INTER-AGENCY HUMANITARIAN EVALUATION

Annexes

INTER-AGENCY HUMANITARIAN EVALUATION of the COVID-19 Humanitarian Response

2022

INTER-AGENCY HUMANITARIAN EVALUATION of the COVID-19 Humanitarian Response

Management and implementation of the evaluation

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Acronyms

AAP	Accountability to Affected Populations
ACAPS	Assessment Capacity Project
ADWG	Age and Disability Working Group
AHF	Afghanistan Humanitarian Fund
ALNAP	Active Learning Network for Accountability and Performance
AoR	Area of Responsibility
CAR	Central African Republic
CASS	*Cellulle d'Analyse en Sciences Sociales (Social Sciences Analysis Cell)*
CBO	Community-Based Organization
CBPF	Country-Based Pooled Fund
CCI	Cross-cutting issues
CEPI	Coalition for Epidemic Preparedness Innovations
CERF	Central Emergency Response Fund
CSO	Civil Society Organization
COVAX	COVID-19 Vaccines Global Access
CP	Child Protection
CVA	Cash and Voucher Assistance
DRC	Democratic Republic of the Congo
EDG	Emergency Director's Group
ERC	Emergency Relief Coordinator
ERP	Emergency Response Preparedness
ESSN	Emergency Social Safety Net
EVD	Ebola Virus Disease
FAO	Food and Agriculture Organization
FGD	Focus Group Discussion
FTS	Financial Tracking Service
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender-Based Violence
GCCG	Global Cluster Coordination Group
GHC	Global Health Cluster
GHO	Global Humanitarian Overview
GHRP	Global Humanitarian Response Plan
GIMAC	Global Information Management, Assessment and Analysis Cell
GOARN	Global Outbreak Alert and Response Network
GPMB	Global Preparedness Monitoring Board
HB	Humanitarian Buffer
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HNO	Humanitarian Needs Overview
HPC	Humanitarian Program Cycle
HRP	Humanitarian Response Plan
IAHE	Inter-Agency Humanitarian Evaluation
IASC	Inter-Agency Standing Committee
ICC	Inter-Cluster Coordination
ICU	Intensive Care Unit

ICVA	International Council of Voluntary Agencies
IDPs	Internally Displaced Persons
IFRC	International Federation of the Red Cross and Red Crescent Societies
IHR	International Health Regulations
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
IPC	Integrated Phase Classification
JEE	Joint External Evaluation
JRP	Joint Response Plan
LMIC	Low- and Middle-Income Countries
L/NA	Local/National Actors
MPTF	Multi-Partner Trust Fund
NGO	Non-Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
OPAG	Operational Policy & Advocacy Group
PHEIC	Public Health Emergency of International Concern
PiN	People in Need
PIP	Pandemic Influenza Preparedness
PPE	Personal Protective Equipment
PSEA	Protection from Sexual Exploitation and Abuse
RA	Reserve Allocation
RC	Resident Coordinator
RCO	Regional Coordinator's Office
RCCE	Risk Communication & Community Engagement
RRP	Refugee Response Plan
SARI ITCs	Severe Acute Respiratory Infection Isolation and Treatment Centres
SARS	Severe Acute Respiratory Syndrome
SARS- CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SDG	Sustainable Development Goal
SEA	Sexual Exploitation and Abuse
SERP	Socio-Economic Recovery Plan
SPRP	Strategic Preparedness & Response Plan
SRF	Solidarity Response Fund
SRH	Sexual and Reproductive Health
STAG-IH	Strategic and Technical Advisory Board on Infectious Hazards with Pandemic and Epidemic Potential
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UN Habitat	United Nations Human Settlements Programme
UNHAS	United Nations Humanitarian Air Service
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNSDCF	UN Sustainable Development Cooperation Framework
UK	United Kingdom
US	United States

WFP	World Food Programme
WHO	World Health Organization

Annexes

Annex 1: IAHE terms of reference

INTER-AGENCY EVALUATION OF THE COVID-19 HUMANITARIAN RESPONSE

TERMS OF REFERENCE

June 2021

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1 INTRODUCTION

1. Inter-Agency Humanitarian Evaluations (IAHEs) were introduced to strengthen system-wide learning and promote accountability towards affected people, national governments, donors, and the public, and are guided by a vision of addressing the most urgent needs of people impacted by crises through coordinated and accountable humanitarian action. IAHEs inform humanitarian reforms and help the humanitarian community to improve aid effectiveness to ultimately better assist affected people. IAHEs are not an in-depth evaluation of any one sector or of the performance of a specific organization.
2. As such, IAHEs cannot replace any other form of agency-specific humanitarian evaluation, joint or otherwise, which may be undertaken or required. Since 2008, the Inter-Agency Humanitarian Evaluation Steering Group has conducted dozens of system-wide evaluations of humanitarian action by the United Nations (UN), Red Cross and non-governmental organizations (NGOs). IAHEs are triggered by the Emergency Relief Coordinator (ERC) and are the only UN-led activity assessing the system-wide humanitarian response to emergencies.
3. In the event of an Inter-Agency Standing Committee (IASC) Scale-Up Activation, IASC protocols require that an IAHE be automatically triggered within 9 to 12 months of the Scale-Up declaration.
4. These Terms of Reference (TOR) provide the rationale and context for the IAHE of the COVID-19 humanitarian response; its subject and scope; rational, objectives and key areas of inquiry; and finally, the users, methodology, management arrangements and key deliverables of the evaluation.
5. The IAHE's primary focus is the collective efforts of the IASC member organizations in support of people, and with government and local actors, in meeting the needs and priorities of the world's most vulnerable people in the context of COVID-19.
6. The evaluation will be carried out under the auspices of the IASC-associated Inter-Agency Evaluation Humanitarian Steering Group (IAHE SG), which is chaired by the Office for the Coordination of Humanitarian Affairs (OCHA) and consists of the Evaluation Directors of the Food and Agriculture Organization (FAO), International Organization for Migration (IOM), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), the United National High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP) and World Health Organization (WHO), as well as representatives from the International Council of Voluntary Agencies (ICVA), International Federation of the Red Cross (IFRC), Interaction, the Steering Committee for Humanitarian Response (SCHR), and the humanitarian learning and accountability network known as ALNAP.
7. This evaluation is one of several looking at various aspects of the international response to COVID-19. These include the evaluation of the Response and Recovery Multi-Partner Trust Fund (MPTF) established to support the UN Socio-Economic Framework for COVID-19, led by the UN Systemwide Evaluation Function under the Executive Office of the Secretary-General; the evaluation by the Independent Panel for Pandemic Preparedness and Responses of WHO's response to COVID-19 and WHO's other reviews of its emergency response through the work of the Independent Oversight andAdvisory Committee for the WHO Health Emergencies Programme (IOAC) and the International Health Regulations (IHR) Review Committee; the WFP evaluation of its response to the COVID-19 pandemic; and the Joint Evaluation of the Protection of the Rights and Refugees during the COVID- 19 pandemic being conducted under the auspices of the COVID-19 Global Evaluation Coalition,

managed by UNHCR, the Ministry of Foreign Affairs of Finland, the Governments of Colombia and Uganda, and ALNAP. Thus, to ensure complementarity with other ongoing evaluative learning mechanisms, the depth of focus of this IAHE may vary between key areas of inquiry.

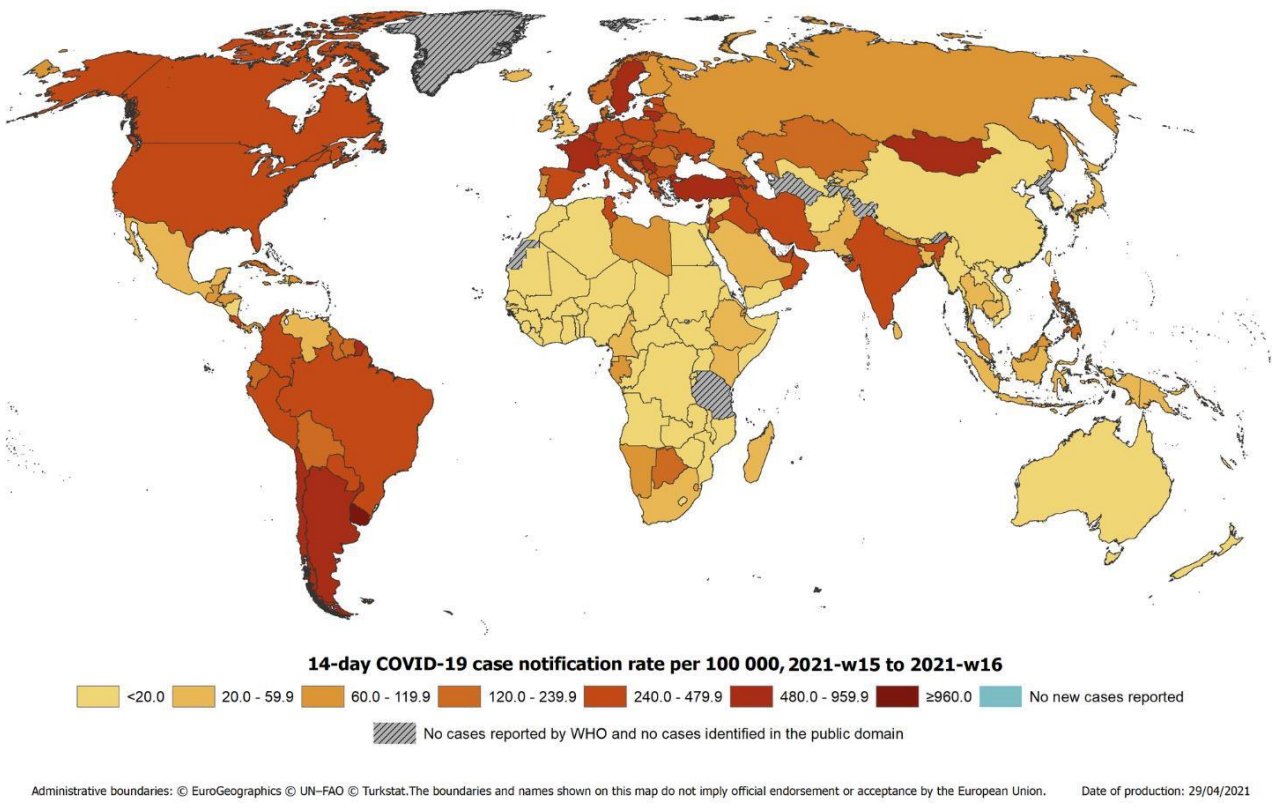
2 THE COVID-19 PANDEMIC

8. In 2020, the coronavirus disease (COVID-19) pandemic triggered an unprecedented global crisis. As of 3 May 2021, the World Health Organization (WHO) had reported a total of 152,534,452 confirmed cases of COVID-19, including 3,198,528 deaths.[1] In addition to the direct health impacts, the related socio-economic crisis is pushing more people into poverty and placing tremendous strain on already overburdened social and health services, and threatening to reverse hard-won development gains.

9. The crisis has affected virtually every country in the world, in communities large and small. Yet across the world, the most vulnerable people have been particularly hard hit by the unprecedented effects of the pandemic on the health systems, economies and societies.

10. These effects were particularly serious for people living in settings affected by humanitarian crises prior to and during the pandemic, where underlying vulnerabilities were already exacerbated by conflict and violence, and by the effects of climate change.

Figure 1: Global spread of confirmed COVID-19 cases



Source: European CDC – Situation Update Worldwide – Last updated 29 April 2021 6:27 (East Central time)

3 THE SUBJECT OF EVALUATION

[1] World Health Organization, 'WHO Coronavirus Disease (COVID-19) Dashboard', WHO, Geneva, https://COVID19.who.int/, accessed 4 May 2021

11. The subject of this evaluation is **the collective preparedness and response of the IASC member agencies at the global, regional, and country level** in meeting the humanitarian needs of people in the context of the COVID-19 pandemic.

12. On 19 March 2020, the United Nations Secretary-General issued a Call for Solidarity in response to the unprecedented global health and development threat posed by the COVID-19 pandemic. The main objectives of this call were: 1) delivery of a large-scale, coordinated and comprehensive health response; 2) adoption of policies that address the devastating socioeconomic, humanitarian and human rights aspects of the crisis; and 3) a recovery process that builds back better.

13. IASC member organizations have been major actors in addressing the humanitarian impacts of the crisis, ramping up an array of collective response mechanisms to meet the most urgent needs of nearly 250 million people in 63 countries.[2] [3] The COVID-19 pandemic necessitated IASC and other humanitarian actors to adapt existing, and where needed, create new programming to respond to and in the context of the COVID-19 pandemic

14. To mobilize resources to meet these needs, the Secretary-General on 25 March 2020 launched the Global Humanitarian Response Plan (GHRP), a consolidated plan that brought together COVID-19 appeals and inputs from WFP, WHO, IOM, UNDP, UNFPA, UN-Habitat, UNHCR, UNICEF and NGOs, and complemented other plans developed by the International Red Cross and Red Crescent Movement.

15. In 2020, 30 per cent of COVID-19 cases and 39 per cent of deaths were recorded in countries covered by the GHRP. Measures to contain the spread of the pandemic – such as travel restrictions, suspension of air travel and border closures – also disrupted supply chains and increased market volatility and economic hardship, which in turn put new constraints on humanitarian and developmental programmes.

16. Combined, these factors have significantly increased food insecurity, reduced essential nutrition services, postponed mass immunization against other vaccine preventable diseases, and for the first time since 1998, dramatically increased the number of people living in extreme poverty.[4] The impacts of the crisis have been disproportionately felt by women and girls: data emerging since its start show that all types of violence against women and girls, domestic violence in particular, has intensified.[5]

17. The GHRP focused strictly on the immediate humanitarian needs caused by the pandemic and associated short-term responses. These requirements were ***in addition*** to $29.8 billion that IASC partners sought for ongoing pre-pandemic humanitarian operations in 2020, which were represented in the 2020 Global Humanitarian Overview.

18. The original version, published in March, was prepared at the corporate level as an agency-based, three-month plan. As the crisis evolved, the GHRP underwent two revisions in May and July, and its focus shifted from agency-driven planning to a country-driven approach in the affected countries, based on the people's needs and collective response priorities as

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2 Of these 63 countries, 40 were covered by a regional response plan (RRP, RMRP, MRP or similar), 25 were covered by an HRP, and 20 by COVID-specific appeals. Some countries were covered by more than one appeal. Please see Annex V for a depiction of GHRP countries by appeal type.

3 Figures refer to the 3rd and final revision of the Global Humanitarian Response Plan, issued in July 2020 and containing revised requirements until the end of 2020. Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/GHRP-COVID19_July_update_0.pdf.

4 Global Humanitarian Response Plan COVID-19. United Nations coordinated appeal. April-December 2020, March 2020. Available at: https://interagencystandingcommittee.org/system/files/2020-03/Global%20Humanitarian%20Response%20Plan%20COVID-19_1.pdf.

5 www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19

defined at the field level.

19. The GHRP initially sought $2 billion, which increased to $9.5 billion by the third iteration, to meet COVID-19-related humanitarian needs. The GHRP aggregated the activities and requirements to meet the needs of the most affected and vulnerable people in 63 priority countries, largely those that already had an ongoing appeal/plans, such as a Humanitarian Response Plan (HRP), Refugee Response Plan (RRP) or multi-country/sub-regional response plan, as well as a few additional countries that requested international assistance. For a geographic depiction of the GHRP coverage by appeal type, please see Annex V.

20. The GHRP and its revisions included not only humanitarian programming to address the health crisis, but increasingly also its non-health effects, such as gender-based violence, psychosocial impacts, out-of-school children, food insecurity and the erosion of livelihoods. It also included activities aimed at addressing global travel restrictions through humanitarian air services for cargo and personnel.

21. The IASC's GHRP complemented the health and social-economic responses by the United Nations and other development actors, as articulated in the COVID-19 Strategic Preparedness and Response Plan (SPRP), coordinated by the World Health Organization (WHO), and the United Nations Framework for the Immediate Socio-Economic Response to COVID-19, co-led by the United Nations Development Programme (UNDP) and the United Nations Development Coordination Office (DCO). The WHO's SPRP focused on supporting the global-level COVID-19 health response and country- level activities articulated in Country Preparedness and Response Plans. The UN Framework for the Immediate Socio-Economic Response to COVID-19 was operationalized through country-level United Nations Country Team (UNCT) socio-economic response plans focused on strengthening development activities to safeguard health care systems, jobs, businesses and livelihoods, while ensuring the safe recovery of affected countries.

22. The collective humanitarian response to the pandemic was funded through long-established and existing collective resource mobilization and humanitarian financing mechanisms such as the IASC global appeals process, the Central Emergency Response Fund (CERF) and country-based pooled funds (CBPF), managed by OCHA in support of Humanitarian Response Plan objectives.

23. Meanwhile, a special COVID-19 Solidarity Response Fund was established to support implementation of WHO's SPRP, and a Multi-Partner Trust Fund (MPTF) to support implementation of the UN Framework for the Immediate Socio-Economic Response to COVID-19.

24. For a visual depiction of the three pillars of the response, and their associated objectives, plans and funding modalities, please see Annex IV.

25. On 17 April 2020, following the development of the first GHRP, the ERC declared a system-wide Scale-Up Activation to respond to COVID-19 to ensure coordinated global support to humanitarian country operations to mitigate the pandemic's impacts. The Scale-Up Activation covered all countries included in the GHRP for an initial period of six months. It was subsequently extended for another three-month period, in line with the regular procedures for a maximum duration of nine months for scaled-up measures to remain in effect.

26. The Scale-Up followed a special protocol, adapted from the existing IASC Protocols for the Control of Infectious Disease Events.[6] The protocol provided for specific system-wide Scale-Up measures, adapted to the pandemic context, to mobilize and expedite support for

[6] For a full list of tools and mechanism see IASC, Protocol 1. Humanitarian System-Wide Scale-Up Activation: Definition and Procedures, 2018

countries and international responders on issues related to the COVID-19 pandemic.

27. Several other multi-stakeholder mechanisms to support coordination and common services were established. For example, the **Global Information Management and Analysis Cell on COVID-19** was created by several United Nations and international NGO partners to support the coordination and analysis of the impacts of COVID-19 and other shocks, and to provide technical support and services to prioritized countries and global decision-makers.

28. These efforts were supported by the fast-tracked development and release of 12 COVID-19-specific interim guidance documents on topics such as emergency response preparedness, scaling up readiness and response operations in camps and camp-like settings, health in poor sanitary settings, the protection from sexual exploitation and abuse and gender.

29. The GHRP concluded as planned on 31 December 2020, at which time COVID-19 and non-COVID-19 humanitarian responses were consolidated in the Global Humanitarian Overview 2021. This also signaled the synchronization of COVID-19 and non-COVID-19 funding requirements and reporting under the regular Humanitarian Programme Cycle in regional and country plans. Meanwhile, new "COVID only" humanitarian plans in the remaining GHRP countries either concluded on 31 December 2020 or were integrated into other development plans or frameworks.

30. For these reasons, and in line with the Scale-Up Activation Protocol for COVID-19 that sets a maximum 9-month limit to the activation period, the ERC declared the deactivation of the IASC Scale-Up response on 25 January 2021. The IASC issued its final progress report on the GHRP on 22 February 2021.

4 RATIONALE

31. In line with IASC protocols, an evaluation of Scale-Up responses is required within 9 to 12 months of the declaration of a Scale-Up to meet its formal learning and accountability needs. In the event of infectious disease events, the protocol states that an IAHE should be conducted "if necessary". Three main considerations provide further rationale for the evaluation of the IASC's collective efforts to respond to pandemic-related humanitarian needs.

4.1 Learning:

32. **There is a documented knowledge gap pertaining to collective humanitarian response to infectious disease events.** Numerous past reviews[7] indicate that even before the pandemic, responding to infectious disease-related humanitarian crises – even in a single country – was a known challenge. In the absence of a specific IASC guidance to prepare for and respond to global infectious disease events, the IASC's response to COVID-19 required an agile and flexible approach to the exceptional and rapidly evolving situation and was a significant test of the humanitarian community's agility. The reviews point to a need for a more comprehensive overhaul of the IASC responses to infectious disease events. For instance, in September 2019, the Global Preparedness Monitoring Board, in its annual report.[8] warned of systemic problems in global preparedness, including in the humanitarian system, for a pandemic scenario involving a respiratory pathogen. The report called upon the Secretary-General, OCHA and WHO to "strengthen coordination in

[7] E.g. 1.) IOAC thematic report commissioned by the Global Preparedness Monitoring Board "What does the 2018–2019 Ebola outbreak in the Democratic Republic of the Congo tell us about the state of global epidemic and pandemic preparedness and response?" September 2019. 2.) GA A/70/723 "Protecting humanity from future health crises" Report of the High-level Panel on the Global Response to Health Crises. 2016.

[8] https://apps.who.int/gpmb/assets/annual_report/GPMB_Annual_Report_English.pdf

different country, health and humanitarian emergency contexts, by ensuring clear United Nations systemwide roles and responsibilities; rapidly resetting preparedness and response strategies during health emergencies; and enhancing United Nations system leadership for preparedness, including through routine simulation exercises." To date, there has been no IAHE of previous responses to country or regional infectious disease outbreaks.

33. Learning from global, regional, and local levels vis a vis joint analysis, planning and programming, as well as how collective systems enabled this, should be captured. The response to the COVID-19 pandemic demanded international cooperation and challenged emergency responders to adapt. It required global, regional and national-level collaboration among humanitarian, health, development and peace and security actors and, as such, was also test of the extent to which humanitarian actors were able to work in solidarity with others, across the health, development and peace spheres to address the primary and secondary effects of a multi-dimensional crisis. Thus, the evaluation will bring together learning from the global, regional and local levels vis a vis both joint programming, as well as the collective systems meant to enable them.

4.2 Accountability:

34. The substantial funding received from the international community through IASC mechanisms bring with it a significant accountability obligation. IAHEs are an integral element of the Humanitarian Programme Cycle, which aims to put the affected persons and their needs at the heart of the emergency response and increase accountability of humanitarian actors and donors for collective results. This IAHE will fulfill this need.

35. To this end, on 10 March 2021, the Emergency Relief Coordinator triggered an IAHE of the humanitarian response to the COVID-19 pandemic.

5 OBJECTIVES

36. The main objectives of this evaluation are threefold, namely to:

1. Determine the extent to which the IASC member agencies' collective preparedness and response actions, including its existing and adapted special measures, were relevant to addressing humanitarian needs in the context of the pandemic;

2. Assess the results achieved from these actions at the global, regional and country level in support of people, and with governments and local actors; and

3. Identify best practices, opportunities and lessons learnt that will help to improve ongoing and future humanitarian responses, including through wider and accelerated adaptation of certain humanitarian policies, approaches, and practices.

6 SCOPE

37. ***Substantive scope:*** The subject of the evaluation is **the collective IASC preparedness and humanitarian response at the global, regional and country level** to meet the humanitarian needs of people in the context of the COVID-19 pandemic. Thus, as with all IAHEs, this evaluation will focus primarily on the **actions and roles of the IASC and its member organizations,** in support of governments and local actors, to meet the needs of the most vulnerable people and those in hard-to-reach areas.

38. It will not focus on agency-specific responses, nor will it duplicate the significant number of evaluative reviews already underway of the WHO-coordinated global COVID-19 response that have been commissioned by the Member States of the World Health Assembly. It will, however, use these and other agency-specific reports to, where applicable, triangulate their

findings against the other sources of evidence gathered in the present evaluation. To the extent possible, the evaluation will seek the views of people about how well the response met their needs and priorities and how they were given the opportunity to effectively collaborate, engage and participate in the response.

39. ***Temporal scope:*** The evaluation will cover the IASC-led humanitarian response to COVID-19 from 1 January 2020, when WHO activated its Incident Management Support Team, up until the time of the IAHE data collection phase. To assess the contribution of the Scale-Up measures to the response, the IAHE will focus on the period from 18 April when the IASC Scale-Up response was activated until 25 January 2021, when it was deactivated. To answer the evaluation questions related to collective preparedness to the pandemic, the evaluation will also review relevant IASC documents, decisions and actions taken prior to 1 January 2020.

40. ***Geographical scope:*** The IAHE is global in scope, with focus on countries included in the GHRP and its revisions, as the only countries in which collective IASC action to address pandemic related needs took place.

7 INTENDED USERS

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

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

42. In doing so, the IAHE will also:

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

8 EVALUATION QUESTIONS

43. IAHEs apply internationally established evaluation criteria that draw from the evaluation criteria in the United Nations Evaluation Group (UNEG) norms and standards, revised Development Assistance Committee of the Organization for Economic Co-operation and Development (OECD/DAC) criteria for development evaluation, and the ALNAP criteria for the evaluation of humanitarian action. The criteria used for this evaluation are listed below alongside the evaluation questions.

44. The matrix provided below contains indicative questions that will be elaborated on during the inception phase of the evaluation to produce the final list of key questions and sub-questions that will guide the evaluation.

Evaluation Criteria	Main Evaluation Question	Sub Questions
Relevance Coverage	To what extent did the IASC's collective response prove relevant and adaptive in meeting the demands of the crisis and the humanitarian needs caused by it?	⇒ How well-tailored to the COVID-19 pandemic were the collective preparedness measures put in place by the IASC prior to the pandemic? ⇒ How well did the IASC collective response, decisions, processes, and fast-tracked mechanisms adapt and evolve in relation to the trajectory of the crisis? ⇒ To what extent did the IASC's collective global and regional humanitarian response planning and prioritization correspond to the national priorities of all affected countries? ⇒ To what extent, and how closely, were country humanitarian plans and response strategies for the pandemic informed by a systematic and comprehensive identification of affected people's needs, in consultation with them? ⇒ To what extent did the humanitarian response adequately cover the humanitarian needs of affected populations, both overall and vis a vis specific vulnerable group? ⇒ To what extent were the cross-cutting themes taken into consideration in humanitarian plans and the response?[9]
Effectiveness	To what extent did the IASC's collective efforts contribute to effectively addressing the humanitarian effects of the pandemic?	⇒ To what extent did the IASC's preparedness measures in targeted GHRP countries after Scale-Up declaration contribute to more effective humanitarian response? ⇒ To what extent were the global IASC strategy and Scale-Up mechanisms effective in ensuring IASC country teams' capacity to lead, coordinate and deliver humanitarian assistance in targeted countries? ⇒ How effectively did the IASC leverage collective mechanisms in planning and responding the response, including vis a vis local participation? ⇒ How effective was the IASC's monitoring framework for the COVID-19 response in supporting operational and strategic decision-making? ⇒ Did the COVID-19 related humanitarian response have any unintended (positive or negative) effects on targeted communities and local actors?
Efficiency	To what extent did IASC decisions and processes facilitate the efficient use of available resources to meet response objectives?	⇒ How well did IASC allocation strategies and mechanisms channel resources to frontline responders, including international and

[9] As per section #10 of these TOR

		local/national NGOs and civil society organizations (CSOs)? ⇒ To what extent were these efforts successful in mobilizing adequate, timely and flexible funding to meet the GHRP requirements? ⇒ To what extent did pooled funds contribute to the provision of adequate, timely and flexible funding to meet the GHRP requirements?
Coherence Connectedness Coordination	To what extent was IASC response coherent, connected, and well-coordinated in its delivery of the response to a multi-dimensional crisis?	⇒ To what extent were the IASC humanitarian policies, strategies, and responses to COVID- 19 consistent and complementary with the health and social economic responses by United Nations and other actors? ⇒ To what extent did IASC organizations consistently coordinate their efforts in responding to the pandemic, in accordance with IASC policies? ⇒ To what extent were there linkages and synergies in COVID-19-related responses across the humanitarian-development-peace nexus aimed at addressing the intertwined effects of the pandemic? ⇒ To what extent did the international humanitarian preparedness and response to COVID-19 complement and empower national and local actors in their efforts and leadership to address COVID-19-related humanitarian needs? ⇒ To what extent have inter-agency information management and communication mechanisms been able to support IASC collective decision-making?
Impact	What were the results of the collective humanitarian response?	⇒ To what extent is there evidence that the IASC's collective response to the pandemic was able to meet the humanitarian needs of affected people, including the most vulnerable groups? ⇒ To what extent did the collective humanitarian response to the pandemic contribute to the overall objectives of the SG's call for solidarity to address the impact of the multidimensional crises?
Lessons learned These questions will apply as learning "lens" for all the key EQs	What are the main challenges and lessons learned from the preparedness and response to the pandemic?	⇒ What are the key strategic and policy challenges and opportunities for improving the IASC's future responses to pandemics and other infectious disease events with multi-country humanitarian impacts? ⇒ What are the key lessons from COVID-19 response that can strengthen humanitarian-development-peace nexus approaches in the future?

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

45. In addition to these criterion-specific questions, a range of cross-cutting questions will be asked. These questions will examine to what extent the cross-cutting themes such as humanitarian principles, protection, inclusivity, gender and accountability to affected people (see section # 10 for cross cutting themes) were taken into consideration throughout the Humanitarian Programme Cycle – from preparedness measures, needs assessments and planning processes for the response itself, as well as the monitoring of it – to ensure that no one, including the most vulnerable, was left behind.

9 EVALUATION APPROACH AND METHODOLOGY

46. The evaluation will use a theory-based approach with contribution analysis, and a comparative case-study design, as well as other methods that might be proposed and justified by the Evaluation Team during the inception phase.

47. The evaluation will be rooted in a utilization-focused approach ensuring that emerging evaluation findings can feed into ongoing planning and response processes.

48. A theory of change (ToC) will be developed at the outset of the evaluation. (Annex III provides a rudimentary results framework that can serve as the basis for the ToC). The selected Evaluation Team will work with this to ensure it encapsulates what has been targeted through the inter-agency effort, under what assumptions, through what pathways, and how these pathways are inter-related.

49. The Evaluation Team will prepare an evaluation matrix, which will be one of its main analytical frameworks. This matrix will set out how each evaluation question and evaluation criteria will be addressed, breaking down the main questions into sub-questions, mapping them against data collection and analysis methods, indicators or/and lines of inquiry, data collection tools and sources of information. It will provide a clear line of sight from the evaluation questions as defined at the start of the evaluation to the findings as outlined in the final evaluation report.

50. The comparative case-study design will help to describe similarities and differences between contexts and approaches, assessing the implications of these similarities and differences and, using the findings from this analysis, subsequently derive conclusions explaining heterogenous results and informing the answers to the TOR's evaluation questions.

51. The comparative case study design will also provide an in-depth look at the evidence at the country level associated with responding to COVID-19 in a purposive sample of up to 10 countries selected for field-based data collection. Considering that this number will not allow for a full-fledged comparative approach, the selection of countries should aim for a broad spectrum of illustrative examples, with the aim of identifying patterns between the different contexts to help answer the evaluation questions. Countries should thus be selected based on several criteria such as the different humanitarian contexts, geographic regions and response leadership and coordination modalities. With regard to coordination modalities, the following typology might be considered 1) countries covered only by an HRP, 2) countries covered only by an RRP/regional response plan, 3) "mixed situations", that is countries covered by both an HRP and RRP/regional response plan; 4) countries with COVID-specific appeal.

52. All potential vendors bidding for the IAHE contract will be requested to propose their

approach for case study country selection. Final selection of these countries will be determined at the inception phase. In addition to case study countries, up to 5 countries will be selected for an extended desk review. These extended desk studies will be lighter reviews, the findings of which will feed into the evaluation report.

53. In assessing the IASC's collective response efforts, the IAHE will base its examination on the GHRP and its revisions; COVID-19 and other relevant Scale-Up protocols and associated actions; IASC bodies' coordination and decision making; and its policies and guidance materials.

54. Within the comparative case study approach, the Evaluation Team could explore options to employ a realist impact evaluation methodology (which emphasizes the importance of context for programme outcomes).[10]

55. Further, the evaluation will rely on a mixed-methods approach to answer the above-mentioned evaluation questions using the best and most appropriate evidence gathered through qualitative and quantitative modalities. These methods will include the following:

    - *Qualitative methods*: The Evaluation Team should plan to undertake semi-structured key informant interviews with IASC senior managers, humanitarian policy makers, donors, and humanitarian government counterparts, including national and local stakeholders and local responders. Another qualitative approach should include focus group discussions, including with 1) beneficiaries of programmes, and 2) frontline workers directly involved. Full reliance on secondary data should be a last resort, and innovative avenues should be sought e.g., leveraging on SMS platforms.

    - *Quantitative methods:* As part of the quantitative component, the evaluation could collect and analyse secondary quantitative data. Several sources of data should be included in the inception report, such as a comprehensive review of primary and secondary sources, including pre-existing survey data, conceptualization of population and aid worker surveys, where necessary to complement available information such as existing survey data, a desk review of relevant documents, an analysis of data, including financial and monitoring data. The feasibility – due to ethical considerations concerning COVID – of the aid worker surveys will be determined during the inception phase. Quantitative data must be analysed using quantitative analysis software, such as STATA or Excel.

56. All data will be triangulated by the Evaluation Team during the data analysis stage through one or more brainstorming sessions framed around the evaluation questions, the evaluation design matrix, and the inferred ToC.

57. The specific contours of the above proposed evaluation approaches and methodologies will be refined during the inception phase under the guidance and supervision of the Evaluation Management Group (MG) and its Manager.

[10] www.betterevaluation.org/en/approach/realist_evaluation

Evaluation risks and mitigation

Potential risks	Possible mitigation measures
1. Possible duplication and overlap between the IAHE and other system-wide evaluative and learning initiatives.	Evaluation Team to map out all ongoing and planned evaluations and lessons learned to identify opportunities for coordinated approaches to data collection and common use of evidence. Members of the MG will also be participating in relevant fora and exchanging information with other partners using UNEG, ALNAP and other evaluation and learning networks. See Annex II for an initial list of other major initiatives.
2. Excessive burden of the ongoing Covid-19 pandemic response on humanitarian aid workers limits their engagement with the evaluation.	Evaluation Team to actively identify ways to reduce evaluative burden, including thorough mapping of and strong coordination with other evaluative exercises and in the selection of case study countries. The Team will also seek to harness pre-existing information, including survey data, without replicating efforts already underway/conducted.
3. Delays in generating evaluative evidence and lessons.	To enable more targeted and timely learning, where possible, the IAHE's findings will be presented in a rolling manner whereby the Evaluation Team will share their preliminary findings and lessons of the COVID-19 response.
4. Logistical, security and access challenges that are currently hard to predict due to international and national travel restrictions related to the COVID-19 pandemic.	The Evaluation Team should propose flexible and adaptive approaches to data collection in line with the evolving situation, such as for instance the two scenarios described below. 1. **Scenario A**. Continued restrictions on international, local and national travel due to the COVID-19 pandemic severely constraining or making it entirely impossible to undertake on-site fieldwork and data collection. In this scenario, the team will be required to undertake most, if not all, data collection using remote data collection methods, leverage pre-existing data and deploy other innovative approaches (e.g., Big Data analysis, mobile surveys or use of third-party data). The team will also prioritize working primarily with and through local field researchers. 2. **Scenario B**. International and national travel restrictions are lifted for most case study countries, making travel to and within most of the key areas targeted by humanitarian activities possible. Restrictions in some countries and regions remain, limiting the Evaluation Team's access to areas, population groups, and/or use of some of the data collection tools. Affected
	people surveys are feasible at least in some case study countries and international or locally based evaluators can conduct field data collection on the ground in most areas. The above two scenarios are not totally mutually exclusive and may overlap in practice.

5. Limited availability of reliable and disaggregated data and evaluative evidence.	The request for proposals for the IAHE will encourage bidding companies to propose innovative data collection methods. Considering the continuing limitations in access to locations and populations as a result of the COVID-19 pandemic, evaluators will be asked to include alternative methods to ensure effective engagement of both humanitarian aid workers and affected populations. In addition, there needs to be a strong emphasis on triangulation for increasing reliability, as well as additional disaggregated data collection using innovative approaches to the extent possible.

10 CROSS-CUTTING THEMES AND SPECIAL CONSIDERATIONS

58. **Humanitarian principles**: Humanitarian action is governed by the four humanitarian principles of humanity, impartiality, neutrality and independence.[11] The evaluation will examine how these principles were considered and applied in the collective response of humanitarian actors to COVID- 19.

59. **Protection**: In line with the *ALNAP Guide: Evaluating Protection in Humanitarian Action* and the IAHE Guidelines, the evaluation will consider the extent to which the inter-agency humanitarian response to COVID-19 has mainstreamed protection issues and considered protection risks, particularly affecting the most vulnerable people. This includes the extent to which the response considered human rights and identified and addressed gaps in the capacity of rights holders to claim their rights and of duty bearers to fulfil their obligations.

60. In a bid to promote durable solutions and sustainability, the IAHE processes will, where possible, seek to understand how underlying issues, barriers and drivers of inequalities are identified and addressed within humanitarian programming. The IAHE will also consider how the IASC strategy and commitments on protection from sexual exploitation and abuse have been integrated into the collective humanitarian response.

61. **Gender:** In line with the UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation,[12] the UN System-Wide Action Plan (UN-SWAP) on gender equality[13] and the 2017 IASC Policy on Gender Equality and the Empowerment of Women and Girls in Humanitarian Action,[14] the evaluation will apply gender analysis in all phases. Further, the evaluation process will seek to understand the processes and methodologies utilized to enhance equity and participation of women and girls in humanitarian activities (both in design and implementation) and in decision- making processes.

62. **Inclusiveness:** The evaluation process will aim to assess the extent to which the differential needs, priorities, risks and vulnerabilities of women, girls, men and boys are being identified, assessed and integrated in humanitarian responses. The evaluation methodology will integrate participatory processes, especially at the community level to adequately engage women, men, boys and girls of different ages and take into consideration the existence of disadvantaged groups, such as people with disabilities.

63. **Accountability to affected people:** The evaluation will examine how the various segments

[11] Humanitarian action should be motivated by the sole aim of helping other human beings affected by conflicts or disasters (humanity); exclusively based on people's needs and without discrimination (impartiality); without favoring any side in a conflict or engaging in controversies where assistance is deployed (neutrality); and free from any economic, political or military interest at stake (independence).

[12] www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=1401

[13] www.unsystem.org/content/un-system-wide-action-plan-gender-equality-and-empowerment-women-swap

[14] https://interagencystandingcommittee.org/system/files/2020-11/IASC%20Policy%20on%20Gender%20Equality%20and%20the%20Empowerment%20of%20Women%20and%20Girls%20in%20Humanitarian%20Action.pdf

of the affected population have been consulted in the design of country-level plans, especially regardingthe prioritization of needs, decision-making processes, and how limitations to participation and inclusion have been addressed.

64. **Ethical considerations:** Due diligence will be given to effectively integrating good ethical practices and paying due attention to robust ethical considerations in the conduct of any IAHE, as stipulated in the *United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation* of 2020. Furthermore, it is vital for the evaluation to fully comply with the precautionary measures put in place by the collective agencies and host governments, in order to protect staff, teams and consultants, partners and people. It is of utmost importance that the 'do no harm' principle consistently guide evaluation efforts across the board, including as it applies to those involved in the on-going COVID-19 response as well as affected populations.

11 MANAGEMENT ARRANGEMENTS AND STAKEHOLDER PARTICIPATION[15]

65. The IAHE will be conducted by a team of external evaluation experts under the guidance, supervision and support of an IAHE Management Group (MG) coordinated by an Evaluation Manager.

11.1 The Evaluation Team

66. The Evaluation Team will be recruited by the MG through OCHA's systems contracts for evaluative services. It will consist of internationally recruited members, including, at a minimum, a Team Leader, a Senior Evaluator, an Evaluator and Research/Data Analyst. Up to ten national consultants may also be recruited to support data collection in case study countries. Together, the selected team will be expected to possess the following collective experience and skills:

⇒ Extensive experience conducting mixed-methods-oriented evaluations of humanitarian strategies, programmes, finance/funding instruments and other key humanitarian issues

⇒ Health policy/public health expertise, including a good understanding of International Health Regulations, with prior experience evaluating health emergencies (including infectious disease events) being highly desirable

⇒ Expertise in developmental economics, livelihood, economic recovery or related fields

⇒ Extensive skills in data analysis and data visualization

⇒ Extensive knowledge of humanitarian law and principles, and experience with using human rights, protection and gender analysis in evaluations (at least one of the team members should have experience in protection and gender analysis)

⇒ Experience with and institutional knowledge of UN, NGO and CSO actors, as well as inter-agency mechanisms at headquarters and in the field

⇒ An appropriate range of field experience

⇒ Solid understanding of cross-cutting issues, such as gender, disability, etc.

⇒ Good understanding of the humanitarian-development nexus

⇒ Experience in facilitating consultative workshops involving a wide range of organizations and participants

67. The Team Leader will be responsible for the overall conduct of the evaluation in accordance with the TOR, including: refining the evaluation approach and methodology, as

[15] For further details on the specific roles and responsibilities of the different IAHE stakeholders, please see "Inter-Agency Process Guidelines", developed by the IAHE Steering Group, May 2018.

described above and in consultation with the MG and Evaluation Manager; managing the Evaluation Team, ensuring efficient division of tasks between mission members and taking responsibility for the quality of their work; representing the Evaluation Team in meetings; ensuring the quality of all outputs; and submitting all outputs in a timely manner.

68. The Team Leader will have no fewer than 15 years of professional experience in the non-profit sector, including at least 10 years of experience in conducting evaluations of humanitarian operations, and demonstrate strong analytical, communication and writing as well as team leadership skills.

69. All team members must have working knowledge of English. At least one international team member must have excellent speaking, reading and, preferably, writing skills in another official UN language (for example, French, Arabic).

11.2 Management Group

70. The IAHE will be managed by an Inter-Agency Management Group (MG) comprised of senior-level evaluation officers representing the independent evaluation offices of IAHE SG members, including the following organizations: ALNAP, ICVA, IOM, SCHR, UNFPA, UNHCR, UNICEF, WFP, WHO, and OCHA (chair). The members of the MG are mandated by their respective Steering Group representatives within all the delegation of authority of the MG to manage IAHE deliverables as per the IAHE guidelines.

71. The independence of the evaluation process will be safeguarded by, and will reside with, the MG. The Team Leader will report to the MG through the Evaluation Manager, with all final quality control and process decisions resting with the MG in order to ensure the smooth functioning of the evaluation. Wherever necessary, the MG will work with the Team Leader to finalize individual evaluation outputs, so as to ensure the maximum quality, credibility and utility of all end products.

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

11.3 Global Advisory Group (GAG)

73. A Global Advisory Group (GAG) will be formed to provide support to the IAHE. Acting in an advisory capacity only, its role will be to comment on draft evaluation deliverables, advise on data and evidence sources and support communication and dissemination activities, with the aim of ensuring the relevance and utility of the evaluation's findings and recommendations to the humanitarian community. The GAG (10-12 members) will include non-IASC actors, including Member States, national or regional NGOs/CSOs and think tanks.

11.4 IAHE Steering Group (IAHE SG)

74. As per IAHE Guidelines, the IAHE Steering Group will approve the TOR, as well as the final evaluation report, based on the recommendations provided by the IAHE Management Group. The Steering Group will also contribute to the development of a communications strategy for the IAHE results.

12 DELIVERABLES

75. The Evaluation Team is responsible for the following deliverables:

Deliverable 1: Inception report

76. The Evaluation Team will produce an inception report not to exceed 15,000 words,

excluding annexes, setting out:

- The Team's understanding of the issues to be evaluated (scope), and their understanding of the context in which the IAHE takes place and any suggested deviations from the TOR, including any additional issues raised during the initial consultations.

- A comprehensive methodological approach for the evaluation, including:
  ⇒ An assessment of data availability in relation to the evaluation questions at hand, and the identification of challenges/gaps and a plan for mitigating them, resulting in a set of final key evaluation questions.[16]
  ⇒ A comprehensive stakeholder mapping and analysis, including a description of how key stakeholders were involved/consulted in developing the inception report, and what their stake is in the evaluation. The stakeholder analysis should have a clear indication of which national entities and communities will be: 1) consulted; 2) engaged with; and 3) involved in the evaluation process, as relevant. Per stakeholder, a plan of action should be proposed, outlining the planned level and scope of engagement in the evaluation.
  ⇒ Evaluation approach and design, which will include an inferred ToC using the preliminary result framework provided in Annex III as its basis. It should also include an evaluation matrix of selected criteria of analysis and sub-questions (building upon the initial list of evaluation criteria and questions provided in the present TOR). This matrix should indicate for each question the assumptions to be assessed, the indicators proposed and corresponding sources of information.
  ⇒ Data collection and analysis tools that will be used to conduct the IAHE (survey instruments, interview guides, field data collection plan and schedule of interviews, and other tools to be employed for the evaluation).
  ⇒ Any limitations of the chosen methods of data collection and analysis and how they will be addressed. This might include, for example, methodological and management measures to reduce any potential bias in data collection undertaken by the consultants that may arise due to their regional, religious or ethnic identity.
  ⇒ A final list of data sources to be used, including where applicable pre-existing survey data, and a finalized sampling strategy.
  ⇒ List of case study and in-depth desk review countries including selection criteria, alternative suggestions for countries and explanation of how each case study/review will contribute to answering evaluation questions and overall objectives of the evaluation.
  ⇒ Furthermore, the inception report should explain how the views of the affected population, as well as protection and gender considerations, will be addressed during the evaluation.
  ⇒ How challenges posed by the context, for instance local or international travel restrictions, will be addressed in the evaluation.
  ⇒ The details of the gender analysis approach.

[16] Challenges, even significant challenges, in answering individual questions will not be considered a reason for not answering them; rather, the identification of these challenges should result in a preliminary indication of the level of robustness with which each can be answered in light of the available data – and, where necessary, what the level of effort will be necessary to increase the robustness of the analysis on key questions, wherever appropriate.

⇒ A detailed updated workplan (including fieldwork plan) for the deliverables.
⇒ A tentative detailed outline of the final evaluation report and the case study reports.
⇒ A description of the team organization and quality assurance arrangements.

77. The draft inception report will also be an opportunity for the MG, GAG and the IAHE SG to provide more detailed feedback on the proposed methodology and approach. The draft inception report will be shared with the MG, after which the Evaluation Team will incorporate the received feedback and finalize the inception report. Following its finalization, the Evaluation Team should field-test the data collection instruments in the first country and incorporate feedback in the final instruments; after which roll-out in the other countries should start.

Deliverable 2: Main evaluation report

78. The evaluation report is the main deliverable of the evaluation and should not exceed 25,000 words (excluding a 4-6 page executive summary and annexes), written in a clear and concise manner that allows readers to understand the main evaluation findings, conclusions and corresponding recommendations, and their inter-relationship. The report should be comprised of a(n):

- Executive summary of no more than 2,500 words.
- Summary table linking findings, conclusions and recommendations, including where responsibility for follow-up should lie.
- Analysis of the context in which the response was implemented.
- Methodology summary. This should be a brief chapter in the main report, with a more detailed description provided in an Annex.
- Main body of the report, including an overall assessment, findings in response to the evaluation questions, conclusions and recommendations. The report should contain a dedicated section that consolidates all the key lessons learned from the response and any innovations that IASC should be further brought to scale.

79. The final report should present recommendations that are specific, clearly stated and not broad or vague; as well as realistic, reflecting an understanding of the humanitarian system and potential constraints to follow-up. They should suggest where responsibility for follow-up should lie and include a timeframe for follow-up.
80. Annexes will include: 1) TOR, 2) detailed methodology, 3) list of persons interviewed, 4) details of qualitative and quantitative analysis undertaken, 5) team itinerary, 6) all evaluation tools employed, 7) list of acronyms, 8) bibliography of documents (including web pages, etc.) relevant to the evaluation, 9) A summary table that links the key findings, conclusions and recommendations of the evaluation.
81. The draft report and its versions will be reviewed by the MG. The final report will be cleared by the IAHE Steering Group prior to dissemination. No limited number of drafts should be set due to the need to optimize the quality of the evaluation report.

Deliverable 3: Country Case Study Reports

82. Case study reports (up to 10) should complement the evaluation report. The reports should provide a high-level overview of the scope of the fieldwork, and then focus on the findings based on the analysis of the local response data. Excluding annexes, each country case

study report should not be longer than 50 pages. Case study reports serve as part of the evidence collection to support the overall findings on the global response; they are not evaluations of a particular country responses and will not produce recommendations for local action.

Deliverable 4: Learning Papers/ Evidence summaries

83. Up to 3 learning papers/evidence summaries will be developed as part of the IAHE. The topics of the learning papers/evidence summaries are to be chosen during the inception phase. These papers will serve as inputs into the final evaluation report but will also be used as a standalone document to inform humanitarian police and practice. Each paper should not be longer than 20 pages without annexes.

Deliverable 5: Validation workshops

84. Prior to finalization of the evaluation report, the Evaluation Team should conduct a validation workshop to collect views on the findings and emerging recommendations from the GAG members. This may include any additional programme or subject experts whose views might be sought to ensure that the findings and recommendations reflect the realities of humanitarian policy and practices in relevant fields.
85. In addition, countries not visited during the assignment may be invited to participate in some sessions of the workshop(s), serving to corroborate the findings with experiences from other countries and further triangulate the conclusions and recommendations. The workshop(s) are to be organized after submission of the draft learning papers/evidence summaries and the presentation on emerging findings and recommendations. Brief 2-page session background papers should be submitted for each session organized.

Deliverable 6: Datasets

86. The Evaluation Team should make available to OCHA's Evaluation Section all data (with due care for protecting confidentiality of the respondents) that has been collected, not limited to but including from the survey, focus group and KIIs.

Deliverable 7: Other evaluation products for dissemination

- **Presentations***:* Based on the communication plan prepared by the Management Group, the Evaluation Team will produce presentations, including for the Humanitarian Coordinator (HC)/ Humanitarian Country Team (HCT), IASC members, donors, and in-country to national and local actors, including affected populations where possible.
- **Factsheets***:* 1-2-page documents that capture all the key findings and recommendations along with selected charts and graphs for each of the learning papers and the final IAHE report,
- **Additional evaluation products** such as briefs, video presentations or précis may be proposed in the inception report for the Management Group's consideration. These additional products will be budgeted and agreed separately with the evaluation company selected for this IAHE.

87. All deliverables listed will be written in standard UK English, and submitted as Word and PDF documents, using the IAHE template. The Executive Summary, a one-page factsheet, and a presentation summarizing the key findings, will be translated into French and

selected national languages in case study countries. If in the estimation of the Evaluation Manager the reports do not meet required standards, the Evaluation Team will ensure at their own expense the editing and changes needed to bring it to the required standards.

13 QUALITY ASSURANCE

88. The evaluation will be guided by the UNEG Norms and Standards and the UNEG ethical guidance for evaluation to ensure the quality of evaluation process. All quality assurance, both of a technical and linguistic nature, will be the responsibility of the Evaluation Team under the leadership of the Team Leader. Key deliverables will be reviewed according to the OCHA Quality Assurance System for Evaluations. All final evaluation products should conform with OCHA's Style Guide. Payment of consulting fees at each stage of the evaluation will be contingent on the MG's satisfaction with the quality of deliverables provided at each milestone. To ensure the quality of the final outputs, the evaluation team should also include a peer review as part of its quality control procedures.

14 DISSEMINATION AND FOLLOW UP

89. In consultation with the GAG and the Evaluation Team, the Management Group will prepare a dissemination, communication, and engagement strategy for the IAHE. The strategy will outline how the evaluation's findings, conclusions and recommendations will be disseminated to all relevant audiences, including affected people and public. The strategy will also outline specific communication products, and their most effective and interactive dissemination channels.

90. The Evaluation Team will conduct the following presentations:

- If in-country field missions will be possible (Scenario B), the Evaluation Team will conduct an exit brief with the relevant international humanitarian response teams (UN/HCT), the relevant Government counterparts, and (remotely) the IAHE Management Group to share first impressions, preliminary findings and possible areas of conclusions and recommendations at the end of the field visit. The brief will help clarify issues and outline expected or pending actions from any stakeholders as relevant and discuss the next steps.
- Upon completion of the draft evaluation reports, the results of the IAHE will be presented by the Evaluation Team Leader to the IASC Operations, Policy and Advocacy Group and to the IASC Emergency Directors Group in Geneva and/or New York and other stakeholders.
- Once the evaluation is completed, presentations of the main findings and recommendations will be made available to various fora as decided by the IAHE Management and Steering Groups. The Evaluation Team may be requested to assist with these presentations.

91. Other dissemination channels:

- The IAHE final reports will be submitted to the ERC and shared with the IASC Principals, the Operations, Policy and Advocacy Group and the Emergency Directors Group.
- The inception, evaluation reports and policy briefs will be made available on the websites of the IASC and the IAHE Steering Group member agencies.
- In addition to the evaluation report and oral briefings, the evaluation findings and recommendations can be presented through alternative means of dissemination, such as websites, social media, videos, etc.

15 MANAGEMENT RESPONSE PLAN

92. The global recommendations of the evaluation will be addressed through a formal Management Response Plan (MRP). The preparation of the MRP will be facilitated by the IASC Secretariat and OCHA and approved by the Emergency Relief Coordinator.

ANNEXES

Annex I: Tentative timeline and phases of the evaluation

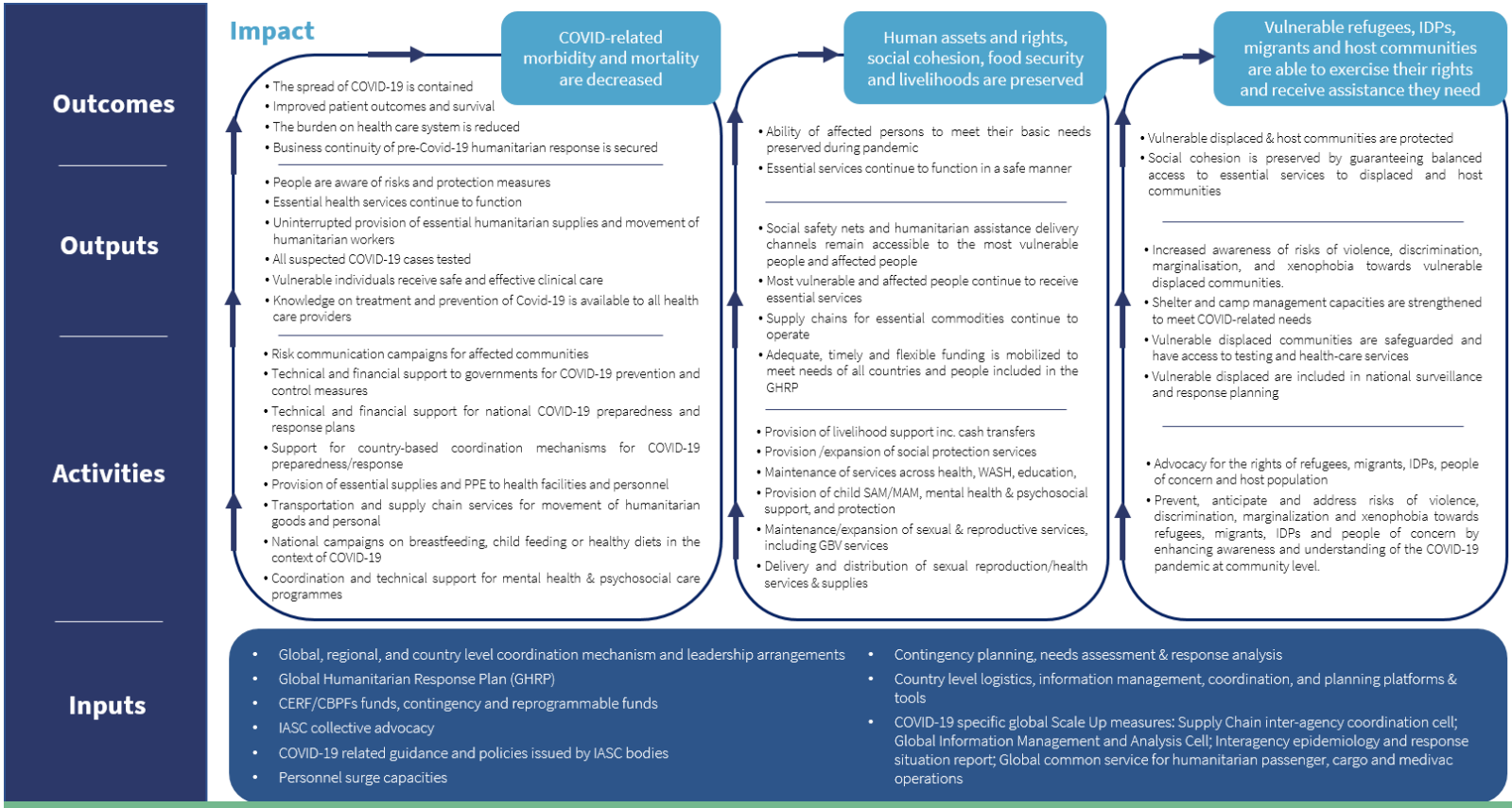
Phase	Tasks and Deliverables
Preparation and Scoping	Final Terms of Reference
Evaluation Company Selection/Team Recruitment	Task Ordersigned with Evaluation Company/contracts with consultants
Inception Phase *(max. 6 weeks)*	Document review Draft and final inception report
Data Collection and Field Mission Phase *(max. 15 weeks)*	Document review, KIIs Staggered country visits select field data collection missions Global Aid workers survey Affected people surveys in selected case study countries Learning papers/evidence summaries are drafted
Reporting Phase *(max. 10 weeks)*	Draft reports Global validation workshop(s) Final report is submitted to ERC
Dissemination *(max. 10 weeks)*	Information products Global briefings for IASC bodies and other stakeholders
Management Response Plan	IASC response to findings recommendations and implementation

ToR Annex II: List of selected system-wide lessons learned and evaluation initiatives on COVID-19 (as of February 2020)

Name/Exercise	Description
IASC Lessons Learned Exercise	At the IASC Principals meeting of 27th July, OCHA was tasked with collecting lessons learned from IASC partners on the GHRP process, in order to strengthen the annual development of the 2021 GHO and be better prepared for similar exercises in the future. In response, OCHA conducted a light "lessons learnt" review of the GHRP process, providing an opportunity for IASC partners to share their views on what worked well, what worked less well, and how a similar exercise might be improved in the future. The review scope is limited to the process of the GHRP development, including the planning process, coordination mechanisms and partner involvement. The review did not assess the results of the GHRP on the humanitarian response to the COVID-19 pandemic. A limited number of key informants were drawn from HQ and field-based offices of UN agencies, donors and NGO partners.
Global health response focused reviews and evaluations	In January 2021, the WHO published an independent and comprehensive evaluation of the WHO response to COVID-19, conducted by an Independent Panel for Pandemic Preparedness and Response (IPPR). In addition, the Independent Oversight and Advisory Committee (IOAC) of the WHO Health Emergencies Programme is conducting its review of WHO's emergency response.
MPTF Evaluation	The MPTF Terms of Reference include a mandatory evaluation of the Fund's activities in support of the UN social and economic framework to fight COVID-19. The evaluation will follow the UNEG norms and standards and will be carried out in line with the Secretary-General's recently established system-wide evaluation (SWE) function, which is intended to complement and not replace the existing evaluation mechanisms. As part of the evaluation of the

	MPTF the Secretary-General's Designate has initiated early lessons learned and evaluability assessment exercise. This exercise is managed by the System-Wide Evaluation Office under the SG and supported by an Evaluation Reference Group, comprised of the two UNEG Chairs, two MPTF donors, and two programme country representatives. The first component focuses on the opportunity for drawing lessons that are significant in the context of the RC system while second addresses the validity of systems for monitoring, measuring and verifying the results of the Fund and socio-economic response plan and the availability of evidence to support a successful evaluation. A draft report for both components of the exercises was prepared in March 2021. The final evaluation report is expected in May 2021.
COVID-19 Global Evaluation Coalition	The Coalition has been set up by the DAC member evaluation offices under the EvalNet network with secretariat support from the OECD to promote information-sharing and collaboration between and among the evaluation units of OECD countries, United Nations organizations and multilateral institutions. The purpose of the Coalition is to provide credible evidence to inform international co-operation responding to the COVID-19 pandemic and the global development community.
Individual agencies' evaluations	Given the significance of the pandemic impact on their areas of work many individual UN agencies, INGOs and local organizations are conducting their own evaluations. To promote coordination and collaboration among its members UNEG has established a COVID-19 working group to regularly exchange information on planned and ongoing evaluations of COVID-19, to promote joint evaluation, and to engage in evidence synthesis work.

ToR Annex III: Draft Results Framework



Assumptions

UN rules, procedures and bureaucracy: UN rules and procedures (and their adaptation) allow for rapid and dynamic action, and entities are able to react quickly to new information and circumstances.

Funding: Funding received for the immediate response is timely and sufficient. Financial planning considers requirements for longer term socio-economic recovery. Member States sustain funding levels to the UN for work across all pillars, and increased funding from a multi-stakeholder pool will be available.

Business continuity: The UN/IASC is able to safely maintain business continuity of its mandated critical functions for its human rights, peace and security, and development pillars.

UN system-wide coordination: UN reform is fully realized at the global, regional and country levels, producing enhanced coordination across the UN system. Coordination is fully enabled at all levels with clear roles, responsibilities, procedures and resources to deliver as one

Delivery partner capacity: Delivery partners (including community-based organizations and NGOs) have the capacity to respond to the need and deliver increased service to beneficiaries despite COVID-19 conditions.

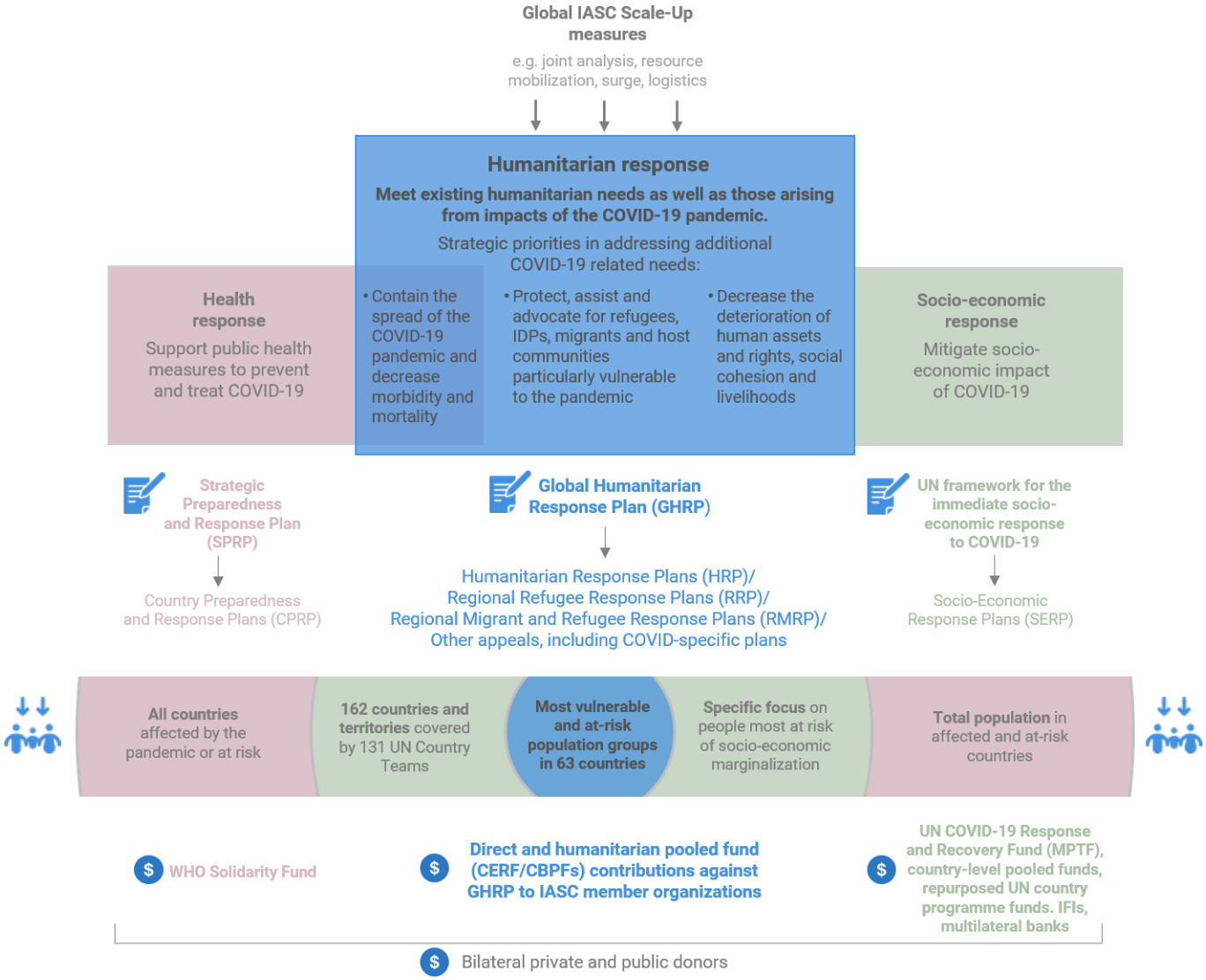
Data collection, analysis and needs assessments: Governments, UN entities, NGOs and other stakeholders have the capacity to undertake timely and reliable data collection, analysis (including health surveillance) and needs assessments of all vulnerable populations

Oversight and learning: IASC/UN continuously monitors, audits, investigates (when needed), evaluates and learns from response implementation in order to ensure that the intended outcomes are being achieved, that it continuously course corrects, and that it is better prepared to respond to future pandemics and other crises.

Regional and sub-regional organizations: Regional and sub-regional organizations have increased capacity to respond to transnational/cross-border response and recovery challenges in coordination with the UN

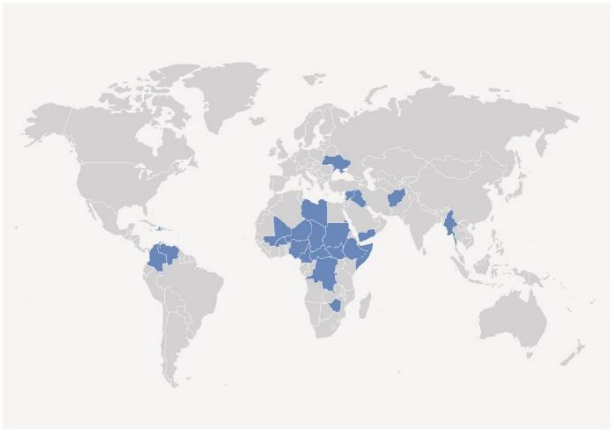
Member State involvement: National governments have the will and capacity to coordinate with each other and the UN to respond to COVID-19, including on agreements on compliance with virus suppression, transmission and universal access to treatment, development assistance, debt, trade, and ceasefire initiatives.

ToR Annex IV: Overview of COVID-19 response components



1.1 ToR Annex V: GHRP countries: per type of humanitarian appeal

GHRP countries: per type of humanitarian appeal



HUMANITARIAN RESPONSE PLANS (HRP)

25

Afghanistan, Burkina Faso, Burundi, Cameroon, CAR, Chad, Colombia, DRC, Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, oPt, Somalia, South Sudan, Sudan, Syria, Ukraine, Venezuela, Yemen, Zimbabwe

REGIONAL REFUGEE RESPONSE PLANS (RRP)

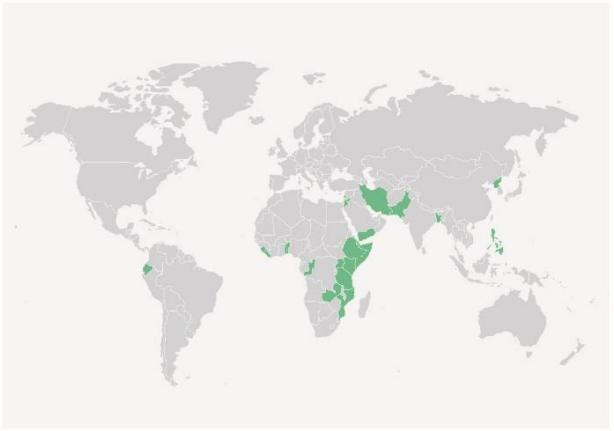
19

Angola, Burundi, Cameroon, Chad, Congo, DRC, Egypt, Ethiopia, Iraq, Jordan, Kenya, Lebanon, Niger, Rwanda, Sudan, United Rep. of Tanzania, Turkey, Uganda, Zambia

REGIONAL REFUGEE AND MIGRANT RESPONSE PLANS (RMRP)

17

Argentina, Aruba (Netherlands) Bolivia, Brazil, Chile, Colombia, Costa Rica, Curaçao (Netherlands), Dominican Republic, Ecuador, Guyana, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, Uruguay



OTHER APPEALS

22

Bangladesh (JRP), Benin, Congo, Djibouti (MRP), DPR Korea, Ecuador, Ethiopia (MRP), Iran, Jordan, Kenya, Lebanon, Liberia, Mozambique, Pakistan, Philippines, Sierra Leone, Somalia (MRP), Togo, Uganda, United Rep. of Tanzania, Yemen (MRP), Zambia

Note: The total of the numbers of countries by appeal types shown here is greater than the number of countries included in the GHRP (63) as some countries have more than one appeal. **Source:** OCHA. **Disclaimer:** The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

* "Other Appeals" include COVID-specific appeals as well as the Regional Migrant Response Plan (MRP) for the Horn of Africa and Yemen and the Joint Response Plan (JRP): Rohingya Humanitarian Crisis.

Annex 2: Approach and methods

This annex outlines the approach and methods that were used to guide and implement the evaluation.

1.2 Background

1. The Inter-Agency Evaluation of the COVID-19 Humanitarian Response is an independent assessment of the collective efforts of the Inter-Agency Standing Committee (IASC) member organizations in support of people, and with government and local actors, in meeting the needs and priorities of the world's most vulnerable people in the context of COVID-19.

2. Inter-Agency Humanitarian Evaluations (IAHEs) were introduced to strengthen system-wide learning and promote accountability towards affected people, national governments, donors, and the public, and are guided by a vision of addressing the most urgent needs of people impacted by crises through coordinated and accountable humanitarian action. IAHEs inform humanitarian reforms and help the humanitarian community to improve aid effectiveness to ultimately better assist affected people. IAHEs are not an in-depth evaluation of any one sector or of the performance of a specific organization.

1.2.1 Rationale

3. In line with IASC protocols, an evaluation of Scale-Up responses is required within 9 to 12 months of the declaration of a Scale-Up to meet its formal learning and accountability needs. In the event of infectious disease events, the protocol states that an IAHE should be conducted *'if necessary'*.[17] Three main considerations provide further rationale for the evaluation of the IASC's collective efforts to respond to pandemic-related humanitarian needs.

- Learning to address knowledge gaps: There is a documented knowledge gap pertaining to collective humanitarian response to infectious disease events. Numerous past reviews[18] indicate that even before the pandemic, responding to infectious disease-related humanitarian crises – even in a single country – was a known challenge. The reviews point to a need for a more comprehensive overhaul of the IASC responses to infectious disease events. To date, there has been no IAHE of previous responses to country or regional infectious disease outbreaks.
- Learning on the collective response: Learning from global, regional, and local levels vis a vis joint analysis, planning and programming, as well as how collective systems enabled this, should be captured. The response to the COVID-19 pandemic demanded international cooperation and challenged emergency responders to adapt. Thus, the evaluation will bring together learning from the global, regional and local levels vis a vis both joint programming, as well as the collective systems meant to enable them.
- Accountability: The substantial funding received from the international community through IASC mechanisms bring with it a significant accountability obligation. IAHEs are an integral element of the Humanitarian Programme Cycle (HPC), which aims to put the affected persons

[17] IASC (2019) *Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events*, April 2019.

[18] For example (i) IOAC thematic report commissioned by the Global Preparedness Monitoring Board What does the 2018–2019 Ebola outbreak in the Democratic Republic of the Congo tell us about the state of global epidemic and pandemic preparedness and response? September 2019. (ii) GA A/70/723 'Protecting humanity from future health crises' Report of the High-level Panel on the Global Response to Health Crises. 2016.

and their needs at the heart of the emergency response and increase accountability of humanitarian actors and donors for collective results. This IAHE will fulfil this need.

1.2.2 Objectives

4. The main objectives of this evaluation are threefold, namely to:

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

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

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

6. In doing so, the findings and recommendations also:

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

1.2.3 Evaluation scope

7. Substantive scope: The subject of the evaluation is the collective IASC preparedness and humanitarian response at the global, regional and country level to meet the humanitarian needs of people in the context of the COVID-19 pandemic. Thus, as with all IAHEs, this evaluation focuses primarily on the actions and roles of the IASC and its member organizations, in support of governments and local actors, to meet the needs of the most vulnerable people and those in hard-to-reach areas.

8. It does not focus on agency-specific responses, nor does it duplicate the significant number of evaluative reviews already underway or that have been commissioned. It does, however, use these and other agency-specific reports to, where applicable, triangulate their findings against the other sources of evidence gathered in the present evaluation. To the extent possible, the evaluation sought the views of people about how well the response met their needs and priorities and how they were given the opportunity to effectively collaborate, engage and participate in the response.

9. Temporal scope: The evaluation covers the IASC-led humanitarian response to COVID-19 from 1 January 2020, when the World Health Organization (WHO) activated its Incident Management Support

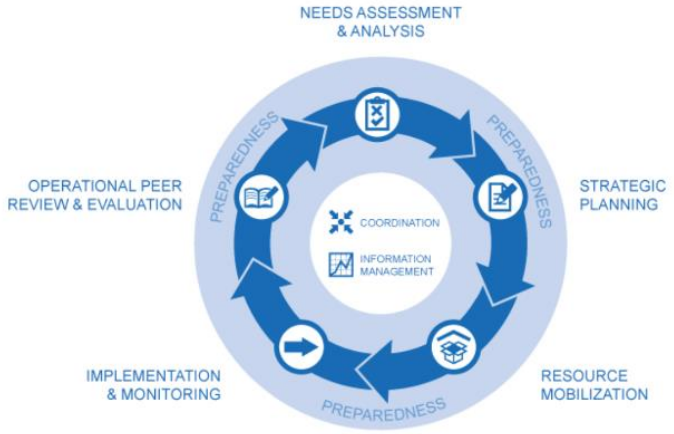
Team, up until the time of the IAHE data collection phase. To assess the contribution of the Scale-Up measures to the response, the IAHE will focus on the period from 18 April 2020 when the IASC Scale-Up response was activated until 25 January 2021, when it was deactivated. To answer the evaluation questions related to collective preparedness to the pandemic, the evaluation will also review relevant IASC documents, decisions and actions taken prior to 1 January 2020.

10. Geographical scope: The IAHE is global in scope, with focus on countries included in the Global Humanitarian Response Plan (GHRP) and its revisions, as the only countries in which collective IASC action to address pandemic related needs took place.

1.2.4 Methodology[19]

11. Given the focus of the evaluation on *'the collective preparedness and response of the IASC member agencies at the global, regional and country level in meeting the humanitarian needs of people in the context of the COVID-19 pandemic'* the HPC has served as a foundation (Figure 1).[20] The evaluation questions are organized according to the HPC (see Table 1 below) and so is the presentation of findings in this report.

Figure 1: The Humanitarian Programme Cycle



12. From this starting point, the evaluation team drew on aspects of Theory of Change thinking to develop a practical analytical framework for the evaluation. Combined with the ToR, this informed a detailed evaluation matrix which was used to organize the evidence and contributed to structuring the main findings.

13. The evaluation used a mix of primary and secondary data. Primary data-gathering included eight country case studies (see below for further details), Key Informant Interviews (KIIs) at global, regional and country level, Focus Group Discussion (FGDs), and extensive engagement with members of the affected communities in each of the case study countries. Secondary data analysis included an extensive review of global and country documentation.

14. Findings from the evaluation were triangulated across case studies and then through detailed work to formulate the report. The report went through a number of review processes, including by the Management Group, the countries that participated in the evaluation, the Global Evaluation Advisory Group and by members of the Emergency Director's Group.

1.2.5 Analytical framework

15. The analytical framework focuses on the collective IASC response to provide a pathway from inputs to activities and results. It captures the activities and anticipated results of collective action in response (see Figure 2). The framework guided the evaluation team's exploration of how and why

[19] This section provides a summary of the approach of the evaluation and the methods that it used. A fuller description of key elements of the methodology are provided in annex 2 of this report.
[20] https://www.humanitarianresponse.info/en/programme-cycle/space.

results have/have not been achieved. For example, the evaluation examines the extent to which needs assessments informed the collective response and, in turn, the results achieved by the response.

16. Given the focus of the evaluation on 'the collective preparedness and response of the IASC member agencies at the global, regional and country level in meeting the humanitarian needs of people in the context of the COVID-19 pandemic' the Humanitarian Programme Cycle (HPC) was used as a foundation to frame the evaluation and organise the evaluation questions. The analytical framework comprises the elements outlined in the Table 1 below.

Table 1: Elements of the conceptual framework

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

17. This approach lent itself well to applying an inductive approach to exploring how these building blocks for collective action were leveraged in case study contexts, the extent to which these have enabled or hindered success, and in identifying good practice and innovation that could be applied elsewhere. The analytical framework is reproduced in Figure 2 below.

1.2.6 Evaluation matrix

18. Based on the ToR for the evaluation and the analytical framework above, the team developed an evaluation matrix during the inception phase, outlining evaluation questions, indicators, sources of evidence, assumptions and how each question addresses the Organisation for Economic Co-operation

and Development (OECD) Development Assistance Committee (DAC) criteria. The matrix is produced in Table 2.

Figure 2: Analytical framework

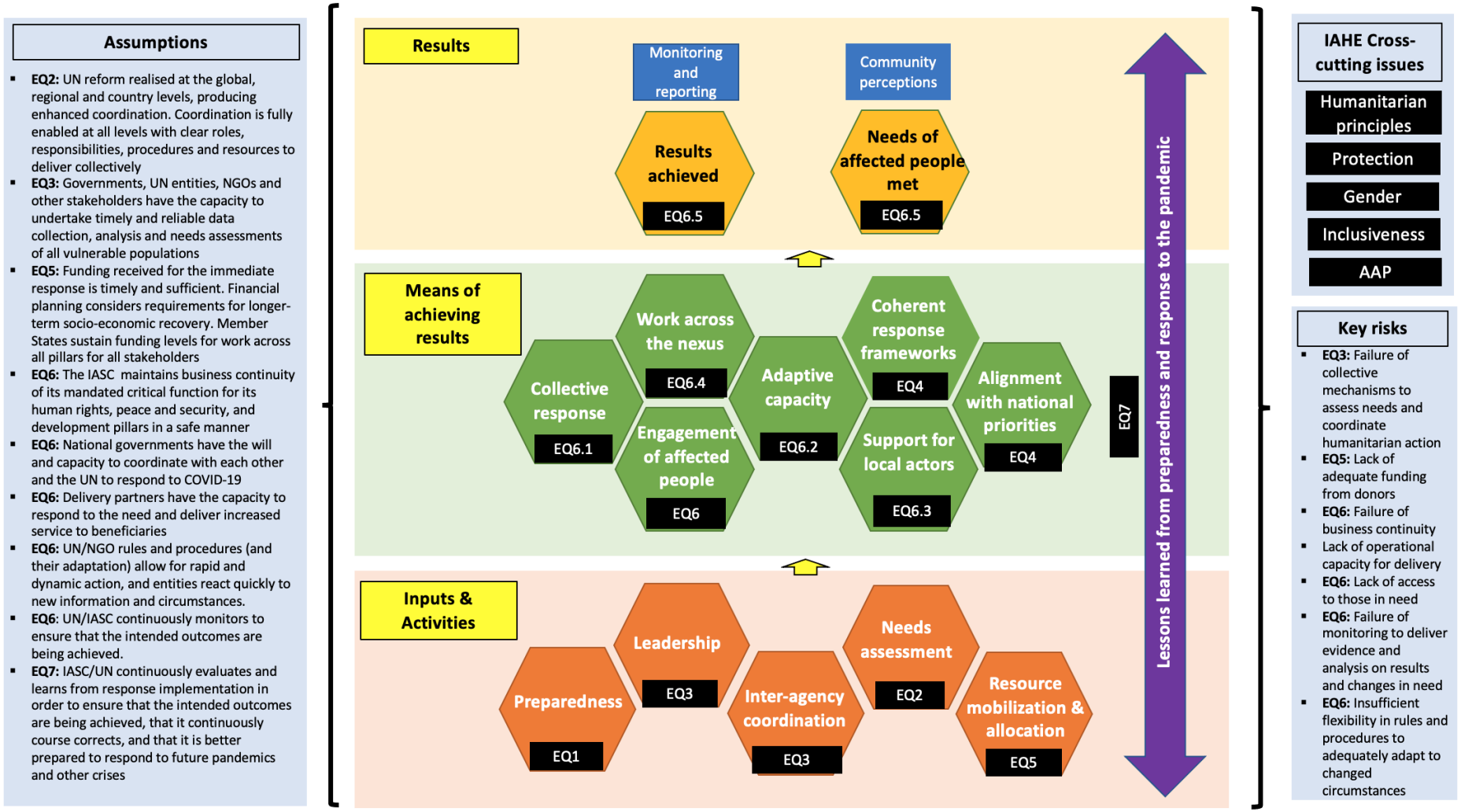


Table 2: Evaluation matrix

Evaluation questions	Indicators	Data sources	Assumptions	Criteria
1. Preparedness: Relevance of measures and contribution to timely and appropriate response				
1.1 To what extent were the collective preparedness measures put in place by the IASC prior to the pandemic relevant and adapted to the COVID-19 pandemic?	▪ Evidence that measures included infection disease/pandemic scenarios ▪ Evidence that measures were designed for a multi-country crisis ▪ Ways in which preparedness measures were adapted, at global and country level ▪ Ways in which IASC preparedness measures took account of national and local capacities and leadership for preparedness ▪ Extent to which measures were designed for situations of restricted movement of aid workers/access to affected populations	▪ Document review of IASC collective preparedness measures ▪ Global KIIs with OPAG, EDG ▪ Country-level KIIs with OCHA staff, IASC member agencies, HCTs, host country governments		Relevance
1.2 To what extent did the IASC's preparedness measures in targeted GHRP countries after Scale-Up declaration contribute to more timely and relevant humanitarian response?	▪ Evidence that IASC member agencies and partners undertook Advanced Preparedness Measures and contingency planning in response to COVID-19 ▪ Evidence that measures contributed to a timely response ▪ Ways in which measures helped to design a response relevant to the needs of affected populations ▪ Ways in which measures helped to design a response tailored to the specific needs of vulnerable groups (women and girls, older persons, persons with disabilities) ▪ Evidence that measures could be adapted as the situation evolved.	▪ Document review of global (GHRP) and country level risk analyses, contingency planning, preparedness exercise documents ▪ Global KIIs with GHRP stakeholders ▪ Country-level KIIs with RC/HCs, HCT members, OCHA staff, cluster coordinators, host country governments		Effectiveness
2. Assessment of needs: Use of evidence for response planning				
2.1 To what extent was the global humanitarian response strategy for the pandemic informed by an assessment of people's needs?	▪ GHRP based on global data and analysis (new section added) ▪ GHRP respond to different needs of segments of affected populations ▪ GHRP identified and responded to protection risks, particularly of the most vulnerable groups	▪ Document review of evidence used to inform the GHRP ▪ Global KIIs with IASC members, OCHA staff	Governments, UN entities, NGOs and other stakeholders have the capacity to undertake timely and reliable data collection, analysis (including health surveillance) and needs assessments of all vulnerable populations	Relevance
2.2 To what extent were country humanitarian plans and response strategies for the pandemic informed by a systematic and comprehensive identification of affected people's needs?	▪ Ways in which collective needs assessments delivered benefits ▪ Needs assessments conducted were timely and systematic ▪ Existence of age- and gender-disaggregated data on humanitarian needs ▪ Needs assessments identified specific needs of women and girls, persons with disabilities, older people, marginalised groups, displaced populations, and other potentially vulnerable population groups ▪ Introduction/existence of innovative and effective approaches to needs assessment which took into account access restrictions and aligned with the (evolving) characteristics of the pandemic ▪ Country humanitarian plans and response strategies based on needs assessment data and analysis	▪ Document review of needs assessments and country humanitarian plans ▪ Global KIIs with needs assessment organisations, cluster coordinators ▪ Country-level KIIs with IASC members, cluster coordinators, local actors, needs assessment organisations		Relevance

Evaluation questions	Indicators	Data sources	Assumptions	Criteria
	▪ Country humanitarian plans and response strategies respond to different needs of segments of affected populations. ▪ Country humanitarian plans identified and addressed protection risks, particularly for the most vulnerable groups ▪ Limitations to participation and inclusion of affected people in needs assessment were addressed			
3. Strategic planning: Coherence and connectedness in planning the response				
3.1 To what extent were the IASC humanitarian policies, strategies and responses to COVID-19 consistent and complementary with the health and socio-economic responses by United Nations and other actors?	▪ Alignment and complementarity between IASC humanitarian policies and strategies, and national health and social economic response plans and strategies ▪ Examples of consistency and complementarity between humanitarian and health and social economic programming ▪ Extent to which the IASC policies, strategies and responses were aligned with the broader social and economic responses contained in the UNDAF/UNSDCF Factors facilitating/hindering consistency and complementarity between humanitarian, health and social economic responses	▪ Document review of evaluations, HRPs, health and social economic response plans (including UNDAF/UNSDCF), IASC policies ▪ Global KIIs with ERC, OPAG, EDG, donors, WHO, UNDP ▪ Country-level KIIs with RC/HCs, HCTs, WHO, UNDP and other UN agencies delivering social economic response, host country governments		Coherence, connectedness
4. Leadership and Coordination: Support to coherent collective response				
4.1 To what extent were the global IASC strategy and Scale-Up mechanisms effective in ensuring IASC country teams' capacity to lead humanitarian assistance in targeted countries?	▪ Perception of IASC country teams that IASC strategy and Scale-Up mechanisms supported leadership of the global response ▪ Degree of alignment between global IASC strategy and Scale-Up mechanisms and country-level humanitarian leadership functions	▪ Review of relevant IASC policies, documents pertaining to humanitarian leadership ▪ Global KIIs with OPAG, EDG ▪ Country-level KIIs with RC/HCs, HCTs, government entities	UN reform is fully realised at the global, regional and country levels, producing enhanced coordination across the UN system. Coordination is fully enabled at all levels with clear roles, responsibilities, procedures and resources to deliver as one	Effectiveness
4.2 To what extent was the IASC response coherent and well-coordinated in its delivery of the response to a multi-dimensional crisis?	▪ Extent to which coordination mechanisms aligned with IASC policies ▪ Global and country level mechanisms for IASC members to coordinate response efforts met regularly and were consistent ▪ Coordination mechanisms were based on clear roles, responsibilities, procedures and adequate resources ▪ Coordination mechanisms promoted coherent response across sectors ▪ Identification of factors influencing the effectiveness of coordination mechanisms	▪ Document review of IASC meeting minutes, inter-agency and communication mechanisms ▪ KIIs with IASC principals, EDG, RC/HC, cluster coordinators, HCT members, national/local actors		Coherence, Coordination

Evaluation questions	Indicators	Data sources	Assumptions	Criteria
5. Resource mobilization: Timeliness, flexibility and adequacy of funds raised and efficiency of allocation				
5.1 To what extent were the IASC's efforts successful in mobilizing adequate, timely and flexible funding to meet the GHRP requirements?	▪ Amount of funds raised against GHRP appeal ▪ Level of un-earmarked funds raised ▪ Timing of donor commitments and disbursement to GHRP appeal ▪ Types of fundraising approaches used ▪ Use of internal IASC agency funding approaches and instruments to provide adequate and timely funding ▪ GHRP process and country level response plans take account of resource mobilisation efforts for longer-term socio-economic recovery ▪ Factors influencing donor decisions to contribute to GHRP appeal ▪ Extent of donor engagement in GHRP planning	▪ Financial data analysis ▪ Global KIIs with donors, IASC members' resource mobilization personnel, ERC ▪ Country-level KIIs with RC/HCs, HCTs, INGOs, national NGOs	Funding received for the immediate response is timely and sufficient. Financial planning considers requirements for longer-term socio-economic recovery. Member States sustain funding levels to the UN for work across all pillars, and increased funding from a multi-stakeholder pool will be available	Efficiency
5.2 To what extent did pooled funds contribute to the provision of adequate, timely and flexible funding to meet the GHRP requirements?	▪ Amount of funding from CERF and CBPFs against GHRP requirements ▪ Level of increase in donor funding to pooled funds to support the COVID-19 response ▪ Timing of pooled fund allocations and disbursements to COVID-19 response ▪ Ways in which CERF and CBPFs provided funding flexibility to recipient organisations	▪ Financial data analysis ▪ Global KIIs with CERF and CBPF staff, ERC, CERF recipient agencies ▪ Country-level KIIs with CBPF staff, RC/HCs, CERF and CBPF funding recipients (including local actors) ▪ Document review of pooled fund allocation documents and guidance		Efficiency
6. Implementation and monitoring				
6.1 Collective response: Added value of collective response mechanisms				
6.1.1 What was the added value of collective mechanisms to the planning and implementation of the response?	▪ Ways in which collective mechanisms for accountability and PSEA delivered benefits for affected population during the COVID response ▪ Ways in which collective mechanisms on risk management and access improved efficiency during the COVID response ▪ Extent to which activation of global IASC strategy and scale-up mechanisms upheld underlying humanitarian principles, the core protection principles, the do no harm principle, as well as good practice on national/localized response, AAP, gender equality, humanitarian-peace-development collaboration, coordination, quality funding and cross-sector collaboration	▪ Review documents on IASC collective mechanisms at global and country level ▪ Global KIIs with EDG, cluster coordinators, needs assessment organisations ▪ Country-level KIIs with RC/HCs, HCTs, cluster coordinators, entities managing collective accountability/PSEA mechanisms, I/NNGOs ▪ Data from collective feedback mechanisms (where available) ▪ FGDs with affected populations		Effectiveness
6.2 Adaptive capacity: Use of evidence to adapt the collective response				

Evaluation questions	Indicators	Data sources	Assumptions	Criteria
6.2.1 To what extent have inter-agency information management and monitoring mechanisms been able to support IASC collective decision-making?	▪ Types, regularity and quality of information mechanisms used by IASC decision-makers (global and country level) ▪ Extent to which other information management mechanisms informed IASC collective decision-making ▪ Evidence that operational and strategic decision-makers had timely access to monitoring data ▪ Evidence that operational and strategic decision-making based on IASC monitoring data ▪ Examples of monitoring data being used to adjust, improve and refine operations	▪ Review of monitoring framework data ▪ Review of operational and strategic decisions made ▪ Document review of IASC meeting minutes, inter-agency and communication mechanisms ▪ Global KIIs with IASC principals, EDG ▪ Country-level KIIs with RC/HCs, HCT members, OCHA staff, information management officers		Effectiveness, coordination
5.2.2 To what extent did the IASC's collective response prove relevant and adaptive in meeting the demands of the crisis and the humanitarian needs caused by it?	▪ Extent and ways in which the IASC's collective decision-making, processes and methodologies adapted and evolved in response to the trajectory of the crisis ▪ Ways in which IASC approaches to providing assistance adapted and evolved in response to the specific challenges posed by the pandemic ▪ Extent and ways in which the collective response adapted to the identified specific needs of women and girls, persons with disabilities, older people, marginalised groups, displaced populations, and other potentially vulnerable population groups ▪ Examples of the way in which the efficiency and effectiveness of the response improved through adaptive measures.	▪ Review of documents relating to IASC decision-making, processes and fast-tracked mechanisms ▪ Global KIIs with IASC Principals, EDG ▪ Country-level KIIs with HCTs, IASC members, CBPF staff, cluster coordinators	UN rules and procedures (and their adaptation) allow for rapid and dynamic action, and entities are able to react quickly to new information and circumstances.	Relevance
6.3 Localisation: Ensuring complementarity and participation of local actors				
6.3.1 To what extent did international humanitarian preparedness and response to COVID-19 complement and empower national and local actors in their efforts and leadership to address COVID-19-related humanitarian needs?	▪ Evidence that national/local actors participated in international preparedness and planning processes ▪ Evidence that national/local actors led or were involved in needs assessments used to inform humanitarian response plans and priorities ▪ Evidence that national/local actors were involved in (or led) response coordination mechanisms ▪ Increase in amount of assistance that national/local NGOs and CBOs delivered to communities ▪ Evidence that government entities led COVID-19 response (including planning) ▪ Evidence that international actors identified national/local response efforts and how to complement them in planning and implementation ▪ Ways in which international actors sought to enhance involvement, and build capacity, of national and local actors as part of the COVID-19 response.	▪ Document review of preparedness plans, HRPs, needs assessments ▪ Global KIIs with INGOs and UN agencies ▪ Country-level KIIs with RC/HCs, HCTs, cluster coordinators, host country government, NNGOs	National governments have the will and capacity to coordinate with each other and the UN to respond to COVID-19. Delivery partners (including community-based organisations and NGOs) have the capacity to	Connectedness

Evaluation questions	Indicators	Data sources	Assumptions	Criteria
			respond to the need and deliver increased service to beneficiaries, despite COVID-19 conditions	
6.3.2 How effectively did IASC collective mechanisms for planning and implementing the response ensure local participation?	▪ Level of local actor participation in clusters or other humanitarian coordination mechanisms ▪ Evidence of national and local actor participation in coordination mechanisms ▪ Ways in which clusters and HCTs have ensured local participation in HRPs or other planning processes ▪ Ways in which clusters and HCTs have ensured local participation in coordination and decision-making fora ▪ Existence of significant examples of local participation contributing to the quality of planning. ▪ Extent of local participation in collective mechanisms for AAP and PSEA ▪ Perception of local actors of the quality of their participation in collective mechanisms for planning and implementing the COVID-19 response	▪ Review of HRPs/planning documents, cluster and HCT documents ▪ Country-level KIIs with HCTs, OCHA staff, cluster coordinators, entities host country government, NNGOs		Effectiveness
6.3.3 To what extent did IASC allocation strategies, mechanisms, and decision-making processes facilitate the efficient use of available resources to meet response objectives, including by channelling resources to frontline responders (international and local/national NGOs and civil society organisations (CSOs))?	▪ Types of prioritisation and decision-making processes in place to make efficient use of resources ▪ Degree of alignment between allocation of resources and response objectives ▪ Time of resource allocation, including to frontline responders ▪ Efforts made to allocate resources to actors best placed to achieve response objectives ▪ Extent to which IASC allocation strategies prioritised funding to frontline responders ▪ Types of mechanisms in place for channelling resources to frontline responders ▪ Level of funding from IASC mechanisms to I/NNGOs and CSOs ▪ Level of flexibility of funding channelled to frontline responders	▪ Financial data analysis ▪ Global KIIs with ERC, donors, UN agencies, CBPF staff, Red Cross Movement ▪ Country-level KIIs with RC/HCs, donors, I/NNGOs and CSOs, Red Cross Movement, cluster coordinators, CBPF staff, government representatives ▪ Review of decision-making and resource allocation documents, CBPF allocation strategies		Efficiency
6.4 Operational coherence and complementarity to address multiple effects of the pandemic				
6.4.2 To what extent did the IASC's collective global, regional and country-level	▪ Extent to which GHRP and regional and country-level humanitarian response plans reflect affected country priorities	▪ Document review of humanitarian response plans, national plans ▪ Global KIIs with GHRP stakeholders, including OCHA	The UN/IASC is able to maintain business continuity of its	Relevance

Evaluation questions	Indicators	Data sources	Assumptions	Criteria
humanitarian response planning and prioritisation correspond to the national priorities of affected countries?	▪ Types of mechanisms used in global, regional and country-level humanitarian planning and prioritisation processes to include and align with national priorities ▪ Evidence that IASC response planning was adapted to evolving government priorities	▪ Regional/country-level KIIs with OCHA, UNHCR, RC/HCs, HCT members, cluster coordinators and host country government	mandated critical function for its human rights, peace and security, and development pillars in a safe manner	
6.4.3 To what extent did the collective humanitarian response to the pandemic contribute to the overall objectives of the SG's call for solidarity to address the impact of the multi-dimensional crises?	▪ Perceptions of the contribution of the GHRP response to the SG's call for solidarity to address the impact of the multi-dimensional crisis ▪ Efforts made to provide assistance across sectors and across the humanitarian-development-peace nexus ▪ Factors facilitating achievement of objectives ▪ Challenges with achieving objectives	▪ Review of results reporting, document review of evaluations ▪ Global KIIs with GHRP stakeholders, EDG, SWE evaluation team ▪ Country-level KIIs with RC/HCs, HCTs, cluster coordinators, development actors		Effectiveness
6.4.4 To what extent were there linkages and synergies in COVID-19-related responses across the humanitarian-development-peace nexus aimed at addressing the intertwined effects of the pandemic?	▪ Efforts to identify intertwined effects of the pandemic ▪ Efforts to establish common objectives and strategies to address pandemic effects through joint planning and priority setting ▪ Efforts by humanitarian, development and peace actors to ensure synergies when planning the COVID-19 response ▪ Extent to which mechanisms for coordinating the response of humanitarian, development and peace actors existed and were used ▪ IASC response was coordinated with development actors and government ▪ Examples of synergies in the humanitarian-development-peace response ▪ Evidence that the humanitarian needs were aligned/coordinated with longer term development needs to ensure smooth transitioning of beneficiaries where necessary	▪ Review of planning documents, evaluations, lessons learned exercises ▪ Global level KIIs with ERC, SWE evaluation team, UNDP, DPPA ▪ Country-level KIIs with RC/HCs, HCTs, host country government, development and peace actors, cluster coordinators		Coherence, connectedness
6.5 Monitoring and results: Extent to which humanitarian needs were addressed				
6.5.1 To what extent did the IASC's collective response to the pandemic meet the humanitarian needs of affected people adequately and effectively, both overall and vis-à-vis specific vulnerable groups?	▪ Level of assistance delivered against needs identified ▪ Number of people reached with assistance against number of people targeted ▪ Evidence that assistance was targeted to address the different needs of women and girls, older persons, persons with disabilities, displaced populations and other potentially vulnerable groups ▪ Availability of disaggregated data on assistance provided to different segments of the affected population ▪ Extent to which assistance provided met minimum standards and upheld humanitarian principles ▪ Prioritisation of protection within the collective response	▪ Review of needs assessments, results reported against GHRP/HRP/other response plans, cluster results reporting, evaluations ▪ Country-level KIIs with RC/HCs, cluster coordinators, OCHA staff, IASC members, frontline responders, including local actors ▪ FGDs with affected populations	UN/IASC continuously monitors to ensure that the intended outcomes are being achieved. The collective nature of the response added value in providing assistance to meet	Coverage, impact

Evaluation questions	Indicators	Data sources	Assumptions	Criteria
	▪ Affected population views on timeliness, relevance and adequacy of assistance received ▪ Level of consistency of the response over time ▪ Evidence of that assistance provided had positive results for affected populations ▪ Identification of any negative consequences of the response	▪ Secondary data on views of affected populations about COVID-19 response (where available) ▪ Data from collective feedback mechanisms (where available)	the needs of affected population.	
7. Lessons learned: Challenges and opportunities to improve future humanitarian responses				
7.1 What are the main challenges and lessons learned from preparedness and response to the pandemic, particularly those that can strengthen the humanitarian-peace-development nexus approaches in the future?	▪ Evidence that results of evaluations and lessons learned exercises of preparedness and response used to course correct ▪ Identification of challenges with coordination, processes, procedures ▪ Factors contributing to effective preparedness activities ▪ Factors that hampered preparedness activities ▪ Challenges that IASC members faced in responding to the pandemic ▪ Ways in which IASC members addressed challenges with the response ▪ Factors contributing to effective pandemic response ▪ Good practice examples of working across the humanitarian-development-peace nexus ▪ Challenges with existing mechanisms for collaboration across the humanitarian-development-peace nexus ▪ Factors contributing to the success or failure of collaboration across the humanitarian-development-peace nexus	▪ Review of reports, evaluations and lessons learned exercise documents ▪ Global KIIs with ERC, OPAG, EDG, donors ▪ Country-level KIIs with RC/HCs, HCTs, IASC members, cluster coordinators, host country government, NNGOs, development and peace actors, SWE evaluation team	IASC/UN continuously evaluates and learns from response implementation in order to ensure that the intended outcomes are being achieved, that it continuously course corrects, and that it is better prepared to respond to future pandemics and other crises	Lessons learned
7.2 What were the innovative approaches, solutions, and new ways of working that would benefit ongoing or future responses, in particular those from local actors?	▪ International actors adopted innovative approaches and solutions and new ways of working involving local actors ▪ Local actors developed innovative approaches and solutions and new ways of working ▪ Examples of improvements brought about by innovative approaches, solutions and new ways of working ▪ Extent to which innovative approaches and new ways of working are relevant beyond the COVID-19 response	▪ Document review of evaluations and lessons learned exercises ▪ Global KIIs with ERC, OPAG, donors ▪ Country-level KIIs with RC/HCs, HCTs, IASC members		
7.3 What are the key strategic and policy challenges and opportunities for improving the IASC's future responses to pandemics and other infectious disease events with multi-country humanitarian impacts?	▪ Strategic and policy challenges that prevented lessons from Ebola crisis being incorporated into preparedness measures ▪ Evidence that lessons from pandemic response are being incorporated into IASC policies and strategies ▪ Identification of opportunities to improve response to future pandemics and other infectious disease events with multi-country humanitarian impacts ▪ Evidence that mechanisms and resources are in place to deliver changes at strategic and policy level	▪ Document review of evaluations and reviews that identify innovative approaches and ways of working ▪ KIIs with EDG, CERF secretariat ▪ Country-level KIIs with HCTs, CBPF staff, IASC members, cluster coordinators, host country government, NNGOs		

19. Table 3 lists the evaluation questions and sub-questions, which are addressed in the findings, conclusions and recommendations sections of this report.

Table 3: IAHE questions and sub-questions

Evaluation questions	DAC criteria
1. Preparedness: Relevance of measures and contribution to timely and appropriate response	
1.1 To what extent were the collective preparedness measures put in place by the IASC prior to the pandemic relevant and adapted to the COVID-19 pandemic?	Relevance
1.2 To what extent did the IASC's preparedness measures in targeted GHRP countries after Scale-Up declaration contribute to more timely and relevant humanitarian response?	Effectiveness
2. Assessment of needs: Use of evidence for response planning	
2.1 To what extent was the global humanitarian response strategy for the pandemic informed by an assessment of needs?	Relevance
2.2 To what extent were country humanitarian plans and response strategies for the pandemic informed by a systematic and comprehensive identification of affected people's needs?	Relevance
3. Strategic planning: Coherence and connectedness in planning the response	
3.1. To what extent were the IASC humanitarian policies, strategies, and responses to COVID- 19 consistent and complementary with the health and social economic responses by United Nations (UN) and other actors?	Coherence, connectedness
4. Leadership and Coordination: Support to coherent collective response	
4.1 To what extent were the global IASC strategy and Scale-Up mechanisms effective in ensuring IASC country teams' capacity to lead and deliver humanitarian assistance in targeted countries?	Effectiveness
4.2 To what extent was the IASC response coherent and well-coordinated in its delivery of the response to a multi-dimensional crisis?	Coherence, coordination
5. Resource mobilization: Timeliness, flexibility and adequacy of the funds raised and efficiency of the allocation	
5.1 To what extent were the IASC's efforts successful in mobilizing adequate, timely and flexible funding to meet the GHRP requirements?	Efficiency
5.2 To what extent did pooled funds contribute to the provision of adequate, timely and flexible funding to meet the GHRP requirements?	Efficiency
6. Implementation and monitoring	
6.1 Collective response: Added value of collective mechanisms for response	
6.1.1 What was the added value of collective mechanisms to the planning and implementation of the response?	Effectiveness
6.2 Adaptive capacity: Use of evidence to adapt the collective response	
6.2.1 To what extent have inter-agency information management and monitoring mechanisms been able to support IASC collective decision-making?	Effectiveness, coordination
6.2.2 To what extent did the IASC's collective response prove relevant and adaptive in meeting the demands of the crisis and the humanitarian needs caused by it?	Relevance
6.3 Localization: Ensuring complementarity and participation of local actors	
6.3.1 To what extent did international humanitarian preparedness and response to COVID-19 complement and empower national and local actors in their efforts and leadership to address COVID-19-related humanitarian needs?	Connectedness
6.3.2 How effectively did IASC collective mechanisms for planning and implementing the response ensure local participation?	Effectiveness
6.3.3 To what extent did IASC allocation strategies, mechanisms, and decision-making processes facilitate the efficient use of available resources to meet response objectives, including by channelling resources to frontline responders (international and local/national NGOs and civil society organizations (CSOs))?	Efficiency
6.4 Operational coherence and complementarity to address multiple effects of the pandemic	
6.4.1 To what extent did the IASC's collective global, regional and country-level humanitarian response planning and prioritization correspond to the national priorities of affected countries?	Relevance
6.4.2 To what extent did the collective humanitarian response to the pandemic contribute to the overall objectives of the SG's call for solidarity to address the impact of the multi-dimensional crises?	Effectiveness
6.4.3 To what extent were there linkages and synergies in COVID-19-related responses across the humanitarian-development-peace nexus aimed at addressing the intertwined effects of the pandemic?	Coherence, connectedness
6.5 Monitoring and reported results: Extent to which humanitarian needs were addressed	

Evaluation questions	DAC criteria
6.5.1 To what extent did the IASC's collective response to the pandemic meet the humanitarian needs of affected people adequately and effectively, both overall and vis-à-vis specific vulnerable groups?	Coverage, impact
7. Lessons learned: Challenges and opportunities to improve future humanitarian responses	
7.1 What are the main challenges and lessons learned from preparedness and response to the pandemic, particularly those that can strengthen the humanitarian-peace-development nexus approaches in the future (conclusions)?	Lessons learned
7.2 What were the innovative approaches, solutions, and new ways of working that would benefit ongoing or future responses, in particular those from local actors (conclusions and recommendations)?	Lessons learned
7.3 What are the key strategic and policy challenges and opportunities for improving the IASC's future responses to pandemics and other infectious disease events with multi-country humanitarian impacts (recommendations)?	Lessons learned

20. This report addresses the evaluation questions and sub-questions but, in some cases, the questions were merged or amended slightly. This was done to avoid duplication and facilitate narrative flow but the evaluation report has responded to the questions outlined in the ToR. Key changes are outlined below.

- Leadership was given greater prominence in the evaluation and added to the coordination EQ.
- The information and communication EQ was merged with the adaptive capacity EQ given the focus of both questions on the use of evidence to adapt the response.

1.3 Stakeholder analysis

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

Table 4: Stakeholder analysis

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

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

	Collaboration/other inter-agency mechanisms	through their research and/or advocacy/policy work.	challenges, successes; nexus, assistance, and the conflict
Engagement of Secondary stakeholders: Secondary stakeholders will have be informed of the outputs of the evaluation through webinars and other dissemination activities as agreed with the MG and IAHE Steering Committee.			

1.3.1 Data collection, process and methods

22. The evaluation used a mixed-methods approach for data collection and analysis. While much of the data was qualitative, quantitative data was collected and analysed, in the form of (i) financial and funding data, (ii) data on outputs, and (iii) secondary data from community perception studies.

1.3.1.1 Desk review of literature and documents

23. The evaluation conducted an extensive review of global and country-level documentation to determine where evidence exists against each of the evaluation questions, and to identify gaps. The document review also helped to refine the evaluation design and tools. Documents consulted included publicly available secondary literature such as agency and country-specific documents relating to the response, evaluation reports, grey literature and peer-reviewed journal articles (see Table 5). All documents were stored in a document library and regularly updated throughout the evaluation.

Table 5: Summary of Literature

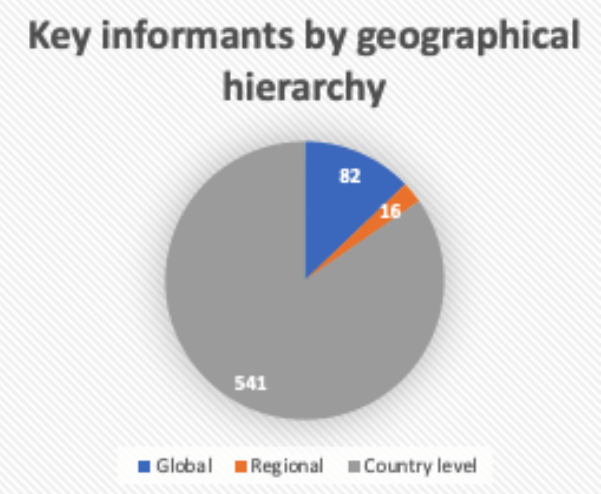
Geographic hierarchy	# documents
Global & regional	1,302
Country – level	2,596
TOTAL	3,898
Country summary	**# documents**
Bangladesh	369
Colombia	359
DRC	225
Philippines	37
Sierra Leone	162
Somalia	1,236
Syria	115
Turkey	93

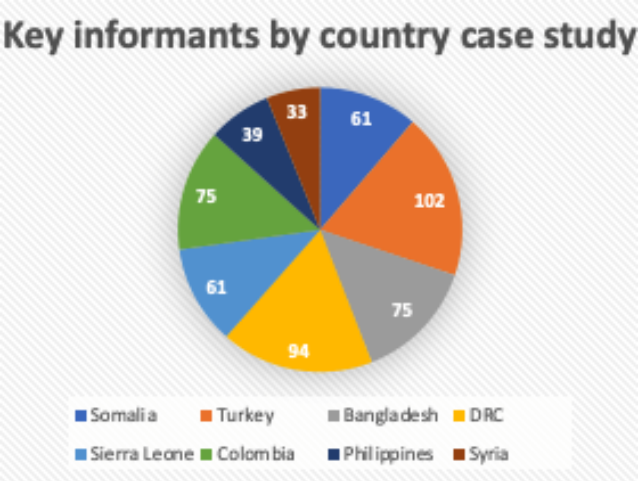
1.3.1.2 Key informant interviews

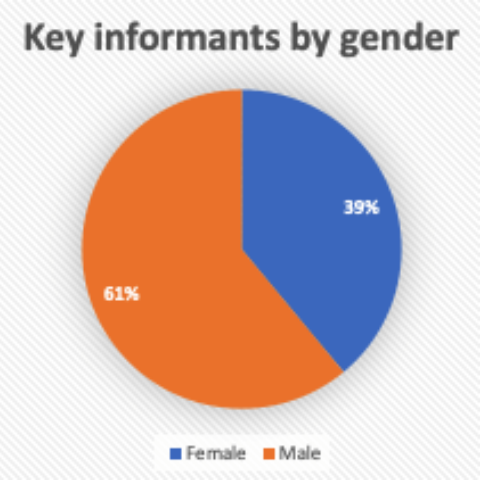
24. The evaluation carried out a total of 640 KIIs (see Figure 3). A stakeholder analysis was carried out in the inception phase to determine the sample. Due to staff rotation at the time that country case study visits were undertaken and the turnover of humanitarian staff throughout the period under evaluation, the evaluation team adopted a snowballing approach to identify the most relevant current key informants. The majority of global Interviews were carried out remotely and the majority of regional and country interviews were carried out in person.

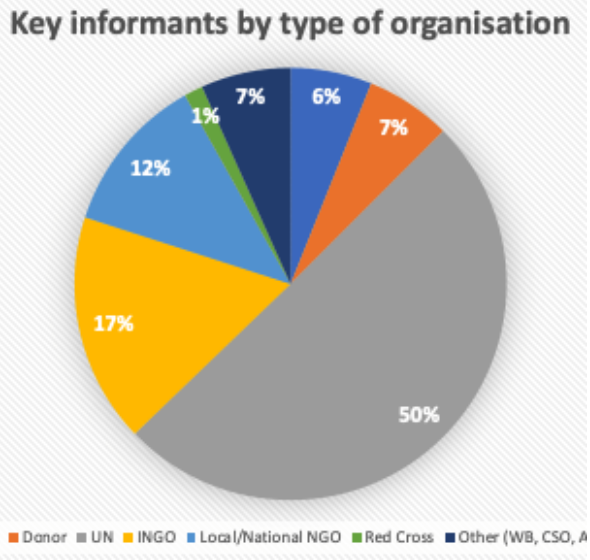
25. The team developed interview guides to support interviews, and wrote up notes from interviews. To preserve respondents' privacy and confidentiality, each respondent's name was anonymized, and the interview transcript assigned a code number. Interviews were stored in a safe repository, with access granted only to evaluation team members.

Figure 3: Summary of KIIs carried out


Key informants by geographical hierarchy
82
16
541
Global
Regional
Country level


Key informants by country case study
61
102
75
94
61
75
39
33
Somalia
Turkey
Bangladesh
DRC
Sierra Leone
Colombia
Philippines
Syria


Key informants by gender
39%
61%
Female
Male


Key informants by type of organisation
6%
7%
50%
17%
12%
1%
7%
Donor
UN
INGO
Local/National NGO
Red Cross
Other (WB, CSO, A

1.3.1.3 Focus group discussions

26. The evaluation has gathered a significant body of evidence from community-level consultations across the eight case studies. National evaluators conducted male and female focus group discussions (FGDs) with affected community members in each of the case study countries in order to elicit perceptions of the COVID-19 response (see Table 6). Specifically, the community consultations were used to examine the evaluation questions on the timeliness, relevance, and effectiveness of the assistance and on issues of targeting and accountability. In each case study country, national consultants were selected for relevant language skills and to ensure access to women and men in each of the countries. The FGDs were conducted in line with guidance the team developed on ethical and safeguarding considerations.

Table 6: Details of focus group discussions by country

Country	Region	FGDs	M	F	TOTAL
Bangladesh	Host communities	8	24	24	48
	Rohingya refugees	11	33	40	73
	TOTAL	19	57	64	121
Colombia	Amazonas	4	16	14	30
	Norte de Santander	5	18	19	37
	Córdoba	4	6	41	47
	TOTAL	13	40	74	114
DRC	Kinshasa	12	40	56	96
	Goma	12	56	41	97
	TOTAL	24	96	97	193
Philippines	Manila	9	30	43	73
	Mindanao	9	37	45	82
	TOTAL	18	67	88	155
Sierra Leone	W. Area Urban	6	39	41	80
	W. Area rural	12	19	20	39
	Kenema	6	19	19	38
	TOTAL	24	77	80	157
Somalia	Kismayo (8 IDP camps)	24	71	76	147
	TOTAL	24	71	76	147
Syria	Damascus	19	42	68	110
x-border from Turkey	Aleppo	12	37	25	62
	TOTAL	41	79	93	162
Turkey (refugees)	Gaziantep	2	9	8	17
	Istanbul	4	14	13	27
	TOTAL	6	23	21	44
	GRAND TOTAL	169	510	593	1103
			46%	54%	

1.3.1.4 Development of Learning Papers

27. Two learning papers were developed during the evaluation to inform both the final report as well as the humanitarian policy and practice of the IASC and its members more broadly. These papers served as inputs into the final evaluation, but are also standalone documents. Because they are separate to the main evaluation report, they were prepared at different phases of the evaluation and played a role in providing high-quality evaluative evidence during the process.

28. The focus of the first learning paper was the process of developing the GHRP; this paper was prepared during the inception and pilot phase and was the first substantive output of the evaluation. The second learning paper was focused on localization and was prepared in tandem with the main evaluation report. A brief rationale for the papers is given in Box 1.

Box 1: Summary of the two Learning Papers

GHRP learning paper

In July 2020, the IASC Principals tasked the Office for the Coordination of Humanitarian Affairs (OCHA) with leading and sharing '*lessons learned from the GHRP process that can be applied to and strengthen the annual*

development of the 2021 Global Humanitarian Overview (GHO)'. Thereafter, OCHA conducted a light lesson learning exercise, which concluded in October 2020.[21] This learning paper builds on the OCHA-led exercise and the findings and recommendations that were documented during that process. The paper responds to two main learning areas: (i) assessing the benefits of the GHRP process as a new approach for collectively responding to the demands of a global crisis; and (ii) understanding the extent to which the GHRP process facilitated an inclusive and well-coordinated response.

Localization learning paper

Localization constitutes a core commitment for the humanitarian community and was identified very early in the COVID-19 response as being critical in light of the travel restrictions, and the need to move fast and quickly to mobilize capacity and respond. Consequently, it is also the subject of a specific set of questions under the IAHE. Localization has also been identified by the Grand Bargain 2.0 as a key priority[22] and has been included in the IASC 2022/23 work plan as one of four enabling priorities.[23] The localization learning paper supports the evaluation in highlighting key lessons and gives voice to the views of local actors on the achievements and challenges of the COVID-19 response. It also feeds into broader localization priorities of the IASC and Grand Bargain.

1.3.1.5 Country case studies

29. The evaluation team conducted a total of six in-person country case study visits in addition to two partially remote case studies (see Figure 4, which shows case study countries in blue, regional hub in green).[24]

[21] OCHA, (2021) GHRP Lessons Learned: Key recommendations, 24 March 2021.

[22] See https://interagencystandingcommittee.org/grand-bargain-official-website/grand-bargain-20-framework-and-annexes-deenesfr.

[23] IASC (2021) *IASC Strategic Priorities*, 2022 – 2023, October 2021.

[24] For the partially remote case studies, remote interviews by international members of the evaluation team and in-person FGDs were undertaken by national team members.

Figure 4: Countries visited during the evaluation

30. Table 7 below provides details of locations that were included in the visits.

Table 7: Summary of locations visited by the evaluation team for each of the case study countries

Country	KIIs	Community FGDs
Bangladesh (refugees and host communities)	Cox's Bazar	Ukhiya and Teknaf (host communities and refugee camps)
Colombia (refugees and IDPs)	Bogotá, Cúcuta, Quibdó	Amazonas, Norte de Santander, Córdoba
DRC	Kinshasa, Goma	Kinshasa, Goma
Philippines	Manila, Mindanao (remote)	Manila, Mindanao
Sierra Leone	Freetown, Kenema	Western Area Urban, Western Area Rural, Kenema
Somalia	Mogadishu	Kismayo IDP camps
Syria	Damascus, NE Syria (remote)	Damascus
Turkey (refugees)	Ankara, Gaziantep	Aleppo governorate, Gaziantep, Ankara

1.3.2 Sampling

31. Since the GHRP included 63 countries, a purposive sampling approach was used to permit the evaluation team to focus on a manageable number of cases to study in some depth.[25] The aim was to identify trends and patterns between the different contexts to answer the evaluation questions.

32. Each of the 63 countries was examined against 18 criteria which included the following: Humanitarian context; response plan; national and local leadership capacity; INFORM Severity Rating (Dec 2020); INFORM Severity rating (DEC 2021); People targeted pre-COVID-19 (GHO, 2020); People targeted (Nov 2020); volume of appeal funding; per cent of appeal funding met; Central Emergency Response Fund (CERF) funding; Country-Based Pooled Fund (CBPF) funding; access; government travel restrictions; COVID-19 trends (cases, transmission); other considerations.

1.3.3 Gender and inclusion

33. In line with UN Evaluation Group Guidance on Integrating Gender Equality and Human Rights in Evaluation (2011), the evaluation treated gender and disability inclusiveness as critical lines of inquiry that cut across all relevant areas of investigation. The evaluation did this in the following ways:

- It examined the extent to which collective response actions sought to ensure attention to issues of gender and the needs of persons with disabilities in the pandemic response.
- Reviewed evidence of the ways in which women and men, boys and girls, and persons with disabilities, were (differently) targeted and engaged in interventions.

[25] Manageable in this instance refers to the envelope of resources and the limited time-frame available for the evaluation, as well as the accompanying burden of work for host countries.

- Identified best practices, opportunities and lessons learned to ensure stronger and more consistent attention to gender and to persons with disabilities in future pandemic responses.

1.4 Data collection, synthesis and analysis

Data collection

34. The ToR lends itself to an inductive approach to data collection and analysis and to assessing the contribution made by the COVID-19 response to achieving results. The evaluation team took an approach that places primacy on exploration and observation as a way of identifying patterns, and by exploring inductively and collaboratively with key stakeholders where good practice exists. In support of this, the evaluation team designed a three-step process that will enable it, in a systematic and transparent way, to gather data so as to minimize bias, and to take a pragmatic but systematic approach to analyzing a substantial volume of qualitative and quantitative data and evidence across a range of case studies (Figure 5).

Figure 5: Three-step process for systematic evidence gathering and analysis

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

- Preliminary assessment: The evaluation team conducted a preliminary analysis during the inception and pilot phase and also undertook a context mapping prior to travel to each of the case study countries. This enabled a more focused approach to be taken during fieldwork to gathering further data and verifying the quantitative and qualitative data that has already been collected.
- Field-level assessment: Based on the preliminary assessment of evidence conducted for each country case study, the evaluation team focused down on the most relevant aspects of the ToR in order to explore the contribution made by the COVID-19 response to change, test assumptions, the relative importance of enabling and inhibiting factors, and the contributory role of key stakeholders.
- Data analysis: The analytical process brings together evidence from these different streams against the evaluation matrix as the main analytical tool. To strengthen the validity of the findings, a series of layered triangulation techniques were applied to the data collection and data analysis processes. These included triangulation of data types, triangulation of data sources, and the triangulation of data collectors (see Box 2).

Box 2: Triangulation techniques used to strengthen the validity of findings

Data Types: The evaluation gathered information via qualitative, quantitative and secondary data tools.

Data Sources: The information sources came from a wide range of stakeholders at both global and country-level. The case countries are reflective of different regions, humanitarian contexts and funding levels. The collection of evidence across these different sources enhanced triangulation and improved the potential for patterns to be observed.

Data Collectors: The evaluation team contained members from diverse backgrounds, roles and experiences. Responsibilities were rotated between members across the team to ensure that no single evaluator has too much influence over specific aspects of the process.

Consistent Tools: The use of a set of systematic tools for the evaluation assisted in ensuring that even though different data collectors and sources are engaged, the techniques were being applied in a consistent manner that could be cross-checked during quality control processes by internal team members.

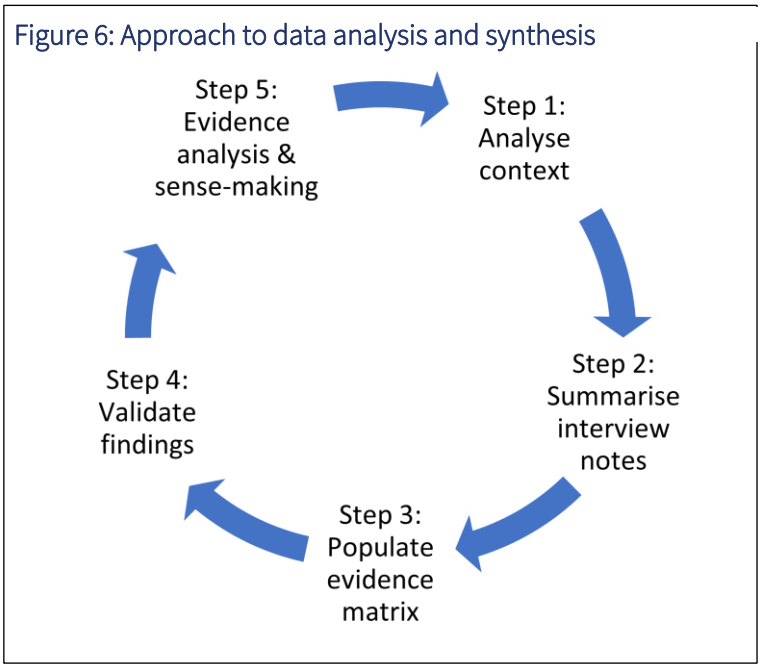
Participatory Analysis: During the evidence assessment and analysis process, the evaluation team sought to ensure that multiple perspectives were considered. To the extent possible, this was be supplemented by an additional consultative approach with findings presented to and validated by the key stakeholders – including debriefings at the end of each

evaluation and engagement with the Global Evaluation Advisory Group during the evaluation process.

Data analysis and synthesis

36. The evaluation team designed a process to gather data in a systematic and transparent way that minimized bias, and took a pragmatic but systematic approach to analyzing a substantial volume of qualitative and quantitative data and evidence across a range of case studies (see below and Figure 6).

Figure 6: Approach to data analysis and synthesis



37. Step 1: For each case study country, the evaluation team ensured that field work is preceded by a contextual analysis that drew from documentation and any interview evidence. This included information on the humanitarian situation/priorities prior to the pandemic; COVID-19 response priorities as of March 2020, including most at risk populations and anticipated and indirect impact; pandemic response - key events and key dates including when the pandemic hit and how it evolved; COVID-19 coordination; key achievements of, and challenges with, pandemic response.

38. Step 2: The team developed an interview summary template organized by evaluation question. These summaries will remain confidential.

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

40. Step 4: For each country case study, the team developed a debriefing PowerPoint which was shared with the respective HCT (or similar body) for purposes of validation. This outlined preliminary findings against each of the evaluation questions, and emerging areas of learning.

41. Steps 5: The evaluation team used an iterative approach to evidence analysis and sense-making. This was important because of the volume of primary and secondary evidence that has been collected and which required review. In order to make sure that the evaluation draws from this evidence, the approach focused on 'sense-making' by:

- Discussing emerging findings in internal team meetings. The evaluation team met in person at regular points during the evaluation process (during the inception phase, after the pilot case studies and at the end of the data collection phase). The meetings were used to discuss emerging findings from country studies, from the learning papers, and against specific evaluation questions and cross-cutting themes. They were used to identify areas that need further exploration or triangulation and where evidence was insufficient. The synthesis of evidence from the team meetings informed the evaluation report.
- Capturing high-level findings in the evidence matrix. After evidence had been collated for each EQ in the evaluation matrix, individual team members used this to identify high-level key findings that were

summarized from the accumulated body of evidence.

- Discussing draft/emerging findings with external stakeholders. This was done informally through discussions with key stakeholders, and formally through (i) the presentation of initial/emerging findings from the inception and pilot phase, and (ii) once the draft evaluation report had been prepared. The GEAG was considered as an important forum to present and discuss the findings of the draft evaluation report.

Note on the use of qualitative data analysis software

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

1.4.1 Limitations and risk mitigation

43. An analysis of risks undertaken during the inception phase is outlined in the detailed methodology in Annex 2. This includes the mitigation measures used by the team. Table 8 below highlights three key limitations that the evaluation team identified at the outset that did indeed prove to be challenging during the evaluation, together with steps taken to mitigate their impact.

Table 8: Key limitations and the evaluation team's mitigation measures

Limitation	Mitigating Measures
The lack of reliable monitoring data on the collective response, particularly at the global level, has meant that it is not possible to determine a complete set of results for the COVID-19 response (see section 10)	The team has analyzed available data on COVID-19 results and complemented this at country level with primary data collection through FGDs with affected communities. This is a relevant approach for this IAHE because the question focuses on the extent to which the collective response met *'the humanitarian needs of affected people'*.
This is the first global IAHE of an operational response; apart from one, all others have focused on a single country.[26] The broad scope of a global evaluation comes at the expense of depth of analysis as there is more ground to cover and hence less time to collect, analyze and synthesize evidence. One of the implications of this is that not every cluster, agency or technical area was analyzed in detail, with those that feature most prominently in the GHRP and the evaluation ToR subject to the greatest focus.	The development of an analytical framework has helped the team to focus on how the humanitarian system works in practice and on the collective nature of the response at both global and country levels. The case studies, selected on the basis of 18 criteria, have generated a wealth of detailed information and illustrative examples that add depth to the findings presented. There are a number of evaluations (completed, ongoing or forthcoming) on individual agencies or specific aspects of the COVID-19 response so this evaluation has also been careful to avoid duplicating these.
The ToR suggested an aid-worker survey for the evaluation, which the team designed during the inception phase. The aim was to use it as a means of gathering data on issues primarily linked with localization. The survey was finalised, translated into the UN languages and circulated to OCHA offices and Resident Coordinator's Office (RCOs) for onward circulation to aid workers with a request to prioritize Non-Governmental Organization (NGO) consortia.	The evaluation team has made a concerted effort to conduct KIIs with national and local NGOs as well as L/NA consortia to reflect their perspectives on localization. It has also made localization the topic of the second learning paper (see box 1 above). The learning paper uses IASC guidance on localization in COVID-19 as a framework and so covers issues that go beyond the evaluation questions addressed in this report.

[26] The gender equality IAHE was the only other global IAHE that has been undertaken. It is noteworthy that in 2015, the decision was taken to undertake a Coordinated Accountability and Lessons Learning (CALL) exercise for Syria in place of an IAHE. See https://interagencystandingcommittee.org/clone-evaluations/content/inter-agency-humanitarian-evaluation-steering-group-coordinated.

Despite follow-up, the survey received insufficient responses to justify its use in the evaluation, which was agreed with evaluation managers.	

1.5 Ethical considerations

44. The evaluation team upholds the 2020 United Nations Evaluation Group (UNEG) Code of Conduct for Evaluation and Ethical Guidelines for Evaluation; UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation, the UN System-Wide Action Plan (UN-SWAP) on gender equality and the 2017 IASC Policy on Gender Equality and the Empowerment of Women and Girls in Humanitarian Action, especially in relation to evaluations including affected populations and vulnerable groups. All team members have in-depth knowledge of humanitarian principles, human rights, social inclusion, and AAP commitments in evaluation practice.

45. KonTerra and Itad applied ethical standards to the data collection process including the protection of rights and dignity of evaluation informants. This included applying the principles of informed consent, voluntary participation, assurances of anonymity and confidentiality of data protection and do no harm principles in all parts of the data collection exercise. Prior to any interview event, participants were oriented to informed consent and voluntary participation. All data was treated with confidentiality. Where personal information was collected, it was removed from the questionnaires or recording transcripts and used only with the Quality Assurance (QA) manager for verification. The activities of the evaluation team followed and respect OCHA data protection guidelines. In interview notes and reporting, source references were framed so as to not be traceable to a single person. Additionally, all interviewees were informed at the start of the interview regarding confidentiality principles, and they will not be directly quoted in the report – unless they give specific consent. Knowing potential interviewees have a high workload or need their time to earn an income, the team kept the interviews as concise and as efficient as possible.

46. Principles of inclusion are important for ensuring that vulnerable voices are not marginalized, and inclusion is considered an ethical issue. This leads to approaches in evaluations such as bringing a differential lens to stakeholder analysis to ensure that all voices are represented, creating environments where vulnerable voices are freer to speak (for example, carrying out gender-disaggregated FGDs with same sex facilitators at least for consultations with women so that participants feel comfortable to speak more freely). The team also made efforts to include persons with disabilities in FGDs or other forms of community consultation.

47. To the extent that was possible in data sets, sex-disaggregated output and outcome data and analysis as well as data on persons with disabilities was included in the evaluation. During data analysis evaluation teams paid special attention to ensuring that perceptions of women, girls, men, and boys were appropriately and accurately represented to ensure gender sensitivity.

48. Do no harm principles are important considerations not only for aid recipients who might feel disempowered, but also for the national consultants and evaluation team members themselves. During the inception phase, the evaluation team assessed the potential of harm to aid recipients or data enumerators across the evaluation process. The team adapted its community engagement methodology to the specificities of case study contexts as needed.

49. The COVID-19 pandemic highlighted additional risks to those participating in group meetings, which was managed through the development of COVID-19 protection measures for FGDs and other group meetings. KonTerra's team upheld WHO and government regulations while conducting evaluations in the field. Moreover, KonTerra has issued a COVID-19 guidance for its KonTerra staff and teams, requiring full vaccination for all evaluation teams travelling to the field in an attempt to ensure the safety of teams and all stakeholders involved.

50. The principles outlined above provided the foundation for a set of ethical and safeguarding considerations for community engagement

Annex 3: List of stakeholders interviewed

#	Country	M/F	Name	Designation	Agency
1	Bangladesh	M	Francis Tabu	Health Sector Coordinator	WHO
2	Bangladesh	F	Sheila Grudem	Senior Emergency Coordinator, Cox's Bazar	WFP
3	Bangladesh	F	Nihan Erdogan	Deputy Chief of Mission	IOM
4	Bangladesh	M	Dr Simon Ssentamu	Public Health Response Officer	WHO
5	Bangladesh	M	Arjun Jain	Principal Coordinator	Inter-Sector Coordination Group
6	Bangladesh	F	Sulakshani Perera	Senior External Relations Officer	Inter-Sector Coordination Group
7	Bangladesh	M	Julien Graveleau	WASH sector coordinator	UNICEF
8	Bangladesh	M	Md. Mahbubur Rahman	Coordinator	Communications with Communities Working Group
9	Bangladesh	M	Khandokar Hasanul Banna	Humanitarian Project Manager	BBC Media Action
10	Bangladesh	F	Shahana Fayat	head of Operations, Humanitarian Crisis Management Programme	BRAC
11	Bangladesh	M	Md. Farukh Hussein Khan	WASH lead	BRAC
12	Bangladesh	F	Flora Macula	Head of sub-office	UN Women
13	Bangladesh	M	Nick Harvey	Senior Humanitarian Adviser	FCDO
14	Bangladesh	M	Majeed Ezatullah	Chief of Field Office, Cox's Bazar	UNICEF
15	Bangladesh	F	Maria Teresa Dico Young	Head, Gender Hub	UN Women
16	Bangladesh	M	Ozbek Bora	PSEA Network Coordinator	Inter-Sector Coordination Group
17	Bangladesh	M	Shah Rezwan Hayat	Refugee Relief and Repartiation Commissioner	Office of the Refugee Relief and Repatriation Commissioner
18	Bangladesh	M	Dr Abu Toha M.R.H. Bhuiyan	Health Coordinator	Office of the Refugee Relief and Repatriation Commissioner
19	Bangladesh	F	Oyessorzo Chowdhury	Information Analyst	NPM/ACAPS Cox’s Bazar Analysis Hub
20	Bangladesh	M	Md Maheen Newaz Chowdhury	Area Office Director, Cox'x Bazar	Save the Children
21	Bangladesh	M	Dr Abdullah Al-Foman	Senior Program Manager, Health	Save the Children
22	Bangladesh	M	Md Abdus Samad	Programme Manager	Save the Children
23	Bangladesh	F	Anna Laming	Third Secretary	Australian High Commission
24	Bangladesh	F	Dr Nazia Sultana	Medical In-Charge, SARI ITC	Relief International

#	Country	M/F	Name	Designation	Agency
25	Bangladesh	M	Nazrul Islam	Country Advisor	Relief International
26	Bangladesh	M	Md. Nazmul Haque	Assistant Manager Coordinator	Bandhu Social Welfare Society
27	Bangladesh	M	Michael Hossu	Country Technical Assistant	ECHO
28	Bangladesh	M	Johannes Van De Klaauw	Representative	UNHCR
29	Bangladesh	M	Enamul Hoque	Head of WASH	Oxfam
30	Bangladesh	M	Dr Somen Palit	Health Manager	IFRC
31	Bangladesh	M	Dr Bayezeed	Health & Psychosocial Manager	BDRCS
32	Bangladesh	M	Rezaul Karim Chowdhury	Executive Director	COAST
33	Bangladesh	F	Teresa Shwarz	Research Manager	REACH
34	Bangladesh	M	Dr Abu Syem Md Shahin (Shahin)	Senior Health Coordinator	IRC
35	Bangladesh	M	Marcel Ratan Guda	Project Director, Emergency Response Program (ERP)	Caritas Bangladesh
36	Bangladesh	F	Tanzila Tasnim	Clinical Psychologist, One-Stop Crisis Centre, Multi-sectoral Programme on Violence Against Women	Ministry of Women and Children's Affairs
37	Bangladesh	M	Abdiwahab Aden Ali	Associate Protection Officer	UNHCR
38	Bangladesh	M	Bimal Dey Sarker	Chief Executive	Mukti Cox's Bazar
39	Bangladesh	M	Syed Yeasin	Liaison Coordinator	Reaching People in Need
40	Bangladesh	M	Badsha Khan	Head of Rohingya Response Project	Reaching People in Need
41	Bangladesh	F	Razia Sultana	Chairperson	RW Welfare Society/Rights for Women
42	Bangladesh	M	Lotas Chisim	Senior Manager, Cox's Bazar Area Coordination Office	World Vision Bangladesh
43	Bangladesh	M	Ram Das	Deputy Country Director – Programme	CARE International
44	Bangladesh	F	Mia Seppo	Resident Representative, UNDP Zimbabwe/former Resident Coordinator, Bangladesh	UNDP
45	Bangladesh	F	Roselidah Raphael	Head of Sub Office	UNFPA
46	Bangladesh	M	Nafiul Azim	SRH Information Management Analyst	UNFPA
47	Bangladesh	F	Caroline Nalugwa	SRH and Midwifery Specialist	UNFPA
48	Bangladesh	F	Ancy Ipe	MHPSS Specialist	UNFPA
49	Bangladesh	M	Christopher Dyson	Humanitarian Coordinator	UNFPA
50	Bangladesh	M	Tafadzwa Carlington Chigariro	SRHR Information Management Specialist	UNFPA

#	Country	M/F	Name	Designation	Agency
51	Bangladesh	M	SMA Rashid	Executive Director	NGO Forum for Public Health
52	Bangladesh	F	Moomtahin Sultana	Medical Coordinator	Food for the Hungry International
53	Bangladesh	M	Dr Bardan Jung Rana	Representative	WHO
54	Bangladesh	M	Siraj Moammad Shajan	WASH Manager	ACF
55	Bangladesh	F	Natalie Torrent	Representative	MSF
56	Bangladesh	M	Dr Saiful Islam	COVID-19 Response Clinical Coordinator	Hope Foundation
57	Bangladesh	M	Dr Md. Alamjin	Health staff member	Hope Foundation
58	Bangladesh	M	Hassan Farooque	Head of Humanitarian Programme	Christian Aid
59	Bangladesh	M	Deb Prosad Sarker	Executive Director	LoCOS
60	Bangladesh	F	Meredith Houck	South Asia Program Manager	BPRM, US Department of State
61	Bangladesh	M	Isteak Ahammed	Refugee Assistant	BPRM, US Department of State
62	Bangladesh	M	Jahangir Alam	Acting Country Director	HelpAge International
63	Bangladesh	M	Md. Siddiqur Rahman	Project Manager	Nabolok
64	Bangladesh	M	Jahangir Alam	Project officer	Nabolok
65	Bangladesh	M	Masum Billah	Working Group Coordinator	CBM Global
66	Bangladesh	F	Humaira Mustary Mowry	Disability Inclusion Coord	Centre for Disability in Development
67	Bangladesh	F	Ayesha Akter Monni	Inclusion Coordinator	Centre for Disability in Development
68	Bangladesh	M	Mr. Tarikul Islam Sajib	Senior Technical Officer-Inclusion	Humanity & Inclusion
69	Bangladesh	M	Mr. Kwang Hee Kim	Disability Inclusion Specialist	UNHCR
70	Bangladesh	F	Bushra Binte Alam	health Service Support	World Bank
71	Bangladesh	F	Matilda Svennson	Coordinator Humanitarian & Development Assistance - Cox's Bazar	Embassy of Sweden
72	Bangladesh	M	Shahinur Selim Sujan	Project Coordinator in charge	Friendship NGO
73	Bangladesh	M	Marco De Gaetano	Senior Emergency and Rehabilitation Officer	FAO
74	Bangladesh	M	Mir Ali Asgar	Head of Sub-office	UNDP
75	Bangladesh	F	Bahia Egeh	External Relations Officer	Inter-Sector Coordination Group
76	Colombia	M	Jairo Vega	Humanitarian Affairs Leader	World Vision
77	Colombia	F	Pilar Andrea Medina	Director	Action Against Hunger
78	Colombia	M	Juan Jose Avila	MEAL Coordinator	Action Against Hunger
79	Colombia	F	Paula	WASH cluster coordinator	Action Against Hunger
80	Colombia	F	Jessica Chaix	Technical Assistant	ECHO
81	Colombia	M	Sebastian Diaz	Leader of Protection cluster (HCT)	UNHCR

#	Country	M/F	Name	Designation	Agency
82	Colombia	M	Daniel Rodriguez	Leader of Protection cluster (GIFMM)	GIFMM
83	Colombia	F	Claudia Rodriguez	Head of Office	OCHA
84	Colombia	F	Paula Cardenas	Unit Head of Coordination	OCHA
85	Colombia	F	Xitong Zhang	Project Coordinator	iMMAP
86	Colombia	M	Alberto Castillo	Information Management Expert	iMMAP
87	Colombia	M	Pietro de Nicolai	MIRE Consortium Manager	Mecanismo Intersectorial de Respuesta en Emergencia (MIRE)
88	Colombia	M	Diego Camilo Sarmiento	MIRE Consortium Manager (Former)	Mecanismo Intersectorial de Respuesta en Emergencia (MIRE)
89	Colombia	F	Lina Fernanda Vega Perez	Coordinator of Multilaterals and the Undersigned	ACP
90	Colombia	F	Ivonne Andrea Ramos Héndez	EP. Multilateral Cooperation & Humanitarian Affairs	ACP
91	Colombia	M	Dr. Mauricio Cerpa	Health Cluster Leader	OPS
92	Colombia	F	Leidy Callerbro	Coordination team member	OPS
93	Colombia	F	Inda Garcia	Coordination team member	OPS
94	Colombia	F	Gaby Pindes	Coordination team member	OPS
95	Colombia	M	Oliver Garcia	Coordination team member	OPS
96	Colombia	M	Cambio Alivia	Coordination team member	OPS
97	Colombia	F	Josefina Ochoa	Coordination team member	OPS
98	Colombia	M	Salazar Luz	Coordination team member	OPS
99	Colombia	M	Vicente Ortega	Coordinator	AECID
100	Colombia	F	Zandra Estupiñan	Cluster Leader	SAN Cluster
101	Colombia	M	Edwin Pinto	Risk Management Specialist	San Cluster
102	Colombia	F	Yohana Pantevis	Local Coordination Team Head	OCHA Amazonas
103	Colombia	M	Dayro Castro	Territorial Office Coordinator, Cucuta	UNICEF
104	Colombia	F	Linda Salamanca Beltran	UNFPA Coordinator	UNFPA
105	Colombia	M	Oscar Diaz	Head of Office, Quibdo	UN Women
106	Colombia	M	Jabby Moya	Head of Office, Quibdo	WFP
107	Colombia	M	Alejando Bernal	Peace and Development Lead, Quibdo	WFP
108	Colombia	M	Javier Garzón	Coordinator of GIFMM, IOM side	GIFMM
109	Colombia	M	Laura Cas	Information and Programme Lead	NRC
110	Colombia	F	Diana Montoya	Head of Office, Quibdo	NRC
111	Colombia	F	Samira Sanchez	Director	Cocomania
112	Colombia	F	Dominga Renteria	Head of Programme	Cocomania
113	Colombia	M	Padre Jhony Milton	Head of social programmes, Quibdo catholic parish	Pastoral Social Quibdo

#	Country	M/F	Name	Designation	Agency
114	Colombia	F	Nimia Teresa Vargas	Executive director	Chocoan Women's Network
115	Colombia	F	Patricia Perea Mosquera	Project coordinator	Chocoan Women's Network
116	Colombia	F	Laura Ochoa	Response Coordinator	CISP
117	Colombia	M	Peter Janssen	Coordinator	GIFMM
118	Colombia	M	William Luengas Garcia	Office Coordinator	OCHA Cucuta
119	Colombia	F	Camila Fuquene	Office Coordinator	OCHA Quibdo
120	Colombia	F	Aida Veronica Siman	Country Representative	UNFPA
121	Colombia	F	Victoria Colamarco	Country Representative	UNICEF Bogota
122	Colombia	M	Irving Prado	Deputy Country Representative	WFP Bogota
123	Colombia	F	Maria Alejanda Garcia	Local Coordinator	WFP Cucutta
124	Colombia	M	Julio Cesar Gualtero	Cluster/Sector WASH Coordinator	UNICEF
125	Colombia	M	Juan Carlos Torres	Regional Liaison, Health Programme	IOM Cucutta
126	Colombia	F	Claudia Milena Cuellar Segura	Director for Epidemiology	MoH Bogota
127	Colombia	F	Viviana Guzman	National Consultant	OPS/OMS Cucutta
128	Colombia	F	Dildar Salamanca	Territorial Coordinator for Emergency Response	UNFPA
129	Colombia	F	Claudia Vinasco	Territorial Office Head	UNFPA
130	Colombia	F	Carolina Guerrero	Programme associate	WFP
131	Colombia	F	Rocío Pachón	International Cooperation Demand Management Director	ACP
132	Colombia	M	Jean François Ruel	Coordinator	GIFMM
133	Colombia	F	Lucía Gualdrón	Inter-Agency Coordination Assistant	GIFMM
134	Colombia	F	Chiara Oriti Niosi	Gender and Humanitarian Action Specialist	UN Women
135	Colombia	F	Claudia Rodriguez	Head agency	OCHA
136	Colombia	F	Sylvia Echeverry	Information Unit head	OCHA
137	Colombia	F	Diana Babativa	Responsible SIGI	Corporación Infancia y Desarrollo
138	Colombia	F	Alejandra Gil	Human Management	Corporación Infancia y Desarrollo
139	Colombia	F	Martha Lucía Rubio	Assistant representative	UNFPA
140	Colombia	F	Erika García Roa	Humanitarian Coordinator	UNFPA
141	Colombia	F	Lucero Soacha Sánchez	International Cooperation Adviser	Ministry of Health and Social Protection
142	Colombia	F	Ingrid Cañas	Associate Senior M&E	WFP
143	Colombia	F	Lorena Becerra	Education in Emergencies Coordinator, Northeastern	NRC
144	Colombia	M	Jesús Quintero	Disaster Management Coordinator, Norte Santander	Red Cross
145	Colombia	F	Jheraldin Mosquera	Programme Officer	CISP
146	Colombia	M	Victor Bautista	Frontier and international cooperation Secretary	Government

#	Country	M/F	Name	Designation	Agency
147	Colombia	F	Blanca Hormaechea	Head of Programme Support Unit	NRC
148	Colombia	F	Laura Osorio	Co-lead Health Cluster	EHP GIFMM
149	Colombia	F	Luisa Pinea	PME Specialist	UN Women
150	Colombia	M	Jose Luis Barreiro	Colombia INGO Forum Coordinator	Foro ONG
151	DRC	M	Ancel Kats	Head of coordination	OCHA
152	DRC	M	Alain Gondo	Head of information management	OCHA
153	DRC	M	Severin Medard Yangon-Bemodo	Humanitarian Fund	OCHA
154	DRC	M	Serge Philippe Barbara	Humanitarian Fund	OCHA
155	DRC	M	Boniface Deagbo	Caritas - Exec sec DRC network	Caritas
156	DRC	M	Nestor Yombo Djema	Government Liaison Officer	OCHA
157	DRC	M	Dr. Jean-Jacques Muyembe-Tamfum	Coordinator of the technical secretariat of the response team against COVID-19	INRB (National institute of biomedical research)
158	DRC	M	Bruno Lemarquis	DRC HC	OCHA
159	DRC	M	Dr Guy Saidi	Health Officer	WHO
160	DRC	M	Dr Alou	Health Cluster Co-coordinator	WHO
161	DRC	M	Dr Gervais Folefack	Emergencies Team Lead	WHO
162	DRC	M	Dr Aime Cikomola	Director of the expanded program of immunisation (PEV)	MoH
163	DRC	M	Dr Jean Mukendi	Director of the expanded program of immunisation (PEV) - adjoint	MoH
164	DRC	M	Dr Guy Saidi	Health Officer	WHO
165	DRC	M	Dr Amédée Prosper Djiguimbe	WHO representative	WHO
166	DRC	M	Kalil Sagno	Health and nutrition programme manager	UNICEF
167	DRC	F	Francoise Kala Konga	Nutrition Cluster Co-Coordinator	MoH
168	DRC	F	Anita Akumiah	Head of GBV	UNFPA
169	DRC	M	Steve Ndikumwenayo	Representative protection cluster	UNFPA
170	DRC	M	Pierre Shamwol	assistant representative , maternal/ reproductive health	UNFPA
171	DRC	M	Vincent Rakoto	Représentant Adjoint	UNFPA
172	DRC	F	Catherine Savoy	Coordination	ICRC
173	DRC	M	Ernst Haridi	Cooperation Coordinator adjoint	ICRC
174	DRC	F	Mercy Laker	Head of the country delegation	IFRC
175	DRC	M	Dr Zeade Leonard NIOULE	IFRC delegation	IFRC
176	DRC	M	Alessandra Giudiceandrea	Head of mission	MSF
177	DRC	F	Roland Nombe	Health Advisor	MSF
178	DRC	F	Sofia Hafdell	Humanitarian Advisor	Embassy of Sweden

#	Country	M/F	Name	Designation	Agency
179	DRC	M	Ian Van Engelgem	Health Advisor	ECHO
180	DRC	M	Johannes Gerhard Ulke	Political Counsellor	Embassy of Germany
181	DRC	F	Verena Essmann	Third Secretary	Embassy of Germany
182	DRC	F	Mwamini Rubasha	Advisor	Embassy of Norway
183	DRC	F	Nancy Foster	Head of Cooperation	Embassy of Canada
184	DRC	M	Alexandros Yiannopou	Humanitarian Advisor	FCDO DRC
185	DRC	M	Marc Sepkon	Food Security Cluster Coordinator	WFP
186	DRC	M	Adossi Koffi Dodzi	Deputy Representative (Operations)	UNHCR
187	DRC	M	Dr Pierre Atchom	Deputy Representative (Protection)	UNHCR
188	DRC	M	Papa Moussa Mdoye	Livelihoods and Economic Inclusion Advisor	UNHCR
189	DRC	M	Yves Djokwa	Associate Reporting Officer	UNHCR
190	DRC	M	Seybatou Aziz Diop	Senior Emergency Officer	UNHCR
191	DRC	M	Anuno Robert	Public Health Officer	UNHCR
192	DRC	M	Fidelis Folifac	WASH Officer	UNHCR
193	DRC	F	Asswan Isabelle	GBV Officer	UNHCR
194	DRC	F	Mylene Mikabare	Assistant Public Health Officer	UNHCR
195	DRC	F	Erica Bussy	Deputy Director/Senior Human Rights Officer	OHCHR
196	DRC	F	Charlotte Lepri	Director of Programmes	Cordaid
197	DRC	M	Dr Olivier Kana	COVID-19 Coordinator	Cordaid
198	DRC	M	Dr Olivier Nadesabe	M&E Coordinator	Cordaid
199	DRC	M	Adama Diallo	Education Cluster Coordinator	UNICEF
200	DRC	F	Sandrine Mabaya	Education Cluster Coordinator	Save the Children
201	DRC	M	Peter Musoko	Country Director	WFP
202	DRC	M	DR Elia Badjo	Coordinator	COSAMED
203	DRC	M	Dr Serge K	Member coordination	COSAMED
204	DRC	M	Constantin Ndemeye	Programme Manager	BIFERD
205	DRC	M	Omar Behe	Coordinator	ARDE
206	DRC	M	Dieudonne Nkurod	Head of programme	ARDE
207	DRC	M	Boudouin Kaseleka	Shelter coordinator	NRC
208	DRC	M	Christian Nsoole	Head of program	SSS
209	DRC	M	Aganze Christian	Head of office	FHI360
210	DRC	M	H.Tbao-Mokokomot	Focal point	Salvation Army
211	DRC	F	Birgit Angela	CCCM	IOM
212	DRC	M	Tresor Sendihi	MEL manager	World Relief
213	DRC	F	Simone Carter	Manager, Social Sciences Analytics Cell (CASS)	UNICEF
214	DRC	F	Fidelia Odjo	GBV Focal Point	UNFPA

#	Country	M/F	Name	Designation	Agency
215	DRC	F	George Biock	Programme Analyst	UNDP
216	DRC	M	Adama Moussa	Country Representative	UN Women
217	DRC	F	Catherine Odimba	Programme Manager	UN Women
218	DRC	M	Sybstain Lnendo	Member coordination	OJPLC
219	DRC	M	Dr Anos Kebuna	PF monitoring	WHO
220	DRC	M	Kamuke Joseph	WASH	UGEAFI
221	DRC	M	Faustin Amant	Program manager	DEBOHS E H
222	DRC	M	Alfred Kanjira	Project manager	ETN
223	DRC	F	Sialla Justine Dede	UNHCR's Camp Coordination Office/ CCCM	UNHCR
224	DRC	M	Félicien Mibulo	Field Associate	UNHCR
225	DRC	M	Berger Bireo	Assistant program coordinator	World Relief
226	DRC	M	Bertin Balame	Project officer (covid)	World Relief
227	DRC	M	Kapalata Ndashmye	Program coordinator	World Relief
228	DRC	M	Jean Nyandwi	Director	World Relief
229	DRC	F	Jennifer Loy Price	Co-Lead Cash Working Group	Mercy Corps
230	DRC	M	Charlotte Helletzgruber	Humanitarian Affairs Officer	OCHA
231	DRC	F	Mira Nkumpanyi	Protection Associate	UNHCR
232	DRC	M	Ebénézer Agordome	Consultant Senior	Humanity & Inclusion
233	DRC	M	Sylvestre Kazadi	Medical Officer	WHO
234	DRC	M	Franklin Mutomboki	WASH Cluster CCIs Focal Point	Medecins Afrique
235	DRC	F	Genevieve Begkoyian	Chief of Health	UNICEF
236	DRC	M	Marco Kalbusch	Head of UN Integrated Office	MONUSCO
237	DRC	M	Rémi Alvernhe	Director	INGO forum
238	DRC	F	Suzanna Tkalec	DHC	OCHA
239	DRC	F	Julie Languille	Special Assistant to the Deputy Humanitarian Coordinator in DRC	OCHA
240	DRC	F	Lea Barbezat	Research Manager	REACH
241	DRC	F	Jolie Laure Mbalivoto Taka	COHP	COHP
242	DRC	M	Nana Esi Yvonne Boham	COHP	COHP
243	DRC	M	Godelieve Sipula	COHP	COHP
244	DRC	M	Patrick Lusala	Medical Coordinator	MDM
245	Global	M	Stephen O'Malley	Peer to Peer Project (formerly Head, COVID-19 Policy Team)	OCHA
246	Global	M	Yasser Baki	Head, COVID-19 Policy Team, OCHA (formerly ERC Chief of Staff)	OCHA
247	Global	M	Gareth Price-Jones	Executive Secretary, Steering Committee for Humanitarian Response	SCHR

#	Country	M/F	Name	Designation	Agency
248	Global	F	Maria Lilian Barajas Calle	Humanitarian Affairs Officer, Coordination Branch	OCHA
249	Global	F	Reena Ghelani	Chair of the EDG and Director, OCHA Operations and Advocacy Division	OCHA
250	Global	M	Kostas Stylianos	Associate Inter-Agency Officer	UNHCR
251	Global	F	Marcy Vigoda	Senior Humanitarian Adviser	OCHA
252	Global	M	Andy Wyllie	Chief, Assessment, Planning and Monitoring Branch	OCHA
253	Global	F	Delphine Pinault	Humanitarian Policy Advocacy Coordinator & UN Representative	CARE International
254	Global	F	Sarah Telford	Lead, Centre for Humanitarian Data	OCHA
255	Global	M	Rein Andre Paulsen	FAO, Director, Office of Emergencies and Resilience; previously Head, OCHA Coordination Division, GVA	OCHA
256	Global	F	Ruth Hill	Lead Economist, Global Unit of the Poverty and Equity Global Practice	World Bank
257	Global	M	David Goetghebuer	Humanitarian Affairs Officer, Monitoring	OCHA
258	Global	F	Françoise Ghorayeb	Senior Adviser Data in Emergencies	UNFPA
259	Global	F	Julie Thompson	Humanitarian Affairs Officer (Financing)	OCHA
260	Global	M	Mark Lowcock	Former Emergency Relief Coordinator	OCHA
261	Global	F	Marina Skuric-Prodanovic	Chair of GCC; Chief, System-wide Approaches and Practices Section	OCHA
262	Global	F	Meg Sattler	Director	GroundTruth Solutions
263	Global	M	Lars Peter Nissen	Director	ACAPS
264	Global	F	Rachel Maher	AAP Focal Point	OCHA
265	Global	F	Meltem Aram	Founding Director	Development Analytics
266	Global	M	Glyn Taylor	Team Leader, Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic	Humanitarian Outcomes
267	Global	M	Christian Els	Data Chief	GroundTruth Solutions
268	Global	M	Ted Freeman	Team Leader, System Wide Evaluation	Consultant
269	Global	F	Gabriella Waaijman	Global Humanitarian Director	Save the Children
270	Global	M	Azmat Khan	Chief Executive Officer	Foundation for Rural Development
271	Global	M	Michael Mosselmans	Head of Humanitarian Programme Policy, Practice and Advocacy	Christian Aid
272	Global	F	Smruti Patel	Founder	Global Mentoring Initiative
273	Global	F	Mary Pack	Vice President Humanitarian Leadership and Partnership	IMC
274	Global	M	Dr Javed Ali	Emergency Response Director/Senior Medical Advisor	IMC
275	Global	M	Andri-van Mens	First Secretary Humanitarian Affairs	Permanent Representation of the Netherlands to the United Nations
276	Global	M	Gopal Mitra	Senior Social Affairs Officer, Disability Team	Executive Office of the UN Secretary-General

#	Country	M/F	Name	Designation	Agency
277	Global	F	Pascale Meige	Director, Disaster and Crisis Prevention, Response and Recovery Department	IFRC
278	Global	M	Anders Nordstrom	Ambassador for Global Health, UN Policy Department	Ministry for Foreign Affairs, Sweden
279	Global	M	Jeremy Wellard	Head of Humanitarian Coordination	ICVA
280	Global	M	Mike Ryan	Executive Director, WHO Health Emergencies Programme	WHO
281	Global	M	Dylan Winder	Humanitarian Counsellor, UK Mission to UN, Geneva	FCDO
282	Global	F	Violet Kakyoma	Resident Coordinator/Humanitarian Coordinator, Chad	Resident Coordinator's Office
283	Global	F	Valerie Guarnieri	Assistant Executive Director, Operations Services co-Chair of the IASC OPAG; WFP	WFP
284	Global	M	Matt Sudders	Acting Deputy Director, CHASE	FCDO
285	Global	M	Brian Lander	Deputy Director, Emergency Division	WFP
286	Global	F	Jennifer Chase	Global Coordinator, Gender Based Violence Area of Responsibility	UNFPA
287	Global	M	Ramesh Rajasingham	Director, Coordination Division	OCHA
288	Global	M	Abdul Majid	Global Food Security Cluster Coordinator	FAO
289	Global	M	Ron Pouwels	Child Protection Area of Responsibility; Global AoR Coordinator	UNICEF
290	Global	F	Kate Hart	Head of Policy and Learning	CaLP
291	Global	F	Ruth McCormack	Technical Advisor	CaLP
292	Global	M	Thorodd Ommundsen	Acting Global Education Cluster Coordinator	UNICEF
293	Global	F	Michelle Brown	Global Education Cluster Coordinator	UNICEF
294	Global	M	William David Gressly	RC/HC	Resident Coordinator's Office
295	Global	F	Monica Ramos	Global WASH Cluster Coordinator	UNICEF
296	Global	F	Naouar Labidi	Global Food Security Cluster; Deputy Coordinator Cluster, WFP	
297	Global	M	Robert Piper	Former Head	UNDCO
298	Global	M	Frederick Matthys	Head of Global Partnerships and Policies, Development Co-operation Directorate	OECD
299	Global	F	Mervat Shelbaya	Head, IASC Secretariat	IASC
300	Global	M	Andrew Wyllie	Co-Chair of RG 1 on Operational Response, Chief, Assessment, Planning and Monitoring Branch; UNOCHA	OCHA
301	Global	M	Alf Blikberg	GHRP focal point for ELACAP	OCHA
302	Global	F	Margot van der Velden	Director of Emergencies; WFP	WFP
303	Global	M	Gareth Leaity	UNICEF, Deputy Director Emergency Programmes	UNICEF

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304	Global	M	Volker Hüls	Head of Division for Effectiveness, Knowledge and Learning	DRC
305	Global	M	John Nkengasong	Director	Africa Centres for Disease Control and Prevention
306	Global	F	Heidi Larson	Professor	London School of Hygiene & Tropical Medicine
307	Global	F	Hibak Kalfan	Executive Director	NEAR
308	Global	M	Mauricio Cardenas	Visiting Senior Research Fellow	Center on Global Energy Policy at Columbia University
309	Global	M	Mohamed Methqal	Director	Moroccan Agency for International Cooperation
310	Global	F	Anusanthee Pillay	Global Women's Protection Advisor	Action Aid
311	Global	M	Jeremy Konyndyk	Executive Director ,	COVID-19 Task Force Office of the Administrator for International Development , Member of the WHO high-level Independent Oversight and Advisory Committee
312	Global	F	Joanne Liu	Professor	Medicine at the University of Montreal Clinical Medicine at McGill University
313	Global	F	Maria Agnese Giordano	Education Cluster; Global Cluster Coordinator; UNICEF	UNICEF
314	Global	F	Linda Doull	Global Health Cluster; Global Cluster Coordinator, WHO	WHO
315	Global	M	PASHA, Eba Al-Muna	COVID-19 Task force	WHO
316	Global	M	Jan Egeland	Secretary General	NCR
317	Global	M	Ted Chaibin	Global Lead Coordinator for COVID Vaccine Country Readiness and Delivery.	UNICEF
318	Global	F	Emma Fitzpatrick	Global Health Cluster; Technical Officer/ GHC, WHO	WHO
319	Global	F	Teresa Zakaria	Health Emergency Officer	WHO
320	Global	M	Farhad Movahed	Humanitarian Affairs Officer, IASC Secretariat	IASC
321	Global	M	Michael Jensen	Chief, CERF secretariat	OCHA
322	Global	M	Nicolas Rost	Head of Programme Unit and Rapid Response Lead, CERF Secretariat	OCHA
323	Global	M	Daniel Hass	Humanitarian Affairs Officer, CERF Secretariat	OCHA

#	Country	M/F	Name	Designation	Agency
324	Global	M	Alf Ivar Blikberg	Section Chief a.i., Asia-Pacific, Europe, Latin America and Caribbean, and Asia-Pacific (ELACAP) Section, Operations and Advocacy Division	OCHA
325	Global	M	Jeoffrey Labovitz	IOM Director for the Department of Operations and Emergencies	IOM
326	Global	F	Annika Sandlund	Head of Partnership and Coordination Service	UNHCR
327	Global	F	Allyson Chisholm	Emergency Specialist, COVID-19 Team	UNICEF
328	oPt	M	Andrea de Domenico	Deputy Head of Office	OCHA
329	Philippines	F	Maria Valdevilla-Gallardo	Head of national office UNHCR	UNHCR
330	Philippines	F	Lindsey Atienza	Protection cluster coordinator	UNHCR
331	Philippines	F	Pamela Muldong	Health field officer	ICRC
332	Philippines	F	Dorsa Nazemi-Salman	Head of operations including the health portfolio, WASH, security and field structures	ICRC
333	Philippines	F	Undersecretary Myrna Cabotaje	Public health services team leader	DoH
334	Philippines	F	Maria Rosario Felizco	Country director	OXFAM
335	Philippines	F	Rhoda Avila	Humanitarian portfolio manager	OXFAM
336	Philippines	M	Atty. Tecson John S. Lim	Chair/ head of national task force and deputy to IATF COVID 19	Office of Civil Defense / NDRRMC
337	Philippines	F	Leila Saiji Joudane	Representative	UNFPA
338	Philippines	M	John Ryan Buenaventura	Humanitarian Project Coordinator	UNFPA
339	Philippines	M	Jose Roi Avena	MEL manager	UNFPA
340	Philippines	F	Rochelle Angela Yu	UNFPA sub office in Mindanao	UNFPA
341	Philippines	M	Matthew Bidder	Head of program for Mindano	IOM
342	Philippines	F	Ilova Dorylane Lorenzo	National project officer for protection division,	IOM
343	Philippines	F	Carol Cabading	Program Officer	World Vision
344	Philippines	M	Gustavo Gonzalez	HC OCHA	OCHA
345	Philippines	M	Josephy Curry	USAID Regional Advisor at USAID/ Bureau for Humanitarian Assistance	USAID
346	Philippines	F	Anna Katrina E. Aspuri	Unit head of development programs PDRF	PDRF
347	Philippines	F	Regina 'Nanette' S. Antequisa	Exec director of ECOWEB	ECOWEB
348	Philippines	F	Manja Vidic	Head of OCHA Philippines	OCHA
349	Philippines	M	Joseph Addawe	Information Management Officer	OCHA
350	Philippines	F	Maria Agnes	National Disaster Response Advisor	OCHA
351	Philippines	M	Dr Rabindra Abeyasinghe	Acting WHO Representative to the Philippines	WHO
352	Philippines	F	Noraida Abdullah Karim	Deputy Director	CSFI

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353	Philippines	F	Karen Janes Ungar	Country representative	CRS
354	Philippines	F	Arlynn Aquino	Humanitarian Aid & Civil Protection (ECHO) Manila Field Office Programme Officer,	ECHO
355	Philippines	F	Cristina V. Lomoljo	Executive Director	CSO
356	Philippines	M	Paul Harrington	Assistant Director	DFAT
357	Philippines	F	Joan Odena	Humanitarian Manager	DFAT
358	Philippines	F	Mei Santos	Senior Program Officer for Humanitarian and Disaster Risk Management	DFAT
359	Philippines	F	Emilie Fernandes	Country Director	Reach International
360	Philippines	F	Sindhy Obias	Humanitarian aid and community development worker	ACCORD
361	Philippines	M	Benjamin B. Delfin II	Director of implementation	Save the Children
362	Philippines	M	Rene "Butch" Meily	President of the PDRF	PDRF
363	Philippines	F	Oyunsaikhan Dendevnorov	Head of office	UNICEF
364	Philippines	M	Jeffrey Dotingco	C19 Incident Manager	WHO
365	Philippines	F	Yui Sekitani	Lead for Health Emergencies	WHO
366	Philippines	F	Rowena Capistrano	Covid-19 For Emergencies Senior Technical Coordinator	WHO
367	Philippines	F	Emily Beridico	Executive Director	COSE
368	Regional	F	Julie Belanger	Formerly Head of Regional Office, West and Central Africa	OCHA
369	Regional	F	Beatrice Teya	Humanitarian Specialist, East and Southern Africa Region	UN Women
370	Regional	M	Shaun Hughes	Senior Regional Emergencies Advisor	WFP
371	Regional	M	Baseme Kulimushi	Senior Operations Coordinator, Regional Bureau	UNHCR
372	Regional	F	Dr Miriam Nanjunja	Team Lead, WHO Hub for Eastern & Southern Africa	WHO
373	Regional	F	Tasiana Samba Mzozo	Partnership Coordinator, WHO Hub for Eastern & Southern Africa	WHO
374	Regional	F	Patricia Gimode	Regional Humanitarian Advisor, World Vision	World Vision
375	Regional	M	Francesco Rigamonti	Regional Humanitarian Coordinator	Oxfam
376	Regional	F	Betty Ojeny	Regional WASH Advisor	Oxfam
377	Regional	M	Mohammed Malik Fall	Regional Director, Eastern & Southern Africa Regional Office	UNICEF
378	Regional	M	Pete Manfield	Regional Chief, Humanitarian Action, Resilience & Peace building Section	UNICEF
379	Regional	M	Pierre Fourcassie	WASH Advisor/Specialist, Eastern & Southern Africa Regional Office	UNICEF
380	Regional	M	Alex Okello	Consultant, Humanitarian Action, Resilience & Peace building Section, ESARO	UNICEF

#	Country	M/F	Name	Designation	Agency
381	Regional	M	Paul Ngwakum	Health Chief,	UNICEF
382	Regional	M	Charles Kakaire	Communication for Development Specialist, Eastern and Southern Africa Region	UNICEF
383	Regional	M	Roger Yates	Regional Director for Eastern and Southern Africa	PLAN Int
384	Sierra Leone	F	Yvonne Forsen	Deputy Country Director & Head of Programmes	WFP
385	Sierra Leone	M	Ernest Sesay	Executive Director	FHM
386	Sierra Leone	M	Braimah Conteh	Head of Child Protection	AMNET
387	Sierra Leone	M	Colonel Dr. Steven Sevalie	Case Management Pillar Lead	Armed Forces of Sierra Leone
388	Sierra Leone	M	Saa Lamin Kortequee	Head	National Commission for People with Disability
389	Sierra Leone	M	John Caulker	Chief Executive	Fambul Tok
390	Sierra Leone	F	Mariama Tommy	Staff member	Fambul Tok
391	Sierra Leone	F	Alimatu George	Staff member	Fambul Tok
392	Sierra Leone	M	Tom Sesay	Director of Reproductive and Child Health	Ministry of Health
393	Sierra Leone	F	Yeama Thompson	Executive Director	Initiatives for Media Development
394	Sierra Leone	M	Aya Mbayo	Education Specialist	UNICEF
395	Sierra Leone	F	Ayodele Bangura	Technical Advisor, Sierra Leone - Health Strengthening Project	GIZ
396	Sierra Leone	M	Dr Thompson Igbu	EPI Team Leader	WHO
397	Sierra Leone	M	Dr Steven Shongwe	Country Representative	WHO
398	Sierra Leone	M	Dr Haj Kella	Deputy Minister	Ministry of Social Welfare
399	Sierra Leone	M	Ansu Konneh	Social Work Coordinator	Ministry of Social Welfare
400	Sierra Leone	F	Kadiaiu B Savage	Mental Health Coordinator	Ministry of Health and Sanitation
401	Sierra Leone	F	Cindy Thai Thien Nghia	Social Behaviour Change Specialist	UNICEF
402	Sierra Leone	F	Claire Buckley	Ambassador of Ireland	Irish Embassy
403	Sierra Leone	M	Dr Sulaiman Sowe	Senior Programme Advisor, Nutrition and Food Security	Irish Embassy
404	Sierra Leone	M	Josephus Ellie	Senior Programme Advisor, Governance	Irish Embassy
405	Sierra Leone	F	Daphne Moffat	Country Director	CDC
406	Sierra Leone	M	Dr Stephen Mupeta	Programme Manager	UNFPA
407	Sierra Leone	F	Eleanor Francisco	Strategic Planning Advisor, RC's Office	UNDCO
408	Sierra Leone	M	Harold Thomas	Risk Communication Lead/ Health Education Programme Manager	Ministry of Health
409	Sierra Leone	M	Ludvik Gerard	OIC	IOM
410	Sierra Leone	M	Daniel Byrne	Monitoring and Evaluation Officer	IOM
411	Sierra Leone	M	Babakunde Ahonsi	Resident Coordinator	UNDCO
412	Sierra Leone	M	Saffa Koroma	Country Health and Nutrition Advisor/National Coordinator for Emergencies	World Vision

#	Country	M/F	Name	Designation	Agency
413	Sierra Leone	M	Magnus Lahai	Health Coordinator	Sierra Leone Red Cross
414	Sierra Leone	M	Joseph Kamana	Director of Resource Mobilisation and Communication	Sierra Leone Red Cross
415	Sierra Leone	M	Samuel Parker	PMER Coordinator	Sierra Leone Red Cross
416	Sierra Leone	F	Tania Fraser	former Gender Advisor	NACOVERC
417	Sierra Leone	M	Tarek Elshimi	Programme Manager	GAVI
418	Sierra Leone	M	Gwenael Rebillon	Emergency Coordinator	UNICEF
419	Sierra Leone	F	Yuki Suehiro	Chief Health and Nutrition	UNICEF
420	Sierra Leone	M	Baboucar Boye	EPI Specialist	UNICEF
421	Sierra Leone	M	Mr. Mohamed A Sesay	Chairman	Kenema District Council
422	Sierra Leone	M	Dr Donald Samuel Grant	District Medical Officer	District Health Management Team
423	Sierra Leone	M	Mr. Francis A Suma	Risk Communication Lead	District Health Management Team
424	Sierra Leone	M	Mr. Umaru Vandy Kondovor	Coordinator	DiCOVERC
425	Sierra Leone	M	Benson Quee	Social Mobilisation Pillar Lead	DiCOVERC
426	Sierra Leone	M	Mohamed Dakona	Public Information Pillar Lead	DiCOVERC
427	Sierra Leone	M	Sylvester S Kallon	Human Rights lead	DiCOVERC
428	Sierra Leone	M	Santigie K. Kanu	Head of Project/Deputy Country Director	Welt Hunger Hilfe (WHH)
429	Sierra Leone	M	Jestina Conteh	Programme Associate, Nutrition	WFP
430	Sierra Leone	M	Andrew Tamba Sallu	Chief of Kenema Field Office	UNICEF
431	Sierra Leone	M	Alhaji Shekhu Kamara	Kenema Head	Inter-Religious Council
432	Sierra Leone	M	Prince Banya	Health project manager, Saving Lives Programme	IRC
433	Sierra Leone	M	Peter Kinie Ndoinje	Area Coordinator	GOAL
434	Sierra Leone	M	Francis Kanneh	Health Programme Manager	GOAL
435	Sierra Leone	M	Bai Sheka Sesay	Coordinator	Sierra Leone Association of NGOs (SLANGO)
436	Sierra Leone	M	Santigie Kargbo	President	Sierra Leone Union on Disability Issues (SLUDI)
437	Sierra Leone	M	Rev. Alimany Kargbo	Member	Inter-religious Council of Sierra Leone
438	Sierra Leone	M	Rev. Usman Fornah	Head of Organisation	Inter-religious Council of Sierra Leone
439	Sierra Leone	M	Harding Wuyango	OIC Country Director	FAO
440	Sierra Leone	F	Yakama Jones	Head of Research	Ministry of Finance
441	Sierra Leone	M	Dr. Abu Kargbo	Operations Officer & Social Protection Specialist	World Bank
442	Sierra Leone	M	Idris Turay	Director	National Social Protection Secretariat

#	Country	M/F	Name	Designation	Agency
443	Sierra Leone	M	Patrick Morovia	Grievance Redress Mechanism	Anti-Corruption Commission
444	Sierra Leone	F	Mona Korsgard	Chief of Evidence, Policy and Social Protection	UNICEF Sierra Leone
445	Somalia	F	Rebecca Semmes	BHA Deputy Regional Director for Sudans, East and Central Africa/formerly covered Somalia	USAID
446	Somalia	M	Moffat Kiprotich	Country Director	ADRA Somalia
447	Somalia	M	Ahmed Abdinasir Mohamed	Chair, Localisation and Partnerships WG (Deputy Director and Head of Programmes)	SSWC Somalia
448	Somalia	M	Alex Binns	Field Coordinator	OCHA Somalia
449	Somalia	F	Angela Kearney	Representative	UNICEF Somalia
450	Somalia	M	Charles Mutai	UNICEF Chief of WASH a.i.	UNICEF Somalia
451	Somalia	M	Kyandindi Sumaili,	UNICEF, Chief of Health a.i.	UNICEF Somalia
452	Somalia	M	Shah Jamal Akhlaque,	UNICEF, Chief of Social and Behavior Change	UNICEF Somalia
453	Somalia	M	Joshua Kakaire, Chief of Planning	UNICEF, Monitoring and Evaluation	UNICEF Somalia
454	Somalia	F	Boiketho Murima	UNICEF, Emergency Manager	UNICEF Somalia
455	Somalia	M	Abdifatah Osman Hussen	UNICEF, Programme Specialist Emergency	UNICEF Somalia
456	Somalia	F	Awes Abdullahi Adan	Humanitarian Affairs Officer/Cluster Support Mogadishu	OCHA Somalia
457	Somalia	F	Barbara Ratusznik	UN Integrated Office (formerly Deputy Head of Office for OCHA)	UN Integrated Office, Somalia
458	Somalia	M	Bernard Omondi	Logistics Officer (Cash Based Transfers)	WFPSomalia
459	Somalia	M	Emmanuel Sabila	Logistics Assistant	WFPSomalia
460	Somalia	M	Burhan Abdulahi	Programme Manager	PUNTLAND MINORITY WOMEN DEVELOPMENT ORGANIZATION
461	Somalia	M	Benjamin Conner	CCCM Cluster Coordinator	IOM Somalia
462	Somalia	M	James Macharia	CCCM Cluster Coordinator	UNHCR Somalia
463	Somalia	F	Cindy Isaac	Former Deputy Head of Office	OCHA Somalia
464	Somalia	M	Mukhtar Jimale	Director General	MOHADM Somalia
465	Somalia	M	Dr Sadiq Syed	Representative	UN Women Somalia
466	Somalia	M	Imanol BERAKOETXEA	Regional Health Advisor	ECHO Regional
467	Somalia	M	Edward Melotte	Access Advisor	OCHA Somalia
468	Somalia	F	Roelofje Christina Van Goor	Health Cluster Coordinator	WHO Somalia
469	Somalia	F	Matilda Kirui	Health Cluster Coordinator	WHO Somalia
470	Somalia	M	Ezana Kassa	Head of Programme	FAO Somalia
471	Somalia	F	Francesca Sangiorgi	Chair, Somalia Cash Working Group	WFP Somalia
472	Somalia	M	Gooni (Mohamed Abdi)	Head of Sub-Office, Garowe, Puntland	OCHA Somalia

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473	Somalia	M	Gordon Dudi	Food Security Cluster Coordinator	FAO Somalia
474	Somalia	M	Guy Griffin	Head of UNSOM Puntland	UNSOM
475	Somalia	M	Richard Crothers	Country Director	IRC Somalia
476	Somalia	M	Kjake Peters	Humanitarian Advisor	FCDO Somalia
477	Somalia	M	Ahmed Abdi	Programme Associate	Juba Foundation, Somalia
478	Somalia	F	Lara Fossi	Deputy Representative	WFP Somalia
479	Somalia	M	Otavio Costa	Logistics Cluster Coordinator	WFP Somalia
480	Somalia	F	Makiha Kimura	Head of Sub Office, Hargeisa, Somaliland,	OCHA Somalia
481	Somalia	F	Meena Bhandari	Senior Advisor, Community Engagement and Accountability	Consultant
482	Somalia	M	Daud Adan Jiran	Country Director	Mercy Corps Somalia
483	Somalia	F	Nimo Hassan	Director	Somalia NGO Consortium
484	Somalia	M	Mohamed Hussein	Programme Manager	Nomadic Development Organisation, Somalia
485	Somalia	M	Hashim Jelle	Information Management Officer, Nutrition Cluster	UNICEF Somalia
486	Somalia	M	John Mukisa	Deputy Nutrition Cluster Coordinator	WFP Somalia
487	Somalia	M	Hanad Abdi Karie	Cluster Officer	UNICEF Somalia
488	Somalia	M	Samuel Otieno	Monitoring and evaluation coordinator	ANPPCAN Somalia
489	Somalia	M	Yousef Daradkeh	Protection Cluster Coordinator	UNHCR Somalia
490	Somalia	F	Lidwien Wijchers	Protection Cluster Co-coordinator	DRC Somalia
491	Somalia	M	Adan Abdullahi	National Protection Cluster Coordinator	UNHCR Somalia
492	Somalia	F	Randa Merghani	Fund Manager, Somalia Humanitarian Fund	OCHA Somalia
493	Somalia	M	Adam Abdelmoula	RC/HC/DSRSG	UNSOM
494	Somalia	F	Hazumi Kawamoto	Special Assistant, Political Affairs	UNSOM
495	Somalia	M	Simon Nyabwengi	Country Programme Director	World Vision Somalia
496	Somalia	M	Kulmiye Hussein	Executive Director	Somali Lifeline Organisation, Somalia
497	Somalia	M	James Swann	SRSG	UNSOM
498	Somalia	F	Se Young	Special Assistant to the SRSG	UNSOM
499	Somalia	M	Abdirizak Rashid	Monitoring and evaluation coordinator	Save Somalia Women and Children, Somalia
500	Somalia	M	Thomas Bissono	Deputy Country Director	ACTED Somalia
501	Somalia	F	Wangechi Catherine Muriithi	SDC Cooperation Officer	SDC Cooperation Office, Somalia
502	Somalia	M	Peter Philips Lukwiya	WASH Cluster Coordinator	UNICEF Somalia
503	Somalia	M	Hassan Diis	National WASH Cluster Coordinator	UNICEF Somalia
504	Somalia	M	Dr. Mutaawe Lubogo	Epidemiologist, Health Emergency Programme	WHO Somalia

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505	Somalia	M	Omar Jama	Chief Executive Officer	Zamzam Foundation, Somalia
506	Syria	F	Miki Tanae	Education sector coordinator	UNICEF
507	Syria	M	Bo Viktor Nylund	Representative	UNICEF
508	Syria	F	Marjanne van Vliet	Country Director	ZOA
509	Syria	F	Memory Cox	Manager of Programme Quality	ZOA
510	Syria	F	Minako Manome	Deputy Resident Representative a.i.	UNDP
511	Syria	F	Maria Kadri Al Tourjuman	Project Coordinator and Health Representative	SSSD
512	Syria	F	Monica Matarazzo	Protection and Gender Officer	WFP
513	Syria	M	Michael Robson	Representative	FAO
514	Syria	M	Patrick Sijenyi	WASH Sector Coordinator	UNICEF
515	Syria	F	Liny Suharlim	Deputy Head of Office	OCHA
516	Syria	M	Imran Riza	RC/HC	Resident Coordinator's Office
517	Syria	M	Dr. Marwan Hammoud	COVID-19 Specialist	Al Bir Wa Ehsan Association in Ras Alain
518	Syria	M	Raymond Youssef	Programme Officer	Al Bir Wa Ehsan Association in Ras Alain
519	Syria	M	Luigi Pandolfi	Head, EU Humanitarian Aid Operations in Syria	ECHO
520	Syria	F	Matilde Gomis-Perez	Country Relations Senior Broker, MENA	Oxfam
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Annex 4: Community engagement methodology

This annex outlines the methodology that the evaluation team used to obtain community feedback on projects implemented by IASC members and their partners. It is a summary of a larger document that was prepared to provide practical guidance both to those assisting the evaluation team to set up community consultation as well as for the national evaluation consultants.

1. Purpose of community engagement

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

2. The data collected through community consultations provided evidence against the evaluation questions and indicators outlined in Box 1 below.

Box 1: Contribution of community feedback to providing evidence for the EQs

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

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

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

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

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

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

2. Overview of community engagement methods

3. The evaluation team used three complementary data collection tools during community consultations to collect evidence for this evaluation. These are described in brief in Box 2 below.

Box 2: Community engagement approach

1. COVID-19 timeline

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

2. Assessing quality exercise

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

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

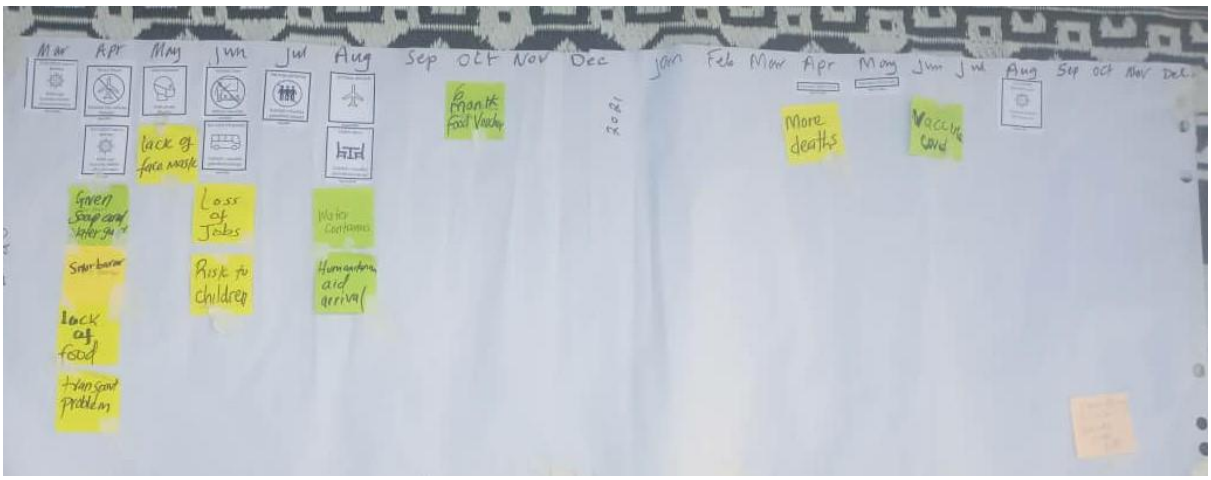
- Effectiveness: What difference the assistance made to people's lives and the extent to which it helped them face the challenges that resulted from the COVID-19 pandemic.
- Targeting: Whether the assistance was provided to the most vulnerable and those most in need and how these recipients were identified.

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

3. Stories of change

During the project site visits, team members sought to identify particularly illustrative stories (for example, through discussions of the effectiveness questions in the FGDs), and documented these in order to obtain details of what assistance was received and its effect. The aim was to highlight how the COVID-19 response had contributed to making a difference to individual people's lives.

Box 3: Example of COVID-19 timeline from Kismayo, Somalia



2.1 Note on attribution/contribution

4. In any location where COVID-19 assistance was provided (either specific projects or adaptations to existing projects), it was anticipated that it would be difficult to attribute interventions and their effects to specific IASC members with confidence. This is due to the temporal scope of the evaluation, and because communities are likely to find it difficult to isolate specific types of assistance or services and attribute them to individual duty bearers or agencies. Even in instances when this was possible, it might not have been possible to determine the extent to which assistance and services contributed to specific changes or improvements in people's lives; changes take place over time and some of these may not be connected with the COVID-19 projects and would have happened regardless of whether or not a particular response occurred. Other changes may have a clearer link to a specific intervention, in which these changes could be attributed to the project.

5. While methods do exist to assist in understanding attribution, given the time and resource limitations of the exercise, the team took a pragmatic approach to making these linkages where possible.

3. Recording and use of data from community consultations

6. Since the community consultations were undertaken in a limited number of locations per country, they could only provide a snapshot of the assistance provided. For this reason, the data from the community consultations is specific to each country, but the evaluation used the data to triangulate or illustrate findings.

7. In terms of record-keeping, consultants facilitating the FGDs kept the flipchart with the timeline and the quality assessment cards, taking a photograph at the end of the FGD and sharing this with the core team. National

consultants wrote up detailed notes of the discussion in the FGD and shared these. To assist in this, the core team developed record sheets that included the following:

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

8. The national consultants provided a remote debrief periodically with a member of the core evaluation team. National consultant team members read their notes from the exercise and highlighted key issues and quotes at the end of each day. This permitted the team to understand any differences in the findings (i.e., gender, age), as well as differences in perspectives according to other characteristics (e.g., age of informants). It also allowed identification of any issues that required follow-up in subsequent FGDs. A final debrief session at the end of the community engagement permitted discussion between the national consultants and core evaluation team members on the issues raised and methods used, and ensured that team reflections, and community discussions have been recorded fully.

Annex 5: Strength of evidence findings

1. The evaluation team developed a criteria to determine the strength of evidence underpinning the findings presented in this report. It uses a Red/Amber/Green colour coding for each strength category and is outlined below.

Category of Evidence	Criteria for determining strength of evidence	Colour coding for category
Strong or '*robust*' evidence	▪ Good data coverage ▪ Evidence is from more than one source/perspective and more than one data collection method ▪ Evidence is consistent across sources ▪ Sources are contextually relevant and reliable	
Sufficient or '*some*' evidence	▪ Data coverage is sufficient but patchy across some aspects of the indicators being assessed ▪ Evidence is from more than one source and moderately consistent across sources ▪ Sources are contextually relevant and reliable	
Weak or limited evidence	▪ Evidence is single source and/or has low levels of consistency ▪ Data coverage is limited or negligible ▪ Sources may lack contextual relevance and reliability	

2. The table below lists the evaluation questions with the colour code to indicate the strength of the evidence for the findings presented in the main report. It also outlines the justification for the strength rating.

Evaluation questions	Rating	Basis for evidence confidence rating
1. Preparedness: Relevance of measures and contribution to timely and appropriate response		
1.1 To what extent were the collective preparedness measures put in place by the IASC prior to the pandemic relevant and adapted to the COVID-19 pandemic?		Evidence gathered from documents and interviews at the global and country levels. Consistency in the analysis was strong but evidence sources were limited, in part because of the limited practice.
1.2 To what extent did the IASC's preparedness measures in targeted GHRP countries after Scale-Up declaration contribute to more timely and relevant humanitarian response?		Evidence gathered from multiple sources, although modest evidence on which to make evaluative judgments on the link between preparedness measures and the timeliness and effectiveness of the response.
2. Assessment of needs: Use of evidence for response planning		
2.1 To what extent was the global humanitarian response strategy for the pandemic informed by an assessment of needs?		Evidence at the global level underpinned by relevant interviews and modest documentation linked to the GHRP and the analysis which informed it.
2.2 To what extent were country humanitarian plans and response strategies for the pandemic informed by a systematic and comprehensive identification of affected people's needs?		Interviews and assessment reports provide a level of assurance from multiple sources. Assessment methodologies not always explicit and complex to make evaluative judgments about how comprehensive assessments were.
3. Strategic planning: Coherence and connectedness in planning the response		
3.1. To what extent were the IASC humanitarian policies, strategies, and responses to COVID- 19 consistent and complementary with the health and social economic responses by United Nations and other actors?		Evidence gathered from documentary evidence as well as global and case study KIIs but limited coverage because relatively small number of interviewees able to address this EQ.
4. Leadership and Coordination: Support to coherent collective response		
4.1 To what extent were the global IASC strategy and Scale-Up mechanisms effective in ensuring IASC country teams' capacity		Significant evidence from both interviews and document review. Minutes of key global

Evaluation questions	Rating	Basis for evidence confidence rating
to lead and deliver humanitarian assistance in targeted countries?		meetings provided quality evidence of global leadership and support.
4.2 To what extent was the IASC response coherent and well-coordinated in its delivery of the response to a multi-dimensional crisis?		Coordination mechanisms benefit from a wealth of documentary evidence in addition to a significant number of interviews both at global level and across the country case studies.
5. Resource mobilisation: Timeliness, flexibility and adequacy of the funds raised and efficiency of the allocation		
5.1 To what extent were the IASC's efforts successful in mobilizing adequate, timely and flexible funding to meet the GHRP requirements?		Evidence from multiple data sources – documents, KIIs with range of stakeholders at global and case study level, and financial data. Evidence consistent across these sources. Good financial data coverage for 2020.
5.2 To what extent did pooled funds contribute to the provision of adequate, timely and flexible funding to meet the GHRP requirements?		
6. Implementation and monitoring		
6.1 Collective response: Added value of collective mechanisms for response		
6.1.1 What was the added value of collective mechanisms to the planning and implementation of the response?		While the EQ is broad, collective mechanisms are comparatively well documented including documentation which supports evaluative judgments. Evidence was also available from a range of informants at different levels of the response, which permitted triangulation of findings.
6.2 Adaptive capacity: Use of evidence to adapt the collective response		
6.2.1 To what extent have inter-agency information management and monitoring mechanisms been able to support IASC collective decision-making?		A wealth of documentary evidence on the mechanisms themselves. More challenging to assess the use of the mechanisms for decision-making although the evaluation was able to elicit opinions from key informant interviews with aid workers at a range of different levels and across the case study countries which strengthened the evidence.
6.2.2 To what extent did the IASC's collective response prove relevant and adaptive in meeting the demands of the crisis and the humanitarian needs caused by it?		Significant evidence received by the evaluation, both documented and from interviews which permitted analysis and synthesis of adaptations.
6.3 Localisation: Ensuring complementarity and participation of local actors		
6.3.1 To what extent did international humanitarian preparedness and response to COVID-19 complement and empower national and local actors in their efforts and leadership to address COVID-19-related humanitarian needs?		Consistent evidence from documents as well as global and case study KIIs. Data sources contextually relevant and reliable.
6.3.2 How effectively did IASC collective mechanisms for planning and implementing the response ensure local participation?		Evidence from documents and KIIs with different stakeholder groups at case study level. Evidence consistent across contextually relevant and reliable sources.
6.3.3 To what extent did IASC allocation strategies, mechanisms, and decision-making processes facilitate the efficient use of available resources to meet response objectives, including by channelling resources to frontline responders (international and local/national NGOs and civil society organisations (CSOs))?		Largely consistent evidence from multiple sources – documents, case study KIIs and financial data. However, limited data available on allocation and decision-making processes.
6.4 Operational coherence and complementarity to address multiple effects of the pandemic		
6.4.1 To what extent did the IASC's collective global, regional and country-level humanitarian response planning and prioritisation correspond to the national priorities of affected countries?		Very good data coverage across case studies. Consistent evidence from documents as well as global and case study KIIs.
6.4.2 To what extent did the collective humanitarian response to the pandemic contribute to the overall objectives of the SG's call for solidarity to address the impact of the multi-dimensional crisis?		Sufficient data coverage across case studies with mainly consistent evidence from documents and case study KIIs.
6.4.3 To what extent were there linkages and synergies in COVID-19-related responses across the humanitarian-development-		Sufficient data coverage with evidence on peace aspect of nexus drawn largely from

Evaluation questions	Rating	Basis for evidence confidence rating
peace nexus aimed at addressing the intertwined effects of the pandemic?		documents. Evidence from documents and case study KIIs broadly consistent.
6.5 Monitoring and reported results: Extent to which humanitarian needs were addressed		
6.5.1 To what extent did the IASC's collective response to the pandemic meet the humanitarian needs of affected people adequately and effectively, both overall and vis-à-vis specific vulnerable groups?		Strong evidence, both documented and from interviews available on monitoring and reporting of the response. Use of a consistent methodology for community engagement across all of the case study countries, relatively large sample size (for an IAHE), and consistency in findings.

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