that missing indicator data could be searched for, extracted, and updated into the ART Indicator Dataset.

Assessing the completeness of the ART indicator dataset's useable, endline data: After consultation with BHA, the ET established that indicator values from final reports – and in lieu of values from final report, indicator values from FY22 annual reports – could be used as 'endline values' for the indicator analysis portion of the performance evaluation. The ET reviewed the ART indicator dataset to determine whether endline data was available for each of the 96 unique NGO awards. All 96 unique NGO awards were classified into one of three categories: awards with no endline values, awards with only FY22 annual report values, and awards with final award report values.

Data gaps identified prior to cross-checking:

Data gap similarities between FY20 ART Indicator data and FY21/22 ART Indicator data: The ART Indicator Dataset gap analysis indicated multiple similarities between the FY 2020 and FY 2021/2022 ART indicator datasets. A selection of similarly identified data gaps found before the endline report cross-checking process include: the mislabeling of non-custom indicators as custom indicators; the mislabeling of type of indicators; variations in indicator labeling that require manual aggregation; and indicators that lacked life of award (LOA) targets, or that were equal to zero.

A table quantifying the number of identified data gaps found in the FY2021/2022 ART Indicator Dataset for each priority indicator, prior to the cross-checking process was provided to BHA by the ET.

Data gaps identified after cross-checking:

Data gap similarities between FY20 ART Indicator data and FY21/22 ART Indicator data: Many of the data gaps identified in the COVID-19 FY20 Supplemental report came to light only after NGO endline report values were cross-checked against the endline values that were submitted to ART. A selection of similarly identified data gaps found after the endline report cross-checking process include: indicator values found in endline reports that were missing/not uploaded to the ART Indicator Dataset; outdated endline indicator values in the ART dataset (where the ET had copies of NGO's final reports, but the ART Indicator Dataset did not include those more up-to-date values); and indicator values in the ART Indicator Dataset that did not match the values found in the same-cited endline report.

Process for retrieving copies of endline reports: After processing the first handover of award data and documents from BHA in late 2022, in March 2023, the ET requested from BHA the remaining endline reports and/or endline indicator tracking tables for the 96 unique NGO awards. Of those, 54 were located and uploaded into the shared drive folders. On a biweekly basis, the ET reviewed the share drive folders to assess which NGO awards numbers it was still missing copies of endline reports for, and periodically shared this information with BHA, so that the remining endline reports could be located, pulled from ABACUS and uploaded onto the share drive. In the two weeks preceding the agreed upon cut-off of May 30th, 2023, the remaining missing reports were collected through direct outreach to AORs near.

The table below summarizes the type of endline reports and the quality of the endline data that the ET was able to collect for the 96 unique NGO awards.

Table 1. Endline report data available for NGO indicator analysis

# Unique NGO Awards	Endline Data Available in ART		Report Collecting Outcomes		Cross-Checking Process
96	No endline values in ART	19	No endline report received	5	Omit from analysis
			Endline report received	14	Cross-check for missing indicators.
	FY22 annual report values	31	Updated, final report received	11	Cross-check for updated values.
			Ongoing Award - Final award values not expected. FY22 Annual report received	20	Cross-check whether values match.
					Cross-check for missing indicators.
	Final report values	46	Final report received	46	Cross-check whether values match.
					Cross-check for missing indicators.

Endline cross-checking process: The way in which the endline reports were utilized depended on the quality of the endline values that were available for each unique NGO award in the ART Indicator Dataset, as well as the type of endline report that the ET received from BHA.

The five NGO awards that had no endline reports and no endline data in the ART Indicator Dataset were omitted from the indicator analysis. The ET received an endline award report for the remaining 14 NGO awards that did not have any endline indicator values in the ART indicator dataset. When priority indicator values were found in these endline reports, the ET extracted and included them in their indicator calculations.

The ET received more up-to-date final award reports for 11 of the NGO awards that only had FY22 annual report values in the ART Indicator Dataset. In such instances, the ET reviewed the priority indicator values in the final award reports and updated the outdated values in the ART dataset.

The ET received a copy of the FY22 Annual Report for the 20 remaining NGO awards with only FY22 Annual Report values in the ART Indicator Database. These reports were cross-checked for whether any of the priority indicators in the FY22 annual report were missing from the BHA Indicator Dataset, as well as for whether the endline indicator values between the FY22 annual report and the dataset matched. Missing indicator values were extracted and included in the priority indicator calculations, while discrepant values found between the report and dataset were assessed on a case-by-case basis. In every instance, a rationale was provided for which value the ET considered to be the most valid.

Copies of final reports were received for all 46 NGO awards that had submitted final report indicator values to the ART Indicator Dataset. These reports were cross-checked for whether any of the priority indicators in the FY22 annual report were missing from the BHA Indicator Dataset, as well as for whether the endline indicator values between the final report and the dataset matched. Missing indicator values were extracted and included in

the priority indicator calculation. Discrepant values found between the report and dataset were assessed, with a rationale provided for every instance where a change was made.

A table summarizing data gaps by priority indicator identified after the cross-checking process was provided by the ET to BHA.

Rationale Matrix: Process for determining the most valid value between discrepant indicator values. As agreed with BHA, when a discrepancy was found between the endline report and ART Indicator Dataset, the ET would review the narrative provided in the endline report to determine why the values for that priority indicator did not match. In every instance, the ET provided a description of the discrepancy, as well as a rationale for why a certain value was determined to be, and selected as, the most valid. As a rule, the ET considered values provided in the narrative report as the most valid, for such values are supported by an accompanying narrative. Similarly, when discrepancies were found between the Indicator Tracking Table and the ART Indicator Dataset, the ET considered values from the tracking tables to be the most valid, as these tables are generally accompanied by an endline report with a supporting narrative.

Indicator Analysis Process

Priority Indicator calculations for aggregated totals, and endline value ranges: Priority indicator totals were presented by aggregated totals for priority indicators with 'number' unit of measurements, or as ranges for priority indicators with 'percent' unit of measurement. The number of unique endline indicators in the ART indicator dataset were provided for each aggregated total, or range.

Assessing whether an award met its priority indicator targets: The ET considered an award a success for a particular priority indicator if the award achieved 90 percent or more of its target. This assessment required awards to provide both a life of award target value and an endline value in the ART dataset for the calculation to be made.

Assessing whether the priority indicator was achieved: The number of awards that achieved 90 percent of their priority indicator targets was then divided by the total number of awards that submitted both a life of award target value and an endline value. If 80 percent of awards achieved 90 percent of their priority indicator targets, the ET considered that priority indicator to have been a success.

As many of the awards were still ongoing during the time of the assessment, the ET provided this calculation for values that came from both final and FY22 annual report endline values, or solely from final report endline values.

Calculating Average Percentage Point Change from Target and Baseline: The percentage point change from the award's target was calculated for each award that provided a life of award target and an endline value. This was calculated by dividing the difference between the endline value and life of award target by the life of award target for every award that provided those two values. After all percentage point change values were calculated, the average of these was taken to calculate the average percentage point change from targets for each priority indicator.

The average percentage point change from baseline calculations were performed for priority indicators that utilized baseline values in the calculation of life of award targets. This was determined by reviewing the BHA Indicator Handbook Annex B for each priority indicator. The calculation was the same as the one used above, for calculating the average percentage point change from target, only baseline values were used in lieu of life of award target values.

PIO (non-World Food Programme (WFP)) indicator data analysis

PIO indicator data was compiled via a review of PIO semi-annual, indicator tracking tables, and final reports. For the initial review, the ET compiled all indicators by sector from each PIO award into a PIO indicator matrix. Once all indicator data were retrieved from award reports, including baseline values, endline values, and targets, the ET reviewed individual indicators from each sector to review what sector specific composite indicators were available. This was necessary because many PIO indicators were non-standardized or slightly differed across awards. In some cases, BHA indicators used for the NGO/ART analysis were available. Where data was available for indicators outside of the indicators used for the NGO/ART analysis, the ET grouped similar indicators provided for multiple PIO awards to create more generalized composite indicators. For each indicator used, the number of awards was tallied, along with the "Output Value (Sum)/ or Outcome Value (% Range)" and the "% of Awards that achieved ≥90% of their Target LOA (if targets available)." Indicator tables were then created for each sector (see Objective Annexes E.1-3) and used for analysis in their respective objective. Note: Objective 4 indicators were not collected in the same way because there were no commonly reported values to build composite indicators across the reports, with the exception of World Food Programme (WFP)/Logistics. Objective 5 indicators were not compiled by sector due to the multisectoral nature of the objective (see E.5. Table 2 for details).

For WFP indicator and data analysis see the end of Annex E.2. Objective 2.

LIMITATIONS

The main methodological limitations to this evaluation study design are the limited availability of quantitative outcome indicator data and the absence of baseline measures. The limited availability of data extends to gaps in the ART database, which lacks cross-checks of NGO endline and baseline reports when the results in the ART system are either missing or questionable. The ET worked closely with BHA and IPs, including PIOs during the Inception Phase of this evaluation to ensure all available indicator data were included. IP endline and baseline reports were reviewed to gather missing or questionable baseline and endline values submitted through ART or through IP AORs. A noted limitation is that PIOs do not report indicators that are standard to BHA or comparable to other partners, limiting the information that can be gleaned on activity outcomes. Additional challenges and/or limitations and their mitigation strategies are described below.

Table 2. Limitations, Challenges, and Mitigation Strategies

Challenge	Description and Mitigation Strategies
Collecting PIO data	PIO indicator data were systematically collected by the ET externally by individually connecting with PIOs for final reports and available indicator data and by searching for annual, country-level reports online. The ET also liaised directly with BHA activity managers to retrieve data for both PIO and non-PIO awards, when possible. Despite this, 97 of 186* Final/Endline reports were missing as of March 2023, when the Inception Report was prepared. The ET then set a cut-off date of May 31, 2023, for collecting reports to ensure inclusion into the evaluation analysis. Considering award end dates, 42 of the 97 awards were expected to have final reports available by the cut-off: 31 of which were PIO awards. With available PIO award reports, the ET then conducted a systematic extraction of indicator and target values from the narrative and tables of the reports. Groupings of similar indicators were constructed to report aggregate results. The ET acknowledges that this may have resulted in a lack of standardization between indicator data reporting procedures for IPs between country programs and a potential lack of alignment between how different IPs chose to report similar indicators. To address this, some indicators are reported through two units of measurement to account for different indicator reporting practices.

Challenge	Description and Mitigation Strategies
	* Out of 186 unique awards: ASEAN was excluded from the document review gap analysis, as it was an FY 2020 funding modification, and the ET does not anticipate an award report for this award.
Lack of awareness about the objectives of the funding	Scoping interviews revealed that multiple IPs were unaware that the FY 2021 Supplemental funds were COVID-19 programming specific. This led to some confusion during scoping calls, the e-survey, and key informant interviews. The ET informed IPs during interviews about the purpose of interviews and the funding, more generally; respondents were asked to reflect on the life of the award during interviews and the ET refreshed respondents on the award number and title during introductory emails to limit confusion. AORs of awardees that indicated they were unaware that the funding was focused on COVID were also interviewed by the ET.
Differentiating ESF-specific results	The commingling of the Economic Security Funds (ESF) funds with International Disaster Assistance (IDA) awards meant that IPs may not have been able to speak to results specific to the Supplemental. The ET tried, when possible, to discern the specific results of the ESF and report ESF funds without IDA funds, reporting commingled funds as 'Total Funds (ESF + IDA)."
Quality and availability of NGO award data - including outcome and output indicator data gaps	The indicator data gap analysis, and the award document gap analysis show that data for some indicators were limited. These data may not have been available, constraining the evaluation, especially without a comparison or baseline point. Secondary data and documents, including final reports and other assessments, typically varied in quality and reliability. Indicators that lacked sufficient data or did not meet the ET's selection criteria were excluded from the evaluation, ensuring only indicators with sufficient and quality data were used for findings in reports. Qualitative methods and contribution analysis were used to support the evaluation, relying on perceived results and attribution, along with triangulation across data sources. The ET was in close communication with BHA to ensure that all available and reported data were provided.
Sensitive nature of information for specific countries and awards	The sensitive nature of some of the countries and their respective awardees/data limited access to documents and subsequently what the team could evaluate. PIO awards were unmasked, allowing for insight into awards that had previously been sensitive. For awards that were masked, the ET attempted to include learning from these awards as best as possible from various methods, including IP e-survey responses and redacted reports.
Length of time since funding – recall and turnover	The majority of the awards ended within 3-6 months of when this evaluation commenced. Thus, the evaluation sought to gather and analyze primary and secondary data for the Performance Evaluation as soon as possible within the first year of the evaluation. E.g., to mitigate the issue of project staff turnover that would lead to difficulties gathering relevant staff input, the evaluation included an IP scoping e-survey for primary data collection during the inception phase. Recall issues for IPs and participants were mitigated by sending sufficient evaluation and award-specific background with interview requests to help clarify the topics to be discussed. The evaluation case study fieldwork conducted in March-April 2024 faced some challenges with recall, however, the main purpose of this fieldwork was for learning for future global responses (related to the Thematic studies). Overall, data quality to contribute to this purpose was not compromised.

B. INTERVIEW LISTS

Table 1. List of BHA scoping interviews conducted from December 2022 through March 2023

Date of interview	Supplemental role (Task Force, Council, Working Group, BET, Other)
12/13/2022	COVID Council (Primary Representative, TPQ Public Health Nutrition (PHN) and Water, Sanitation, and Hygiene (WASH))
12/16/2022	COVID Working Group
01/04/2023	COVID Council (Asia, Latin America, and the Caribbean (ALAC))
01/06/2023	COVID Council (Coordinator)
01/09/2023	TPQ Food Security and Livelihoods (FSL) Evaluation Contact
01/12/2023	COVID Working Group
01/12/2023	COVID Council (Coordinator)
01/13/2023	COVID Council (Office of Humanitarian Business and Management Operations)
01/17/2023	TPQ Public Health Advisor Evaluation Contact
01/17/2023	TPQ Public Health Advisor Evaluation Contact
01/17/2023	TPQ WASH Advisor Evaluation Contact
01/17/2023	TPQ Public Health Advisor Evaluation Contact (FY 2020 Response Management Team (RMT))
01/18/2023	TPQ Protection and Community Capacities Evaluation Contact (FY 2020 RMT), provided technical input to COVID Council and Working Group
01/18/2023	TPQ Protection and Community Capacities Evaluation Contact
01/18/2023	TPQ Protection and Community Capacities Evaluation Contact
01/26/2023	TPQ Health Advisor, Task Force member and provided technical input to COVID Council
01/30/2023	Budget and Finance Division and BET
01/30/2023	COVID Council (ALAC)
02/01/2023	BET member (Office of Africa (OA))
02/08/2023	BET member (ALAC)
02/09/2023	BET member – substitute Middle East, North Africa, and Europe (MENAE)
02/24/2023	G3PC
03/14/2023	BHA Mission (OA): Discussion about 2 PIO awards (10 respondents)
03/16/2023	BHA (ALAC): Discussion about 2 PIO awards (3 respondents)

The scoping interviews also included a select sample of PIO awards to explore indicator and results data availability, including 28 respondents.

Table 2. Overview of IP e-survey respondents conducted February 2023

Survey question	Location	Count
B3b. Where is your role based?	Country office/sub-office/field office based	73
	Headquarters (HQ), regional, or remote based	18
	Total	91
PRIME- Organization type-PIO/NGO	PIO	48
	NGO	43
	Total	91
BHA Region	OA	56
	ALAC	24
	MENAE	6
	Global	5
	Total	91
Office	Africa (AFR)	58
	ALAC	23
	MENAE	5
	TPQ	5
	Total	91

Table 3. Remote KIIs with BHA and IPs conducted through January 2024

Date	Organization	BHA/IP Region	Relevance to Evaluation/Objective (Obj)	# of respondents
BHA Interviews				
9/7/2023	BHA TPQ	N/A	Nutrition/Obj 1	2
9/7/2023	BHA TPQ	N/A	Health/Obj 1	2
9/8/2023	BHA Disaster Data, Assessments, and Information Management Team (DDAIM)	N/A	Humanitarian Coordination, Information Management, & Assessments (HCIMA)/Obj 4	1
9/11/2023	BHA TPQ	N/A	WASH/Obj 1	1
9/13/2023	BHA (Formerly DDAIM)	N/A	HCIMA/Obj 4	1
9/19/2023	BHA TPQ	N/A	Protection, Gender and Social Inclusion/Obj 3	1
9/26/2023	BHA AOR G3PC	N/A	Global Nutrition/Obj 5	1
9/27/2023	BHA AOR G3PC	N/A	Global Nutrition + Protection/Obj 5	3
9/29/2023	BHA AOR G3PC	N/A	Global Health/Obj 5	2
10/5/2023	BHA AOR G3PC	N/A	Global Nutrition/Obj 5	1

10/25/2023	BHA DDAIM	N/A	HCIMA/Obj 4	1
11/3/2023	BHA GEO South Sudan	OA	All	1
11/13/2023	BHA Syria	MENAE	All	1
11/13/2023	BHA Mali	OA	All	1
11/14/2023	BHA Malawi	OA	All	1
11/20/2023	BHA DRC	OA	All	1
11/20/2023	BHA Mozambique	OA	All	2
11/29/2023	BHA Central America	LAC	All	2
1/5/2024	BHA G3PC	N/A	Global Health/Obj 5	2
11/20/2023	BHA Kenya	OA	WFP/Obj 2	2
11/22/2023	BHA Niger	OA	WFP/Obj 2	1
11/29/2023	BHA Nigeria	OA	WFP/Obj 2	1
11/29/2023	BHA Nigeria	OA	WFP/Obj 2	1
11/29/2023	BHA Syria	MENAE	WFP/Obj 2	1
12/5/2023	BHA DRC	OA	WFP/Obj 2	1
12/5/2023	BHA Colombia	ALAC	WFP/Obj 2	1
12/7/2023	BHA Madagascar	OA	WFP/Obj 2	1
12/8/2023	BHA Somalia	OA	WFP/Obj 2	1
12/12/2023	BHA Honduras	ALAC	WFP/Obj 2	1
1/3/2024	BHA Yemen	MENAE	WFP/Obj 2	1
12/20/2023	BHA Jordan	MENAE	WFP/Obj 2	1
IP Interviews				
5/18/2023	United Nations Children's Fund (UNICEF) Brazil	ALAC	Protection/Obj 3	1
6/9/2023	UNICEF Kenya	OA	Nutrition/Obj 1	1
6/15/2023	Cooperative for Assistance and Relief Everywhere (CARE) Guatemala	ALAC	Protection/Obj 3	1
9/5/2023	International Organization for Migration (IOM) Nigeria	OA	HCIMA/Obj 4	1
9/6/2023	WFP Peru	ALAC	HCIMA/Obj 4	3
9/8/2023	IMPACT Initiatives	N/A	HCIMA/Obj 4	1

9/13/2023	WFP DRC	OA	HCIMA/Obj 4	5
9/14/2023	ACTED Niger/IMPACT Initiatives	OA	HCIMA/Obj 4	4
9/14/2023	Information Management and Mine Action Programs (iMMAP)	Global	HCIMA/Obj 4	1
9/19/2023	UNICEF Malawi	OA	WASH/Obj 1	4
9/20/2023	IOM Libya	MENAE	WASH + Health/Obj 1	2
9/20/2023	Global Internews	Global	Health + Risk Communication Community Engagement (RCCE)/Obj 1	3
9/21/2023	UNICEF Honduras	ALAC	Nutrition + Health RCCE/Obj 1	2
9/25/2023	Alight Sudan	OA	Health + WASH + Nutrition/Obj 1	4
9/26/2023	IOM Mozambique	OA	Protection/Obj 3	2
9/27/2023	Catholic Relief Services (CRS) South Sudan	OA	Health + WASH + Nutrition/Obj 1	2
9/28/2023	Norwegian Refugee Council Global/ACAPS	Global	HCIMA/Obj 4	1
10/2/2023	Médecins du Monde DRC	OA	Health + WASH + Nutrition + (some Protection)/Obj 1	2
10/2/2023	Première Urgence Internationale Ukraine	MENAE	Protection/Obj 3	1
10/3/2023	IOM Yemen	OA	Health + WASH + Shelter and Settlements (S&S)/Obj 1	5
10/3/2023	Regional Pan American Health Organization (PAHO)	ALAC Regional	Health/Obj1	1
10/9/2023	United Nations Population Fund (UNFPA) Syria	MENAE	Protection/Obj 3	3
10/11/2023	International Medical Corps (IMC) ZIMBABWE	OA	Health + WASH + Nutrition/Obj 1	6
10/12/2023	ACAPS	N/A	HCIMA/Obj 4	1
10/12/2023	Save the Children Mozambique	OA	Health + WASH + Nutrition/Obj 1	3
10/13/2023	United Nations Office for the Coordination of Humanitarian Affairs (OCHA) South Sudan	OA	HCIMA/Obj 4	1
10/13/2023	UNFPA Latin America and the Caribbean/Regional	ALAC Regional	Protection/Obj 3	3

10/16/2023	Red Cross Vietnam	ALAC	WASH + Nutrition/Obj 1	2
10/17/2023	International Federation of Red Cross and Red Crescent Societies (IFRC) Global	Global	Global Health/Obj 5	2
10/18/2023	Cooperazione Internazionale Niger	OA	Health + Protection/Obj 1 + Obj 3	2
10/19/2023	IOM Yemen	MENAE	HCIMA/Obj 4	1
10/24/2023	World Health Organization (WHO) Syria	MENAE	Health/Obj 1	
10/24/2023	UNFPA Global	Global	Global Health + Protection/Obj 5	4
10/26/2023	WHO Gaziantep	MENAE	Health/Obj 1	2
10/30/2023	WHO Global/Health Cluster	Global	HCIMA + Humanitarian Policy, Studies, Analysis, or Application (HPSAA)/Obj 5 + Obj 4	1
10/31/2023	UNICEF Global	Global	Global Nutrition/Obj 5	1
11/2/2023	UNICEF Global	Global	Protection/Obj 3	2
11/8/2023	WHO Global	Global	Protection + Mental Health and Psychosocial Support (MHPSS)/Obj 5	1
11/10/2023	UNICEF Global	Global	Accountability to Affected Populations + Community Engagement and Accountability + RCCE/Obj 5 + Obj 3.2	1
1/16/2024	UNICEF Global	Global	Global Nutrition/Obj 5	1
1/16/2024	WFP Jordan	MENAE	FSL/Obj 2	2
1/18/2024	WFP Madagascar	OA	FSL/Obj 2	2
1/18/2024	WFP Niger	OA	FSL/Obj 2	7
1/19/2024	WFP Somalia	OA	FSL/Obj 2	5
1/23/2024	WFP Yemen	MENAE	FSL/Obj 2	1
1/23/2024	WFP Kenya	OA	FSL/Obj 2	2
1/23/2024	WFP Honduras	ALAC	FSL/Obj 2	4
1/25/2024	WFP Nigeria	OA	FSL/Obj 2	2
1/26/2024	WFP Colombia	ALAC	FSL/Obj 2	3
1/30/2024	WFP Syria	MENAE	FSL/Obj 2	2

Note: The ET conducted more than one interview with some respondents related to fieldwork planning.

Table 4. Summary of fieldwork data collection

IP/Focus	Number of KIIs (total respondents-res)	Number of Focus Group Discussions (FGDs) (male-m/female-f project participants)	Health Worker Survey
Jordan (March 3-6)			
WFP Jordan	8 KII (15 res)	8 FGDs (42 M/26 F)	N/A
Other/Amman level (IPs/BHA)	3 KII (5 res)	N/A	
Total	**11 KIIs (20 res)**	**8 FGDs (42 M/26 F res) 38% female**	
Syria (April 4-9; Break for Religious Holiday; April 16-May 1)			
WHO	Government of Syria (GoS): 5 KIIs (13 res) North of Syria (NS): 3 (3 res)	GoS: 2 (10 M/9 F) NS: 4 (8 M/24 F)	GoS: 19 NS: 21
UNFPA	NS: 4 (6 res)	GoS: 2 (10 M/12 F) NS: 4 (0 M/44 F)	GoS: 7 NS: 6
UNICEF	GoS: 4 (5 res) NS: 3 (3 res)	GoS: 8 (32 M/40 F) NS: 6 (30 M/30 F)	GoS: 10 NS: 12
WFP	GoS: 6 (6 res) NS: 4 (4 res)	GoS: N/A NS: 4 (20 M/20 F)	N/A
Total	**GoS: 15 KIIs (24 res) NS: 14 KIIs (16 res) Plus 16 KIIs remote (36 res) Total: 45 (76 res)**	**GoS: 12 (52 M/61 F) NS: 18 (58 M/118 F) Total: 30 FGDs (110 M/179 F res) 62% female**	**Gos: 36 NS: 39 Total: 75**
Kenya (March 3-15)			
WFP Nairobi urban area	Cash: 3 KIIs (3 res) Nutrition: 5 (5 res)	Cash: 5 FGDs (15 M/ 40 F) Nutrition: 1 (7 F)	N/A
WFP Mombasa urban area	Cash: 2 (2 res) Nutrition: 3 group KIIs (22 res) County official: 2 (4 res)	Cash: 5 FGDs (13 M/ 22 F) Nutrition: 3 FGDs (9 M/33 F)	
Kenya Country Office (CO) level/ regional other	10 (15 res)	N/A	
WFP Kenya staff field offices	5 (5 res)	N/A	
Total	**30 KIIs (57 res)**	**14 FGDs (37 M/102 F res) 73% female**	
South Sudan (March 16-28)			
IPs Juba level (WFP, Samaritans Purse, World Vision, CRS, IMC, and Internews	7 (19 res)	N/A	N/A

World Vision operational area	11 (project staff and government) (13 res)	6 female FGDs (72 res) 5 male FGD (55 res)	12
CRS operational area	N/A (unable to reach field staff due to isolated areas)	N/A (unable to reach field staff due to isolated areas)	10
USAID/BHA	2 (2 res)	N/A	N/A
Total	**20 (24 res)**	**11 FGDs (55 M/72 F) 56% female**	22
Honduras (March 12-22; Break for Religious Holiday; April 8-18)			
Global Communities	2 (2 res)	8 FGDs (22 M/65 F res)	
UNICEF (including partners)	3 (3 res)	6 FGDs (0 M/44 F res)	32
WFP (including partners)	1 (1 res)	4 FGDs (23 M/73 F res)	N/A
Red Cross	2 (2 res)	4 FGDs (11 M/29 F res)	N/A
Country/regional IP remote KIIs	5 (13 res)	N/A	N/A
Total	**13 (21 res)**	**22 (56 M/211 F res) 79% female**	**32**
Overall Total	**119 KIIs (198 res)**	**85 FGDs (890 res)**	**129 Health Worker Surveys**

Table 5. Summary of Thematic KIIs.

IP/Focus	Number of KIIs (total respondents)
Thematic 1: WHO Global/WHO Health Emergencies Programme	7 (11 respondents)
Thematic 1: WHO Global/Health Cluster	1 (2 respondents)
Thematic 1: IFRC Global	2 (5 respondents)
Thematic 1: Centers for Disease Control and Prevention (CDC)	2 (2 respondents)
Thematic 1: Bureau of Global Health (BGH)	4 (4 respondents)
Thematic 1: BHA (G3PC, CDC liaison, logistics)	3 (3 respondents)
Thematic 1: JSI Research & Training Institute	1 (1 respondent)
Thematic 1: Save the Children Global	1 (1 respondent)
Thematic 2: BHA HQ	2 (2 respondents)
Thematic 2: BHA Jordan-Syria Desk	1 (2 respondents)
Total	**24 (33 respondents)**

C. FUNDING OVERVIEW

FUNDING OBJECTIVES

Table 1. Strategic framework funding objectives

<table>
<tr><th colspan="2">Obj 1: Support and Strengthen the Public Health Response</th><th>Obj 2: Prevent Famine and Mitigate Severe Food Insecurity</th><th colspan="2">Obj 3: Provide Protection</th></tr>
<tr><td colspan="2">Mitigate and respond to the public health impacts of the COVID-19 pandemic in humanitarian settings to reduce morbidity and mortality.</td><td>Alleviate severe food security impacts of the COVID-19 pandemic in humanitarian settings by investing in emergency food assistance and livelihoods interventions.</td><td colspan="2">Address the exacerbated protection challenges caused by COVID-19 and the gendered impact of the pandemic on populations experiencing humanitarian crisis.</td></tr>
<tr><td>Sub-obj 1.1: Mitigate COVID-19 transmission, including RCCE and infection prevention and control (IPC)

Sectors: Health, WASH, S&S</td><td>Sub-obj 1.2: Maintain primary/ community level healthcare and child nutrition services

Sectors: Health, Nutrition</td><td>Sub-obj 2.1: Provide emergency food and/or nutrition security (2.1a) and livelihoods (2.1b) programming for needs exacerbated by pandemic effects

Sectors: Food Assistance, Agriculture, Economic Recovery and Market Systems (ERMS), Multipurpose Cash Assistance (MPCA)</td><td>Sub-obj 3.1: Increase access to protection services

Sectors: Protection</td><td>Sub-obj 3.2: All programming must address COVID-19-specific gender and protection issues

Sectors: Gender, age, and social inclusion (GASI)</td></tr>
<tr><th colspan="2">Obj 4: Strengthen Humanitarian Operations and Coordination</th><th colspan="3">Obj 5: Improve and Strengthen Humanitarian Architecture to support the scale-up of Infectious Disease Response Capacity</th></tr>
<tr><td colspan="2">Support global, regional, and country-based operations capacity, common services, and information management as a key part and in support of ongoing humanitarian response to COVID-19 and its impacts.</td><td colspan="3">Mitigate current, future, or recurring waves of COVID-19 transmission and build infectious disease/outbreak and pandemic readiness within the humanitarian ecosystem.</td></tr>
<tr><td>Sub-obj 4.1: Enhance logistics platforms and common services

Sectors: Logistics</td><td>Sub-obj 4.2: Improve humanitarian information management and coordination services

Sectors: HCIMA</td><td>Sub-obj 5.1: Support humanitarian system and sector capacities to coordinate and respond to pandemics

Sectors: Health, Nutrition, Protection, HPSAA, HCIMA</td><td colspan="2">Sub-obj 5.2: Develop BHA COVID-19 lessons learned and learning agenda

(not included in evaluation scope as the funding includes this evaluation)</td></tr>
</table>

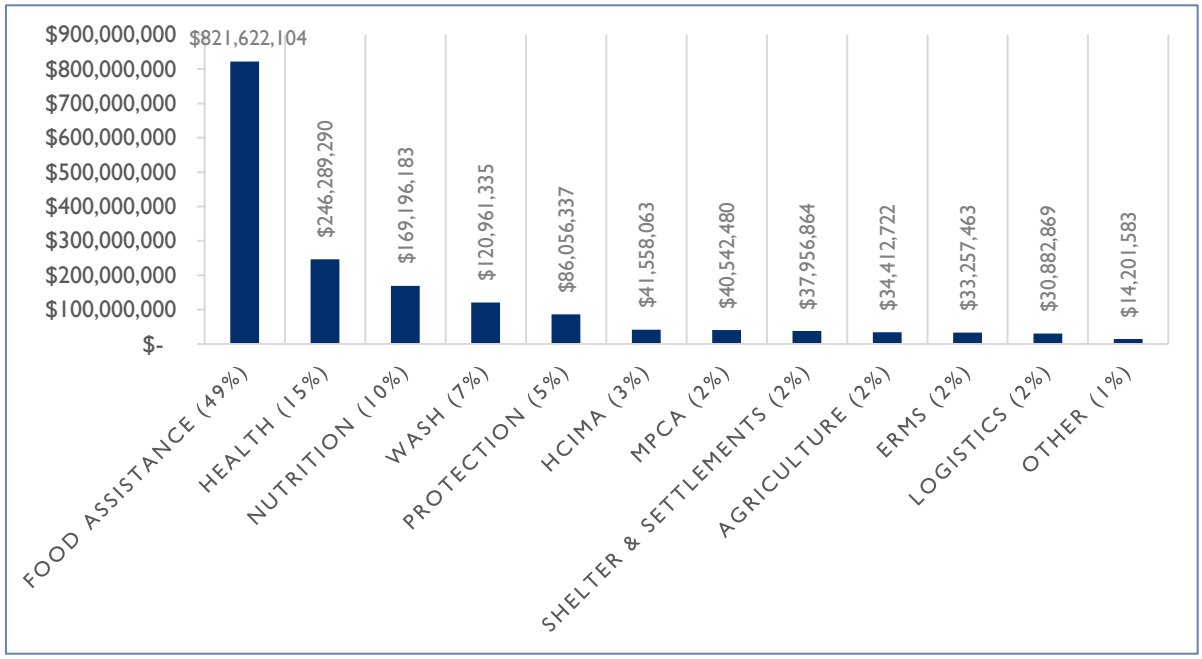
Note: Sub-objectives are paraphrased. They align with BHA's FY 2021 COVID-19 Supplemental Guidance to partners.

FUNDING BY SECTOR AND REGION

FY 2021 COVID-19 Supplemental funding sector overview

The following bar chart provides an overview of the FY2021 COVID-19 Supplemental funding's total budget (ESF+IDA) by sector. The total (ESF+IDA) Supplemental funding for all sectors totaled United States Dollar (USD) $1,676,937,293.

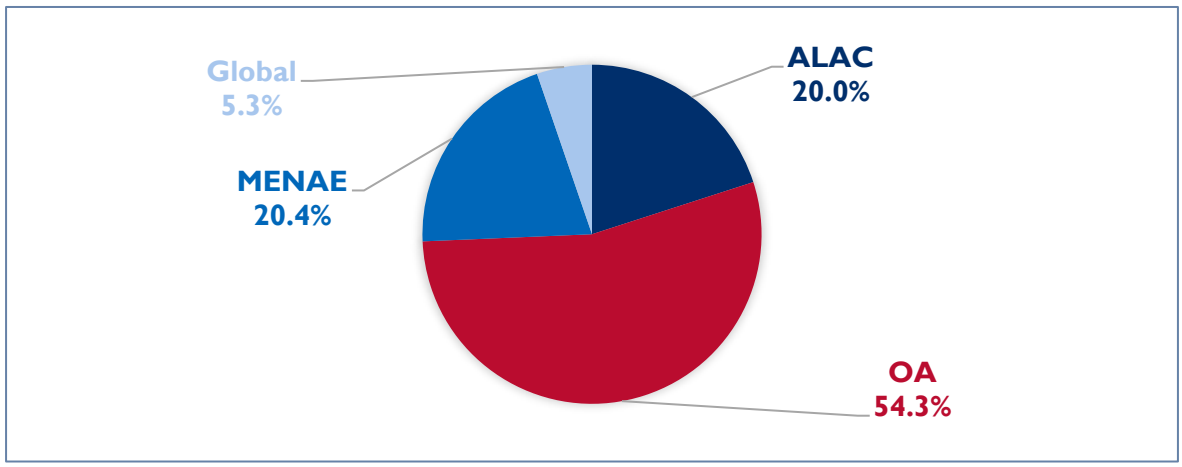
Figure 1. Distribution of funding totals (IDA+ESF) by sector



FY 2021 COVID-19 Supplemental funding regional overview

The majority of FY 2021 COVID-19 Supplemental funds (IDA+ESF) were distributed to the OA region, which amounted to 54.3 percent of the total funds ($910,686,335). The region that received the second largest proportion was the MENAE region, with 20.4 percent of the total funds ($342,267,194), followed by the ALAC region, with 20 percent ($335,785,752). The remaining 5.3 percent of the total funds went to global awards ($88,198,012).

Figure 2. Distribution of funding (IDA +ESF) by BHA region

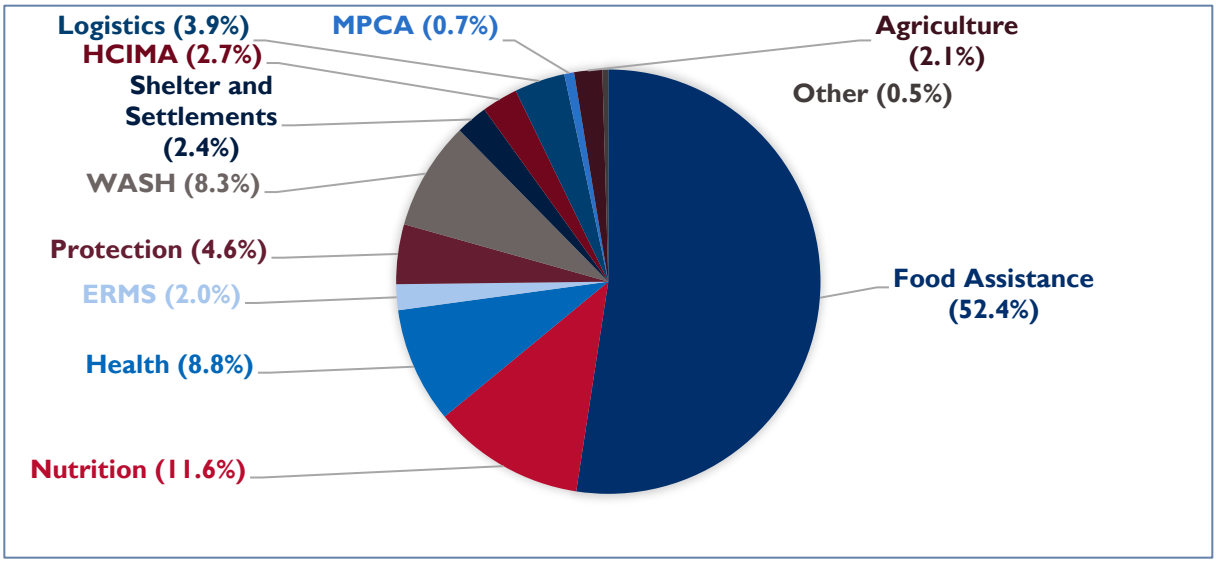


Office of Africa (OA) regional analysis

OA region budget breakdown by sector

The Food Assistance sector received most of the funding (52.4%) in the OA region, followed by Nutrition (11.6%), Health (8.8%), and WASH (8.3%). Each of the remaining sectors received less than 4 percent of the regional funding total.

Figure 3. Breakdown of FY 2021 COVID-19 Supplemental Funding Budget (IDA+ESF) in OA Region by Sector

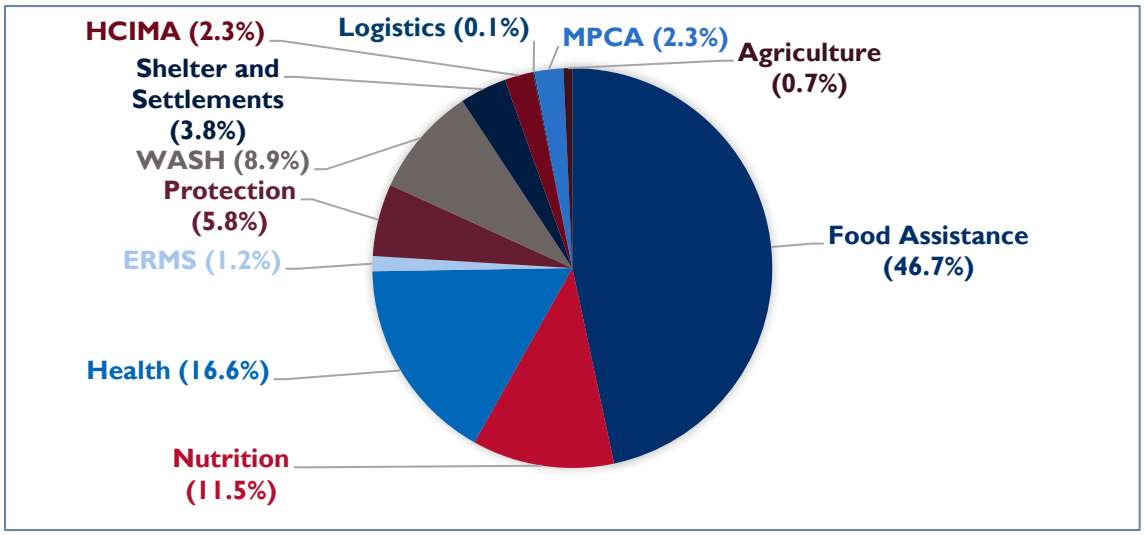


Office of Middle East, North Africa, and Europe (MENAE) regional analysis

MENAE region budget breakdown by sector

In the MENAE region, the Food Assistance sector received most of the Supplemental's total funds (46.7%) followed by Health (16.6%), Nutrition (11.5%), WASH (8.9%), and Protection (5.8%). Each of the remaining sectors received less than 4 percent of the MENAE region's total funding.

Figure 4. Total sector breakdown (IDA+ESF) of American Rescue Plan (ARP) FY 2021 budget in MENAE region

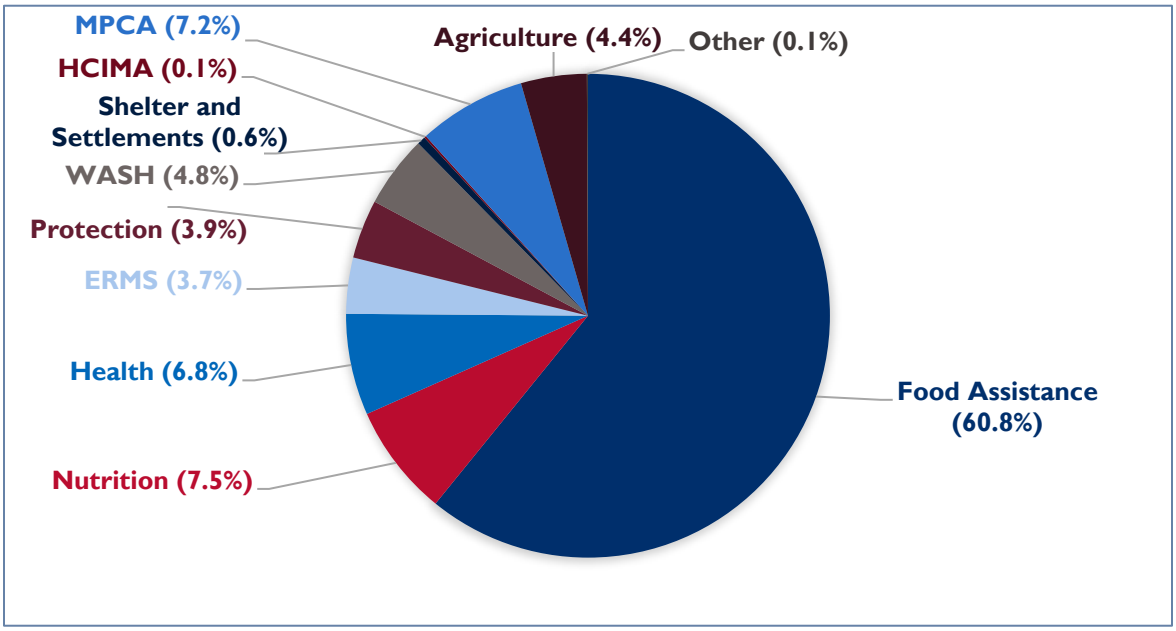


Office of Asia, Latin America, and the Caribbean (ALAC) regional analysis

ALAC region budget breakdown by sector

In the ALAC region, the Food Assistance sector received most of the funding (60.8%), followed by Nutrition (7.5%), MPCA (7.2%), and Health (6.8%). Each of the remaining sectors received less than 5 percent of the ALAC region's total funding.

Figure 5. Total sector breakdown (IDA+ESF) of ARP FY21 budget in ALAC region

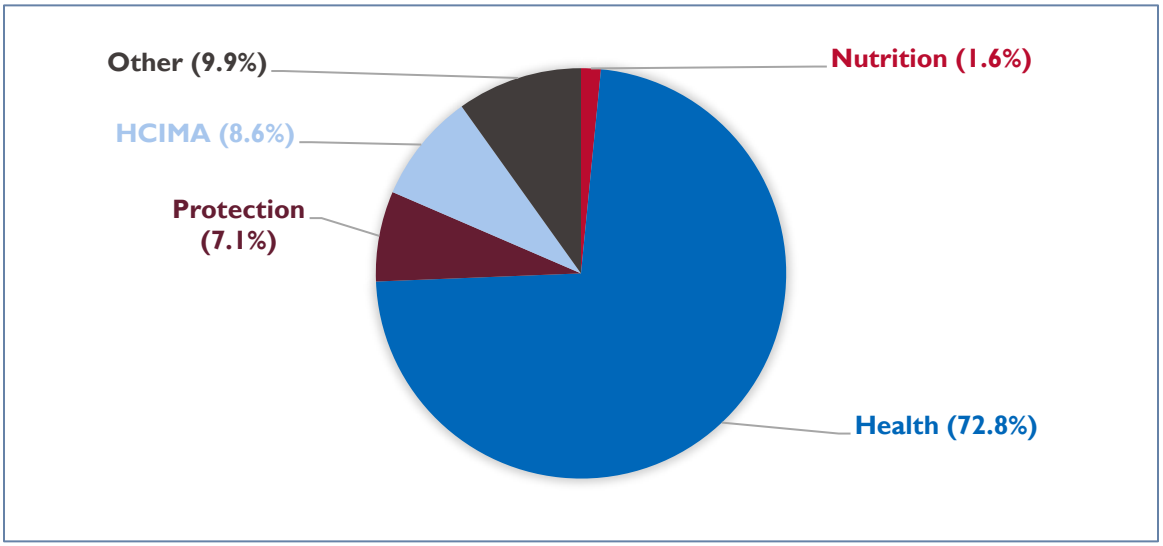


Global awards analysis

Global award budget breakdown by sector

Of the Global Awards (excluding macro/regional awards), 72.8 percent of the funds went to Health programming. HCIMA programming accounted for 8.6 percent of total funds, while 7.1 percent went to protection programming.

Figure 6. Total sector breakdown (IDA+ESF) of ARP FY21 budget for global awards



D. BRIEF 1 SUPPORTING INFORMATION

Note: Brief 1 is internal to BHA.

Table 1. IP Overlap of FY 2021 Supplemental ESF and Title II

Name of Country that Received Title II Funds	IP that Received Title II and ESF Funds in Country	Total FY21 ARP Title II Funds Received	Total FY21 ESF Funds Received	Total FY21 (Title II+ESF)
Sudan	PIO	$4,397,926	$500,000	$4,897,926
Niger	PIO	$19,701,468	$6,500,000	$26,201,468
Yemen	PIO	$115,989,902	$57,000,000	$172,989,902
South Sudan	PIO	$,993,803	$27,500,000	$27,500,000
Sudan	PIO	$23,035,009	$15,500,000	$38,535,009
Zimbabwe	NGO	$1,925,355	$1,460,285	$3,385,640
Madagascar	PIO	$5,597,901	$4,500,000	$10,097,901
Madagascar	NGO	$1,716,852	$2,000,000	$3,716,852
Ethiopia	PIO	$37,581,425	$70,000,000	$107,581,425
Somalia	PIO	$19,286,252	$52,550,000	$71,836,252
DRC	PIO	$2,261,960	$7,500,001	$9,761,961
Somalia	PIO	$7,673,239	$34,700,000	$42,373,239
Chad	PIO	$1,240,174	$7,000,000	$8,240,174
CAR	PIO	$1,318,753	$13,000,000	$14,318,753

Table 2. IP e-survey question on COVID-19 response shifts from 2020 to 2021-2022

C4. Did your COVID-19 activities shift/change in 2021-2022 as compared to the first year of the pandemic (2020)? Select one.		Not at all/very little	Moderately/ very much	Don't Know/ Not Applicable	*Total*	*Total Count*
PRIME-Organization type-PIO/NGO	PIO	33%	60%	6%	*100%*	*48*
	NGO	30%	53%	16%	*100%*	*43*
	Total	32%	57%	11%	*100%*	*91*
Respondent-CO vs. HQ based	Country office/sub-office/field office based	34%	58%	8%	*100%*	*73*
	Headquarters, regional, or remote based	22%	56%	22%	*100%*	*18*
	Total	32%	57%	11%	*100%*	*91*
B4b. Is your organization a subcontract/local partner [select one]	Prime/awardee	32%	55%	13%	*100%*	*78*
	Subcontractor/local partner	31%	69%	0%	*100%*	*13*
	Total	32%	57%	11%	*100%*	*91*
BHA Region	OA	38%	54%	9%	*100%*	*56*
	ALAC	17%	71%	13%	*100%*	*24*
	MENAE	50%	33%	17%	*100%*	*6*

	Global	20%	60%	20%	*100%*	*5*
	Total	32%	57%	11%	*100%*	*91*

Table 3. IP e-survey question on COVID-19 related focus of award activities

C2. Do you agree with this statement: The award was primarily used to address humanitarian challenges specifically tied to COVID-19 impacts/needs		Yes, agree (award was primarily used to address COVID-19-specific impacts)		Both (award was used for both purposes)		No, disagree (award supplemented general humanitarian programming)		Total	
		Count	Row N %	Count	Row N %	Count	Row N %	*Count*	*Row N %*
PRIME-Organization type-PIO/NGO	PIO	26	54%	19	40%	3	6.3%	*48*	*100%*
	NGO	22	51%	14	33%	7	16.3%	*43*	*100%*
	Total	48	53%	33	36%	10	11.0%	*91*	*100%*
Respondent-CO vs. HQ based	Country office/sub-office/field office based	38	52%	28	38%	7	9.6%	*73*	*100%*
	Headquarters, regional, or remote based	10	56%	5	28%	3	16.7%	*18*	*100%*
	Total	48	53%	33	36%	10	11.0%	*91*	*100%*
B4b. Is your organization a subcontract/local partner [select one]	prime/awardee	41	53%	27	35%	10	12.8%	*78*	*100%*
	subcontractor/ local partner	7	54%	6	46%	0	0.0%	*13*	*100%*
	Total	48	53%	33	36%	10	11.0%	*91*	*100%*
BHA Region	OA	34	61%	13	23%	9	16.1%	*56*	*100%*
	ALAC	10	42%	13	54%	1	4.2%	*24*	*100%*
	MENAE	0	0%	6	100%	0	0.0%	*6*	*100%*
	Global	4	80%	1	20%	0	0.0%	*5*	*100%*
	Total	48	53%	33	36%	10	11.0%	*91*	*100%*

E. BRIEF 2 SUPPORTING INFORMATION

This section provides supporting information for USAID/BHA FY 2021 COVID-19 Performance Evaluation: Evaluation Question 2 Brief, found here.

INDICATOR GUIDE

Objective 1. Support and Strengthen the Public Health Response	
Sub-obj 1.1: Mitigate COVID-19 transmission, including RCCE and infection prevention and control (IPC)	
Health	H15: Number and percentage of community members who can recall target health education messages
	H20: Percent of target population who can recall two (2) or more protective measures
	PIRS Indicator: Number of people reached through risk communication activities by channel
WASH	W04: Percent of households targeted by the WASH promotion activity that are properly disposing of solid waste
	W07: Number of people receiving direct hygiene promotion (excluding mass media campaigns and without double-counting)
	W08: Percent of households targeted by the hygiene promotion program with soap and water at a designated handwashing location
	W13: Number of people directly utilizing improved sanitation services provided with BHA funding
	W19: Percent of latrines/defecation sites in the target population with handwashing facilities that are functional and in use
	W23: Percent of hand washing stations built or rehabilitated in health facilities that are functional.
	W25: Total number of people receiving WASH Non-Food Items (NFIs) assistance through all modalities (without double-counting)
	W26: Percent of households reporting satisfaction with the contents of the WASH NFIs received through direct distribution (i.e., kits) or vouchers
	W27: Percent of households reporting satisfaction with the quantity of WASH NFIs received through direct distribution (i.e., kits), vouchers, or cash
	W28: Percent of households reporting satisfaction with the quality of WASH NFIs received through direct distribution (i.e., kits), vouchers, or cash
	W29: Number of people directly utilizing improved water services provided with BHA funding
	W30: Number of individuals gaining access to basic drinking water services as a result of BHA assistance
	W39: Percentage of people targeted by the hygiene promotion program who know at least three (3) of the five (5) critical times to wash hands
S&S	S13: Number and percent of households in identified settlements occupying shelter that is provided by BHA
	S12: Number of households occupying shelter that is provided pursuant to relevant guidance appearing in the Sphere Project Handbook
Sub-obj 1.2: Maintain primary/community level healthcare and child nutrition services	
Health	H01: Number of health facilities supported
	H02: Percentage of total weekly surveillance reports submitted on time by health facilities
	H03: Number of health facilities rehabilitated
	H04: Number of health care staff trained
	H06: Number of Community health workers (CHW) supported (total within project area and per 10,000 population)
	H23: Number of people trained in medical commodity supply chain management
Nutrition	N01: Number of children under five (0–59 months) reached with nutrition-specific interventions through BHA
	N07: Number of individuals screened for malnutrition by community outreach workers

	N09: Percent of children 6–23 months of age who receive foods from five (5) or more food groups (Minimum Dietary Diversity (MDD))
Objective 2. Prevent Famine and Mitigate Severe Food Insecurity	
Sub-obj 2.1: Provide emergency food and/or nutrition security (2.1a) and livelihoods (2.1b) programming for needs exacerbated by pandemic effects.	
Food Assistance	FS01: Percent of households with poor, borderline, and acceptable Food Consumption Score (FCS)
	FS03: Percent of households with moderate and severe Household Hunger Scale (HHS) scores
	FS04: Number of individuals participating in BHA food security programs
	F01: Number of unique participants receiving in-kind food
	K01/K02: Total amount distributed (USD), by modality (cash and voucher)
	K03: Quantity distributed (metric tons), by commodity
MPCA	M01: Number of unique participants receiving support, per modality (cash and voucher)
	M06: Percent of (beneficiary) households reporting adequate access to household non-food items
Livelihoods, ERMS, Agriculture	E01: Number of individuals assisted through livelihoods restoration activities
	E03: (to be potentially merged with E01) Number of individuals assisted through new livelihoods development activities
	A01: Number of people directly benefiting from improving agricultural production and-or food security activities
	A03: Number of individuals (beneficiaries) who have applied improved management practices or technologies with BHA assistance
Objective 3. Provide Protection	
Sub-obj 3.1: Increase access to protection services.	
Protection	P01: Number of individuals participating in child protection services
	P03: Number of individuals accessing Gender-based Violence (GBV) response services
	P05: Number of individuals trained in protection
	P06: Number of individuals participating in psychosocial support services
Sub-obj 3.2: All programming must address COVID-19-specific gender and protection issues.	
Gender, Age, Social Inclusion	M03: Percent of beneficiaries reporting that humanitarian assistance is delivered in a safe, accessible, accountable, and participatory manner
Objective 4 Strengthen Humanitarian Operations and Coordination	
Sub-obj 4.1: Enhance logistics platforms and common services	
Logistics	No BHA standard indicators used with PIO-only reporting
Sub-obj 4.2: Improve humanitarian information management and coordination services.	
HCIMA	I01: Number of humanitarian organizations actively coordinating in the proposed area of work
	I02: Number of humanitarian organizations actively participating in inter-agency coordination mechanisms
	I03: (to be potentially merged with I07) Number and percent of humanitarian organizations participating in joint assessments
	I07: Number and percent of humanitarian organizations utilizing information management services
	I08: Number and percentage of humanitarian organizations directly contributing to information products
	I09: Number of products made available by BHA funded information management services that are accessed by stakeholders

E.1. OBJECTIVE 1

This section provides supporting information for USAID/BHA FY 2021 COVID-19 Performance Evaluation: Evaluation Question 2/Objective 1 Brief, found here.

Additional Funding Information

Table 1. Key Objective 1 sector results and targets reached by PIOs and NGOs

Health	WASH
Total sector funding: $246,289,290 (15%) Across 76 awards (48 NGO/ 28 PIO) and 23 countries MENAE highest funded region Syria highest funded country	Total sector funding: $120,961,335 (7%) Across 72 awards (58 NGO/ 14 PIO) and 23 countries OA highest funded region Syria highest funded country
Shelter and Settlements	**Nutrition**
Total sector funding: 37,965,864 (2%) Across 15 awards (9 NGO/ 6 PIO) and 10 countries OA highest funded region South Sudan highest funded country	Total sector funding: 169,196,183 (10%) Across 55 awards (30 NGO/ 25 PIO) and 20 countries OA highest funded region Yemen highest funded country

NGO/PIO Indicator Tables

Table 2. Health sector indicator results for NGOs/ART

Indicator/Activity Type	N (Number of awards)	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved >90% of their Target LOA (if targets available)
Indicator name	**Number**	**Number or %-%**	**%**
Number of health facilities supported	32	1,091	100%
Number of health facilities rehabilitated	13	126	54%
Number of health facilities health care staff trained	39	10,075	81%
Number of people reached through risk communication activities by channel	16	103,648,770	64%
Number of people trained in medical commodity supply chain management	31	1,753	75%
CHW supported (total within project area and per 10,000 population)	25	4,962	67%
Percent of target population who can recall 2 or more protective measures	11	26.5-100%	82%
Number of community members who can recall target health education messages	13	330,635	46%

Percentage of community members who can recall target health education messages	17	15.4-112%	47%
Percent of total weekly surveillance reports submitted on time by health facilities	29	48-300%	88%

Table 3. Health sector indicator results for PIOs

Indicator/activity type	N (Number of awards)	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved >90% of their Target LOA (if targets available)
Indicator name	**Number**	**Number or %-%**	**%**
Number of supplies/equipment distributed (COVID-19 or infectious disease related) Number of other supplies/equipment distributed	6	data not available *	N/A
Estimated number of mass comms/social media RCCE sessions or/ number of mass comms activities Estimated number of community members reached with RCCE	11	13,707,654 individuals reached with RCCE	30%
Number of healthcare workers (HCWs) who received capacity building or trainings and support related to covid, IPC, outbreak preparedness, or covid vaccination	9	4,704 CHWs 5,350 HCWs	67%
Number of HCWs who received capacity building or trainings on other health services topics	11	data not available *	N/A
Number of health facilities supported	10	data not available *	N/A
Number of people reached/health services provided (referrals)	3	13,404 referral services provided	33%
Number of people reached/services provided with basic health services (consultations - includes Primary Health Care (PHC), pre/antenatal care, and mobile clinics)	11	615,548,384 consultations/services	47%
Number of people reached/services provided (mental health Treatments ((TX)/services)	4	data not available *	N/A
Number of people reached/health services provided (sexual and reproductive health (SRH), maternal and child health TX)	5	data not available *	N/A
Other misc. Health services or treatment	2	data not available *	N/A

Number Of pandemic or IPC-related protocols/guidelines developed	2	data not available *	N/A
Number Of assessments of protocols supporting implementation/adherence of IPC	2	data not available *	N/A
Number of people reached with vaccines (all types)	5	962,716 vaccinations	12.5%
Outcome type indicator examples	7	data not available *	N/A
Other misc. Pandemic responses	6	data not available *	N/A

* Output values could not be calculated because data were not reported consistently across awards.

Table 4. WASH sector indicator results for NGOs/ART

Indicator/activity type	N (Number of awards)	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved >90% of their Target LOA (if targets available)
Indicator name	**Number**	**Number or %-%**	**%**
Number of people directly utilizing improved water services provided with BHA funding	33	3,007,203	72%
Number of people receiving direct hygiene promotion (excluding mass media campaigns and without double-counting)	43	2,652,818	83%
Number of individuals gaining access to basic drinking water services as a result of BHA assistance	12	1,317,397	83%
Number of institutional settings gaining access to basic drinking water services as a result BHA assistance	6	40	50%
Total Number of people receiving WASH Non-Food Item (NFIs) assistance through all modalities (without double-counting)	33	709,629	71%
Percent of hand washing stations built or rehabilitated in health facilities that are functional.	10	50-100%	90%
Number of basic sanitation facilities provided in institutional settings as a result of BHA assistance	13	120	70%
Number of people directly utilizing improved sanitation services provided with BHA funding	24	1,822,522	67%
Percent of people targeted by the hygiene promotion program who know at least three (3) of the five (5) critical times to wash hands	33	50-100%	75%
Percent of households with soap and water at a handwashing station on premises	16	23-99%	81%

Percent of households reporting satisfaction with the contents of the WASH NFIs received through direct distribution (i.e. kits) or vouchers	27	72-100%	100%
Percent of households targeted by the WASH promotion activity that are properly disposing of solid waste	7	16-98%	71%
Percent of households reporting satisfaction with the quantity of WASH NFIs received through direct distribution (i.e. kits), vouchers, or cash	17	70-100%	87%
Percent of households reporting satisfaction with the quality of WASH NFIs received through direct distribution (i.e. kits), vouchers, or cash	23	72%-100%	96%
Percent of latrines/defecation sites in the target population with handwashing facilities that are functional and in use.	6	29-100%	83%

Table 5. WASH Sector indicator results for PIOs

Indicator/activity type	**N (Number of awards)**	**Output Value (Sum)/ or Outcome Value (% Range)**	**% of Awards that achieved >90% of their Target LOA (if targets available)**
Indicator name	**Number**	**Number or %-%**	**%**
Number of IPC or WASH messages given/promoted	1	144	100%
Number of people reached/ receiving hygiene promotion/messaging (all campaigns)	6	1,123,993	83%
Number of individuals with access to safe water (domestic use/overall/ unspecific use)	7	935,513	51%
Number of individuals gaining access to basic drinking water services as a result of BHA assistance	1	data not available *	0%
Number of people receiving WASH NFIs assistance through all modalities (including emergency supplies, and specialized kits) [no double counting…individuals gaining access to basic drinking water services as a result of BHA assistance	10	995,297	60%
Number of health facilities supported with hand washing or other WASH supports built or rehabilitated	6	71	83%
Number of other facilities built or rehabilitated (alt term: supported)	7	37,721	85%
Number of people with access to hand washing stations (that were built or rehabilitated in health	6	541,387	50%

facilities) or other facilities (equals improved sanitation services)			
"Number other specific ""facilities"" constructed (new) ex. Latrines, hand pumps, etc."	2	data not available *	50%
Number of water committees trained or that have the knowledge with WASH operation skills	2	22	50% (1/2)
Number of community leaders, CHWs, or healthcare staff trained in WASH management	2	120	50% (1/2)
Number people or groups of people (ex. Internally Displaced Persons (IDPs), schools) "benefitting" from WASH interventions/services	4	data not available *	75% (3/4)
Other	14	data not available *	71% (10/14)

* Output values could not be calculated because data not reported consistently across awards.

Table 6. Nutrition sector indicator results for NGOs/ART

Indicator/activity type	N (Number of awards)	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved >90% of their Target LOA (if targets available)
Indicator name	**Number**	**Number or %-%**	**%**
Number of individuals screened for malnutrition by community outreach workers	21	2,114,603	80%
Number of children under five (0-59 months) reached with Nutrition-specific interventions through BHA	17	521,315	63%
Percent of children 6–23 months of age who receive foods from 5 or more food groups Minimum Dietary Diversity (MDD)	22	2% - 98%	50%

Table 7. Nutrition sector indicator results for PIOs

Indicator/activity type	N (number of awards)	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved >90% of their Target LOA (if targets available)
Indicator name	**Number**	**Number or %-%**	**%**
Number of individuals screened for malnutrition	8	data not available *	66%
Number of individuals treated for Moderate Acute Malnutrition (MAM)/ Severe Acute Malnutrition (SAM)	19	789,873 Children 28,687 Pregnant and Lactating Women (PLW)	56%

Prevention of malnutrition (via commodity distribution)	11	data not available *	71%
Support to health workers and/or facilities	6	data not available *	50%
Nutrition messaging, counseling, care groups, training to caregivers	9	data not available *	71%
Percent of children 6–23 months of age who received minimum acceptable diet (MAD) (all from WFP)	9	15.9-57.8%	35%**
MAM and SAM Treatment recovery/success rates	5	76.9-95.6% range for SAM 87.1-97% range for MAM	100%

* Output values could not be calculated because data was not reported consistently across awards.

** While 12 of the WFP awards received funding, 26 of the WFP awards have this indicator. WFP typically uses BHA funding for a general top up across their programs, as such there's no way to verify that only the 14 awards in the nutrition sector used the funding for nutrition.

Table 8. Shelter and Settlements sector indicator results for NGOs/ART

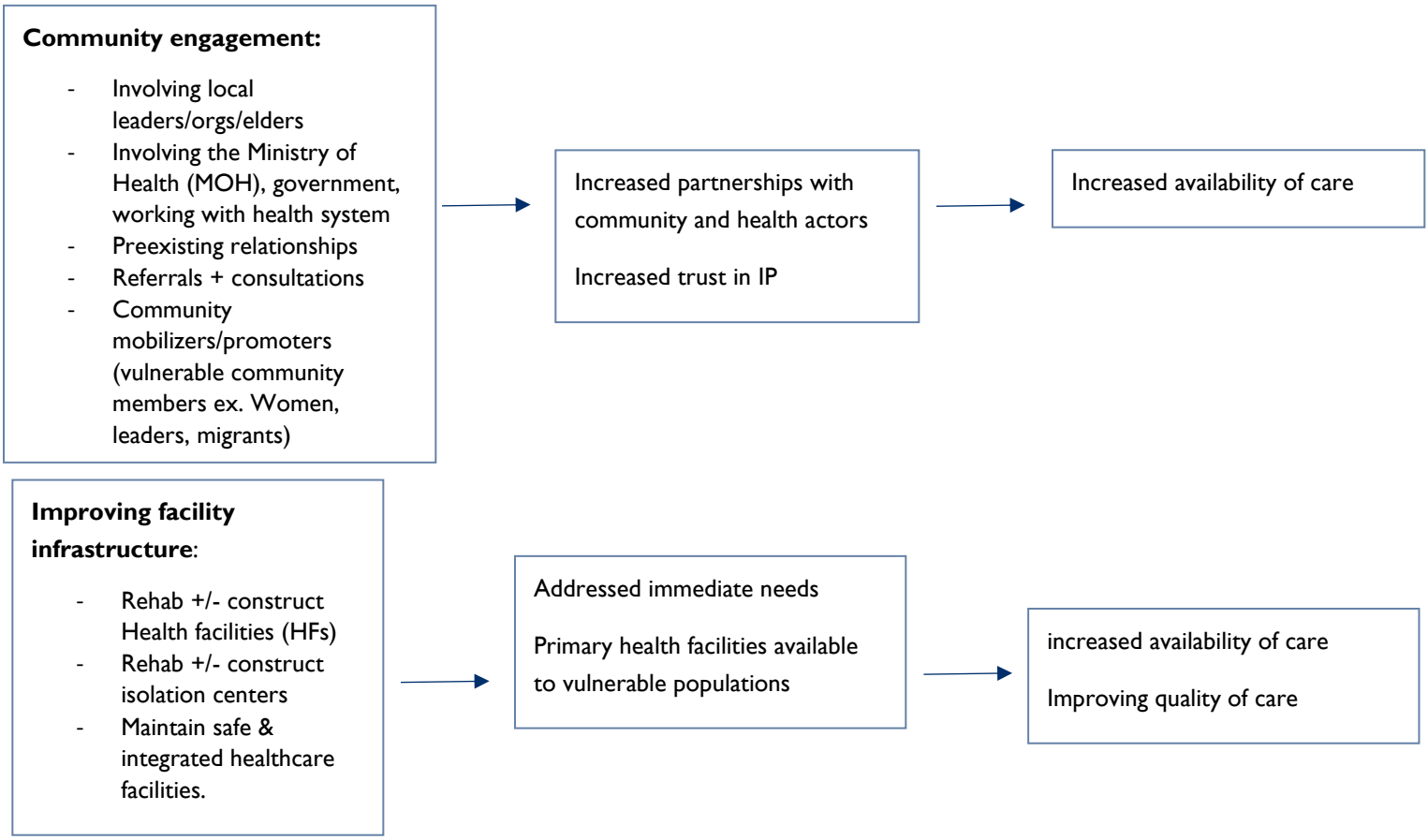
Indicator/activity type	N (number of Awards)	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved ≥90% of their Target LOA (if targets available)
Indicator name	**Number**	**Number or %-%**	**%**
Number of households occupying shelter that is provided pursuant to relevant guidance appearing in the Sphere Project Handbook	7	12,506	57%
Number of households in identified settlements occupying shelter that is provided by BHA	5	18,963	100%
Percent of households in identified settlements occupying shelter that is provided by BHA	3	68.2% - 100%	100%
Percent of beneficiaries reporting satisfaction with the quality of the NFIs received	2	85.5% - 100%	100%

Table 9. Shelter and Settlements sector indicator results for PIOs

Indicator/activity type	N (number of Awards)	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved ≥90% of their Target LOA (if targets available)
Indicator name	**Number**	**Number or %-%**	**%**
Number of Households (HHs) that received Emergency Shelter Kits and transitional shelter support	3	2,923	100%
Number of Shelters Constructed	2	2,656	100%
Number of individuals and households that received improved shelter solutions/services	5	1,732 households 4,530 individuals	100%
Number of HHs receiving Shelter-NFI assistance (in-kind, or through cash transfers or voucher to purchase NFI)	5	91,048	83%

Drivers and Outcome Pathways Qualitative Analyses

Figure 1. Health sector drivers, intermediate outcomes, and outcomes pathways



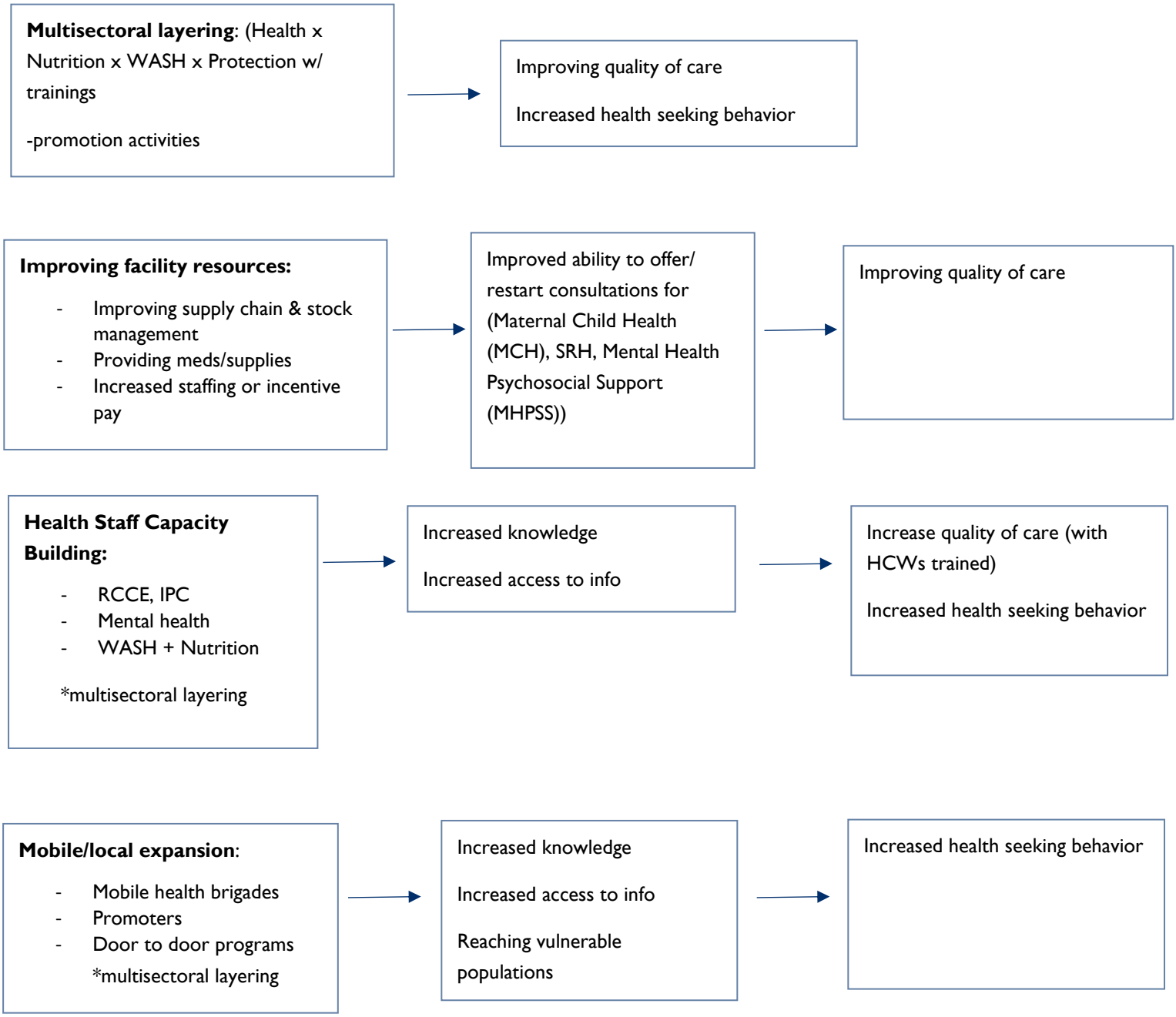

Multisectoral layering: (Health x Nutrition x WASH x Protection w/ trainings
-promotion activities
Improving quality of care
Increased health seeking behavior
Improving facility resources:
- Improving supply chain & stock management
- Providing meds/supplies
- Increased staffing or incentive pay
Improved ability to offer/ restart consultations for (Maternal Child Health (MCH), SRH, Mental Health Psychosocial Support (MHPSS))
Improving quality of care
Health Staff Capacity Building:
- RCCE, IPC
- Mental health
- WASH + Nutrition
*multisectoral layering
Increased knowledge
Increased access to info
Increase quality of care (with HCWs trained)
Increased health seeking behavior
Mobile/local expansion:
- Mobile health brigades
- Promoters
- Door to door programs
*multisectoral layering
Increased knowledge
Increased access to info
Reaching vulnerable populations
Increased health seeking behavior

Figure 2. Nutrition sector drivers, intermediate outcomes, and outcomes pathways

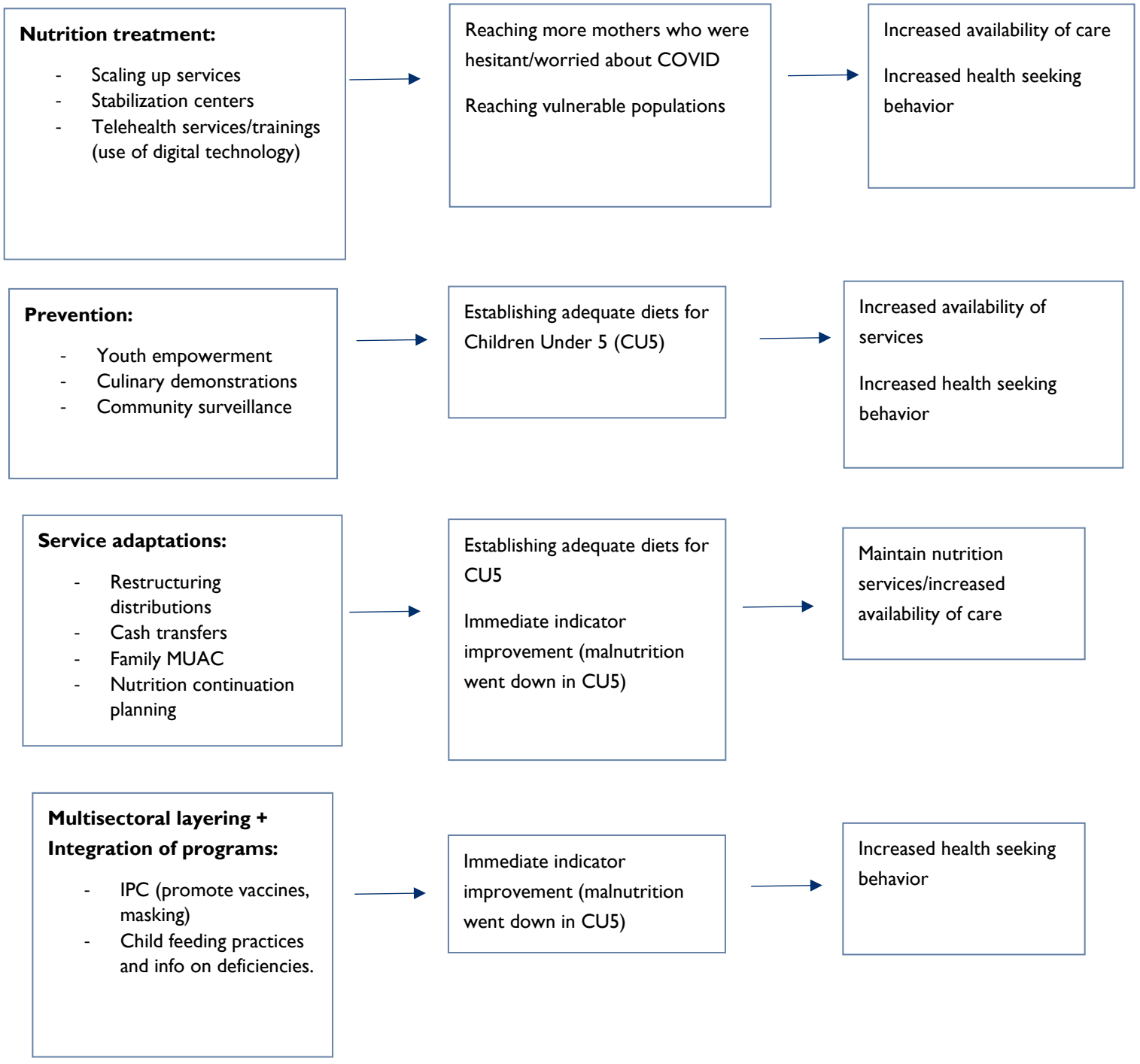
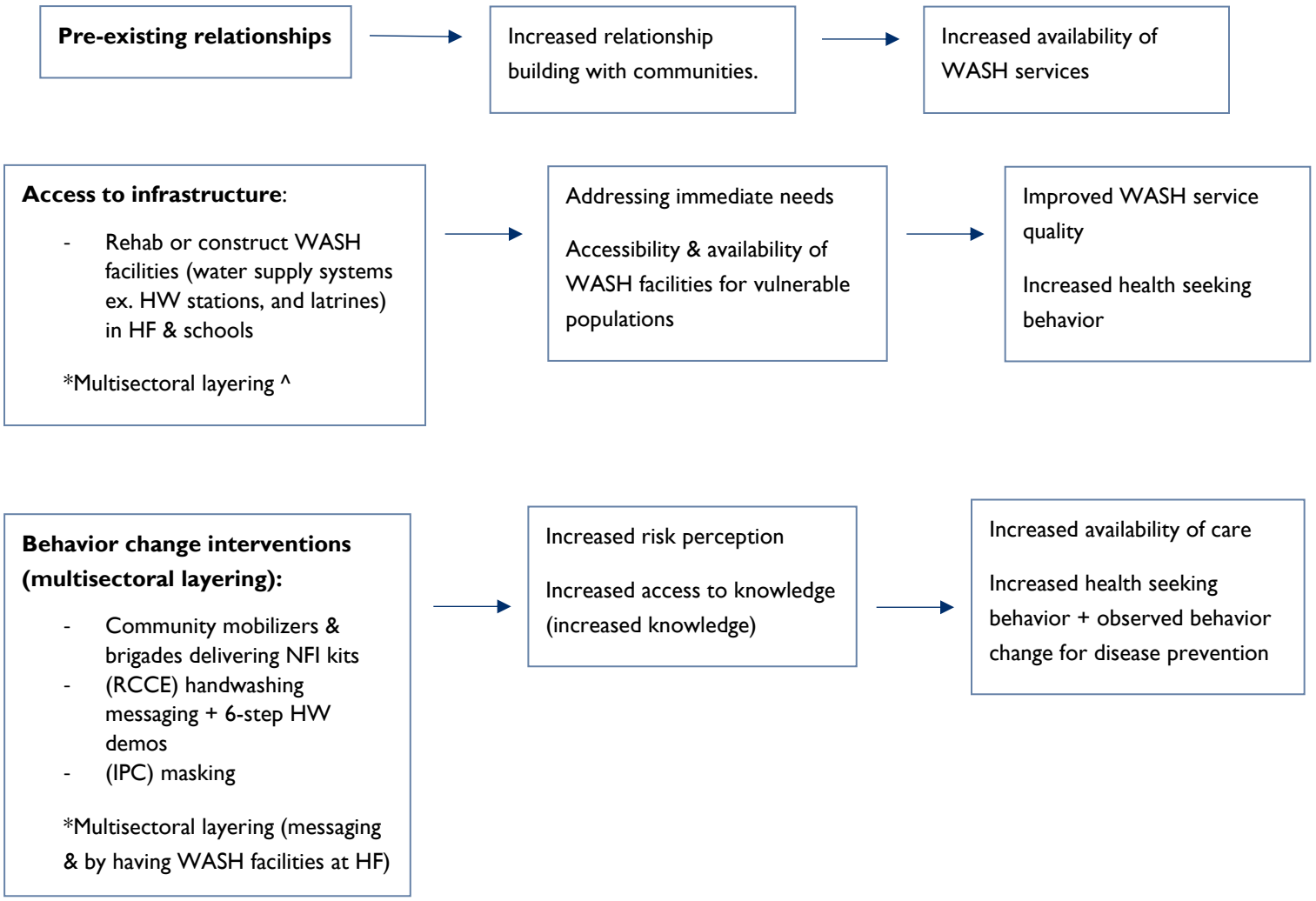


Figure 3. WASH sector drivers, intermediate outcomes, and outcomes pathways



Thematic comparison of IP successful activities and best received practices across Objective 1

In the health sector, successful activities focused on rehabilitation and revitalization of health facilities, ensuring sustained healthcare services. Meanwhile, the provision of essential services, such as healthcare facility construction and basic water supply, were perceived as well received by the communities. Similarly, in the WASH sector, successful activities aimed at improving access to handwashing facilities and promoting hygiene practices. Initiatives like establishing WASH committees and promoting handwashing behavior adoption resonated well with communities. In contrast, Nutrition sector activities prioritized sustaining health and nutritional outcomes through continuous engagement and targeted interventions. While successful activities emphasized community involvement in rehabilitation efforts, best received practices were built around tailored interventions and context-based communication methods. Overall, the alignment between successful and best received activities displays the effectiveness of community-driven approaches and stakeholder engagement in addressing humanitarian challenges.

Health Worker Survey Tables

Table 10. Role or job title during the pandemic (since 2021)

Types of Health Worker (HW) Positions	Government of Syria (GoS) controlled	Northern Syria (NS)	Syria	Honduras	South Sudan	Totals
Clinical Healthcare Worker at primary health facility or clinic	75.0	35.9	54.7	78.1	50.0	59.7
Non-Clinical Healthcare Worker at primary health facility or clinic	8.3	10.3	9.3	12.5	0.0	8.5
Other facility staff (cleaning or waste management)	0.0	12.8	6.7	3.1	0.0	4.7
Community Health Worker or Volunteer	13.9	41.0	28.0	0.0	13.6	18.6
Community Hygiene Promoter or WASH Volunteer	2.8	0.0	0.0	0.0	13.6	3.1
Nutrition Worker at nutrition treatment center	0.0	0.0	1.3	0.0	4.6	0.8
Other (please specify)	0.0	0.0	0.0	6.3	18.2	4.7
n	**36**	**39**	**75**	**32**	**22**	**129**

Table 11. Percent of HWs reporting that communities had a big concern for the spread of COVID-19

Level of Concern	GoS	NS	Syria	Honduras	South Sudan	Totals
High-level of concern	94.4	84.6	89.3	90.6	77.3	87.9
Moderate-level of concern	5.6	15.4	10.7	3.1	22.7	10.9
Low-level of concern	0.0	0.0	0.0	3.1	0.0	0.8
No concern	0.0	0.0	0.0	3.1	0.0	0.8
n	**36**	**39**	**75**	**32**	**22**	**129**

Table 12. Percent of HWs reporting that the project/organization met the basic Health/WASH/or Nutrition needs of the most vulnerable populations affected by COVID-19 in 2021-2022

Response	GoS	NS	Syria	Honduras	South Sudan	Totals
Yes	61.1	59.0	60.0	43.8	90.9	61.2
Partially	38.9	23.1	30.7	15.6	4.6	22.5
No	0.0	5.1	2.7	21.9	4.6	7.8
Do not know	0.0	12.8	6.7	18.8	0.0	8.5
n	**36**	**18**	**75**	**32**	**22**	**107**

Table 13. HWs' satisfaction with the training received related to the COVID-19 pandemic

Satisfaction Level	GoS	NS	Syria	Honduras	South Sudan	Totals
Not satisfied	2.8	0.0	1.3	4.4	0.0	1.7
A little satisfied	36.1	2.6	18.7	8.7	0.0	13.6
Satisfied	52.8	43.6	48.0	43.5	42.1	46.2
Very satisfied	8.3	51.3	30.7	43.5	57.9	37.6
n	**36**	**39**	**75**	**23**	**19**	**117**

Literature Review Methods and Findings

This literature review employed a comprehensive search strategy to capture lessons learned and evidence for effective strategies in the WASH, Nutrition, and Health sectors during the COVID-19 pandemic. The search terms aimed to encompass a holistic understanding of adaptations and multi-sectoral responses in humanitarian contexts, including phrases such as "WASH lessons learned," "Nutrition adaptations during COVID-19," "health service utilization during COVID-19," and "humanitarian health responses." Data were sourced from global clusters, Google Scholar, ReliefWeb, and scholarly databases like PubMed. The review identified 51 publications that provided significant qualitative and empirical insights, particularly focused on humanitarian settings.

The pandemic exacerbated existing WASH/Nutrition/Health service gaps and vulnerabilities within humanitarian contexts, and these impacts were a significant focus of much of the identified literature. Reductions in funding for maternal, newborn, child health, and nutrition increased morbidity and mortality rates (Rodo, 2022). The challenges of accessing family planning and reproductive health services were magnified for internally displaced women in Nigeria, whose already unmet needs grew during the pandemic (Evens et al., 2023). Meanwhile, the pandemic disrupted acute care and routine management of chronic diseases raising concerns about indirect consequences of pandemic restrictions (Chandir, 2020; Chudasamma et al., 2023). In the WASH sector, public access limitations due to movement restrictions further complicated service delivery, such as in refugee settlements (Ali et al., 2022).

Across all three sectors, stakeholders demonstrated resilience through innovative service delivery adaptations. In the WASH sector, the promotion of hand hygiene through the construction of handwashing stations and effective community engagement efforts showed positive results (Gyaltshen, 2021). The Nutrition sector witnessed successful adaptations, including decentralized service delivery or screening, and the use of technology to support intervention (Colón-Ramos, 2021). In low and middle-income countries, telehealth and virtual consultations emerged as critical tools, with these methods applied where possible in humanitarian settings (Chandir, 2020; Eslami & Ayatollahi, 2023). These innovations proved essential in managing both COVID-19 and non-COVID-19 health needs while addressing the collateral damage caused by lockdowns and resource reallocation to pandemic response efforts.

Collaboration and layering activities across sectors proved vital for effective responses to COVID-19. In Bangladesh, well-organized local authorities facilitated partnerships among government entities, NGOs, and community organizations to deliver essential services (Dube et al., 2020; Ruszczyk et al., 2022). Furthermore, integrating WASH messages into nutrition and health initiatives enhanced community outreach and engagement, thereby countering misinformation and increasing public awareness about health and hygiene practices (Sommariva, 2021). Effective communication strategies, including social listening and community involvement, were essential in addressing challenges and ensuring that information reached humanitarian populations (McBride et al, 2021; Sommariva, 2021).

The pandemic exposed enduring challenges across all sectors, including sustaining hygiene practices in WASH, funding deficits for Nutrition programs, and resource constraints for maintaining Health services. Notably, the lack

of empirical outcome data on WASH responses in humanitarian settings during the pandemic reveals a critical gap in understanding the unique challenges faced by these populations (Global WASH Cluster, 2021; Gyaltshen, 2021). A significant barrier to effective WASH implementation early in the pandemic were the logistical challenges associated with procurement and supply chain management (Giné -Garriga, 2021; Gyaltshen, 2021). Moving forward, there is a pressing need for increased investments in durable infrastructure, improved multi-sectoral coordination, and strategic planning to support both immediate and long-term health and nutrition outcomes (Global Nutrition Cluster, 2020; USAID Advancing Nutrition, 2023).

E.2. OBJECTIVE 2

This section provides supporting information for USAID/BHA FY 2021 COVID-19 Performance Evaluation: Evaluation Question 2/Objective 2 Brief, found here.

Additional Discussion

Challenges

Layered shocks: Additional shocks, such as natural disasters, conflict, and droughts, compounded the challenges presented by COVID-19, especially in contexts with pre-existing vulnerabilities. Nearly all interviewees in South Sudan, Somalia, Kenya, and Honduras noted the multi-shock context of their implementing areas, over which COVID-19 was layered but not necessarily of most immediate concern for populations targeted by the Supplemental. WFP interviewees in Yemen indicated that, in general, beneficiaries did not recognize the difference between the Supplemental and "regular activities" and that they "did not care." Some contexts experienced natural disasters coincident with implementation of the FY 2021 Supplemental. Others experienced conflict or significant safety concerns in all or parts of the country, making effective humanitarian response even more challenging. Somalia, Kenya, and South Sudan all implemented significant humanitarian responses to drought at the end of or immediately after the Supplemental. Honduras experienced two hurricanes in November 2020 and received USD 80,688,452 in emergency funding from BHA in FY 2021 (USAID 2022), including USD 2.3 million from the Supplemental for additional FSL activities.

Logistical and operational challenges: Delays in fund delivery, logistical hurdles, supply chain disruptions, and the short expenditure window were mentioned across the eleven awards from which WFP insights were gathered. IPs mentioned delays of imported nutrition supplies and limitations on IP staff movement as negatively affecting their capacity to implement programming. BHA's flexibility in providing no-cost extensions helped IPs deal with both challenges. In Somalia, WFP was unable to scale-up their nutrition activities due to market shortages, which resulted in coordination with UNICEF. One PIO in Yemen also noted that although the United Nations (UN) and WFP imposed COVID-19 guidance and regulations, the Yemeni government did not, which complicated operations.

Limited accountability for WFP funds: Reliance on WFP contributed generally to timeliness of response but also to a lack visibility on funding outcomes. According to KIIs with HQ and Country Office (CO) staff from both BHA and WFP, WFP has responded to large-scale diversions of food assistance and/or fraud, which were reported in Ethiopia, Somalia, Syria, DRC, and Yemen, among others, prompting corrective actions in some cases and new guidance from BHA (e.g., criteria for partner selection) for decision-making regarding new applications for funding. One interviewee (BHA KII) suggested that "large-scale Supplementals with time-bound spending requirements are not good responses." If good programming is the priority, then partners need to be held accountable. Otherwise, according to them, large supplements end up primarily "feeding folks who don't need it and giving power to bad actors." An NGO in South Sudan recalled how the large – and rapid – influx of food aid into some communities in Upper Nile flooded the markets (i.e., with contraband food). According to the interviewee, stronger systems are needed to prevent such leakage.

NGO/ART Indicator Tables

Table 1. Food Assistance Priority Indicators

Indicator/activity type	Awards	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved >90% of their Target LOA
Indicator name	**Number**	**Number or %-%**	**%**
Number of beneficiaries receiving food assistance	16	723,763	88%
Total USD value of cash transferred to beneficiaries	36	$122,593,864.36	78%
Total USD value of vouchers redeemed by beneficiaries	14	$28,182,623.66	79%
Number of individuals participating in BHA food security programs	13	1,322,387	85%

Table 2. Nutrition and Food Security priority indicators

Indicator/activity type	Awards	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved >90% of their Target LOA
Indicator name	**Number**	**Number or %-%**	**%**
Number of individuals screened for malnutrition by community outreach workers	20	2,114,603	80%
Number of children under five (0-59 months) reached with nutrition-specific interventions through BHA	16	521,315	63%
Percent of children 6–23 months of age who receive foods from 5 or more food groups (MDD)	20	2% - 98%	50%
Percent of households with moderate and severe Household Hunger Scale (HHS) scores	14	2% - 87.8%	86%
Percent of households with poor, borderline, and acceptable Food Consumption Score (FCS)	20	7% - 100%	80%

Table 3. MPCA priority indicators

Indicator/activity type	N (number of Awards)	Output Value (Sum)/ or Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved ≥90% of their Target LOA
Indicator name	**Number**	**Number or %-%**	**%**
Total number of individuals (beneficiaries) assisted through multipurpose cash activities	19	292,745	79%
Percent of (beneficiary) households reporting adequate access to household non-food items	11	10% - 95%	27%

Table 4. Livelihoods priority indicators

Indicator/activity type	N (number of Awards)	Output Value (Sum)/ or Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved ≥90% of their Target LOA (if targets available)
Indicator name	**Number**	**Number or %-%**	**%**
Number of individuals assisted through livelihoods restoration activities	11	42,079	73%
Number of individuals assisted through new livelihoods development activities	6	4,110	50%
Number of individuals (beneficiaries) who have applied improved management practices or technologies with BHA assistance	17	158,886	71%
Number of people directly benefiting from improving agricultural production and-or food security activities	21	473,195	86%

WFP Outcome Data

Change in percentage of households with acceptable FCS and Coping Strategy Index (CSI) scores between 2021-2022 by country and region

Out of six awards[1] in MENAE, there was an overall improvement in the percentage of households with acceptable FCS and CSI between 2021 and 2022 (Table 5). Only Turkey and Yemen failed to show any improvement in the percentage of households with an acceptable FCS between 2021 and 2022 (see Table 5). Improvements in both indicators occurred in Egypt and Jordan while Lebanon and Syria showed positive change in acceptable food consumption but negative change in CSI.

[1] Egypt, Jordan, Lebanon, Syria, Turkey and Yemen.

Table 5. MENAE: Change in percentage of households with acceptable FCS and CSI between 2021 and 2022

Country	Region	Change in %HHs w/acceptable FCS	Change in CSI
Egypt	MENAE	9.05	-5.85
Jordan	MENAE	1.20	-5.00
Lebanon	MENAE	10.80	1.68
Syria	MENAE	5.80	0.54
Turkey	MENAE	-3.70	-0.98
Yemen	MENAE	-4.20	0.59

In OA region, both indicators showed negative change between FY 2021 and FY 2022 (Table 6). Countries in which there was a positive change for the FCS indicator but a negative change for CSI include Burkina Faso, CAR, Kenya, South Sudan, Sudan and Uganda (Table 6). Only Mali, DRC, and Mozambique showed positive changes in both indicators.

Table 6. OA: Change in percentage of households with acceptable FCS and CSI between 2021 and 2022

Country	Region	Change in %HHs w/acceptable FCS	Change in CSI
Burkina Faso	AFR	-4.83	-2.30
Burundi	AFR	1.04	0.48
Cameroon	AFR	0.00	0.00
Central African Republic	AFR	-2.40	-1.53
Chad	AFR	-9.23	0.00
Congo	AFR	-25.36	0.74
Democratic Republic of the Congo	AFR	0.73	-0.07
Djibouti	AFR	-8.32	2.74
Ethiopia	AFR	-28.24	5.92
Kenya	AFR	-13.93	-0.70
Madagascar	AFR	8.80	2.00
Mali	AFR	22.60	-2.00
Mozambique	AFR	20.60	-5.95
Niger	AFR	1.30	5.30
Nigeria	AFR	-14.10	4.80
Rwanda	AFR	-5.40	0.67
Somalia	AFR	-12.00	2.27

South Sudan	AFR	-31.60	-2.00
Sudan	AFR	-1.10	-0.38
Tanzania	AFR	NA	NA
Uganda	AFR	-6.40	-4.10

In ALAC, the change between 2021 and 2022 was positive overall for both indicators (Table 7); people were more food secure and less likely to use negative coping strategies in 2022 compared to 2021. In Colombia and Honduras, there was a negative change in households with acceptable FCS coupled with a positive change in CSI (Table 7).

Table 7. ALAC: Change in percentage of households with acceptable FCS and CSI between 2021 and 2022

Country	Region	Change in %HHs w/acceptable FCS	Change in CSI
Afghanistan	ALAC	0.00	1.00
Bangladesh	ALAC	17.25	-4.48
Myanmar	ALAC	NA	NA
Colombia	ALAC	-3.25	-4.67
Ecuador	ALAC	32.80	-8.59
Guatemala	ALAC	54.00	-11.00
Honduras	ALAC	-4.2	-0.30
Peru	ALAC	0.00	0.00

The largest positive changes occurred in Guatemala (54 percentage points), followed by Ecuador (32.8 percentage points) and the largest negative changes occurred in South Sudan (-31.6 percentage points), followed by Ethiopia (-28.24 percentage points) (see Table 6 and 7). There was no change in either indicator in Afghanistan, Cameroon, or Peru. In some of the most fragile countries (e.g., Syria, Yemen), there was strong agreement among those interviewed that the "no regrets approach" supported through the FY 2021 Supplemental reached more people and helped prevent famine, even though it did little to improve food security outcomes post-award.

The results are similar for CSI; just over one-half of countries analyzed (17 out of 33) showed a positive change (Table 5, 6, and 7). Guatemala (-11.00 percentage points) and Ecuador (-8.59 percentage points) showed the largest positive change in CSI while Niger (5.3 percentage points) and Nigeria (4.8 percentage points) showed the largest negative change.

Table 8. Change in percentage of households with acceptable FCS and CSI between 2021 and 2022 by region

Region	Average Change in FCS	Average Change in CSI
ALAC	13.80	-4.00
AFR	-5.39	0.29
MENAE	3.16	-1.50
World	0.23	-0.94

Change in percentage of households with acceptable FCS and CSI scores between 2020-2021

In 2021, many countries in which large-scale food assistance was provided with BHA surge funding showed small but positive change in both food security indicators (as measured with FCS and CSI) compared with 2020 (see Table 9). For example, the MENAE region had declined significantly between 2020 and 2021 in terms of food security indicators (FCS = -10.9, CSI = +3.9) but showed positive changes in both between 2021 and 2022. Countries in Africa for which food security showed negative change across both time periods include Burkina Faso, CAR, Chad, Congo, Djibouti, Somalia, Sudan, and Yemen.

Table 9. Change in percentage of households with acceptable FCS between 2020 and 2021

Country	Change in %HHs w/acceptable FCS (percentage points)	Change in CSI
Afghanistan	32.00	-2.00
Bangladesh	-10.00	-2.90
Burkina Faso	-18.10	-4.00
Myanmar	15.55	0.50
Burundi	-11.40	-6.40
Cameroon	-30.70	-3.00
Central African Republic	-12.40	2.43
Chad	-26.60	0.30
Colombia	17.00	-4.00
Congo	-5.80	-5.78
Democratic Republic of the Congo	25.00	-11.76
Djibouti	-3.89	5.31
Ecuador	30.80	-7.76
Egypt	-10.60	1.97
Ethiopia	9.90	-4.06
Guatemala	5.00	0.00
Honduras	37.70	2.60
Jordan	-10.86	5.53
Kenya	9.80	0.40
Lebanon	-15.30	9.39
Madagascar	-5.80	-4.79
Mali	-10.90	-0.60
Mozambique	20.00	2.80
Niger	3.30	-2.00

Nigeria	6.30	-1.06
Rwanda	35.70	-1.68
Somalia	-13.40	-0.70
South Sudan	25.20	4.60
Sudan	-8.20	1.20
Syria	-19.00	1.51
Tanzania	-6.20	7.20
Turkey	1.70	4.11
Uganda	19.70	-2.20
Yemen	-11.50	1.07
AVERAGE	1.88	-0.41

WFP annual report analysis methodology

For the 2021 and 2022 WFP Annual Reports, a comprehensive methodology was employed to analyze data from countries that received a COVID-19 supplementary award. The primary focus was to extract and analyze outcome and output indicators relevant to WFP's operations during this period. In order to do so, data was gathered by accessing WFP country annual reports for 2021 and 2022, covering all countries that received COVID-19 Supplemental fundings. For 2021 annual reports, the following baseline (2020, and where available, 2019) and endline (2021) outcome indicators were extracted:

- Coping Strategy Index (CSI)
- Percent of households with poor, borderline, and acceptable Food Consumption Scores (FCS)
- Proportion of children aged 6-23 months receiving a minimum acceptable diet (MAD)

Additionally, the following output indicators were also extracted:

- Quantity of commodities distributed (measured in metric tons)
- Number of unique participants receiving in-kind food
- Total amount distributed (measured in USD) by cash transfers.

Furthermore, notes were taken on any potentially interesting information related to COVID-19 and the subsequent lockdown, with a focus on how the pandemic impacted WFP operations.

To estimate the number of beneficiaries reached through the award, the total number of beneficiaries reached and the total WFP budget for the year were collected. The number of beneficiaries reached through the award was then calculated through the following formula:

$$Award\ Beneficiaries = \frac{Award\ Budget}{Total\ Budget} * Total\ Number\ of\ Beneficiaries$$

For 2022, a similar approach was followed, with the analysis primarily focused on the percent of households with an acceptable FCS and CSI, since the main objective was to design a map illustrating the changes in said indicators

between 2021 and 2022. Moreover, the target values for 2022 were also retrieved to assess whether the WFP met its goals for that year.

WFP population-based data analysis

The WFP partners with Geopoll and other agencies to monitor food security at the national level through daily phone-based surveys of randomly selected households conducted in countries with active assistance programs. While these surveys are not specifically intended to assess the impact of assistance, in several countries the questionnaires do ask respondents whether they are currently aid beneficiaries. Where levels of assistance are high, a question of interest is whether the average food security level of aid recipients (as assessed by standard indicators) is significantly different from that of non-beneficiaries. However, such a comparison is complicated by the presence of time-varying trends in overall food security due to economic, environmental, political, and cultural factors, as well as random variation in sampling frequencies at the regional level. To account for these concerns, the evaluation adopted a time series modelling approach that incorporates covariates to estimate the daily average food consumption score (FCS) and reduced Coping Strategies Index (rCSI). Slowly varying trends are accounted for via first-order differencing, in which the daily differences in the model residuals are assumed to follow a stationary process with mean 0 and constant variance. Correlations among these residuals are estimated as a Moving Average process, in which there is dependence in the "noise" that is not captured by the model but not in the observations themselves. The ET applied this approach to analyze the role of assistance in daily mVAM averages for FCS and rCSI during 2020-2022 in four countries of interest for which sufficient/ minimal data could be utilized: Yemen, Syria, Colombia, and Honduras. For each country, the last month of 2022 was withheld so that the accuracy of the fitted models could be assessed via predictions.

Note: Literature review for Objective 2 focused on grey literature including food security reports from WFP, Global Network Against Food Crises, and resources on the Food Security Information Network. See References.

E.3. OBJECTIVE 3

This section provides supporting information for USAID/BHA FY 2021 COVID-19 Performance Evaluation: Evaluation Question 2/Objective 3 Brief, found here.

Additional Funding Information

Geographically, Office of Africa (OA) received the most funding ($35,860,725), followed by MENAE ($26,200,655), ALAC ($16,511,528), and Global ($7,483,429). Syria received the most protection funds ($16,501,436), followed by South Sudan ($10,503,685), and Venezuela ($6,154,776). IPs working in Syria and South Sudan also received the most awards (7 each), followed by Mozambique (6 awards).

NGO/PIO Indicator Tables

Table 1. Protection sector priority indicator results for NGOs

Indicators	N (# of awards)	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved >90% of their Target LOA
Indicator name	**#**	**# or %-%**	**%**
# of individuals accessing GBV services	22	304,417	72.7
# of individuals participating in child protection services	20	324,033	90.0
# of individuals participating in psychosocial support services	24	342, 066	95.8
# of individuals trained in protection	14	9,213	78.6

Table 2. Protection sector priority indicator results for PIOs

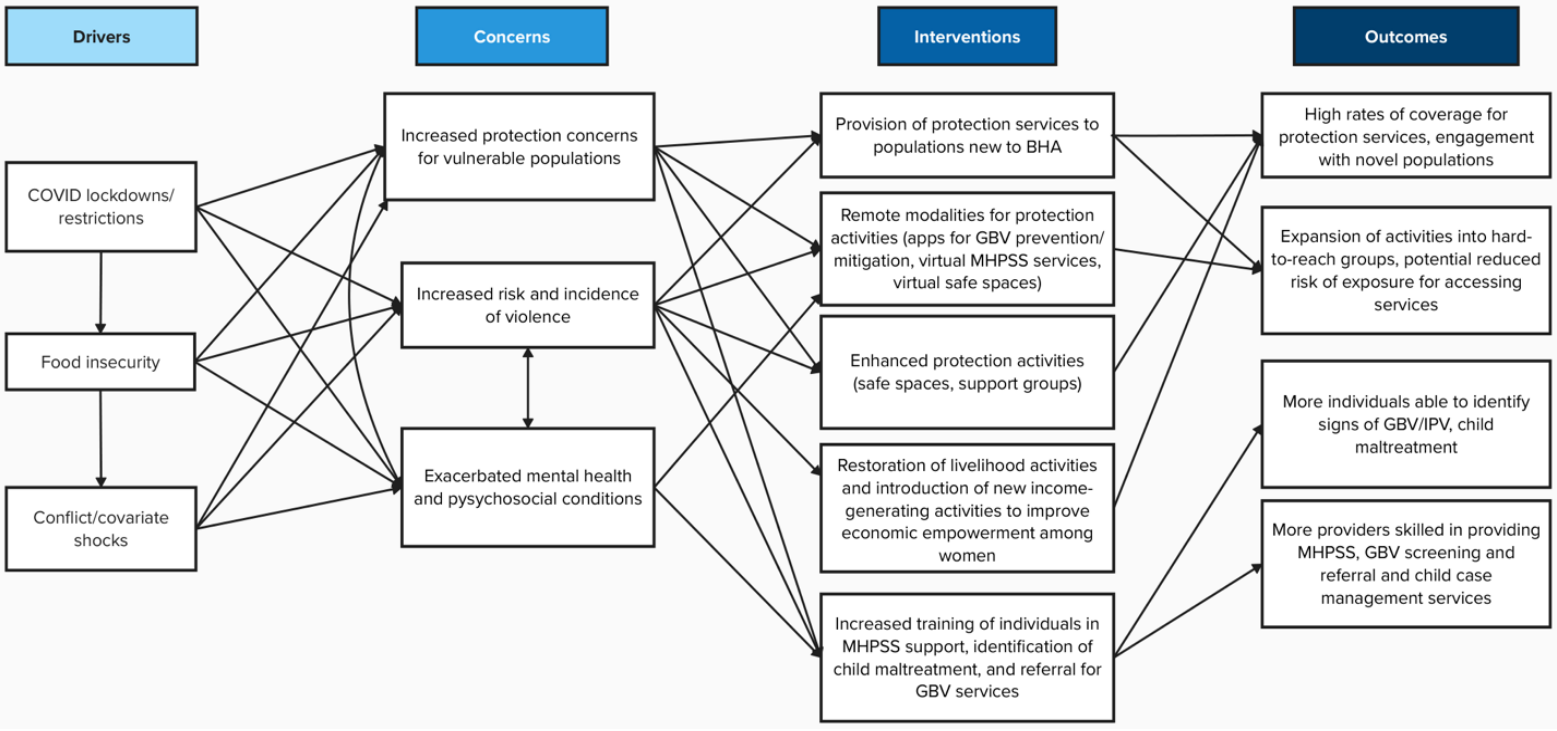
Indicators	N (# of awards)	Output Value (Sum)/ or Outcome Value (% Range)	% of Awards that achieved >90% of their Target LOA
Indicator name	**#**	**# or %-%**	**%**
# of individuals accessing GBV services (e.g., risk mitigation, prevention, and response)[2]	10	602,982	60.00% (6/10) 75% of final reports met their targets
# of individuals participating in child protection services	6	111,720	50.0% (3/6) 50% of final reports met their targets
# of children receiving case management	2	11,758	100% (2/2)
# of children participating in child protection services	5	99,962	40.0% (2/5)

[2] May also capture beneficiaries who received case management

			50% of final reports met their final targets
# of individuals participating in psychosocial support services	16	229,827	50.0% (8/16) 77.78% of final reports met their targets
# of individuals trained in protection	11	74,406	63.64% (7/11) 83.33% of final reports met their targets
# of individuals receiving case-management services	10	19,850	70.0% (7/10) 100% of final reports met their targets
# of individuals who received services for persons with special needs	2	1,481	100% (2/2)
# of individuals who received prevention of sexual exploitation and abuse (PSEA) services	1	14,325	100% (1/1)

Drivers and Outcome Pathways Qualitative Analyses

Figure 1. Drivers, concerns, interventions, and outcomes pathways for protection sector activities



Notable Interventions: Sub-objective 3.1 Access to dedicated protection services

Table 3. Sub-objective 3.1 access to dedicated protection services

Notable interventions focused on MHPSS with documented outcomes/impact		
Intervention	**Approach**	**Impact**
[OA Award] Deployed psychosocial mobile teams to provide direct services. Improved remote services provisions, such as remote counselling and psychosocial responses. Enhanced beneficiaries' life skills, problem-solving skills, good parenting skills, etc. Provided tailored services based on improvement plans developed by each field location, premised on identified needs and MHPSS concerns, resilience factors, and community/family strengths. Improved the provision of specialized mental health services. Conducted outreach activities dissemination of protection-focused messages.	Provided MHPSS to 69,258 beneficiaries. 8,426 beneficiaries received psychosocial support (PSS) and psychological first aid (PFA) services through face-to-face methods, in addition to toll-free lines and confidential spaces. Strengthened the capacity of 21 community support structures, 42 groups, and 180 community members with social skills development and family and group support techniques, which provided support to individuals and families. Conducted quarterly needs assessments which informed their work plans to address psychological needs. Facilitated 3,313 referrals for specialized mental health care. A team of psychiatric nurses and a consultant were deployed to the field to develop tools for assessment, treatment plans, and supervision protocols. 3,479 individuals received messaging on counter-trafficking. 6,328 individuals received messaging on GBV. Radio and other media outlets were used to distribute messages on violence prevention. Staff were trained on Engaging Men through Accountability Practice to prevent violence against women and girls.	92.28% of beneficiaries reported that services improved their quality of life. Crisis-affected populations benefitted from improved and interconnected mental health and psychosocial well-being.
[OA Award] Conflict-affected populations were provided with focused non-	Vulnerable populations received services such as counselling, PFA, support groups, psychoeducation, awareness raising activities, and	Outcome: Improved psychosocial well-being of conflict affected populations.

specialized and social MHPSS, and community and family support. Community members and leadership, humanitarian actors and service providers were provided with knowledge on community based MHPSS.	coping mechanisms and parenting skills. Conducted MHPSS trainings on counselling, support group facilitation, mindfulness, and other skills. Social workers trained on referrals, case management, accompaniment of families, conflict mediation, PFA, and counselling. Community members, humanitarian actors, and service providers trained on PFA, MHPSS, and Interagency Standing Committee (IASC) guidelines	Output: 19% of participants in MHPSS activities report an increase in psychosocial well-being.

Table 4. Notable interventions focused on GBV with documented outcomes/impact

Notable interventions focused on GBV with documented outcomes/impact		
Intervention	**Approach**	**Impact**
[ALAC Award] Established Child-Friendly Safe Spaces in community spaces and shelters. Conducted targeted activities and engaging with girls, boys, parents, and community members both in communities and in shelters. Provided unaccompanied girls, boys, and adolescents and survivors of violence with services through case management.	IP developed a toolkit for the implementation of safe spaces in shelters and communities, including a manual and a guide for various games and activities. IP constructed community-led strategies to prevent GBV during emergencies and strengthen social mechanisms to reduce risks for girls and women. Strategies included community-led emergency preparedness plans and strategies to reduce violence against children. These strategies intended to strengthen identification and registration and referral for children separated from caretakers or victims of violence to child protective services. Activities included culturally appropriate and gender and age-sensitive information for the promotion of gender equality. Assisted in the mobilization of child protection teams to investigate and provide child protective services through case management.	Establishment of Safe Spaces in community spaces and in shelters for girls, boys, and adolescents to access gender-sensitive, age-appropriate, and culturally acceptable emergency MHPSS, counselling and protective services to address their urgent needs and traumas, both through community-based emergency PSS. Violence against children and sexual and gender-based violence (SGBV) prevented through targeted activities and engagement with girls, boys, parents, community members, and in shelters which included the construction of community-led strategies that prevented GBV during the immediate emergency and strengthening social mechanisms to reduce risks for girls and boys and create more resilient communities. Child and adolescent survivors of violence including SGBV accessed timely, quality, multisectoral response services through case management.

	Established child protective services including housing arrangements at safehouses, and alternative residential care for children separated from caretakers.	
[MENAE Award] Women and girls were provided with awareness raising sessions, case management, and individual and group PSS.	Support for 11 health facilities, including obstetric and neonatal care facilities and mobile clinics, as well as 18 Women and Girls' Safe Spaces. Safe spaces provided vocational training on cooking and food processing, resilience-building activities, and income-generation skills enhancement, such as literacy and language classes. Income generating activities with a focus on vulnerable individuals such as survivors of violence, female headed households, women with disabilities, and older women. Activities were paired with capacity building efforts to assist beneficiaries in maintaining profitable business.	148,900 beneficiaries reached with GBV prevention and response services.
[ALAC Award] Strengthened GBV prevention and access to information. Strengthened and provided comprehensive GBV response and services for GBV survivors. Strengthened local government capacities to provide multi-sector response to address GBV.	Used awareness raising interventions and behavior change communication strategies. Strengthened GBV coordination mechanisms for multi-sector responses at national and local levels. Improved case management and referral systems. Established and strengthened GBV safe spaces and PSS services. Supported development of public policies and programs and training public officials and service providers from different sectors.	28,424 vulnerable women and girls of reproductive age received life-saving information regarding availability of services. 3,820 vulnerable women and girls of reproductive age were provided with dignity kits. 7,913 GBV case management and PSS sessions provided. 1,408 sub-national GBV working group members and service providers received training on minimum standards for GBVIE.

Table 5. Notable interventions focused on child protection with documented outcomes/impact

Notable interventions focused on child protection with documented outcomes/impact		
Intervention	**Approach**	**Impact**
[OA Award] Awareness raising sessions, case management, and individual and group PSS to women and girls, including survivors of GBV at Women and Girls' Safe Spaces.	5,643 vulnerable children were identified and assisted. Family tracing and reunification was conducted when possible, and all children not reunited with families were placed into foster care or independent living. Children received recreational and didactic activities covering play, singing, drawing, dancing, games, reading, and numeracy. Adolescents participated in sports, debates, literacy and numeracy activities, and referral to health services. Women's safe spaces allowed women and girls to participate in didactic interventions, discussions, skills development, and counselling. Survivors of GBV were provided with case management and referrals to health services.	The most vulnerable children affected by covariate shocks had increased access to timely and quality child protection services and were protected from violence, abuse, neglect, and exploitation, including GBV.
[ALAC Award] Specialized services and referrals for health, social welfare, protection, and justice services among indigenous communities.	Meetings were scheduled with indigenous youth and female leaders to create a youth-led network to identify child protection issues and solutions. Individuals across four ethnic groups were brought together to discuss safe spaces for children as well as when and where to place them. Indigenous women leaders participated in child protection training and the development of a needs assessment.	Strengthened indigenous child protection system to prevent and respond to violence against children (including GBV) with community-based child protection plans (including referral mechanisms) and the promotion of safe spaces for children. 292 indigenous leaders, guardianship councilors, and other actors from the local protection network were trained on the diagnosis and safe spaces. 5,242 children were identified as in need of specialized services and referred to health, social welfare, and justice services

Notable Interventions: Sub-objective 3.2 COVID-specific gender and protection issues

Table 6. Notable interventions focused on COVID-specific gender and protection issues

Notable interventions focused on COVID-specific gender and protection issues		
Intervention	**Approach**	**Impact**
[OA Award] Provided primary healthcare consultations and COVID-19 symptoms screenings through the mobile outreach team. Provided MHPSS assistance.	MHPSS services included using remote methods such as a helpline. Beneficiaries, including IDPs and migrants received PFA, basic counselling, psychosocial assessments, support group sessions, needs assessment sessions, art-based psychosocial activities, and recreational activities for children. The psychosocial mobile team limited the number of participants for group activities in response to COVID-19 risks.	Vulnerable populations have increased access to critical health and MHPSS services, essential to overcoming COVID-19. 77% of respondents were satisfied with individual activities, and 86% were satisfied with the one-on-one consultations received. Vulnerable populations have access to primary and secondary healthcare, protection, MHPSS services, and COVID-19 screening.

Literature Review Methods and Findings

To capture best practices and evidence for effective strategies for protection activities during the COVID-19 pandemic, the ET conducted a literature review utilizing peer-reviewed literature and gray literature. The search strategy utilized protection sector specific search terms such as "Gender Based Violence," "Child Protection," "MHPSS," and "Mental Health and Psychosocial Support;" coupled with "humanitarian," "evaluation," "intervention," "lessons learned," and "best practices." A total of 11 publications were identified from Google, Google Scholar, Global Protection Cluster, and ReliefWeb searches. Publications were selected according to a predetermined set of inclusion and exclusion criteria. To be considered for inclusion, publications must have discussed protection activities in the context of the COVID-19 pandemic and have a publication date of January 2021 or later. Exclusion criteria included any publications that were not focused on protection-specific terms, did not include mention of COVID-19, were not in humanitarian settings, and were published prior to January 2021.

The identified sources covered a range of topics such as the 'shadow pandemic' (i.e., increase in gender-based violence (GBV) during COVID-19 lockdowns), child protection and GBV activities, and methods for adapting protection activities to accommodate social distancing measures. Geographically, the literature consisted of articles on the global scale and was heavily focused on low- and middle-income countries (LMIC). Some studies focused on single countries, including Bangladesh (1), Australia (1), and Uganda (1).

Approaches documented in the literature included utilizing hotlines for case referral (Armijos et al., 2023; Banke-Thomas & Yaya, 2021; Pfitzner et al., 2022); remote case management and MHPSS (UNICEF, 2021; Metzler et al., 2021); GBV, COVID, and child protection sensitization using remote platforms (e.g., radio, audio recordings, chatbots, mobile trucks, WhatsApp, social media) (Williams & Pontali, 2021; Armijos et al., 2023; Metzler et al., 2021; Banke-Thomas & Yaya, 2021). Other innovative methods included integration of GBV responses into essential services, such as medical care and childcare (Pfitzner et al., 2022), adding GBV messaging to cookbooks and sanitary napkins (UNICEF, 2021), and utilizing codewords and physical signals at pharmacies (Pfitzner et al.,

2022). These interventions were critical to address GBV specifically, as cellphones, which can be used to reach hotlines or safe spaces, were often controlled by abusive partners during lockdowns (Pftizner et al, 2022).

Remote modalities presented challenges. A study among MHPSS service providers revealed considerable obstacles in delivering quality care remotely, such as lack of technological devices, poor internet connection, low technological literacy, data safety, and difficulties reaching vulnerable populations (Ibragimov et al., 2022). A study in Uganda found that although distributing child protection messaging on radios was the preferred forum (Metzler et al., 2021), only one fourth of households participating in the program had access to a radio, thus programming reach was limited by technological availability (Metzler et al., 2021). Future protection services should have a comprehensive understanding of technological access and literacy before shifting to remote modalities.

E.4. OBJECTIVE 4

This section provides supporting information for USAID/BHA FY 2021 COVID-19 Performance Evaluation: Evaluation Question 2/Objective 4 Brief, found here.

Additional Discussion:

Coordination system challenges

Overall challenges and system-wide issues persist in the Cluster system and across humanitarian coordination platforms that affect the effectiveness of coordination supports. These include the competition that exists among humanitarian actors and continued resistance among some actors to share data; the ability of large actors to work in isolation; and limitations of OCHA to fulfill its role in some contexts. Globally, levels of local NGO participation at the strategic levels in the Cluster system are low (IAHE, 2022; USAID READY, 2023). But for responses to be more effective, including future pandemic response, local NGOs must play a greater role. It should be noted that there is also much documented about government actor's coordination role during the pandemic. Active participation in the Cluster system exposes local actors to the global humanitarian system, connecting them with global entities, processes and thinking. This alone can indirectly contribute to the humanitarian community's localization agenda by creating a cadre of local actors conversant with the international humanitarian system, funding, and stakeholders. One key barrier to local actors' participation, in addition to internet connectivity issues for virtual meetings, also confirmed by this evaluation's evidence, is language (IAHE, 2022; WHO, 2023). Translation into local languages is expensive and time consuming; yet, for Clusters to authentically bring in a wider range of local actors, the issue of language, and funding translation, will need to be addressed.

NGO/ART Indicators

Table 1. HCIMA indicator calculations for NGOs

HCIMA Indicators	Indicator Type	Unit Of Measurement	# of EL Indicator Values	LOA Value Aggregated Total
Number and percent of humanitarian organizations utilizing information management services	Outcome	Number	14	7,707
Number and percent of humanitarian organizations utilizing information management services	Outcome	Percent	11	4.9% - 113%
Number of humanitarian organizations actively coordinating in the proposed area of work	Output	Number	11	3,267
Number of humanitarian organizations actively participating in inter-agency coordination mechanisms	Output	Number	9	368
Number of products made available by BHA funded information management services that are accessed by stakeholders	Output	Number	15	3,714

Number and percentage of humanitarian organizations directly contributing to information products	Outcome	Number	13	4,903

E.5. OBJECTIVE 5

This section provides supporting information for USAID/BHA FY 2021 COVID-19 Performance Evaluation: Evaluation Question 2/Objective 5 Brief, found here.

Table 1. Objective 5 indicators

Objective 5 Indicators	Indicator Type	Unit Of Measurement	# of Awards	LOA Value Aggregated Total
Situation/Service Monitoring Systems Improved	Outcome	Number	2	2
New preparedness and response Standard Operating Procedures (SOPs) and strategies adopted	Outcome	Number	6	18
Platforms Adopted or Improved	Outcome	Number	5	8
Tools and Toolkits Designed	Output	Number	11	26 Tools 8 Toolkits
Lessons Learned Reports and Case Studies Written	Output	Number	6	9 Lessons Learned 45 Case Studies
Surge Deployment Capacities Developed or Improved (including prescreening personnel and financing mechanisms)	Output	Number of Awards	6	-

Note: Due to the multisectoral nature of this objective five, combined with the fact that the majority of global awards went to PIOs, indicators were not consistent across award reports. For this reason, key outputs related to humanitarian architecture and infectious disease preparedness and response capacity were selected through a review of individual award reports.

F. BRIEF 3 SUPPORTING INFORMATION

This section provides supporting information for USAID/BHA FY 2021 COVID-19 Performance Evaluation: Evaluation Question 3 Brief, found here.

BHA FY 2020 COVID-19 EVALUATION RECOMMENDATIONS:

Conclusions and Recommendations

The evidence illustrates both the challenges and capacity of BHA and its partners to rapidly respond to a global emergency and novel disease. IPs leveraged their Supplemental awards with other donor assistance to meet participant needs and fill gaps during the dynamic and challenging first year of the global pandemic. IPs programmed the short-term funds efficiently and adapted approaches where possible to address community feedback. The BHA funding shift in mid-2020 to support food assistance was critical. The results of this evaluation show awards were effective in building awareness for COVID-19 prevention and supporting local health systems in humanitarian contexts, with engagement of community and local partnerships being critical to their success.

As part of the evaluation's function for accountability and learning, it is important for BHA partners to be aware of the following recommendation areas for BHA with accompanying partner programming considerations.

Recommendation 1: Cash coherence

For BHA: Develop cross-sector cash (MPCA and Cash and Voucher Assistance (CVA)) guidance and related outcome indicators within BHA to widely promote and expand this activity as a critical tool in emergency response, particularly for NGO partner awards.

Partner programming considerations: Partners can support cash coherence by including MPCA/CVA in multi-sectoral project designs, and better measuring food security and intermediate outcomes related to cash activities.

Recommendation 2: Localization momentum

For BHA: Invest in the local organizations that respond to ongoing shocks, to be included as formal partners in future pandemics. One step in this direction is to promote more sub-awards to local organizations.

Partner programming considerations: Partners can support localization by developing the capacity of local institutions ahead of emergencies and including them in future emergency sub-award partnerships.

Recommendation 3: Strategic investments in coordination

For BHA: Develop a strategic coordination strategy for pandemic and global emergencies, in particular to provide clarity for HCIMA sector investments and to promote cross-sector coordination.

Partner programming considerations: Partners can support strategic coordination by improving cross-sector coordination mechanisms, which include pandemic preparedness planning with governments and other actors.

Recommendation 4: Valued guidance through BHA-IP relationships

For BHA: Continue to support BHA's direct communications with IPs through award managers/field contacts, promoting award alignment with BHA priorities without issuing lengthy technical guidance in addition to those IPs utilized most (from governments or clusters).

Partner programming considerations: Partners can support BHA-IP relations by continuing regular and direct communication channels, and by initiating discussion of ongoing project results with award managers/field contacts to support adaptive management.

Recommendation 5: Monitoring and Evaluation (M&E) for humanitarian decision-making

For BHA: Strengthen the award data quality and monitoring system to improve its utilization for decision-making within BHA and learning for partners.

Partner programming considerations: Partners can support BHA M&E by ensuring correct submission of final reports and indicator values, and by discussing project results with BHA field contacts for adaptive management.

Recommendation 6: Novel pandemics always involve great uncertainty – design awards accordingly

For BHA: Propose a directive that would allow for longer award timeframes and greater flexibility for future funding of this nature.

Partner Programming considerations: Partners can support novel pandemic response by ensuring readiness to pivot across sectors and to sustain results as understanding/or waves of the disease progress.

FY 2020 Evaluation summary report found here.

G. CASE STUDY FINDINGS

HONDURAS

Summary

Selection criteria: Honduras was selected as one of the case studies for this BHA COVID-19 evaluation due to a combination of factors. Honduras experiences a myriad of covariate challenges, including increased vulnerability to water and sanitation-related illnesses exacerbated by hurricanes Eta and Iota in November 2020, an upsurge in dengue cases, with Honduras being particularly affected by the disease during this period, and persistent insecurity driven by gang violence. (Amnesty International, 2020; ReliefWeb, n.d.; Pan American Health Organization, n.d.). Despite the challenges, Honduras has robust community networks and a public or government health system that, while weak, can be fortified through collaborative efforts with implementing partners to strengthen healthcare delivery, particularly through rehabilitation and institutional strengthening initiatives at community health centers.

Funding summary: Honduras received five awards totaling $32 million in the FY 2021 Supplemental across 11 sectors, with Food Assistance being the highest funded. In the broader Northern Triangle Region (NTR), Guatemala received $51 million across eight sectors and nine awards, while El Salvador received $5 million across five sectors and three awards, both with MPCA as the highest funded sector. Altogether, the NTR region received $88 million in support. Among the IPs supported in Honduras were Global Communities, UNICEF, Catholic Relief Services (CRS), WFP, and GOAL, while the Red Cross Honduras (IFRC), Pan American Health Organization (PAHO), and International Rescue Committee also contributed to programs in Honduras through regional awards. Additionally, CRS and GOAL were further evaluated in another BHA-commissioned regional evaluation for the same time period focused on livelihoods.

Data collection: The case study, conducted between March and April 2024, involved data collection from 302[3] respondents across eight departments in Honduras. The majority of data collection took place in Cortes, a region that was heavily impacted by the hurricanes. The research team worked with four IPs in this evaluation case study, selected for their diverse sector programming expertise, responsiveness, and capacity to contribute effectively. These partners were chosen to complement the variety of IPs across case studies, ensuring representation from NGOs to Red Cross, and UN agencies. Study sites were selected with the IPs through purposive sampling, prioritizing communities with accessibility and for their range of activities across partners. The data collection activities by IP and sectors covered are provided in the table below:

Table 1. Overview of Honduras case study data collection activities

IP	FGDs (n=)	KIIs (n=)	HW Surveys (n=)	Sectors
UNICEF	6	3	32	Health/Nutrition, Protection
Red Cross Honduras	4	2	-	Health/Nutrition, WASH/Shelter/MPCA
WFP	4	1	-	Food Security/Livelihoods

[3] This count includes total respondents, which may include some double counting of respondents across interview types.

Global Communities	8	2	-	Food Security/Livelihoods, WASH/Shelter/MPCA
Total	**22**	**8**	**32**	N/A

Following data collection, an analysis workshop was held from April 30 to May 2 to identify preliminary findings. This workshop culminated in a half-day validation session with IPs. This study was made possible by a highly competent and dedicated local research team:

Table 2. Honduras fieldwork research team.

Honduras Fieldwork Research Team	
Name	**Position**
Siomara Bertrand	Study Manager, ANED
Rose Cooper	Consultant, ANED
Carmen Flores	Consultant, ANED
Kristie Reyes	Assistant/Analyst, ANED
Maria Posas	Assistant, ANED
Angelina Reyes	Analysis Workshop/Facilitator, ANED
Maryada Vallet	Technical Assistance to Non-Governmental Organizations (TANGO) International
Tripura Talagadadeevi	TANGO International

Key findings/outcomes triangulated across Honduras/Northern Triangle interviews:

Objective 1: Health and Nutrition

Effectiveness

- The communities had access to comprehensive primary health services without any discrimination; this allowed them to better manage the crisis situation in the context of the pandemic and hurricanes, reducing excess morbidity and mortality from the crises.
- Through trainings and support to integrate nutrition services within health centers, health staff have improved their knowledge of child nutrition, including the measurement of nutrition levels using Median Upper Arm Circumference (MUAC) measurements. Beneficiaries, including community volunteers, have also learned the importance of MUAC measurement and referrals to health centers.
    - As a result, children and pregnant women had access to nutritional supplements during the emergency situation, which improved their nutritional status, e.g., ready-to-use therapeutic foods.
- Severe food and nutrition insecurity in children was mitigated through layering of food assistance, basic health services, health promotion, and first aid materials.
- The health systems improved their capacity to respond to the needs of the community by strengthening human resources, including support from health committees, equipment, and supplies provided. In doing so, they strengthened health centers, providing continuity of services, including across WASH and Nutrition (multi-sector layering).

- Communities have become empowered in COVID-19 prevention, health promotion, and delivery of health services, due to the support of community volunteers and health committees, who created greater confidence/trust in COVID-19 guidelines and health-seeking behaviors.
    - Pregnancy Clubs, supported through initiatives like mobile brigades, played a vital role in improving access to immunizations and dispelling vaccine-related myths among pregnant women for COVID-19 and other vaccines.

"Help arrived and was very helpful, both for the mothers who received the training, and for the children. It was easier because the classes were received in schools. The children wanted to leave their homes, so the call reached many children and the parents supported." – Honduras FGD

Overall Performance Evaluation Objective 1.2 outcomes that findings confirm: continued access to care, knowledge growth and behavior change among participants, immediate needs were met, and improved nutrition outcomes.

Relevance to Needs

- The health and nutrition assistance in Honduras was highly relevant to the needs of vulnerable groups, particularly through essential mental health services (and MHPSS, under Protection), community-based malnutrition detection and care for children, and reactivation of health centers after the end of pandemic restrictions and hurricanes, in some cases with higher demand than capacity. Involvement of local governments early in the assistance was crucial for sustainability.

Objective 1: WASH, Shelter, and MPCA

Effectiveness:

- Water systems were recovered and most of the homes gained access to water for household needs (non-potable).
- In some areas, water service coverage was extended to more communities and households due to the involvement of the municipal mayor's office through the Ministry of Health (CODEM).
- Supplying tool kits, equipment, and materials enabled affected individuals to construct temporary shelters or tents in response to housing damage caused by tropical storms. Further, immediate roofing needs were met through the erection of tents, repair of roofs, and provision of temporary shelters to select participants. Communities valued the temporary shelter service as a crucial solution during emergencies, with these shelters remaining occupied due to the availability of energy and water for multiple uses.
- Good basic sanitation, hygiene practices, and the application of IPC measures have been instilled among the participant population through multisector IP health/hygiene promotion and community-based messaging.
- Engaging the community and community water boards from the outset was effective in identifying WASH facility needs and achieving goals, with community volunteers actively supporting the rebuilding of shelters and the water system.
- MPCA was perceived as helpful in meeting beneficiaries' emergency needs.

"[Health committee member] We are a bastion for them." – Honduras FGD

Overall Performance Evaluation Objective 1.1 outcomes that findings confirm: Immediate care / needs were met, more vulnerable people were reached, and continued access to WASH services was provided.

Relevance to Needs

- WASH: The WASH assistance was relevant for the hurricane response, but faced issues like unmet latrine construction, and inadequate activities to provide drinking water sources or purification.

- Shelter: S&S assistance effectively addressed emergency housing needs but faced challenges such as quickly degraded materials, and they were temporary solutions without plans for transition to permanent shelters in some communities; support for rehabilitating homes was very appropriate to help families who had been living in temporary shelters, yet budget shortfalls limited all repair needs being met.
- MPCA: The cash assistance was highly satisfactory, providing direct and immediate financial relief to the hurricane-affected communities.
- Overall, the communities felt the situation would be worse without the assistance received, and the services and assistance responded to the felt needs of the population made vulnerable to various health and other issues due to the hurricanes.
- Some hurricane-affected communities newly reached because of the emergency by the IP had a difficult time keeping lines of communication with the IP, who didn't have a regular presence in the community and didn't establish feedback mechanisms.

Objective 3: Protection

Effectiveness

- The participants had greater protection in the emergency context. Participants experienced emotional relief with the direct assistance and mental health and psychosocial support (MHPSS) with the trainings, feeling listened to and encouraged amidst of all the uncertainty. IPs worked with local government to provide this MHPSS care.
- Parents, especially mothers, received Parent School training on GBV and domestic violence and demystifying psychosocial needs. This allowed women to increase their knowledge of violence and improve well-being and of their children. It was reported as evident that there were changes in the mothers, in their emotional management, and in sensitive parenting of their children.
- PSEA trainings for kids, volunteers, and parents helped improve beneficiaries' knowledge of their rights, to identify acts of abuse and know what to do in such situations, to know the routes for reporting and safety, and to know who to turn to as guarantors of their rights.
- Holistic intersectional protection programming and services were provided (a new intersectoral way of designing the programming with cross identifying needs of vulnerable populations.) This included prioritizing uniquely vulnerable populations such as IDPs, those in the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA) community, and older persons.
- Working with local partners was also key to providing support on an interpersonal and individual level- led to a social cohesion focus as well.

"Personally, the talks that the psychologist gives motivate me, they distract me and make me feel good. Because you learn a lot and it is an escape from the daily routine." – Honduras KII

Overall Performance Evaluation Objective 3 outcomes that these findings confirm: Increased and expanded GBV care reached more vulnerable populations, there was knowledge growth and behavior change among participants.

Relevance to Needs

- The Protection assistance was generally relevant to the needs of the population who needed such services, providing timely MHPSS support during crises and building community structures/referrals.
    - Protection services were very timely because people were going through difficult times and COVID-19 restrictions in Honduras were extensive: the situation of managing confinement with children, food shortages, fear of illness, lack of resources, difficult relationships, and others.
    - Women suggest that IPs ensure men also receive training on gender-based violence.

- In terms of inclusivity mainstreamed across sectors, there were some challenges. Overall, the services reached the population that needed them, including people with disabilities. However, in some cases, support/services were not designed inclusively for people with disabilities e.g., shelters and latrines.
    - This case presents key learning on ensuring relevance to needs for communities facing gang violence. The presence of criminal groups did not limit the development of most activities. And as noted above, reaching LGBTQIA groups with protection activities was a key success.

Objective 2: Food Security and Livelihoods

Effectiveness

- In some communities, farmers learned how to increase crop production, and entrepreneurs learned how to better manage their income, also attributed to IPs layering their programming with long-term development programming to leverage livelihood outcomes.
- The gender focus (on women) in the selection of entrepreneurs was fundamental to the creation of new livelihoods.
- Food assistance was successfully delivered to all vulnerable communities through the establishment of organizational structures (comprising of boards of directors representing various communities and local government agencies). This approach not only ensured comprehensive coverage but also facilitated capacity building within these institutions.
- Collaboration between the community and IP staff at every stage of the project-built community knowledge and trust, enabling autonomous management of cash-based assistance by beneficiaries following training. Additionally, involving participant populations in identifying needs, along with feedback and accountability mechanisms, further strengthened community empowerment in this sector.

Overall Performance Evaluation Objective 2 outcomes that these findings confirm: Immediate needs were met and knowledge growth and behavior change occurred. Layering with other programming allowed IPs to provide more livelihood support than the Supplemental alone.

Relevance to needs

- The FSL assistance in Honduras implemented primarily through NGOs prioritized food insecure and economically vulnerable communities, with IP visits and community leader involvement to ensure inclusivity, which was appropriate. Participants report the projects to mitigate business and income impacts were relevant, especially when small business cash was combined with training, although it did not cover all needs or impacts of the pandemic and hurricanes.
- Some issues with delivery affected appropriateness of the assistance to needs e.g., cash transfer access due to extra fees/banking issues and travel distances, infrequent distribution, and perceptions of insufficient proportional distribution of food assistance with consideration for household size.

"All the help was good, but the main thing was what was given for medicine and food, which was what we needed at that time" – Honduras FGD

Overall Performance Evaluation Objective 2 outcomes that these findings confirm: Immediate needs were met and knowledge growth and behavior change occurred. Layering with other programming allowed IPs to provide more livelihood support than the Supplemental alone.

NTR Livelihood Evaluation findings shared with this evaluation (for three awards also covered in this Supplemental)

The project helped a majority of project beneficiaries in all three countries to generate income for the household from the re-establishment or creation of new economic activities.

Practical training on relevant technical themes enhanced the implementation and achievement of livelihood activities (mentioned most frequently by IPs and local partners).

IPs effectively leveraged multi-level networks, including national government authorities, municipalities, local leaders, and a broad NGO support network, and coordination through UN Cluster Groups, enhancing BHA's intervention efforts and follow-up potential in early recovery emergency response.

All of the implementing partners in the three countries incorporated within their intervention approaches specific strategies to avoid a duplication of effort, while at the same time leveraging one another's knowledge and resources to maximize their results.

Short implementation period: Need at least a year and a half to implement FSL.

Promising practices

- **Child-Household knowledge sharing:** Teaching children about IPC measures empowered them to share this knowledge with adults in their households, effectively amplifying awareness efforts.
- **Community Trust-building:** Engaging and collaborating with communities proved to be a successful approach, fostering trust and increasing receptiveness to programs (preexisting organizations vs new organizations within communities).
- **Enhancing Community Collaboration in Primary Healthcare**
    - Utilizing Technology for Peer-to-Peer Communication: Group chats on platforms like WhatsApp facilitated direct communication among parents, children, facilitators, and volunteers, and collaboration with IPs enhanced community involvement in programming initiatives.
    - Empowering Community Voices through Feedback Mechanisms: The implementation of suggestion boxes as Accountability to Affected Populations mechanisms provided avenues for community members to voice their opinions, suggestions, and concerns, and the IP response ensured that community feedback played a significant role in decision-making processes.
    - Strengthening Coordination between Health Committees and Health Centers: The coordination of actions between local health committees and health centers enabled the alignment of community health priorities with healthcare service delivery, leading to more effective and targeted interventions.
        i. Pregnancy clubs significantly raised awareness about mental health issues and effectively debunked COVID-19 rumors, contributing to improved health outcomes, including increased vaccination rates for women and children.

Conclusions

Health and Nutrition

- The support of basic health/nutrition service packages was effective because it supported this system at multiple levels: community, health worker, health center, and to some extent system-wide supports to allow the population to continue accessing services.
- To achieve the empowerment of the communities, the creation and development of health committees and voluntary health collaborators is key, which not only favors access to services but also the confidence of the population due to the community link with these actors.

- Capacity building and training of community and local health systems was critical, and this should continue in responses to endemic disease and new outbreaks or health risks.
- Individualized and collective mental health and MHPSS services were vital to generate capacities for managing distress, emergency situations, and the problems resulting from them.

WASH, Shelter, MPCA *(Hurricane Response)*

- The integrated set of interventions (WASH, Shelter, Cash) combined with community involvement in targeting and implementation were the most successful, especially with women in leadership roles. This contrasts with cases where selection of non-durable materials and placement of infrastructure were not coordinated with communities.
- Longer-term planning for post-hurricane recovery, such as for permanent shelters and potable water access, was missed in some communities, and where possible, occurred when IPs layered with existing programming/other funding.
- The WASH strategy addressed the needs of targeted communities overall, and also increased coverage in terms of numbers of communities, but these WASH investments may not be maintained without ongoing community training and support.
- IP's previous experience in-country and with communities in emergency response situations, including IP adherence with standard humanitarian practices, is key to positive results and enhances the results' sustainability.

Protection

- Communities have the capacity to implement MHPSS in emergencies including psychological first aid, which is necessary to stabilize individuals during crises and promote acceptance of the importance of mental health of the disaster-affected population.
- The integration of protection with other sectors (FSL, WASH, Health and Nutrition, gender/age/disability focus, and inter-agency coordination) allowed for input to identify vulnerable groups and better deliver services.
- There is widespread recognition by IPs and communities of the need to establish more multisectoral partnerships to address and provide timely and coordinated response to emergency situations ensuring inclusion of Protection sector.

Food Security and Livelihoods

- Working in the communities under consensual and coordinated decisions and actions between IPs, community organizations, and local governments dynamizes the course of activities, empowers communities to continue livelihoods, and strengthens the capacities of local government, enhancing the sustainability of services and investments made.
- Cash assistance that can be easily delivered/accessed was particularly effective, it generates trust as participants can cover their needs, and also favors the local economy.
- Practical training on relevant technical/business themes enhanced the implementation and achievement of livelihood activities. Yet, livelihood recovery programming requires longer-time frames to achieve results.

SOUTH SUDAN

Summary

Selection criteria: South Sudan was selected as a critical case study for this BHA COVID-19 evaluation due to its multifaceted challenges, including recurrent flooding, armed conflict, and severe impacts of climate change. In 2021–2022, South Sudan experienced the most severe flooding in six decades, affecting an estimated one million people. These floods have displaced over 300,000 refugees primarily from Sudan, Ethiopia, and the Central African Republic, adding immense pressure to South Sudan's already fragile infrastructure and humanitarian resources (Crisis Group, n.d.; UNHCR, n.d.). In addition to hosting refugees, South Sudan faces internal displacement caused by over a decade of factional conflicts since gaining independence in 2011. This internal displacement has led to widespread humanitarian needs and disrupted livelihoods within the country (Crisis Group, n.d.; Mercy Corps, n.d.). The economic impact of the recurrent floods has been devastating, exacerbating food insecurity and disrupting agricultural activities, which are vital for rural livelihoods (Mercy Corps, n.d.; ODI HPN, 2024). The country also faces internal displacement from over a decade of factional conflicts, since gaining independence in 2011, resulting in disrupted livelihoods and trade routes- driving up the prices of essential commodities by as much as 60 percent (ODI HPN, 2024). The ongoing war in Sudan has led to a sudden influx of returnees and refugees, further straining South Sudan's fragile infrastructure and resources. During this period, South Sudan received substantial Supplemental funding across all major and minor technical sectors, with variation in partner type.

Funding summary: South Sudan received 16 awards totaling $99,375,000 (87% ESF/13% IDA), and including a WFP Logistics award. All sectors are represented, with the highest funded being Food Assistance ($20 million), followed by Health ($12.8 million) and WASH ($10.8 million). With a focus on WFP across other case study countries, this case fieldwork focused on NGO partners who implemented diverse programming and were responsive and available: CRS and World Vision.

Data collection: Interviews were conducted between March 16th and 18th in 2024 and involved data collection from 173 respondents from fieldwork in South Sudan. Data collection took place in Juba and Upper Nile (e.g., Kodok, Melut, Malakal). Due to security concerns and difficulties in logistics, data collection from CRS sites in Upper Nile was not possible. The research team interviewed staff from BHA, WFP and five NGOs. Study sites were selected by IPs through purposive sampling with communities prioritized by their accessibility. Data collection included conducting KIIs with IP staff and government officials, FGDs with beneficiaries, and health worker (HW) surveys by community health workers trained through the Supplemental. The data collection activities are broken down by IP, interview type and sector in the table below:

Table 1. Overview of South Sudan case study data collection activities

IP	FGDs (n=)	KIIs (n=)	HW Survey (n=)	Sectors
WFP	-	1	-	Health/Nutrition, Food Security/Livelihoods, Protection and WASH
IMC	-	1	-	Health, Protection and WASH
World Vision International	11	19	12	Health/Nutrition, Food Security/Livelihoods, Protection and WASH

Catholic Relief Services	-	6	10	Health/Nutrition, Food Security/Livelihoods, Protection and WASH
Samaritan's Purse	-	5	-	Health/ Nutrition, Food Security/Livelihoods, Protection and WASH
BHA	-	2	-	Health/Nutrition, Food Security/Livelihoods
Internews	-	2	-	Health/Nutrition, WASH
Total	**11**	**36**	**22**	N/A

The South Sudan field team included two consultants from TANGO International and three highly competent local consultants with many years – and high levels – of relevant experience:

Table 2. South Sudan fieldwork research team.

South Sudan Fieldwork Research Team	
Name	**Position**
Tim Frankenberger	President, TANGO
Suzanne Nelson	Senior Research Associate, TANGO
Veronica Kenyi	General Practitioner and Consultant
William Deng	Consultant
Ken Miller	Consultant

Key findings/outcomes triangulated across South Sudan interviews:

Objective 1: Health, WASH and Nutrition

Effectiveness

- Communities felt that health messaging limited the spread of COVID-19 and created behavioral changes for sanitation practices throughout the community.
    - Handwashing became a continuous practice and community members not only learned of the importance of using soap but were taught about alternative options if soap is unavailable.
    - Mitigated the spread of misinformation within the community regarding the link between vaccinations and infertility.
- Establishment of WASH facilities in public settings led to an increase in handwashing and improved hygiene. Additionally, community members felt prepared to ensure access to safe drinking water as a result of training on the correct procedures for water filtration.
    - Local water committees were set up to manage water treatment and testing, although most WASH facilities now lack adequate treatment due to lack of incentives for their maintenance and not all facilities are operational.
- Community members gained access to basic health services and healthcare workers felt equipped with knowledge on preventative measures to reduce the spread of disease. However, there is a need for additional support for health facilities to continue functioning and providing the proper medical equipment.

- FGD participants in the Malakal area felt the most important trainings included community management of acute malnutrition screenings and awareness on infant and young child feeding practices because they help ensure appropriate services at the community level.
- A family MUAC screening methodology led to earlier identification of health warning signs and cases of malnourishment, such as bilateral pitting edema, wasting, fever, and diarrhea, which then led to timely health seeking behavior.
- Due to unforeseen environmental disasters such as floods, the program saw successful adaptations such as mobile clinics and increased healthcare access for PLW and children. Additionally, strategic partnerships reinforced nutrition services across multiple counties despite challenges like COVID-19 and community displacements.

- Community members acknowledged that nutrition interventions had a positive impact on malnourished women and children.
  - According to several partners, services were inaccessible to people in remote villages due to mobility constraints and lack of proper infrastructure. A PIO partner noted that funding for infrastructure was secured to use murram to level the road from Bor to Ayod, ensuring it remains passable for 2-3 months to facilitate the prepositioning of items in those locations.
  - Community members trained on MUAC measurement reduced the risk of exposure to COVID-19 by gathering in health or nutrition centers, and this created capacity within communities to identify cases in need of referral.

Relevance to Needs

- The health messaging provided through the Supplemental was highly relevant as communities were unaware of basic hygiene practices and how to prevent the spread of disease. There was an initial spread of misinformation by local media regarding COVID-19 vaccinations, but with concerted interventions around messaging provided by local volunteers, community members felt the messaging could be trusted. Vaccination rates increased dramatically as a result of communications messaging supported through the Supplemental.
- Due to the limited access to health facilities and nutrition services, communities were in need of a well-coordinated response, capacity building of local health workers, and proper supplies to manage the pandemic.
- Child feeding programs and services for pregnant and lactating mothers were implemented in response to food shortages experienced during the pandemic and had a significant positive – though short-term – effect on malnutrition. Gains in reducing malnutrition eroded once the Supplemental ended.

"[The] lack of mobility or logistics [meant] hard to reach and far locations did not receive similar COVID-19 awareness and vaccinations."- South Sudan, KII

Overall Performance Evaluation Objective l outcomes that these findings confirm: Transmission of disease was mitigated through RCCE that raised awareness of preventive practices, ultimately developing increased trust in messaging provided by IPs. Government and community health workers have increased knowledge / skills to manage future pandemics due to healthcare trainings. Community members benefitted from better access to health services as healthcare workers felt better equipped with knowledge on preventative measures to reduce the spread of disease.

Objective 2: Food Security and Livelihoods

Effectiveness

- Food assistance, cash transfers, and other types of livelihoods support (e.g., seeds, fishing kits) helped households mitigate the economic impact of COVID-19 lockdowns, disrupted supply chains, and food price inflation.
- Food security and malnutrition among children and PLW improved due to food assistance and nutrition support; both eroded after the Supplemental ended.

- Livelihood support in the form of in-kind assistance, including water pumps, seeds, fishery kits and others, allowed for increased production of vegetables as well as improved livestock and fish production. Improved skills in irrigation allowed farmers to diversify the types of crops they grew, including onions, which was new to farmers in World Vision implementation areas in Upper Nile. Improved fishing skills and practices resulted in dry fish being available in local markets; improved livestock practices meant milk was also available in local markets.
- According to one NGO, efforts invested in community sensitization and provision of agricultural inputs and trainings increased youth involvement in farming.

Relevance to Needs

- Where implemented, CVA were widely acknowledged to have helped households meet their immediate food consumption needs.
- In areas where COVID-19 resulted in market closures, food distributions – rather than CVA – helped households meet their immediate food and other household needs.
- Livelihoods support such as trainings in agriculture / livestock production, linkages to markets, access to finances, and distribution of tools, seeds, fishery kits, etc. helped producers continue to earn income during the pandemic.

Overall Performance Evaluation Objective 2 outcomes that these findings confirm: Vulnerable households had improved food security as a result of food and / or cash assistance, but it eroded after the Supplemental ended due to continued exposure to existing shocks and new / emerging threats. Nutrition status of PLW and children improved as a result of the Supplemental but lack of government capacity to maintain health services and infrastructure contributed to backsliding of malnutrition, food insecurity, and maternal mortality rates.

Objective 3: Protection

Effectiveness

- Participants who received gender-based violence support felt a sense of empowerment and a boost in their self-esteem. More targeted interventions are needed to address the needs of specific groups at risk of violence against women and girls, including those with disabilities.
- Interventions supported women in the community through women- / girl-friendly spaces, NFIs (e.g. dignity kits), and cash assistance. Although interventions were focused on immediate – emergency – needs, case workers were trained, and communities felt that more individuals are now able to identify protection concerns. Better treatment plans, including safe houses and government infrastructure, are still needed, as is prevention.
- Government and community health worker capacity for GBV, MHPSS and child malnutrition screening, referral, and treatment / support was strengthened, and the services utilized, at least until the Supplemental ended.
- Child protection activities helped reduce the incidence of parents' threatening or removing their children from school / the village to prevent reporting of abuse.

Relevance to Needs

- Community members expressed a need for gender-based violence assistance due to insufficient awareness and cultural norms contributing to incidents of gender-based violence. Awareness of GBV as a type of abuse and the need for protection services remains low overall.
- Pregnant women, mothers and caregivers required encouragement to access healthcare during the pandemic without fear of triggering gender-based violence.
- Community members expressed a need for mental health services in response to impacts of COVID-19.
- Child protection activities supported school children with NFIs, school fees, and exemptions from activities, such as firewood collection, that might put them at risk.

Overall Performance Evaluation Objective 3 outcomes that these findings confirm: Community members perceived they have increased awareness of and better support and access to care for GBV as a result of the Supplemental. However, service provision in GBV and MHPSS, is limited.

Promising practices

- Building trust and distributing effective communications to community members through trusted volunteers regarding the importance of social distancing, handwashing and avoiding large social gatherings to reduce the spread of COVID-19 and other potential diseases.
- Supply distribution: distribution of supplies to community members, including portable handwashing stations (e.g. buckets with lids), soap, face masks and COVID-19 vaccinations to promote hygiene and reduce the spread and impact of COVID-19.
- Establishment and enhancement of existing WASH facilities aimed at promoting hygiene practices among community members and within health facilities.
- Training sessions conducted for healthcare workers, farmers and community members:
    - Training sessions conducted for community members on proper water filtration techniques in cases where existing water treatments faced complications, which included boiling water or using sand or cloth filters.
    - Training sessions conducted for healthcare workers on the correct utilization of personal protective equipment such as coveralls, hoods, masks and gloves.
    - Training sessions provided for farmers on agricultural production techniques, including the use of new irrigation methods.
    - As highlighted by BHA, PIO and NGO stakeholders, it is imperative for organizations to build the capacity of local staff to ensure they can independently manage operations during crises with minimal external assistance.
- Strengthening of livelihoods: distribution of agricultural supplies such as tools, fishing kits and seeds, with a recommendation to switch to local seeds from South Sudan, along with connecting farmers and fisherman to markets.
- Preparation and planning before an emergency helps facilitate effective implementation of surge funding such as the Supplemental. Pre-positioning of supplies and food commodities, including logistical "enablers" who can move supplies and staff quickly and efficiently (e.g., UN Humanitarian Air Service), coordinated response mechanisms (e.g., the OCHA-coordinated Ebola response), and good understanding of partner capacities (e.g., map existing partner capacity rather than bringing new partners up to speed) all contribute to effective management of surge funds and positive outcomes.

Conclusions

The South Sudan case study was somewhat unique in that: i) cases of COVID-19 were well under expectations (i.e., there were very few reported cases), and ii) the coordination mechanisms developed under the earlier Ebola Response allowed for a fairly easy and fast roll-out of the COVID-19 response supported by the Supplemental. There were, however, also unique circumstances that mitigated the potential positive impact of the Supplemental, most notably continued / new threats related to climate extremes, security concerns, and an emerging humanitarian crisis in northern South Sudan. The following are some of the key insights from interviews with stakeholders in South Sudan (e.g., BHA, PIOs, NGOs, beneficiaries).

"The combined effects of COVID-19, inter-communal conflict, economic crisis, and poor harvests [have] significantly affected people's access to food and has likely doubled [since the Supplemental ended]." – South Sudan, FGD

Health, WASH and Nutrition

- Local capacity in healthcare and health services were strengthened at the community level, particularly in malnutrition screening / referral, GBV, maternal health, and MHPSS among others, but lack long-term

sustained investment by the Government. One NGO was able to continue health service provision for a short time after the Supplemental ended, but health and nutrition outcomes continued to worsen as many of the existing health centers and services stopped.

- RCCE is an effective approach for affecting behavior change that contributes to improved health, WASH and nutrition outcomes. In particular, youth engagement in messaging to counter misinformation and rumors can help increase awareness of and attitude changes regarding vaccinations, GBV, and mental health, etc.

Food Security

- Emergency assistance in the form of either cash or in-kind assistance helped mitigate the economic impact of COVID-19 on people's food security. However, a general lack of recovery interventions, coupled with the vacuum left when the Supplemental ended, meant that most people managed to "survive" the pandemic but did not necessarily recover from it.
- Pre-positioning of commodities helps ensure timely and efficient distribution of food assistance to vulnerable populations and is critical in areas prone to conflict / security concerns, areas without roads (e.g., boat / canoe access), or those where road accessibility may be restricted at certain times of the year (e.g., from seasonal flooding).

On the importance of Early Warning and Response Systems, "[the] timely identification of emerging threats to enable proactive response measures, including pre-positioning of resources and coordination with community-based relevant stakeholders (e.g., community structures)." – South Sudan, KII

Protection

- Protection services (prevention, treatment) are an important and often overlooked need in emergency programming. SGBV often increases during emergencies and can have long-term detrimental impacts on people's ability to fully recover. Interventions need to involve more prevention approaches (e.g., including men) and treatment options.
- Women, girls, and children felt they were exposed to less abuse / violence as a result of the Supplemental but fears exist that such results will not last in the wake of new crises. Long-term and sustained support by the Government is needed.

KENYA

Summary

Selection criteria: Kenya was selected as a case study due to its recent experience with one of the most severe drought periods in recent history and BHA's new emphasis on urban and peri-urban areas. The failure of the short rain season from 2021 to 2022 marked the third consecutive below-average rainfall season, devastating agricultural and pastoral communities in eastern and northern Kenya (ReliefWeb, 2022). The scarcity of pasture and water resources led to atypical livestock migration, declining livestock health / death, and fueled violence in northern Rift Valley (FEWS NET, 2021; International Crisis Group, n.d.). The Arid and Semi-Arid Lands region of Kenya has experienced four back-to-back below-average rainy seasons, leading to the longest drought in at least 40 years (International Crisis Group n.d.; ReliefWeb, 2022). This resulted in more than 4.2 million people needing humanitarian assistance and triggered significant rural-to-urban migration, straining resources and infrastructure in urban and peri-urban areas (Cornell Alliance for Science, 2024; FEWS NET, 2021). This case study focuses on BHA's support to WFP in preventing famine and alleviating severe food insecurity in Nairobi and Mombasa, a shift from its traditional focus on Arid and Semi-Arid Lands counties. By integrating nutrition as a key theme and introducing programming in urban areas, WFP Kenya provides a critical case for evaluating the effectiveness of these interventions.

Funding summary: USAID Kenya received $26 million in support from the BHA FY21 Supplemental, with WFP as the primary implementing partner across two awards. Regionally, Kenya received 12 percent of the total budget allocated to East African countries, including Djibouti, Ethiopia, Mozambique, Madagascar, Mali, Rwanda, Somalia, Tanzania, and Uganda. Kenya received 3 percent of the overall budget for all OA countries. Nutrition, followed by Food Assistance were the two highest-funded sectors in Kenya's programming.

Data collection: FGDs and KIIs were conducted from March 5th to15th in 2024 and involved 195[4] respondents from fieldwork in Kenya. Data collection took place in Nairobi across the following sub-counties: Dagoretti, Kasarani, Mathare, Lang'ata, Embakasi and Starehe, and in Mombasa across the sub-counties of Changamwe, Jomvu, Kisauni and Nyali. The data collection activities are broken down by location, intervention and interview type below:

Table 1. Overview of Kenya case study data collection activities

Location	IP	FGDs (n=)	KIIs (n=)	Sectors
Nairobi	WFP	5	3	Cash Transfer
Nairobi	WFP	1	5	Nutrition
Nairobi	WFP	-	10	-
Mombasa	WFP	5	2	Cash Transfer
Mombasa	WFP	3	3	Nutrition

[4] This count includes a rough estimate of total respondents.

Mombasa	WFP	-	5	-
Mombasa	County Official - Nutrition	-	2	Nutrition
Total	**N/A**	**14**	**30**	N/A

The Kenya field team included two consultants from TANGO International and four consultants from Nathe Enterprises LTD:

Table 2. Kenya fieldwork research team

Kenya Fieldwork Research Team	
Name	**Position**
Tim Frankenberger	President, TANGO
Suzanne Nelson	Senior Research Associate, TANGO
Jesse Njoka	Consultant, Nathe Enterprises
Sammy Mutua	Consultant, Nathe Enterprises
Irene Mwende	Consultant, Nathe Enterprises
Wachira Theuri	Consultant, Nathe Enterprises

Key findings/outcomes triangulated across Kenya interviews:

Objective 1: Health, WASH and Nutrition

Effectiveness

- The food and nutrient supplements provided by WFP had a positive impact on children, older persons, PLW and people with chronic illnesses. Distribution was efficient, including no stockouts or delays in shipments.
- Children who were treated for MAM maintained a safe weight and were less likely to relapse to a weight that would be dangerous or deadly.
- WFP collaborated with government entities to identify vulnerable households in urban settings rather than using their systems for targeting, as the government had better data available.
- Investment in building national and local government capacity in nutrition/health and WASH, among others, provides a solid foundation for continued collaboration, coordination, and training, and was key to the success of the Supplemental.

Relevance to Needs

- Lockdowns prevented households in urban / peri-urban areas from working, resulting in a lack of income and purchasing power. Kenya's national safety net program does not currently include the urban / peri-urban poor, many of whom are engaged in the informal sector and were particularly hard hit by lockdowns.

- An increase in malnutrition cases was reported at the time of COVID-19 due to the increase in market prices and unavailability of food – affordable or otherwise. Especially hard hit were the most vulnerable populations, including children, older persons, PLW and people with chronic illnesses.

"WFP support was timely in uplifting some households who faced the challenges during the lockdown" – Kenya FGD

Overall Performance Evaluation Objective l outcomes that these findings confirm:

- *The experience of WFP as a long-term member and active participant in the Kenya Food Security Steering Group allowed for an efficient process of conducting baseline surveys and identifying vulnerable cases.*
- *Targeting in urban / peri-urban areas requires new partnerships and approaches, different than those used in the Arid and Semi-Arid Lands. WFP already had warehouses in Nairobi and Mombasa but needed i) new "last mile delivery" of nutrition supplements to health facilities (i.e., transport providers), ii) to ensure proper storage conditions (e.g., temperature control, pest control), and iii) to provide training to health workers in managing nutrition commodities (e.g., frequency of shipments, accounting, recording).*
- *Urban areas are vulnerable to shocks and need support, including capacity building in urban areas / institutions. Emergency nutrition support should be coupled to longer-term support (e.g., beneficiaries targeted for nutrition support are eligible for CVA) but also needs to be more inclusive of targeted beneficiary groups (e.g., HIV-affected, older persons).*

Objective 2: Food Security and Livelihoods

Effectiveness

- Cash transfers to urban and peri-urban households were provided in a timely manner that helped mitigate food insecurity at a household level. Market analyses by WFP helped ensure that the cash-based transfers were aligned with changing food prices.
- Recovery activities allowed some beneficiaries to initiate or revive small businesses, providing a cushion and preventing – or at least limiting – backsliding in well-being outcomes (e.g., food security) following the conclusion of funding.
- In urban and peri-urban settings, WFP shifted from providing food assistance to distributing cash, which was more relevant to beneficiaries' needs and more efficient, as food distributions suffered from supply chain delays, waste and storage challenges, and diversion issues.
- Given that humanitarian programming in urban areas was a "new area" for WFP, there was need to develop appropriate targeting criteria and an effective – and transparent – mechanism for its validation. Good collaboration with the government and "community chiefs" helped smooth the targeting process. Open and regular communication with communities – including both targeted and non-targeted populations – was also critical to ensure that the most vulnerable were served, fraud was minimized, and concern by those not targeted for assistance was assuaged.
- The Supplemental required significant scaling-up of programming capacity at the country level. In order to serve increased caseloads within the short timeframe required by Congress, new staff were needed to implement activities quickly. Previous experience suggested to WFP CO management that the time and effort needed to bring new hires up to speed for an emergency would compromise their ability to launch a timely and effective response. Several years prior to the COVID-19 pandemic, WFP Kenya ran simulations to test their emergency response processes and systems (e.g., in response to drought). Staff were cross trained in all aspects of emergency response (e.g., logistics, supply chains, M&E, finance) so that "everyone knew what everyone else was doing." This system was utilized – and fine-tuned – on several occasions prior to the pandemic and allowed WFP to scale-up almost exclusively with existing staff to quickly and efficiently mobilize FY 2021 surge funding.

Relevance to Needs

- COVID-19 lockdowns disrupted market supply chains (e.g., vegetables, cooking oil and meat were commonly unavailable) and price increases occurred on goods that were still available. Both had a negative

effect on households' ability to meet daily needs as well as their food security. Cash transfers allowed vulnerable populations to address their immediate needs as they saw fit (e.g., food, rent, medicine).

- The impacts of COVID-19 included widespread job losses, reduced income, and ultimately food insecurity, which contributed to increased SGBV. Men felt unable to adequately provide for their families and lockdown measures confined people to smaller spaces for longer periods of times, intensifying tensions.
- The loss of income and school closures prompted women to engage in transactional relations, resulting in an increase of teenage pregnancies and child marriages.
- COVID-19 was only one of several shocks experienced in 2021/2022 across Kenya, including one of the worst droughts in 40 years. A significant humanitarian response to drought was implemented by the Government of Kenya at the end of or immediately after the Supplemental.

"Some cash transfer money was used to start small businesses, which are still operating and growing." – Kenya FGD

Overall Performance Evaluation Objective 2 outcomes that these findings confirm:

- *Cash transfers are preferred by urban and peri-urban beneficiaries than food distributions due to the flexibility and sense of dignity they provide in determining how/when to meet their needs in the face of a shock / stressor. Telecommunications services (e.g., mobile phone and internet coverage) and financial service providers with mobile money/banking applications are critical to the success of CVA.*
- *Partnerships with government officials at national and county levels and use of available economic data from the Kenya Bureau of Statistics allowed WFP to conduct a rapid assessment for targeting vulnerable beneficiaries.*
- *Effective scaling down of surge funding can be accomplished with good community engagement, particularly of community leaders, and open and transparent communication with communities. Frequent and honest communication helps manage beneficiary expectations and create buy-in.*
- *Effective operationalization of emergency surge funding is enhanced by a priori preparation and preparedness, including ways to minimize expansion – and subsequent retraction – of new staff hires through thorough cross-training of existing staff. Such a strategy builds capacity for emergency response at the national and local levels (e.g., as people change jobs).*

Promising practices

Nutrition

- To treat cases of Moderate Acute Malnutrition (MAM), "Plumpy'Nut" (Ready-to-Use Supplementary Food, RUSF) was provided to children and 7.5 kilograms of "unga" (Corn-Soy Blend Plus Plus, CSB++) to adults. Individuals in urban / peri-urban areas are not typically targeted for WFP's nutrition support.
- WFP conducted a series of training sessions for Community Health Promoters (CHPs) to build local capacity and help ensure sustainability following the conclusion of funding.
    - Training was conducted on the identification and treatment of MAM, as well as methods for CHPs to effectively share their knowledge with mothers and caregivers.
    - Comprehensive trainings were conducted to teach CHPs on the proper handling and preparation of commodities.
    - Additional trainings focused on overseeing and documenting the impacts of WFP initiatives at the community level.
    - Trainings were provided to CHPs, mothers and caregivers on how to prepare nutritious meals using locally available food and resources.

"I reluctantly went to the health facility after being referred by a CHP but the Plumpy Nut saved my child." - Kenya FGD

Cash Transfers

- To minimize negative impacts of scaling down after large tranches of surge funding, beneficiary expectations need to be better managed and strategies for smoothing the transition considered. Although

scaling-down had a generally negative effect on beneficiaries, good community engagement in messaging about the targeting and timeline for assistance helped create a "smoother" scale-down in Kenya. In particular, engagement of community leaders was perceived to be very effective in managing beneficiary expectations and gaining buy-in.

- Serving new geographic areas can require new service providers, facilities, and other infrastructure. For their urban response in Mombasa, WFP Kenya was able to rely on existing partners (e.g., transport, telecommunications, financial service providers) in Nairobi who also operated in Mombasa. Time was still required, however, to negotiate or renegotiate contracts to cover a new service area.
- Safaricom and MPesa were utilized to facilitate mobile cash transfers to recipients in Kenya, leveraging the capabilities of a leading network operator to deliver wired transfers directly into beneficiaries' registered MPesa accounts. WFP collaborated with community volunteers and local administration to facilitate a registration process with Safaricom. For those without phones, community members borrowed neighbors or friend's phones to facilitate the process.
    - WFP collaborated with Safaricom to ensure that beneficiaries received their full payment, regardless of any outstanding loans from previous borrowings.
- WFP leveraged existing government relationships to ensure the beneficiary selection process was transparent and inclusive.
    - The collaboration between WFP and the national and county levels of government was crucial in promptly accessing community data. This enabled the rapid compilation of a targeted beneficiary list and helped ensure a timely emergency response.
    - The Enhanced Single Registry (ESR) system, a comprehensive data management platform, was used by WFP in collaboration with the Government of Kenya to facilitate and streamline the cash transfer program and provide efficiency, scalability and transparency, ensuring that assistance reached the most vulnerable households.

Conclusions

The critical interventions of cash transfers and nutrition support provided by WFP during the COVID-19 pandemic to address food insecurity, malnutrition and socio-economic challenges in Kenya were quite effective. The relevance of these interventions is underscored by the severe disruptions in market supply chains and loss of income. Cash transfers provided timely financial support, enabling households to mitigate food insecurity, start or revive small businesses and handle other immediate needs. The effectiveness of the cash transfers was supported by WFP's market analysis to ensure alignment of the value of support with food price increases and the strategic collaboration with Safaricom in terms of mobile cash transfers. Nutrition interventions addressed increasing malnutrition, particularly among vulnerable populations, through the distribution of food supplements and training of CHPs. These efforts ensured that children, older persons, PLW and people with chronic illnesses received essential nutrients, maintaining safe weight levels and preventing severe malnutrition. Overall, the WFP team leveraged existing structures and data provided by national and county level government entities to identify beneficiaries and vulnerable populations in need of assistance.

Cash Transfers

- Promising practices with cash transfers include WFPs partnership with Safaricom and MPesa for providing mobile cash transfers, ensuring beneficiaries received full payments despite having any outstanding loans, and leveraging existing government relationships for transparent and inclusive beneficiary selection.
- The use of community knowledge through local administrative structures and geo-tagging for beneficiary verification further ensured accurate targeting and timely emergency response.
- Conducting cash transfers digitally, when applicable, minimized unnecessary contact, helping to reduce the spread of COVID-19 while delivering essential support.

- Expansion into urban and peri-urban areas was extremely relevant, given the impact of COVID-19 restrictions on urban populations and people relying on the informal sector for their livelihoods. WFP's urban response resulted in the Government of Kenya acknowledging vulnerability of the urban poor and efforts are currently underway to push through a national policy for expanding social protection to the urban / peri-urban poor, who are not included in existing policies.
- Although large-scale emergency, or surge, funding is primarily meant to meet immediate needs of vulnerable populations, its ultimate withdrawal should not be precipitous such that backsliding occurs and people are potentially worse off than before. Large emergency response may be necessary at first in order to help as many people as possible (i.e., going big) with immediate needs but some recovery activities are also needed, at least for a subset of vulnerable people in order to provide an off-ramp, even at a small scale. The need for food and nutrition assistance remains high in many countries due to other pre-existing and on-going vulnerabilities (e.g., drought, floods, hurricanes, conflict).

Nutrition

- Promising practices with nutrition interventions include CHPs playing a critical role by providing the proper treatment for MAM cases. Comprehensive training sessions for CHPs on identifying and treating MAM, handling and preparing commodities and educating mothers and caregivers on nutritious meal preparation contributed to the sustainability of the interventions.
- Providing nutritional support and education contributed to an increase in women reporting healthier pregnancies, highlighting an improvement in maternal and infant health outcomes during challenging times.
- Overall, targeted nutritional interventions contributed to a significant decrease in malnutrition cases by helping to ensure that vulnerable populations received essential nutrients.

"The pandemic was a wake-up call regarding urban areas and vulnerability" – Kenya WFP KII

JORDAN

Summary

Selection criteria: Jordan was selected as one of the case studies for the BHA COVID-19 evaluation based on a combination of critical factors to learn lessons around surge support for refugee food assistance in camp and non-camp/urban areas. Jordan is situated in a region with rapidly increasing refugee crises and ongoing insecurity or conflict in the MENAE region. Additionally, many refugees live in urban areas, and the COVID-19 emergency Supplemental expanded IP targeting in Jordan to reach urban refugees who were disproportionately impacted by the economic impacts of COVID. This include non-Syrian refugees, who were previously not within the purview of the IP in Jordan that received Supplemental funding. This situation makes Jordan a key case study, as the refugee crisis continues to escalate and food insecurity among individuals living in communities and refugee camps worsens (ReliefWeb, 2020; WFP, n.d.). In 2021, Jordan hosted 752,282 refugees, including 664,414 Syrians and 88,868 individuals from other nationalities (e.g., Sudan, Iraq). Of these refugees, the majority (80 percent) resided in urban areas, 20 percent lived in camps (WFP, 2022a). Food insecurity in 2021 was as high among refugees as it had been in 2012, during the initial influx of Syrian refugees (Jordan Center for Strategic Studies, 2021). Notably, poor food consumption scores in 2021 were observed both inside and outside camps, despite expectations of higher scores within camps. In 2021, WFP was the sole income source of 16 percent of refugees and comprised 59 percent of refugee household income. During this time, refugees took on an average of 1200USD in debt. Further, despite grappling with an ongoing economic decline before the pandemic, Jordan's situation deteriorated further during COVID-19, leading to a worsening unemployment rate of 24.4 percent. (Center for Strategic and International Studies, 2020; International Monetary Fund, 2020; The World Bank, 2023). The increasing severity of the refugee crisis and the worsening food and economic insecurity in Jordan faced by refugees and nationals illustrate the urgent humanitarian challenges faced by the country and have elevated the country's priority for BHA funding.

Funding summary: WFP Jordan received one award from the FY 2021 (COVID-19 Supplemental) and also received the FY 2020 COVID-19 Supplemental and the Ukraine Supplemental in FY 2022. Regionally, MENAE received $448 million in support for FY 2021 across Yemen, Syria, Jordan, Lebanon, Egypt, Iraq, Libya, Turkey, and Ukraine.

WFP Jordan is supported by two key donors 1) USAID and 2) the government of Germany. WFP Jordan does not typically rely on Supplemental awards to support funding streams and Supplemental funding inflated expectations of how much funding WFP Jordan can program. Prior to receiving the FY 2021 Supplemental, WFP Jordan communicated to BHA that they expected a "pipeline break" in funding in April 2021. The FY 2021 Supplemental was requested because of this shortfall. BHA requested that WFP expand assistance to individuals most vulnerable to the impact of COVID-19 and during that time 40,000 additional individuals were added to WFP's caseload. This caseload was unsustainable for WFP's General Food Assistance program, and a retargeting exercise was planned for May 2021 to guide assistance cuts for households considered "less vulnerable." Scale-down was pushed to July 2021 after receiving the Supplemental, with reduced caseloads (21,000 individuals) taking effect in October-November 2021. Since then, there have been notable scale-downs in the number of participants who receive assistance, contributable to a $41 million shortfall in funding.

Data collection: The field work was conducted between March 3-5, 2024, and included FGDs with 68 refugees and KIIs with 20 IP respondents and their subcontractors (Table 1). Data collection took place in Amman (Amman Refugee Help Desk/Community Center, supermarket within Amman that accepted refugee MPCA) and within Azraq Refugee Camp (Sameh Mall, WFP office within Azraq Refugee Camp, 24-hour helpdesk). The research team worked with UNWFP in this evaluation case study, as they were the primary awardee in this country. Study sites

were selected by UNWFP to provide a diverse sample. Respondents were convenience sampled, although vulnerable community members were requested to attend. Data collection included Key Informant Interviews (KII) with WFP and their partners operating in Jordan and Focus Group Discussions with community and participant respondents. KIIs were also held with BHA contacts at the USAID Mission in Amman.

Table 1. Overview of Jordan case study data collection activities

IP	KIIs (n=)	FGDS (n=)	Sectors
WFP	2	-	Food Assistance, MPCA
WFP IP Norwegian Refugee Council Helpdesk (Azraq Refugee Camp)	3	-	Food Assistance, MPCA
Sameh Mall (Azraq Refugee Camp)	1	-	Food Assistance, MPCA
Save the Children Helpdesk	1	-	N/A
Save the Children Field Coordinator	1	-	N/A
Supermarket Vendor (Amman)	1	-	Food Assistance, MPCA
Refugees living in Azraq Camp	-	4 (n=38; 24 men, 14 women)	Food Assistance, MPCA
Refugees living in Amman	-	4 (n=30; 18 men, 12 women)	Food Assistance, MPCA
BHA Jordan	2	-	WFP Award (Food Assistance, MPCA)
Total	**11**	**8**	N/A

This study was made possible by a dedicated research team:

Table 2. Jordan fieldwork research team

Jordan Fieldwork Research Team	
Name	**Position**
Maryada Vallet	TANGO International
Shalean Collins (Kapur)	Tulane University
Tamara Suleiman Aref Abuzneimah	Trust Consultancy
Mohammed Bani Mustafa	Trust Consultancy

Key findings/outcomes triangulated across Jordan interviews:

Objective 2: Food Security and Multipurpose Cash Assistance (MPCA)

Effectiveness

- Participants viewed the assistance as crucial for survival, even though it was often insufficient to meet all needs.
    - Individuals often purchased only basic needs like rice and oil, avoiding vegetables and meat.
    - Participants emphasized that without this support, they would not be able to provide food for themselves, especially in camps with limited job opportunities.
    - Participants indicated that if assistance stopped, it would be a 'dead end' or 'catastrophe' for them.
- Some participants relied on household members to find work to supplement income, but job opportunities were very limited both within Azraq refugee camp and for non-Syrian refugees, who are unable to legally engage in the labor market.
- High prices at Sameh Mall and monopoly of market providers in the Azraq refugee camp made it challenging to stretch assistance to cover monthly needs.
- Accessing assistance from WFP was perceived as very easy, contrasting with experiences with other aid organizations.
- During COVID-19, assistance was sufficient to meet immediate needs. Participants had to reduce quantities of essential goods or avoid purchasing items like oil, meat, and poultry.
    - Rising prices during COVID-19 led refugees to purchase lower quality foods, and operational hours reduced due to lockdowns made accessing goods in Amman difficult, although Sameh Mall inside of Azraq Camp had extended hours to allow refugees to purchase the items they needed.
    - Sameh Mall expanded their offerings to provide soap, masks, and cleaning supplies in 2021.
    - Individuals allocated the insufficient MPCA funds to rent, electricity, and school expenses, diverting it from purchasing food.

"*We would have died of hunger.*" – *Amman Refugees FGD*

"*If we had not received this support, we would not have been able to provide food for ourselves.*" – *Camp Refugees FGD*

Relevance to Needs

<u>Essential needs and food security:</u>

- Assistance was crucial for purchasing food, especially during times of vulnerability.
- It was easy to access, with no issues in obtaining or using the transfers. Refugees had the option of an e-wallet or a card within Amman and e-wallet or iris scanning/Blockchain within Azraq Camp. Yet, purchasing power due to price increases and decreased transfer amounts in the camp setting, which is isolated from other market options, led to frustration among participants.
- Although the assistance did not cover all needs, participants felt that most people could find work to supplement their income. Although this carried inherent risk, especially for non-Syrian refugees who are not allowed to legally work in Jordan. Some respondents indicated removing their oldest male children from school to engage in the labor market and provide economic support to their households.
    - In areas with limited job opportunities, assistance was vital for survival, with participants stating that they would not be able to eat or survive without it.
- Assistance helped families avert poverty or resort to negative coping strategies that could have led to protection issues, particularly those ineligible for formal employment. Participants report it promoted dignity in highly vulnerable time.
- The principal complaints received by the Helpdesk centered around the insufficiency of assistance (Amman and Azraq Camp) and aid discontinuation (Amman) after WFP's vulnerability reassessment.

"Especially in the camp, we cannot cover our needs without assistance because there are not job opportunities." – Camp Refugees FGD

Impact of economic factors:

- Inflation and changes in funding affected the adequacy of assistance, with current reductions making smaller families worse off.
- Participants tended to buy larger quantities of some items for fear of potential shortages, especially during COVID-19.
- The quality of goods at Sameh Mall deteriorated with concurrent price increases, reducing the overall purchasing power of vouchers and subsequent consumption of some items.

Flexibility and trust:

- There was a high level of trust in the assistance provided by WFP.
- WFP and partners set up 24-hour hotlines, help desks, and held regular meetings to maintain continuous communication with refugees. SMS notifications kept participants informed of changes to assistance, though often with perceived insufficient notice.
    - Participants found it easy to communicate with WFP, with high responsiveness to phone calls or in-person visits to the help desk.
    - Despite the established mechanisms, some participants felt their complaints regarding the quality of goods and services at Sameh Mall were not adequately addressed.
- WFP was seen as responsive, conducting visits to determine the adequacy of assistance and providing contact cards for further communication.
- WFP's vulnerability criteria were intentionally opaque, which frustrated some individuals who expressed that they did not understand why some households received more vs. less assistance under the tiered schema.

"We knew we could come to [IP] (WFP Helpdesk in the community) if we faced any issues related to the food assistance." – Amman Refugees FGD

"Just from talking about it, the idea of cutting the assistance, gave me anxiety." – Amman Refugees FGD

Overall Performance Evaluation Objective 2 outcomes that these findings confirm: Participants' food security was stabilized during the project period as per Food Consumption Score for camp and non-camp participants, which they attributed to the assistance (WFP, 2022c; WFP, 2022d). However, as seen in the trend globally, when higher levels of assistance ended in 2022, food security and recovery has eroded amongst many vulnerable populations. Other drivers and intermediate outcomes validated through this case study include key expansions to non-Syrian/urban refugees and the important use of cash transfers and mobile modalities or new technologies used to meet various household needs.

Promising Practices

- The E-wallet was both cheaper for WFP and preferred by most participants, it was easy to expand and roll out and was well-accepted.
- The Helpdesk was widely acknowledged as a go-to point for participants to provide feedback and subsequent responses from WFP.
- WFP's regular communication with refugees via SMS and social media was well regarded and improved overall perceptions around assistance.

Conclusions

- Cash assistance was highly relevant and effective, enabling participants to address various needs beyond food, including rent and healthcare expenses.

- Remote modalities used for assistance distribution were well-received by refugees in Jordan and could be rapidly expanded and scaled-up by WFP. Due to the success of mobile money, WFP intends to transition all beneficiaries to this modality.
- Food assistance was timely, meeting essential needs during a period of high demand and vulnerability.
- WFP Jordan models adaptive management and the strategic use of technologies and innovations to remain accountable to participants in a highly variable and unpredictable funding landscape.
- Transfers, although lifesaving, were largely insufficient to support livelihood recovery or promote saving.
- Cash was regularly used to pay for non-food needs such as school fees, rent, medicine, and transport, and refugees shared a number of coping strategies (i.e., removing children from school, purchasing lower quality items) that highlighted this insufficiency.

SYRIA

Selection criteria: Syria serves as a critical case study for evaluating the BHA FY21 Supplemental award, given the complex interplay of political, economic, and social factors driven by the prolonged Syrian Civil War. This conflict has resulted in a severe and enduring humanitarian crisis, characterized by extensive internal and external displacement and significant economic disruption—one of the largest displacement crises in recent history.

From 2020 to 2022, the economic collapse in Syria intensified due to multiple factors. The Syrian pound's value plummeted, and inflation surged, leading to a 236 percent increase in food prices by the end of 2020. This economic downturn left over 80 percent of Syrians living below the poverty line, a dramatic rise from pre-war levels of around 10 percent (Concern Worldwide, 2022; International Rescue Committee, 2022). The impact of the COVID-19 pandemic further strained the economy, compounding food insecurity and reducing access to essential services such as healthcare and clean water, especially in refugee camps (COAR, 2022).

The healthcare system, already crippled by years of conflict, faced additional pressure from disease outbreaks and a lack of resources. Only 17 percent of healthcare needs were met according to the 2021 Humanitarian Response Plan (COAR, 2022). The scarcity of clean water and sanitation facilities exacerbated the spread of diseases like cholera, meningitis, and hepatitis, further compromising public health nationally (Concern Worldwide, 2022; COAR, 2022). Refugee camp conditions have profoundly impacted the well-being of refugees, as many face significant challenges in meeting basic needs. This struggle has led to increased rates of malnutrition, deteriorating mental health, and greater exposure to diseases (Concern Worldwide, 2022; International Rescue Committee, 2022). These compounded shocks make Syria a compelling focus for BHA support.

Funding summary: Through the FY 2021 (COVID-19 Supplemental), Syria received 246 million across 17 awards, and received the highest sector funding for Protection, Health, and WASH. The PIO IPs who received the funding included WHO, UNFPA, UNICEF, and WFP. Regionally, MENAE received $448 million in support for FY 2021 across Yemen, Syria, Jordan, Lebanon, Egypt, Iraq, Libya, Turkey, and Ukraine.

Data Collection: The evaluation study conducted from April 4 to April 28, 2024, with a break for Eid Al-Fitr. The fieldwork was organized across the North of Syria (NS, northeast and northwest under opposition control) and Government-controlled areas (GoS). The NS operates with autonomous governance requiring tailored aid approaches, while the GoS is centrally managed, creating distinct humanitarian responses. Fieldwork covered five sectors, Health, WASH, Nutrition, Protection, and Food Assistance and was conducted with all four funded UN agencies, UNICEF, UNFPA, WFP, and WHO in both regions. Due to the masked nature of NGO awards, only UN agencies were included in this data collection. In addition, due to significant funding reductions and the cessation of broader food assistance by WFP in December 2023, which caused tensions along with WFP Syria strategic retargeting at the time of the study, interviews with WFP participants were limited to camp-based participants of the previous programming, who were still receiving assistance. As agreed with BHA and WFP, key informant interviews with WFP partners and sub-office staff were prioritized to obtain the community-level perspectives. Additionally, they recommended leveraging existing secondary data to gain insights. Overall data collection included FGDs and KIIs in NS, and KIIs in GoS. This collaborative approach ensured efficient and smooth execution of the data collection phase.

Table 1. Overview of Syria case study data collection activities

Location	IP	FGD (n=)	KIIs (n=)	HW surveys (n=)	Sector
NS	**WHO**	4	3	21	Health/ Nutrition
NS	**UNFPA**	4	4	6	Health /Nutrition, Protection
NS	**UNICEF**	6	3	12	Health/ Nutrition, WASH
NS	**WFP**	4	4	0	Food Security/Livelihoods
GoS	**WHO**	2	5	19	Health /Nutrition, Protection
GoS	**UNFPA**	2	0	7	Health/ Nutrition
GoS	**UNICEF**	8	4	10	Health/ Nutrition, Protection, WASH
GoS	**WFP**	-	6	-	Food Security/Livelihoods
Total	**N/A**	**30**	**29**	**75**	N/A

The study was completed by a team of local researchers from Trust Consultancy and Development and TANGO International:

Table 2. Roles of the Syria fieldwork research team

Syria Fieldwork Research Team	
Name	**Position**
Yousef Almustafa	Senior evaluator
Abdo Almustafa	Operation manager
Nasser Al-issa	Field supervisor
Nina Fock	Project coordinator
Alaa Alyasin	Data collector
Mwafaq Deeb	Data collector
Moutaz Alshibli	Data collector
Mohamed Suhaib Alhammoud	Data collector
Owaisa Hamwiyeh	Data collector
Shaimma Al-Azzam	Data collector

Fatima Almustafa	Data collector
Husam M. H. Al Zuwayny	TANGO/Tulane University Case Study Coordinator

Key findings/outcomes and high-level analysis triangulated across Syria interviews:

Government of Syria (GoS):

Objective 1: Health, WASH, and Nutrition

Effectiveness

- There was a marked increase in community awareness and adherence to COVID-19 prevention measures, which facilitated better health practices and behavioral changes.
- Diverse communication methods like mobile messages, TV broadcasts, and community sessions played a critical role in disseminating health information broadly and effectively.
- Targeted nutrition interventions led to improvements in the nutritional status of children and pregnant women, directly impacting vulnerable populations.
- There were notable improvements in water supply and sanitation facilities, though challenges with water quality and access persisted.
- Knowledge and practices related to hygiene and sanitation were enhanced, helping mitigate disease spread and instilling long-term behavioral changes.

Relevance to needs

- The health interventions were timely and closely aligned with the immediate needs related to COVID-19 prevention, demonstrating their relevance and direct impact on improving community health standards.
- Nutritional support was specifically focused on the most vulnerable groups, ensuring that interventions directly addressed their distinct needs.
- WASH programs were highly relevant, addressing urgent and ongoing community needs through educational sessions and provision of essential resources, with a focus on practical solutions to enhance daily living conditions.

"We received messages through mobile medical teams and awareness sessions in school, it was very satisfying" – Syria FGD

"Provided Supplemental nutrition for children and pregnant women." – Syria FGD

"Our children received a box containing hygiene tools. They received an awareness session about Corona– its exposure and prevention, and how to wash hands in the correct way and even do not waste water." – Syria FGD

Overall Performance Evaluation Objective I outcomes that these findings confirm: The Health, Nutrition, and WASH interventions in GoS successfully achieved increased partnerships with community and health actors, elevated trust in implementing partners, and addressed immediate needs effectively. The functioning of health facilities and services supporting increased utilization and knowledge reflect a strong alignment with the objectives to support and strengthen the public health response and maintain essential services.

Objective 2: Food Security and Livelihoods (FSL)

Effectiveness

- The interventions appeared to support improvements in food security and livelihoods, providing essential food supplies crucial during economic challenges.

- Enhanced accuracy in reaching the most vulnerable was achieved through targeted beneficiary selection tools, ensuring that aid was distributed to those most in need.

Relevance to Needs

- The interventions were highly aligned with the immediate and pressing needs of the communities, addressing acute food shortages and enhancing livelihood opportunities.
- The assistance focused on vulnerable groups such as children, breastfeeding women, pregnant women, and families most in need during the pandemic.

"The method of distributing the baskets and adopting the hybrid system with continuous modernization helped reach the most vulnerable groups and their food security was maintained. " – Syria KII

Overall Performance Evaluation Objective 2 outcomes that these findings confirm: Food security and livelihood interventions in GoS have shown potential success in meeting their objectives, as indicated by the utilization of cash-based transfers, which helped meet household needs, and the expansion of activities into hard-to-reach populations. Efforts to strengthen government and partner capacities are believed to improve the management of future emergency funding surges. However, the lack of direct feedback from FGDs necessitates a cautious interpretation of these results. The reported improvements and alignment with objectives to prevent famine and mitigate severe food insecurity should be considered alongside these acknowledged data limitations.

Objective 3: Protection

Effectiveness

- The protection efforts were notably successful in raising awareness and changing behaviors regarding early marriage and educational involvement, which positively impacted local communities.
- Strong emergency response capabilities addressed challenges posed by COVID-19 and natural disasters such as earthquakes, thus meeting urgent community needs and mitigating the effects of crises.

Relevance to Needs

- Targeted programs addressed critical local issues such as child labor and early marriage, aligning closely with specific community needs and ensuring the relevance of interventions.
- Feedback from the community confirmed the helpfulness and appropriateness of the programs, which improved trust and engagement among affected populations.
- The implementation of effective feedback systems, including complaints boxes, direct contact options, and social media platforms, facilitated better communication and program improvement, enhancing accountability.
- Ensuring fair and open access to services helped to build community trust by making sure that support was equitably distributed and accessible to those most in need.

"Psychosocial support was provided by mobile teams to displaced, immigrants, and people living in poor environments, helping deliver health and psychological services." – Syria KII

Overall Performance Evaluation Objective 3 outcomes that these findings confirm: Protection services in GoS have comprehensively increased access to dedicated services and ensured that all programming addresses COVID-19-specific gender, age, disability, and protection issues. High rates of service coverage, reduction in risks associated with accessing services, and expansion into hard-to-reach populations demonstrate a robust fulfillment of the objectives, with skilled providers enhancing the effectiveness of MHPSS, GBV, and child maltreatment support.

North of Syria (NS):

Objective 1: Health, Nutrition, and WASH

Effectiveness

- The health initiatives significantly improved public health knowledge and preventive behaviors against COVID-19, resulting in a notable reduction in the spread of the virus and better management of public health emergencies.
- There was a general improvement in nutritional knowledge and practices, particularly focusing on child nutrition which led to the prevention of malnutrition cases.
- Significant improvements were made in water and sanitation infrastructure, enhancing hygiene practices and reducing disease spread within communities.

Relevance to needs

- Health programs were well-aligned with the urgent and evolving health needs of the community, particularly in addressing the challenges posed by the pandemic.
- Nutritional programs were specifically tailored to meet the needs of vulnerable groups, with a strong focus on prevention and treatment.
- WASH interventions were responsive to the urgent hygiene and sanitation needs of the populations, particularly during the pandemic, with structured yet adaptable feedback mechanisms to incorporate community input.

"Yes, some practices are continuing now but at a rate of 50%.... we sterilize our hands when we touch any contaminated surface or when shaking hands." – Syria FGD

"Mothers have started using MUAC bands to monitor their children's nutrition at home." – Syria KII

"Yes, large sinks were built for each gathering of 20 tents, what is called the sub-sector. These sinks were provided with a number of tanks that were constantly filled and soap was distributed to the tents." – Syria FGD

Overall Performance Evaluation Objective 1 outcomes that these findings confirm: In NS, the combined efforts in health, nutrition, and WASH sectors have effectively met the objectives. The initiatives not only addressed immediate health and sanitation needs but also promoted sustainable behavioral changes, enhancing community resilience. Increased health knowledge, improved access to services, and reaching vulnerable groups align perfectly with the objectives to support and enhance public health responses.

Objective 2: Food Security and Livelihoods in NS

Effectiveness

- The initiatives were highly effective in maintaining the continuity of aid, ensuring essential food supplies reached those in extreme vulnerability, especially during critical periods such as the COVID-19 pandemic.
- Efficient coordination ensured comprehensive coverage in aid distribution, including hygiene supplies.

Relevance to Needs

- The focus was strategically placed on the most critical needs within the community, ensuring that vulnerable and at-risk populations received adequate supplies. The response was adaptive and flexible, meeting diverse community demands effectively.

"Every month I receive a food basket which is sufficient for my family until the following month. " – Syria FGD

Overall Performance Evaluation Objective 2 outcomes that these findings confirm: The food security and livelihood initiatives in NS have shown remarkable alignment with the set objectives. The use of cash-based transfers to adapt to household needs and the expansion of services into newly vulnerable and hard-to-reach populations have significantly mitigated food insecurity and supported economic stability, even under the challenging conditions of the pandemic.

Objective 3: Protection

Effectiveness

- There was a significant improvement in community resilience and mental health awareness.
- Targeted support sessions and psychological assistance effectively addressed the stressors related to displacement and the COVID-19 pandemic, enhancing the community's ability to manage stress and promote mental well-being.

Relevance to Needs

- The programs were highly responsive to the evolving needs during the pandemic, particularly in enhancing psychological support and providing essential sanitary supplies. This responsiveness ensured that services were adapted to meet the heightened health risks and psychological stress within the community.
- Enhanced coordination and referral systems were established to ensure that vulnerable groups received comprehensive support. This included specialized medical referrals and integrated service delivery, improving access to necessary resources and services.

"Psychological support is considered one of the most important benefits. Many of the beneficiaries have become more able to deal with their families, get rid of stress, and increase awareness of the importance of cleanliness." – Syria KII

Overall Performance Evaluation Objective 3 outcomes that these findings confirm: Protection services in NS have robustly met the objectives by increasing access to dedicated services tailored to COVID-19 related and other contextual vulnerabilities. The effective implementation of comprehensive support mechanisms for mental health, GBV, and child maltreatment, alongside expanding activities to hard-to-reach populations, underscores the successful alignment with the objective to enhance community protection and resilience.

Promising practices in GoS

- The integration of various services, including mobile clinics and local health centers, fostered community trust and participation, significantly enhancing health behaviors.
- Nutritional education integrated into regular health services increased community knowledge and improved dietary behaviors, highlighting the effectiveness of providing specific dietary advice and supplements.
- Innovative distribution mechanisms, such as the hybrid system combining food baskets with cash vouchers, allowed for greater flexibility and responsiveness to beneficiary needs.
- Effective community engagement ensured that feedback and needs were directly incorporated into program adjustments.
- Multi-sector partnerships, including collaborations with local associations and international organizations like the Syrian Red Crescent, increased the reach and effectiveness of food distribution efforts.
- The deployment of mobile teams to remote areas ensured that education and psychological support were accessible to those in harder-to-reach communities, greatly enhancing service reach and adaptability.
- The integration of various services, such as health and psychological support, via mobile teams and centers contributed to a comprehensive support system that bolstered overall community resilience.

Promising practices in NS

- Mobile health services were effectively used to extend healthcare access to remote and underserved populations, integrating health services with COVID-19 preventive measures to enhance overall community health.
- Localized and targeted nutritional support interventions were implemented, including the distribution of specialized nutritional supplements and therapeutic food, effectively addressing malnutrition in children.
- Community engagement and innovative adaptations in managing WASH facilities contributed to their sustainability and effective use.

- Adaptations in food distribution were responsive to local needs, with changes in the composition of food baskets informed by community feedback. These adaptations facilitated a tailored approach, improving the relevance and acceptance of aid among beneficiaries.
- The implementation of comprehensive GBV response services within community centers was a key development. These services included both preventative measures and reactive support to handle cases of violence effectively, ensuring a holistic approach to GBV.

Conclusions

GoS:

Health, Nutrition, WASH

Objective 1 sectors demonstrated strong effectiveness and relevance. Health interventions effectively increased COVID-19 awareness and improved hygiene practices, while Nutrition efforts targeted the most vulnerable with tailored support. WASH initiatives enhanced sanitation facilities and hygiene education, though some challenges with water quality and access persisted. Across all sectors, the strategic use of diverse communication platforms and local partnerships significantly bolstered community engagement and program impact.

Food Security and Livelihoods (FSL)

The performance of food security and livelihood initiatives in GoS was effective, as supported by WFP food security measures and the strategic use of targeted distribution tools. The integration of hybrid systems combining food baskets with cash vouchers appears to have bolstered food security and addressed critical livelihood needs. While effective community engagement and multi-sectoral partnerships were reported to enhance responsiveness to vulnerable populations' needs, the absence of direct beneficiary confirmation suggests caution in fully validating these outcomes. Therefore, these findings which are primarily based on KIIs, secondary data and partner reports, may reflect a partial view of the impact.

Protection

Focusing on Protection was highly effective. The initiatives successfully enhanced community awareness on critical issues like early marriage and child labor and demonstrated strong emergency response capabilities. Mobile teams played a key role in ensuring the accessibility of educational and psychological support, particularly in remote areas. Feedback mechanisms and inclusive service provision fostered trust and accountability within the community, making the programs not only relevant but also deeply appreciated by those served. This comprehensive approach underscores a strong alignment with community needs and the program's ability to adapt to and address complex challenges effectively.

NS:

Health, WASH, Nutrition

The combined efforts in the Health, Nutrition, and WASH sectors under Objective 1 in the North of Syria have shown substantial effectiveness, relevance, and adaptability. The initiatives not only met immediate needs but also fostered long-term behavioral changes that contribute to the resilience and health of the community. Each sector demonstrated a strong alignment with community-specific challenges, particularly in addressing the direct impacts of the COVID-19 pandemic. The strategic integration of services across these sectors enhanced the overall impact, making the interventions particularly effective in improving living conditions and health outcomes.

Food Assistance and MPCA

The overall implementation of Objective 2 in the North of Syria has been notably successful. The program demonstrated a strong ability to adapt to local conditions and feedback, ensuring that food security interventions were both effective and well-received. Challenges related to reductions in aid highlight the need for ongoing reassessment of aid distribution strategies to better support the most vulnerable populations. The program's ability to navigate logistical challenges and maintain aid continuity during the pandemic underscores its resilience and capacity to meet community needs under adverse conditions.

Protection

The North of Syria showcased strong performance in addressing protection needs within affected communities. The targeted interventions and comprehensive service offerings have significantly contributed to improving mental health and community resilience. The strategic incorporation of GBV response services and the adaptive measures taken during the pandemic highlight the program's effectiveness and relevance. Enhanced coordination mechanisms further ensured that services were delivered efficiently and that vulnerable individuals received the support they needed. The overall approach under Objective 3 not only met immediate needs but also laid the groundwork for sustained community support and empowerment.

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