Final Evaluation Report

Islamic Relief's Global Covid-19 Response & Recovery Programme 2020/21

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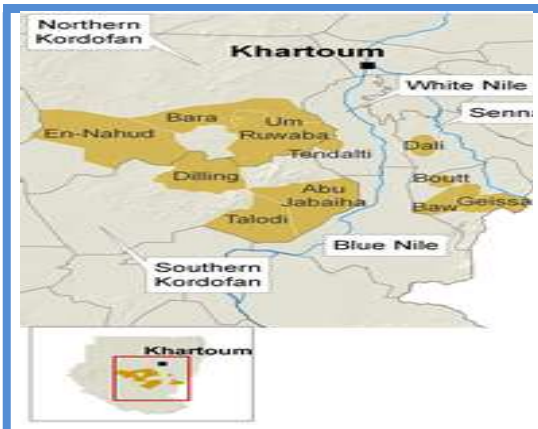

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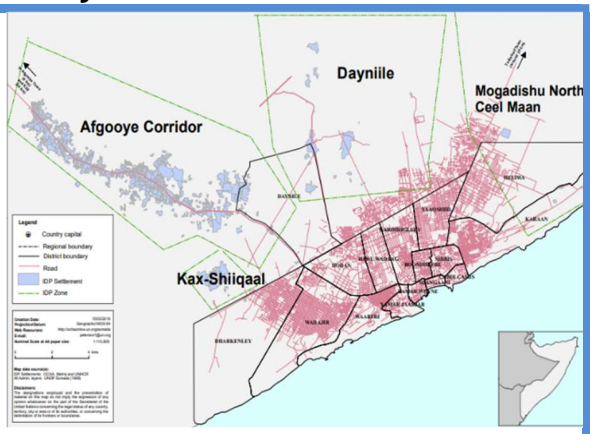

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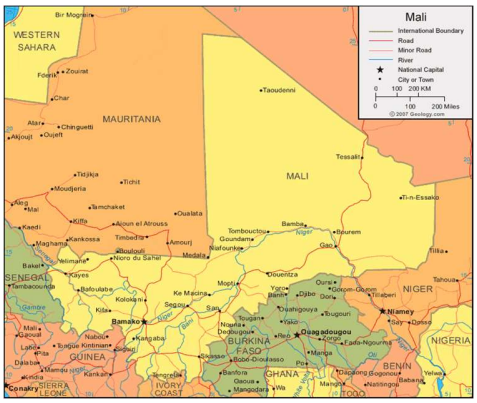

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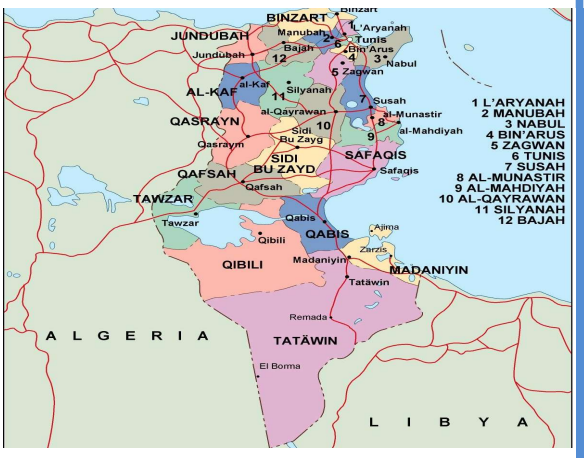

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ABBREVIATIONS

CAPER	COVID19 Awareness and Protection Emergency Response
CBO	Community Based Organization
CNIC	Computerized National Identity Card
CORPS	Covid-19 Response Project
CRM	Complaint and Response Mechanisms
CSO	Civil Society Organization
DDMA	District Disaster Management Authority
DEC	Disasters Emergency Committee
DEO	District Education Officer
DRMD	Disaster Risk Management Department
FGD	Focus Group Discussion
GLA	Government Line Agency
GOB	Government of Balochistan
HAC	Humanitarian Aid Commission
HDI	Human Development Indicator
InDPIABS	Integrated Development Project to Improve Access to Basic Services
IR	Islamic Relief
IRW	Islamic Relief Worldwide
KII	Key Informant Interview
MH Tunisia	Ministry of Health Tunisia
NADRA	National Database and Registration Authority
NDMA	National Disaster Management Authority
NFI	Non-food Items
PDMA	Provincial Disaster Management Authority
PPE	Personal Protective Equipment
PSLMS	Pakistan Social and Living Standards Measurement Survey
PWDs	Persons with Disabilities
RCCE	Risk Communication and Community Engagement
RCPP	IR- USA Response to Coronavirus Precautions and Preventions
SERF	Socio Economic Recovery Framework
SMoH	State Ministry of Health
TACVA	Transformation & Adaptation against Climate Variability Affected-Areas
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme

EXECUTIVE SUMMARY

BACKGROUND

The Covid-19 pandemic is the biggest global health emergency in nearly a century with huge long-term consequences for the global economy. It has disrupted people's lives, livelihoods and children's education and is disproportionately affecting the poor and those in existing humanitarian crises, conflict zones and refugee settings in all IRW countries. IRW and its country programs launched significant response efforts to confront Covid-19's primary and secondary impact. Initial responses were focused on short-term lifesaving needs including risk communication and community engagement (RCCE), strengthening of health systems to take care of Covid-19 affected patients, and provision of emergency food security assistance to those impacted by lockdowns. IRW also recognised the need to act on the secondary impact through livelihoods work in subsequent phases to guide a more holistic recovery effort focused on secondary impacts of Covid-19.

The global IRW response to date in both phases includes 37 projects funded by Islamic Relief USA worth over GBP 8 million and 169 projects worth over GBP 21 million by all donors across 28 countries in Asia, Africa and Europe. The actual amount of Covid-19 work is much higher since many existing projects reallocated funds for Covid-19 related work. The biggest programs were in Yemen, South Sudan and Lebanon, which together constituted nearly one-third of the total IRW response.

The purpose of this evaluation is to map IRW global Covid-19 response and recovery programs and assess their effectiveness with reference to outcomes and outputs as well as draw lessons for future programming and preparedness. This evaluation, which was conducted over April and May 2021, is in line with IRW's commitment to learning and accountability to communities and partners. It takes into consideration the OECD/DAC Evaluation Criteria as well as the Core Humanitarian Standards (CHS) highlighted below to evaluate the quality of the interventions. An overall judgment of "satisfactory" and "needs improvement" are given on each commitment. Performance on a commitment is considered satisfactory when beneficiary satisfaction was above two-thirds for field-level commitments and where strong systems exist in case of commitments related to agency systems and processes.

To answer these questions, this evaluation covered five countries directly, including Mali, Pakistan, Sudan, Somalia and Tunisia. The 12 projects include both Phase 1 projects focused on basic needs in the areas of WASH, health, food and protection and Phase 2 projects focused on livelihoods and income. However, most of these latter projects were still in the early phases of implementation and as such only a basic evaluation could be conducted for them. The evaluation also provides a broader picture of the overall global response based on secondary documents and a brief survey to cover the countries beyond the five mentioned above. A total of five additional countries responded to the survey that represent another 20% of the IRW Covid-19 global response. Thus, the ten countries covered directly or indirectly in this evaluation represent nearly half the IRW global response budget.

The external evaluation team consisted of a Global Team Leader and national consultants for the five countries directly covered. The team collected information through documents review, key informant interviews with IR staff and external stakeholders in government and other aid agencies, a large-scale household survey in Mali, Sudan and Somalia and a smaller one in Tunisia and focus group discussions in all countries except Tunisia. The tight evaluation duration, Ramadan, Covid-19 threat, and security issues were significant hindrances that affected field work and the ability to capture in-depth information. The main conclusions are as follows:

FINDINGS

IRW provided critically needed services in all five countries. In Mali, the first project provided WASH kits and awareness-raising on Covid-19 to nearly 1,800 persons and hygiene and WASH kits and protective clothing (gloves and masks) to 22 health centres in Bamako. The second project was implemented within 40 villages across 4 Communes of Gourma Rharous (Northern Mali) to strengthen technical capacities of health workers through training and PPE provision; increase community awareness on covid-19, prevention through WASH kit distribution and community-led and faith-based risk communication; and enhance capacity of the most vulnerable to meet basic needs in the covid-19 context via cash transfers for 400 households. The third project aims to contribute to enhanced resilience and socio-economic recovery of 1,500 vulnerable HHs within the Circle of Douentza. The key good practice in Mali was the use of faith leaders to increase awareness about Covid-19 in communities. In Pakistan, the first project primarily provided direct support to the health departments in terms of medical equipment, personal protective equipment (PPE), installation or fixing of movable water and WASH facilities and awareness-raising through hygiene sessions and media campaigns. The second project focuses on clean water sources, livelihood support in livestock and climate-adaptive agricultural support for 16,800 persons and awareness-raising on Covid-19. The key good practice in Pakistan was the close collaboration with local health and district authorities. In Sudan, the first project focused on providing COVID-19 services and cash assistance to the most affected 10,000 individuals in South and North Kordofan through distribution of hygiene/ sanitary kits and PPEs. The second project aims at providing the affected vulnerable communities with sustainable basic services through improvements in food security at the household level, enrolment and retention of school-going children, gender and culturally sensitive WASH and protection services, and sustainable environmental practices. The key good practice in Sudan was the use of radio messaging to increase awareness on Covid-19 among communities.

In Somalia, the first project targeted Daynille and Bondhere IDP camps in Banadir region and Balcad IDP camp in Middle Shabelle region and included provision of: (a) Hygiene kits, mobile handwashing stands, facemasks, and hygiene promotion campaigns to 1,000 poor and vulnerable IDP households, 400 in Daynille, 400 in Bondhere, and 200 in Balcad; (b) Temperature screening facilities at health centres; (c) Six mobile communal handwashing stands to promote good hygiene practices and conduct handwashing demonstration and COVID awareness campaigns in IRS operated primary health care facilities in Daynille, Bondhere and Balcad; (d) N95 facemasks to the health staff working at the primary health care facilities to minimize exposure and hospital based transmission; and (e) Recruitment and training of five health educators to promote good hygiene practices and behaviour changes and complement the IEC materials.

The second project provided aid to the most affected population, including children and women in IDP camps in Daynile, Mogadishu; Baidoa and Garowe. Overall the project provided immediate support for the vulnerable population, strengthened preparedness of health facilities in Covid-19 prevention and treatment, provided immediate support to vulnerable people, and strengthened the purchasing power of the target right-holders (666 households or 3,996 individuals) through both conditional and unconditional cash grants in Qardho/Burtinle and Baidoa. The key good practice in Somalia was the use of both conditional and unconditional cash transfers. In Tunisia, two projects reinforced capacity of the Ministry of Health to fight the spread of Corona virus through infrastructure improvement of public health hospitals. The project provided the following medical equipment and supplies: ICU electric syringe pumps; Monitors for ICU beds; Suction Machines; ICU Machines; Beds; Laboratory equipment; Automated Biochemistry Machines; Protective masks(helmet), Gant vinyl, Gel hydroalcolique, and Surblouse. The third project is providing a reliable source of income for 50 female headed households through the creation of 50 micro-projects. The women groups are supported through technical and administrative training, work tools and equipment, and marketing of their products. The project also provides awareness of the target rural women groups on issues, including reproductive health, women basic rights, GBV, and first aid techniques. The key good practice in Tunisia was the close collaboration with health authorities. The performance of these projects on the OECD-DAC criteria and CHS commitments is as follows:

1. RELEVANCE

CHS Commitment 1: Humanitarian response is appropriate and relevant

The services and support provided were largely relevant and the focus of support was generally on persons who were most affected. The vast majority (above 75%) of both females and males in the three countries where household surveys were conducted, said that the project services met some of the most important needs of their families either fully or partially. The regions selected were among the most isolated and amongst the worst affected by the pandemic. There were some complaints related to perceived inclusion of persons with lesser needs and the need for some ancillary services to complement current services such as health equipment. Performance on this commitment is satisfactory.

CHS Commitment 4: Humanitarian response is based upon communication, participation, and feedback

The evaluation concludes that participation of communities and institutional right-holders was high as between 76-100% of respondents across the three survey countries expressed satisfaction with community participation in different project phases. This success was based on the use of different approaches, including committees, community mobilizers, local authorities, faith leaders and remote means when travel was not possible and was supported by previous work and links in these committees. The main challenge was ensuring the participation of people who were away from communities due to work and finding ways to involve people busy in daily work locally.

CHS Commitment 5: Complaints are welcomed and addressed

Based on triangulation from all the different sources of information, the evaluation team concludes that complaint mechanisms were present and satisfactory. However, some improvements are needed in terms

of use of multiple channels of raising concerns or feedback, providing instructions in local languages, summarizing and analysing complaints and ensuring adequate use and access by the most marginalized sections of the community like illiterate persons, women, older persons and persons with disability.

Overall, the performance on relevance was satisfactory. Some gaps existed in terms of i) delays in addressing income and livelihoods needs in some places, ii) the perceived inclusion of some persons with lesser needs in Somalia, iii) the lack of complaint mechanism instructions in local languages in some places, and iv) the need to use multiple complaint mechanisms/feedback channels that cater to the needs of all community members and summarizing complaint data. However, overall, good participation of communities and institutional right-holders ensured a focus on relevant needs and worst-affected persons.

2. EFFECTIVENESS

CHS Commitment 2: Humanitarian response is effective and timely

Overall performance on **CHS Commitment 2** is good, especially with the issue of promises kept and quality of services with at least 75% of respondents expressing satisfaction. The most satisfaction was expressed with regard to WASH and informational services related to Covid-19 awareness in all countries.

CHS Commitment 3: Humanitarian response strengthens local capacities and avoids negative effects

Overall, performance on **CHS Commitment 3** was satisfactory. Previous projects had successfully built the informational and income capacities of vulnerable communities to deal with the current crisis in all countries, thus somewhat alleviating misery after Covid-19. New services helped communities avoid harm from Covid-19 to a great extent while 79-100% respondents said that project activities did not cause harm to communities. IRW work also help build the capacities of health authorities in Pakistan, Mali and Tunisia and increased community cohesion in all countries.

CHS Commitment 8: Staff is supported to do their job effectively, and are treated fairly and equitably

Overall, the agency performed well in keeping staff safe from infection through the development of Covid-19 working guidelines under **CHS Commitment 8**, which required the provision of protective equipment to staff and maintaining adequate distancing etc, resulting in few Covid-19 infections among staff. However, the IRW global guidelines could be made more detailed and presentable.

Overall performance on effectiveness was satisfactory. The projects were rated highly on keeping promises and the quality of services though there were complaints about timeliness in several countries. The agency succeeded in achieving these high levels of effectiveness while keeping staff and communities safe during the Covid-19 crisis.

3. EFFICIENCY

CHS Commitment 6: Humanitarian responses are coordinated and complementary

The agency performed a good job at coordinating its work with government and UN agencies and other partners during the Covid-19 crisis despite the restrictions on meetings. This resulted in improved quality of work and reduced bottlenecks and challenges.

CHS Commitment 7: Humanitarian actors continuously learn and improve

Countries undertook learning activities on their own on an ad-hoc basis but no formal lessons learned exercises were held as required by the IRW MEAL Framework. Performance along **CHS Commitment 7** must be improved by ensuring the learning requirements in the IRW MEAL Framework is adhered to by country teams and this should be supported and assured by IRW DRMD, Regional and Programme Quality Teams and through updating its emergency manual and toolkits to incorporate pandemic programming, SERF and CHS commitments.

CHS Commitment 9: Resources are managed and used responsibly for their intended purpose

While performance on **CHS Commitment 9** was adequate, with each country using its own approach to use resources well, a clearer approach developed by IRW head office on ensuring, measuring and reporting the efficient use of resources would have been helpful. Such an approach could use Value for Money and cost-benefit analysis to evaluate the efficient use of resources.

The work on efficiency needs improvement. It has done an excellent job at coordinating with external stakeholders in all countries, especially with government partner agencies. This has helped in increasing relevance, effectiveness, impact and sustainability of project work. However, the work on learning and support to country programs and ensuring good use of resources lacks global harmonization and has been done on an ad-hoc basis by each country. Thus, there is the need to develop more globally harmonized approaches on these issues and aligning its emergency work more closely with the CHS commitments.

4. IMPACT AND SUSTAINABILITY

The discussion under impact and sustainability falls beyond the CHS Commitments framework, which in itself is reflective of the problems involved in measuring impact and sustainability during emergencies given the high and compressed needs, the implementation challenges, the short duration of projects focused mainly on alleviating suffering and the difficulties involved in documenting impact and sustainability during emergencies, especially a pandemic. Still, the agency managed to create impact and sustainability from its Phase 1 projects especially on hygiene matters where 81-100% of survey respondents reported positive impact while 89-95% of those reported sustainable impact. Overall, as expected the greatest **impact and sustainability** in all countries was on social inclusion and protection components of SERF given that Phase 1 projects focused on basic needs while Phase 2 projects that focused on livelihoods work were in very early stages of implementation.

In summary that means good performance on core commitments focused on relevance, participation, quality, coordination and to a lesser extent impact and even sustainability but improvements needed in capturing and sharing learning, ensuring efficient use of resources, complaints handling and timely delivery of Phase 2 projects.

RECOMMENDATIONS

1. OVERALL

The overall recommendations relate to steps that IRW HQ units like Program Quality and DRMD are advised to take to strengthen adherence to the CHS commitments and preparation for future pandemics and other disasters

CHS Commitment 1: Humanitarian response is appropriate and relevant.

1. Develop programming guidelines as part of SERF that encourage countries to adopt a programming continuum for emergency work consisting of relief, early recovery and development that covers not only basic needs in the areas of social inclusion and social protection but also livelihoods opportunities in the areas of economic strengthening (Lead role: DRMD).

CHS Commitment 2: Humanitarian response is effective and timely.

2. Streamline HQ procedures to ensure more timely approval of proposals and budget changes to allow work to start quickly at the field level and keep communities informed about the reasons for delays to manage expectations (Lead role: PFPD)
3. Help countries develop an efficient supply chain system that can immediately be activated after the crisis to ensure timely delivery of inputs (Lead role: Global Procurement)

CHS Commitment 3: Humanitarian response strengthens local capacities and avoids negative effects.

4. Develop the capacities of country offices and partners to undertake pandemic-related work in case international deployments are not possible during pandemics and also consider developing remote deployment options (Lead role: DRMD).

CHS Commitment 4: Humanitarian response is based upon communication, participation, and feedback

5. Develop external stakeholder partnership guidelines that encourage countries to build on the successes achieved in ensuring participation by working with faith leaders at both local and national level, community leaders and local authorities while ensuring that the broader values and agendas of such actors do not conflict with the faith-based or global humanitarian values of IRW (Lead role: PFPD).

CHS Commitment 7: Humanitarian actors continuously learn and improve.

6. Include pandemic work as a priority in the next Strategic Plan and align planning, implementation, monitoring and reporting templates in line with the CHS commitments and SERF and update emergency manual and other toolkits accordingly (Lead role: Program Quality/DRMD).
7. Develop more expertise in core sectoral areas that build on existing capacities and can help attract more funding from external donors, e.g., cash transfers, WASH and early recovery livelihoods work, for basic needs sectors so that its own resources can be freed up to focus on economic strengthening work which is less funded by external donors (Lead role: Program Quality/DRMD).

8. Undertake emergency training on new frameworks above for country-level emergency staff (Lead role: Program Quality/DRMD).

CHS Commitment 8: Staff is supported to do their job effectively, and are treated fairly and equitably.

9. Develop more detailed and presentable guidelines on staff safety during pandemics on HR issues such as leave compensation, overtime, hazard pay, Covid-19 precautions, remote work and physical work with sufficient SOPs etc. (Lead role: Global Security/HR).

CHS Commitment 9: Resources are managed and used responsibly for their intended purpose.

10. Develop a clearer approach on ensuring, measuring and reporting the efficient use of resources would have been helpful. This could include approaches such as Value for Money and cost-benefit analysis to evaluate the efficient use of resources (Lead role: Program Quality/DRMD).

CHAPTER 1: INTRODUCTION

1. EMERGENCY BACKGROUND

The Covid-19 pandemic is the biggest global health emergency in nearly a century with huge long-term consequences for the global economy. It has disrupted people's lives, livelihoods and children's education and is disproportionately affecting the poor and those in existing humanitarian crises, conflict zones and refugee settings. 2020 will remain an unforgettable year for humanity with the exponential spread of Covid-19 across the world and the resultant loss of life, widespread lockdowns, and restrictions in social contact in most countries. The global humanitarian impact from Covid-19 during 2020 is summarised by UNOCHA's Global Humanitarian Response Plan Update (February 2021)[1]. In less than one year (March-December 2020), more than 82 million COVID-19 cases and 1.8 million deaths were recorded. Closures and lockdowns, and market volatility pushed over 270 million people worldwide into acute food insecurity. Gender-based violence sharply increased, fuelled by the loss of referral pathways, access to information, the closures of schools and safe spaces, and the day-to-day isolation of women and girls during lockdowns. The pandemic also increased the abuse and neglect of older persons who are at most risk of dying from COVID-19. Health service disruptions also led to a 30 per cent reduction in the global coverage of essential nutrition services, leaving nearly seven million additional children at risk. The closure of schools led to the loss of important early intervention opportunities for protection, mental health and psychosocial support, and nutrition programs. The economic contractions worldwide brought about the first increase in extreme poverty since 1998, potentially increasing the number of people living in extreme poverty by between 143 and 163 million during 2020 and 2021.This situation was reflected to varying extent in all five countries covered directly in this evaluation.

The COVID-19 pandemic reached Mali on March 25, 2020 and occurred in a context of a security and humanitarian crisis where almost a quarter of the population depended on humanitarian assistance to meet their basic needs. Livelihoods, services and social systems were weakened. The health care system in Mali was unprepared for a COVID-19 outbreak which rapidly overwhelmed and exhausted existing capacities. Low levels of knowledge about COVID-19, the inability of communities to observe social distancing and isolation, lack of access to WASH infrastructures and items, and closure and low capacities of existing health centres all exacerbated the situation.

The virus reached Pakistan on February 26, 2020. Pakistan currently has the 2nd highest number of confirmed cases in South Asia (after India); the 9th highest number of confirmed cases in Asia; and the 31st highest number of confirmed cases in the world. Poor health infrastructure and low levels of adherence to health protocols have contributed to the spread of the virus. Lockdowns and other travel and work restrictions have severely impacted livelihoods for the poor in an economy already suffering from low growth and high inflation.

[1] https://gho.unocha.org/monthly-updates/global-humanitarian-overview-february-update

Sudan too has been experiencing the unprecedented social and economic impact of the COVID-19 pandemic since early March 2020. The Sudanese economy was already suffering from structural trade and fiscal deficits, mass poverty, high inflation, high levels of inequality, and limited public expenditures on basic services. The health sector has been starved of resources for many years. The global pandemic has reduced prospects for agricultural exports, and remittances by the Sudanese diaspora. Oil export proceeds and transit fees for South Sudanese oil will also decline substantially due to lower oil prices. IMF projects a further 7.2 percent GDP contraction for 2020 as a result of the COVID-19 pandemic. The rapid spread of COVID-19 and the government's containment measures too have had significant negative impact on the Sudanese population and economy. Weak health infrastructure, lack of awareness and low levels of adherence have also exacerbated the impact of the crisis. The COVID-19 pandemic reached Somalia on March 16, 2020 when the first case was confirmed in Mogadishu. The death toll and socio-economic impact in the country may increase due to poor working relations between the central government and federal states. Somalia has 2.6 million IDPs who have limited access to quality essential health care, water and sanitation services and live in crowded urban and semi-urban areas. It lacks proper health infrastructure and effective mechanisms for identifying, screening, isolating and managing covid-19 patients. Thus, the case number may be high due to lack of reporting mechanism and poor government capacity both at the centre and in regions and the high displacement and continued conflict. The disease reached Tunisia on March 2, 2020. Tunisia was already battling high unemployment before the start of the pandemic. There were four broad channels through which the pandemic affected poor households in Tunisia further: labour income loss, non-labor income loss, direct effects on consumption, and the disruption of services. Households with per capita consumption in the poorest 20 percent of the population, concentrated in Tunisia's Central, West and South-East regions, were the hardest hit. The most affected persons were women living in large households, without access to health care and employed without contracts. The tourism sector collapsed, increasing misery for the poor dependent on it.

2. IRW AND HUMANITARIAN RESPONSE

Islamic Relief Worldwide (IRW) is an international development charity, which aims to alleviate the suffering of the world's poorest people. It was founded in the UK in 1984. Beyond responding to disasters, it promotes sustainable economic and social development by working with local communities regardless of race, religion or gender. Its humanitarian response globally is coordinated by a UK-based Disaster Risk Management Department (DRMD). Over the years, DRMD has developed a wide range of tools, processes and documents to support efficient and effective emergency work as shown in Table 1.

Thus, IRW has a comprehensive set of resources to support emergencies including an emergency manual, alert system, surge deployment and emergency templates. It has used them to support a variety of earthquake, conflict, flood, hurricane and tsunami related crises in the past. However, the global scale of this crisis was unprecedented while the travel restrictions also undermined the effectiveness of tools like surge deployments. This suggest the need to develop mechanisms for future disasters that are not reliant on surge deployments, including remote surge support and capacity strengthening to local offices and partners. Thus, IRW is looking for suggestions based on lessons from this response on how to be better prepared for similar crises in the future and strengthen its tool of processes and resources further.

TABLE 1: IRW EMERGENCY RESPONSE TOOLKIT

No.	Document Name	Purpose
1	**Emergency Templates & Guidance**	This summary document explains which forms and templates are included in the DRMD Toolbox, and how and when to use them.
2	**GEF and 24/7 Fund Guidelines**	This document refers to the guidelines for the 2 internal emergency funding streams: the General Emergency Fund and the 24/7 Fund
3	**Emergency Process Flowchart**	This diagram shows how the Emergency Process within IRW works.
4	**Categorization of Emergencies**	This document explains the 3 different levels of emergency categorization, the criteria, and how you should reference when emergencies occur.
5	**Anticipatory Alert Template**	This is the document that needs to be filled to raise an alert for an anticipated emergency situation, before the crisis actually occurs.
6	**Emergency Alert Template**	This document is filled to raise an alert a country; the country focal point should send this to the RDC, copying in the DRMD
7	**Unified Project Proposal Documents**	These documents provide templates to be used as a means of which emergency (and other) projects are funded.
8	**Unified Project Reporting Documents**	These documents provide templates for reporting
9	**Supporting Documents for Project Templates**	These documents provide supporting templates for projects
10	**MEAL Framework Tools & Guidelines**	These documents provide templates for M&E tools
11	**Unified Project Cycle Documents Issue Log**	These documents provide templates for developing Logframes
12	**Emergency Update Template**	This template should be filled in by country teams and sent to RDC for review and sharing with Partners.
13	**Disaster Preparedness Plan Template**	This document provides a basis for country teams/ regional desks on the types of emergencies a country may face and how it will respond
14	**Needs Assessment Key Informant Template**	This is a Key Informant template to use during emergency assessment.
15	**Needs Assessment Template**	This is a suggested Needs Assessment template to use during an emergency.
16	**Partner Implementation-Emergency Project Checklist**	In emergency situations where countries will be implementing either solely or partially through a partner, this checklist provides the rationale.
17	**GEF Application Form**	This form needs to be filled in by the relevant RDC, and signed off by DRMD and Finance prior to the release of funds.
18	**Surge Roster- Staff Request Form**	In emergency situations, countries may require additional staff capacity by filling this form.
19	**Surge Roster- Post Deployment Form**	Once a surge deployment has been completed, this form is filled to evaluate the roster member and provide feedback.
20	**Humanitarian Surge Deployment Guidelines**	This document provides an overview of the deployment procedure
21	**Emergency Response Plan/Strategy Template**	This template is used in order to ensure that response planning is structured and is in line with IPD requirements
22	**Inclusive Protective Programming Framework**	This is a reference document for inclusive protection programming in emergencies
23	**IRW Disaster Response Handbook (2012)**	This handbook provides useful information to guide emergency response. This is due to be updated during 2021.

3. IRW COVID-19 RESPONSE

IRW and its country programs launched significant response efforts throughout 2020 to confront Covid-19's primary and secondary impact. The DRMD developed a global response framework based on discussions with the regional, country and global technical teams. Initial responses were focused on short-term lifesaving needs including risk communication and community engagement (RCCE), strengthening of health systems to take care of Covid-19 affected patients, and provision of emergency food security assistance to those impacted by lockdowns. While detailed examples of the type of responses in different countries during the first phase (April – September 2020) are provided in the TORs in the Appendix, its initial response strategy is summarized below:

- ❖ Working with communities to promote good hygiene practices and equip them with the information they need to halt the spread of the virus
- ❖ Supporting and strengthening healthcare services
- ❖ Making sure the long-term impacts of the crisis are addressed from the outset.

FIGURE 1: IR'S SOCIO-ECONOMIC RECOVERY FRAMEWORK

IRW also recognised the need to act on the secondary impact through livelihoods work in subsequent phases. In September 2020, it unveiled a 'Socio-economic Recovery Framework' (SERF) to guide a more holistic recovery effort focused on secondary impacts of Covid-19 (Figure 1). Under this model, the Covid-19 crisis is impacting households by affecting their livelihoods, food security and social cohesion.

The overarching Theory of Change underpinning this framework "posits that vulnerable households will be better able to protect, rebuild and strengthen their livelihoods in the Covid-19 crisis if they have access to a multi-faceted and appropriate mix of resources and tools sustained over several years. This will ensure

they are more resilient to similar recurrent shocks in the future. Moreover, the Theory of Change recognizes the disproportionate impact of the Covid-19 crisis on certain population groups of all ages, including the poorest, women, older people and people with disabilities (PWDs) due to their pre-existing inequalities and vulnerabilities that make them less able to cope with the impacts of the coronavirus pandemic. Thus, IRW focuses on protecting, rebuilding and enhancing livelihoods and resilience strengthening through programs focused on financial and social inclusion, economic strengthening and social protection among right-holders with the ultimate result that households regain resilient food and livelihoods security. Some examples of the type of IRW interventions in Phase II 'recovery phase', which started from September 2020 onwards, are provided in Table 2.

TABLE 2: EXAMPLES OF TYPE OF IRW INTERVENTIONS IN PHASE II

INTERVENTIONS	***12 months***
Strengthened food security of most vulnerable households affected by multiple hazards	X
Increased employment opportunity through VSLA and income generating activities	X
Strengthened capacity of existing health facilities and services to combat Covid-19	X
Improved access to safe water and enhanced coverage of sanitation and hygiene services	X

Table 3 provides an overview of the global IRW response to date in both phases. It includes 37 projects funded by Islamic Relief USA worth over GBP 8 million and 169 projects worth over GBP 21 million by all donors across 28 countries in Asia, Africa and Europe. The actual amount of Covid-19 work is much higher since many existing projects reallocated funds for Covid-19 related work. The biggest programs were in Yemen, South Sudan and Lebanon, which together constituted nearly one-third of the total IRW response.

However, this evaluation focused mainly on the following five countries and twelve projects in terms of primary data collection. These five countries together constitute nearly 25% of the IRW global Covid-19 response and cover four out of its five regions (West Africa, East Africa, Middle East and Asia). While IRW's SERF was only launched in September 2020, making it difficult for country programs to fully build their programs around it, the comprehensive nature of SERF ensured that all programs fall into one or more of its programs foci: Financial Inclusion (sustainable debt and credit), Social Protection (consumption aid and basic services), Social inclusion (enhanced rights awareness and social cohesion) and Economic Strengthening (basic income, adaptive skills and assets provision) components of SERF.

Thus, all projects built on the theory of change in SERF which focuses on protecting, rebuilding and enhancing livelihoods and resilience strengthening through programs focused on financial and social inclusion, economic strengthening and social protection among right-holders with the ultimate result that households regain resilient food and livelihoods security.

TABLE 3: LIST OF GLOBAL COVID-19 PROJECTS

Country	IRUSA Covid related funding (37 projects)	Total Covid-related project funding value - all donors (169 projects	% of Total Covid related Funding	Number of completed projects	Number of ongoing Covid-related projects
Yemen	£1,274,920	£2,997,679	14.1%	3	8
South Sudan	£1,232,865	£2,146,597	10.1%	2	3
Lebanon	£392,080	£1,953,588	9.2%	5	12
Sudan	£1,061,954	£1,511,585	7.1%	1	5
Syria	-	£1,437,315	6.8%	7	2
Bangladesh	£463,725	£1,405,116	6.6%	4	4
Afghanistan	-	£1,395,747	6.6%	5	5
Somalia	£382,799	£1,202,988	5.7%	6	2
Pakistan	£380,621	£1,133,718	5.3%	8	1
OPT (Gaza)	-	£1,015,319	4.8%	5	10
Tunisia	£265,844	£737,371	3.5%	1	3
Mali	£177,369	£667,350	3.1%	10	5
Nepal	£591,715	£624,683	2.9%	2	2
Niger	£422,184	£582,709	2.7%	8	1
Indonesia	£381,218	£439,655	2.1%	3	1
Turkey	£374,690	£374,690	1.8%		1
Bosnia & Herzegovina	£111,036	£328,749	1.5%	5	2
United Kingdom	-	£199,590	0.9%	4	
Philippines	£72,819	£188,685	0.9%		2
Jordan	£80,928	£184,923	0.9%	3	
Ethiopia	£112,865	£158,333	0.7%	2	
Albania	£46,667	£153,687	0.7%	1	1
Myanmar	£74,371	£101,014	0.5%		3
India	-	£86,797	0.4%	1	
Kenya	£80,928	£80,928	0.4%	1	
Kosovo	£56,650	£74,236	0.3%	2	
Spain	-	£57,658	0.3%	6	
Macedonia	-	£45,084	0.2%		1
Total	**£8,038,248**	**£21,285,795**	**100.0%**		

TABLE 4: EVALUATION PROJECTS AND COUNTRIES

Country/Project	Locations	SERF Component and Sectors	Right-holders/ Households	Project Dates
Mali				
Bamako COVID-19 Response	Bamako	Social Protection: WASH Social Inclusion: Awareness raising	317 HHs	April-July 2020
Mali COVID-19 Response-II	Gourma Rharous	Social Protection: Health Social Inclusion: Hygiene services	400 HHs	July-December 2020
Supporting Economic Recovery and Resilience in the Circle of Douentza, Mali	Douentza	Economic Strengthening: Livelihoods and assets Financial Inclusion: Credit Social Inclusion: Awareness	1,500 HHs	July 2020 to July 2022
Pakistan				
CAPER	Balochistan	Social Protection: WASH and Health Social Inclusion: Protection, Awareness	5,000 HHs	June-October 2020
TACVA	Balochistan	Social Protection: WASH, Eco strengthening assets Social Inclusion: DRR, Awareness, policy	1,200 HHs	August 2020-July 2022
Somalia				
DEC	Daynile – Mogadishu; Baidoa and Garowe	Social Protection: Health Eco Str: FSL Social Inclusion: DRR, awareness	10,500 HHs	July2020-January 2021
CORPS	Mogadishu and Middle Shabelle	Social Protection: WASH	1,000 HHs	May 2020-June 2021
Sudan				
Response to Coronavirus precautions and prevention	North & South Kordofan States	Eco Str: Cash, Social Protection: WASH Social Inclusion: Awareness	10,000 HHs	September 2020-February 2021
Integrated Development Project to Improve Access to Basic Services by Conflict Affected Vulnerable Communities	Blue Nile and Kordofan States	Eco Str: FSL Social Protection: Education, WASH and Health Social Inclusion: Awareness	12,000 HHs	January 2021-June 2022
Tunisia				
Emergency Support to Prevent the Spread of Second Wave of COVID-19 in Tunisia	Country-wide	Social Protection: Health Social Inclusion: Awareness		October 2020-May 2021
Emergency Support	Country-wide	Social Protection: Health Social Inclusion: Awareness		
Rural Women Empowerment	Tataouine	Eco Str: FSL Social Protection: Health Social Inclusion: Awareness	50 women	February 2021-February 2023

CHAPTER 2: EVALUATION OVERVIEW

1. EVALUATION FOCUS

The purpose of this evaluation is to map IRW global Covid-19 response and recovery programs and assess their effectiveness with reference to outcomes and outputs as well as draw lessons for future programming and preparedness. This evaluation is in line with IRW's commitment to learning and accountability to communities and partners. It takes into consideration the OECD/DAC Evaluation Criteria as well as the Core Humanitarian Standards (CHS) to evaluate the quality of the interventions as follows:

Relevance

- CHS Commitment 1: Humanitarian response is appropriate and relevant
- CHS Commitment 4: Humanitarian response is based upon communication, participation, and feedback
- CHS Commitment 5: Complaints are welcomed and addressed

Effectiveness

- CHS Commitment 2: Humanitarian response is effective and timely
- CHS Commitment 3: Humanitarian response strengthens local capacities and avoids negative effects
- CHS Commitment 8: Staff is supported to do their job effectively, and are treated fairly and equitably

Efficiency

- CHS Commitment 6: Humanitarian responses are coordinated and complementary
- CHS Commitment 7: Humanitarian actors continuously learn and improve
- CHS Commitment 9: Resources are managed and used responsibly for their intended purpose

Impact and Sustainability

The evaluation focuses on the following objectives:

- Identifying lessons and good practice from the overall Covid-19 response and recovery program to inform IRW and potentially wider sector to future response to similar health emergencies.
- Assessing the extent to which planned outputs and outcomes have been achieved using the OECD DAC criteria for evaluating humanitarian responses including assessing for relevance, connectedness, coherence, coordination, effectiveness, efficiency, impact and sustainability and recommend priorities and any changes to approach for subsequent phases of Covid-19 recovery.
- Evaluating the appropriateness and extent of application of quality standards, with a particular focus on the CHS.
- Examining the level of preparedness at IRW headquarters and country offices had / could have had, what went well in the coordination / management of it, what didn't and what ought to be done differently going forward etc.

The detailed questions are given in the appendix in the evaluation TORs. This evaluation covered the five countries and their projects mentioned in the last chapter. They include both Phase 1 projects focused on basic needs in the areas of WASH, health, food and protection and Phase 2 projects focused on livelihoods and income. However, most of these latter projects were still in the early phases of implementation and as such only a basic evaluation could be conducted for them. The evaluation also provides a broader picture of the overall global response based on secondary documents and a brief survey to cover the countries beyond the five mentioned above. A total of five additional countries responded to the survey that represent another 20% of the IRW Covid-19 global response. Thus, the ten countries covered directly or indirectly in this evaluation represent nearly half the IRW global response budget.

2. EVALUATION PROCESS

Stage 1: Preparation and planning (April 1-18)
The evaluation team consisted of a Global Team Leader and a national consultant for the five countries. The team reviewed project documents, including project proposal, progress reports (narrative and financial), internal monitoring/mission reports, case stories, yearly plan of operation, operational reports, progress reports, strategic framework, output/outcome indicators, etc., and conducted informative interviews with key IR country and global staff to prepare an inception report.

Stage 2: Fieldwork (April 19-May 7)
The team used qualitative and quantitative techniques to collect primary and secondary data from multiple sources to ensure triangulation as follows:

i) Key Informant Interviews (KIIs)
The evaluation conduct key informative interviews with IR country team staff and external stakeholders such as officials of government departments and UN agencies like UNICEF and FAO.

ii) Focus Group Discussions (FGDs)
FGDs were conducted in selected field locations covering different districts, project phases, gender, disabilities, age and other key dimensions. FGDs focused on collecting rich information on the "why" and how" related to the key objectives. Each FGD included 6 participants only in view of Covid-19 and was conducted in open space with sufficient distance between the respondents and with masks compulsory.

iii) Household Survey
The household survey in each country used closed-ended questions focused on "what and when" related to the dimensions covered in KIIs and FGDs. The survey tool was pre-tested in the field and genuine inputs and feed backs incorporated in the final survey tool. This also provided opportunity for training of enumerators. The household survey sample size was based on the number of right-holders for each country. The minimum sample size was set at 90% confidence level and 7% margin of error. These numbers were decided given the tight end date of evaluation, with time reduced further due to Ramadan, Covid-19 issues, travel distances and security issues in some areas. Stratified sampling was used and the relevant strata like gender, districts etc. The right-holders were randomly selected from project right-

holders list in each stratum, with 10-15% oversampling done to cater to non-presence of some right-holders in the field. In view of Covid-19 crisis, interviews were conducted in open space with sufficient distance between the respondents and interviewer and with masking compulsory.

The Household survey could not be undertaken in Pakistan, as mentioned in the original evaluation TORs, due to project stage, Covid-19 and security situation. In Tunisia, two projects focused on providing health equipment to hospitals and did not have any field right-holders. The third project included only 50 female right-holders and was still in a very early stage of development. Also, the evaluation contract only provided for hiring a national consultant to undertake KIIs with IR and health staff while field work was to be done by the IR Tunisia team, which undertook a small-scale household survey with nine out of the 50 women while FGDs were not possible due to Covid-19 situation. It also proved difficult to get cooperation from some external KIIs. As such analysis for the Tunisia work is more limited compared with the other four countries. No field work could be done for the "Supporting Economic Recovery and Resilience in the Circle of Douentza, Mali" due to time constraints and the fact that the project was still in a very early stage of implementation. The sampling size for the household survey and FGDs in each country is provided below. There were equal number of male and female FGDs (with persons with disabilities included there), but overall two-thirds of the household respondents were females due to the higher number of females among project right-holders. The number of KIIs in Sudan and Somalia was lower as some of the suggested key informants were not available for interviews.

TABLE 5: SAMPLING SIZE FOR HOUSEHOLD SURVEY, KIIS & FGDS

Country	Survey	FGDs	Internal KIIs	External KIIs
Mali	150	12	4	6
Pakistan	None	12	5	12
Somalia	166	18	3	2
Sudan	155	7	4	3
Tunisia	9	None	3	7
Total	**480**	**49**	**19**	**30**

iv) Global Staff Survey

A global staff survey was also conducted with the program staff of the remaining IRW operational countries beyond the five countries directly covered. The survey asked the countries to rate their performance on each CHS commitment out of ten and list the major challenges and accomplishments under each commitment. They were also requested to comment on the impact and sustainability of their programs. Five additional countries responded to the survey out of over 20 remaining countries.

The National consultant recruited local enumerators for data collection. Standard protocols were applied to ensure data quality, including adequate training of enumerators, cross-checking in data entry and rechecking by the National Consultants (Team Leader) for a sample of data. The National Consultants took steps to ensure that the evaluation respected and protected the rights and welfare of the people and communities involved and ensured that the evaluation is technically accurate and reliable, is conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. The teams took every reasonable available measure to ensure the greatest possible reliability and validity of the evaluation findings and conclusions. Standard data protection protocols were followed by obtaining consent, maintaining confidentiality and security of data and data retention and disposal processes. In order to ensure quality, security and adherence to IRW codes, strict protocols were followed. After the approval of the inception report, the Global Evaluator trained the National Evaluator on the TORs requirements, logic and content of each instrument, IRW codes against slavery, sexual exploitation, confidentiality, cultural sensitivity and codes on 'do no harm to right-holders'. The National evaluators also trained the enumerators thoroughly on all these aspects subsequently. The evaluation team took stringent measures to keep themselves and respondents safe from Covid-19 risks. For KIIs, interviews were held remotely due to Covid-10 restrictions and security situation in some places. For FGDs, the number of respondents were restricted to a maximum of six and held in the open with physical distancing and masking.

Stage 3: Data analysis and report writing (May 7-May 20)

Following the fieldwork, the evaluation team initiated data analysis. The data was disaggregated by gender, disabilities, and age. The evaluation team employed a structured approach as follows:

- Summarized key informant interview and FGD notes, and coded them according to themes relevant to the evaluation.
- Prepared tally sheets identifying the themes that emerged in the document review, FGDs and key informant interviews to facilitate systematic and rigorous data analysis aimed at identifying key evaluation findings.
- Compared responses of different stakeholder groups with each other and information provided in project documents in order to triangulate as effectively as possible.
- Compared information provided by project staff with information provided by the respondents (right-holders), and addressed factual discrepancies as well as differences across stakeholder groups in consultation with IR.
- Analysed the quantitative data by preparing cross-tabs and frequency distributions from the household survey, which were processed and analysed using Excel.

An overall judgment of "satisfactory" and "needs improvement" are given on each CHS commitment. Performance on a commitment is considered satisfactory when beneficiary satisfaction was above two-thirds for field-level commitments and where strong systems exist in case of commitments related to agency systems and processes.

Moreover, to address potential limitations, the evaluation conducted the data collection and analysis in a highly systematic manner by triangulating across multiple sources, methods and investigators to ensure the reliability and validity of findings and conclusions. More precisely, the methodology allowed for:

- **Data Triangulation.** Primary data was drawn from across stakeholders and included in the evaluation. Only information that was reported by multiple informants was included in the findings.
- **Methodological Triangulation.** Different data collection methods were used, including project reports/documents, individual interviews and focus group discussions. Additionally, qualitative information was triangulated with secondary data from project documents/reports.

Due to the security situation, the evaluation teams took thorough briefing from IR office, local authorities and their own contacts and stringently followed essential protocols advised by UN and IRP country office. Due to a security incident in Quetta, Pakistan, the field visit had to be cut short and the remaining interviews were conducted remotely. Due to a security incident, field work had to be done remotely in Somalia for the Middle Shebelle project. Covid-19 wave also affected field work in Sudan.

CHAPTER 3: MAIN FINDINGS

This chapter provides the findings of this evaluation. The findings are presented along the five OECD-DAC criteria, i.e., relevance, effectiveness, efficiency, impact and sustainability, as required in the evaluation TORs. Furthermore, the discussion under these criteria is also arranged according to the CHS commitments relevant to it, as identified in the evaluation TORs. The overall evaluation questions mentioned in the evaluation TORs are also all linked to the different DAC criteria. The discussion under each section draws upon the information collected from the documents review, household survey, FGDs and internal and external KIIs and the global survey. While the survey data for three countries is presented together, readers are cautioned against making inter-country comparisons on different dimensions given the vastly different context, budgets, project details and beneficiary backgrounds in each country.

1. RELEVANCE

CHS Commitment 1: Humanitarian response is appropriate and relevant

Figure 2: Appropriate targeting of needs and right-holders

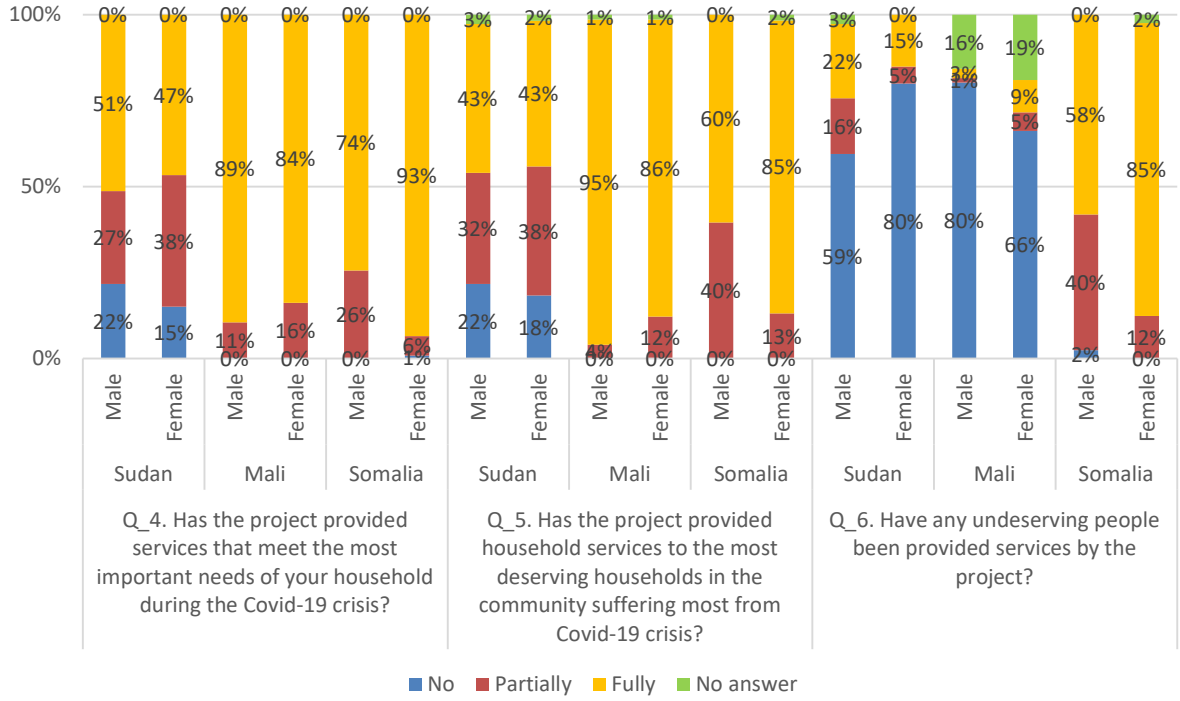
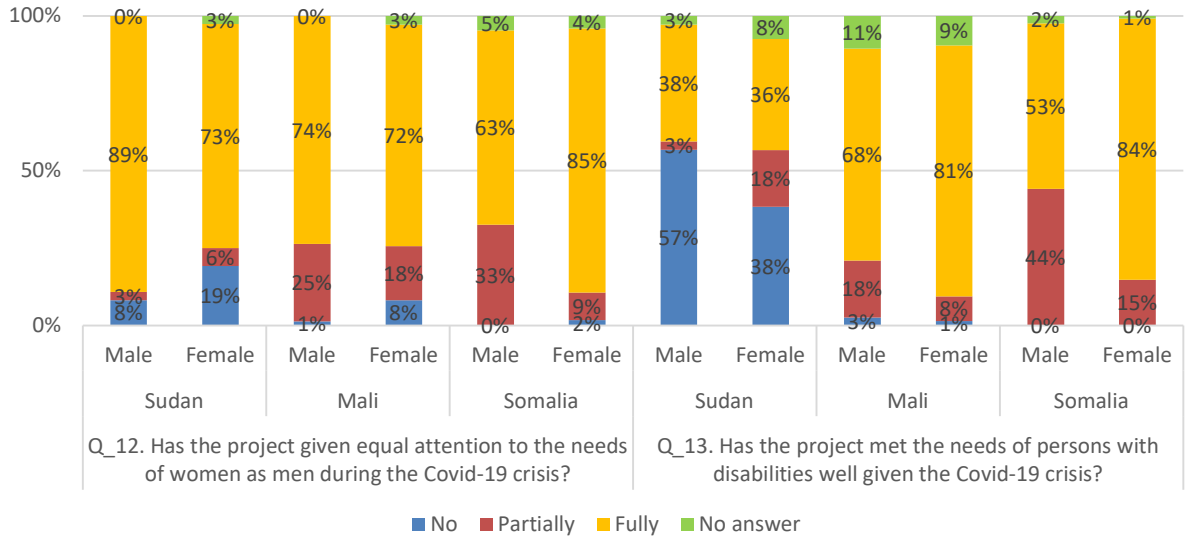


Figure 2 shows that the vast majority (above 75%) of both females and males in all three countries said that the project services met some of the most important needs of their families either fully or partially. The vast majority (above 90% of males and females) in all three countries also said that the projects had focused on the worst-affected families. However, in Somalia, a majority of respondents also felt that some

less affected persons had also been provided support. In Tunisia, the percentages of people fully or partially satisfied with the first two dimensions were 100% and 89%, while most respondents felt that some less affected persons had been helped. The average score assigned by the respondents in the global survey to performance on CHS 1 was 8.9 out of ten. The three biggest challenges reported by these global survey respondents in achieving this commitment were restrictions such as travel, security and distance ones; the lack of awareness among communities about Covid-19 and limited resources to deal with all the needs. The main successes identified in meeting this commitment were increase in awareness among people, increase in people's income and being able to get faith leaders to cooperate.

The vast majority of household respondents in all three countries felt that the agency had fully or partially given attention to the needs of women and persons with disabilities, especially nearly 90% of males in Sudan felt so about the attention given to the needs of women (Figure 3). However, the corresponding figures among Sudanese males with respect to the needs of persons with disabilities was below 50%. Seven out of nine respondents in Tunisia agreed fully or partially with the first question and all did so for the second question. Majority of the male and female FGD participants in Pakistan also indicated that the project had equally addressed the needs of men and women in their respective communities. Disaggregated data by old age and disabilities in family is provided in the appendix and is largely in line with general population responses.

Figure 3: Focus on women and persons with disabilities



FGD information from the four countries where they were done supplemented these overall findings. FGD information shows that the Covid-19 crisis affected them in multiple ways. Firstly, it created scare and uncertainty among the communities about the hazard posed by the virus to their health. Secondly, it also affected their livelihoods and income potential due to travel restrictions and the overall economic slowdown in their countries. Thirdly, it also intensified the need for social services in the areas of food security, health and education. Thus, health and hygiene information and food, livelihoods and income

related needs were generally mentioned as the most important ones. The health and hygiene needs were generally provided in all the projects. However, in projects focused on basic needs like health, people also expressed the need for food, income and livelihoods support directly or through referral pathways.

In Pakistan, the majority of male and female FGD participants indicated that all the services, including Covid-19 related awareness sessions, provision of masks, soaps, and sanitizers, provided under the CAPER project and provision of seeds, food items, water tank repairs and awareness sessions under the TACVA project, were relevant to their needs. However, they also said that other crucial needs like access to water, food supplies, cash grants and livelihood opportunities were not delivered. People in Harnai explained that due to drought, low level of underground water table, and the lack of other income opportunities, their livelihoods were severely affected by the pandemic. The majority expressed their dissatisfaction with the delay of services promised under the TACVA project.

In Somalia, FGD and KIIs participants highlighted that the intervention was appropriate and relevant to their needs. The distribution of non-food items (NFIs) was considered the most relevant component. The distributed NFIs included soaps, masks and jerricans which were very important during the covid19 crisis. The FGD and KIIs respondents confirmed that IR was continually present in their communities, inquiring about needs.

FGD participants in Mali appreciated the services received but also listed important needs which were not covered by the project. This included insufficient health worker training and lack of equipment in some health centres (e.g., generators and x-ray/scanners); lack of IR assistance for health centres in Bamako; insufficient quantity of kits provided in communities and health centres; lack of food assistance; and lack of children education services. The unique feature of the program recognized in FGDs in Sudan was the inclusion of cash transfers in response to a clear need of the right-holders as Covid-19 has affected their income and livelihood especially of those living in remote villages. The communities also appreciated awareness work, masks, sterilizers and training sessions but highlighted lack of pre-project counselling on the programs.

Wask kits and hand washing station in Somalia

There were no complaints in FGDs from any of the countries about highly affected persons being left behind, though a general comment in several countries was that more persons should have been helped as almost everyone in the communities was affected. In Mali, FGD participants also suggested to focus on children. They also confirmed that the two projects identified right-holders in collaboration with technical services (health and social development), community leaders (village chiefs and advisers, traditional communicators, representatives of women, young people, and persons with disabilities). All right-holders were identified in a participatory manner according to criteria defined by local stakeholders themselves focusing on inclusivity and vulnerability. Right-holders included mostly elders, widows, persons with disabilities, women heads of households, and internally displaced people (IDPs).

In projects where the main focus was on provision of health equipment to hospitals, as in Pakistan, Mali and Tunisia, health professionals felt that the personal equipment provided was very relevant to their needs of keeping themselves safe while dealing with Covid-19 patients. Interviews with the doctors in Pakistan indicate that IRP assessed the hospitals' needs before procuring the required items, which comprised of portable X-ray machines, ventilators, Cardiac Monitors, and PPE kits. All the items provided by IRP were crucial for treating the patients at the hospitals and clinics but the portable X-ray machines and ventilators were most important. Interviews with the staff of Education Department indicated that IRP's support was relevant to its needs because IRP conducted needs analysis before providing the support, which comprised of construction of toilets and washing facilities in schools. All the items provided by IRP were crucial to addressing the hygiene requirements of the students at the school.

In Tunisia, the emergency health project started in March 2020 with three phases, and is being implemented throughout the country. The Health sector is vital in the Covid crisis and the response aims to protect the health of the medical staff and reinforce the capacities of the public hospitals by delivering health equipment. Only public health facilities were aided because they are accessible to all the public, including the most vulnerable. External interviewees from partner agencies like MOH and hospitals considered the response appropriate since it helped to overcome the limitation of resources, materials and equipment in vulnerable and poor regions. The consolidation of the project with livelihood and women empowerment in Tataouine was also considered appropriate and relevant because it reinforced access to health for vulnerable women.

Hospital equipment delivery, Tunisia.

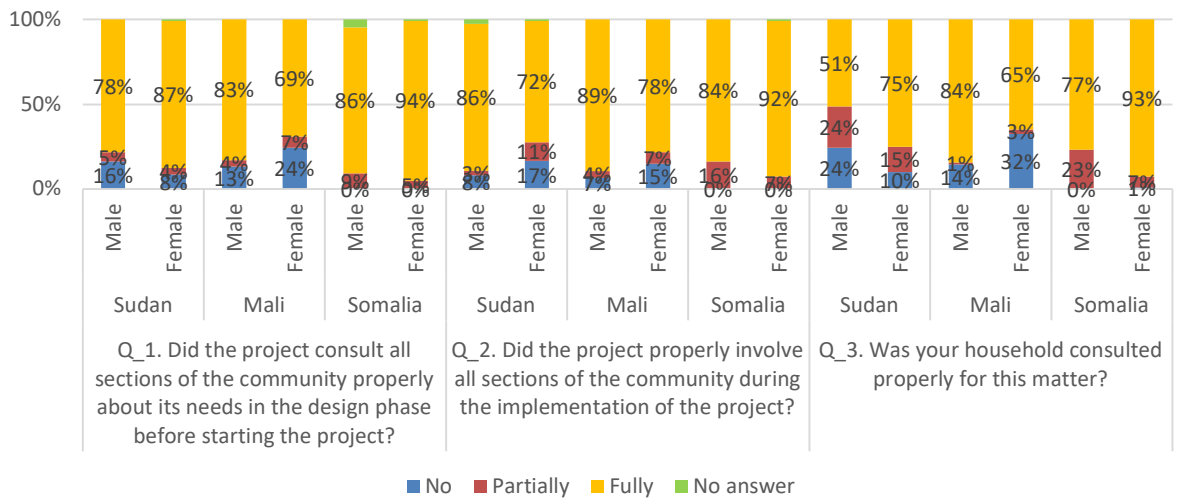
External stakeholders also expressed a high degree of satisfaction. In some cases, the projects had been designed in close coordination with government agencies, for example the PDMA and health officials in Pakistan, who were generally happy with the IR coordination. Similarly, in Sudan, consultation was done adequately with the health and social welfare officials. The program was discussed with the health authority in Kordofan and was agreed upon before its start. The mode of working in coordination and cooperation with the local authorities, HAC and the state ministry of health (SMoH) facilitated the selection of the most affected people. The department of social welfare in the targeted localities had good information and lists of affected families which were further verified by IR staff. Awareness campaigns through radio messages, drama, and songs and awareness-raising among school children were highlighted by the Kordofan Radio & TV Station. The SMoH appreciated the ToT training for SMoH cadre and support in terms of supplies and equipment. The SMoH indicated that the program is very effective in raising health awareness. However, improving the health promotion strategy in remote areas like Sodari locality in North Kordofan and Heiban locality in South Kordofan is seriously needed. Collaboration with the UN-WFP blanket food distribution to IDPs and Refugees raised the efficiency of the IR project.

In Somalia, the local authorities too felt that they had participated in the design and selection of the project locations. In Mali, external stakeholders confirmed that the work guided by the UN actions and consultations with national and local stakeholders, political authorities, health authorities, and local social affairs. KIIs in Mali suggested that the Covid-19 Project should have been combined with a resilience project to improve livelihoods in the Covid-19 context, particularly for women. They suggested to set up a mobile device (wash kits, gel) which can be loaned to communities during event such as weddings, baptisms, and funerals; sensitize communities to establish watch committee on hygiene issues during events; provide schools and mosques with prevention kits against covid-19; raise awareness among other NGOs on Covid-19 prevention measures; and review the vulnerability criteria by selecting households that cannot afford more than one meal per day or inactive people due to Covid-19 (e.g., small retailers).

The regions selected were also among the most badly affected in most countries according to KIIs. The districts in Pakistan faced the brunt of the pandemic due to their proximity with Iran, lack of health facilities and poverty due to drought. Similarly, the regions selected in northern Mali, Somalia and Sudan were highly vulnerable due to a combination of conflict, displacement and overall poverty. In Mali, Bamako was the epicentre of the pandemic with 72 percent of confirmed cases of Covid-19 and municipality/communes 2 and 4 were the most affected at the start of the project and were therefore selected. There was a need to intervene during Covid-19 in all parts of Sudan. However, Kordofan was selected as one of the most vulnerable states with large numbers number of the affected population and few partners and stakeholders intervening. In Tunisia too, the projects focused on the poorest areas in the four regions of the country.

Thus, based on triangulation from different sources, the evaluation team found performance on this **CHS Commitment 1** to be satisfactory. The services provided were largely very relevant and the focus was on highly affected persons. The regions selected were among the most isolated and worst-affected. The main complaints related to provision of services and addition of more right-holders that went beyond budgets available. Other complaints related to inclusion of less affected persons and the need for some ancillary services closely to current services such as health equipment.

Figure 4: Beneficiary Consultation



CHS Commitment 4: Humanitarian response is based upon communication, participation, and feedback

Opinions about beneficiary consultation during the design and implementation phases and about the participation of the respondent's household in project activities were largely positive, ranging above 75% in all cases across the three countries (Figure 4). The only exception were females in Mali, 32% of whom felt that their household had not been properly consulted. In the small-scale survey in Tunisia, the percentages agreeing fully or partially with these statements were 100% for the first two questions and 67% for the third one. In the global survey, respondents assigned an average score of 9 out of 10 for achievement on this commitment. The main challenges reported were the travel restrictions which made it difficult to consult communities and the inability to incorporate the feedback given by communities during consultations due to limited funds. The major successes were being able to still consult communities using local administration and faith leaders who had mobility and remote techniques like cell phones.

FGD participants in Pakistan also felt mostly positively along these dimensions. The majority of the female participants said that one female from each household in their respective communities was called to attend the awareness sessions who shared the information with others. Participants also said that IRP ensured participation of vulnerable groups in both the projects through the formation of community groups and conducting FGDs with these groups in the target communities. In Mali FGDs, the majority of participants reported that IR consulted all sections of the community, especially the most needs ones like women, elderly, persons with disabilities, widows, IDPs. Health workers also reported that Health centres were involved not only for the identification of needs but also in project design and implementation. Some health centres in Bamako would have appreciated closer collaboration with Islamic Relief. In some places in Somalia where seasonal migration is high, some FGD right-holders felt that all sections could not be consulted as some were away from communities. Thus, where feasible, for example where parts of the

communities migrate together to feed their animals in distant areas, agencies could look into the possibility of consulting them remotely in groups. In Somalia, the FGD participants indicated that they have been consulted before the commencements of the project. The consultation process involved different categories of the communities including, women, children, elderly and disables persons. The persons with disabilities were present in the FGDs sessions.

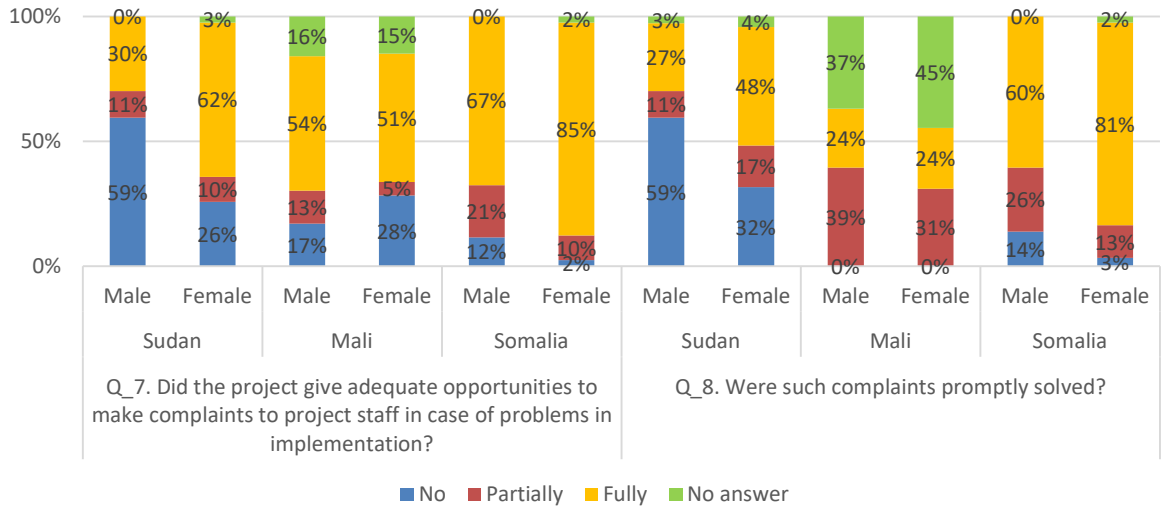
According to Sudan FGDs right-holders, since IR Sudan had already been working with many of the targeted communities though other programs, there was good knowledge about the communities which aided their participation positively. The training and awareness provided to community committees helped to increase the community participation. The use of community mobilizers from the same communities also increased the participation. However, not all sections of the IDPs community were consulted because some were busy with agriculture in remote areas. A wide range of communication channels was used including links with the local authorities, the local community leaders such as the President of the Women's Association, and the GK state radio that enabled wide beneficiary participation. Mobile phone and other online contacts were used when field visits were not possible as in 2020.

KIIS show that the IR Tunisia Covid-19 response was built on the active participation of institutional right-holders given the nature of the program focused on the protection of the medical staff and supporting the hospitals with the needed equipment to respond to the crisis. This choice was based on the vulnerability of the health sector identified by the Government. IR Tunisia reinforced the relationship and communication with the regional directorates and the central Ministry of Health (MoH). It signed an MoU with the ministry while it already had an MoU with the Tataouine government from a previous project. The MoH determined the overall needs (which consisted of hygiene products, consumables, blouses, syringe shoots, beds for intensive care, etc.), prepared the technical characteristics of the equipment, provided the list of suppliers, determined the list of beneficiary hospitals according to needs, facilitated the delivery of equipment and the customs clearance procedure, etc. The MoH requested the intervention to target the hospitals where there is a lack of equipment. The team contacted the directors of the regional hospitals to obtain data about needs and coordinated the distribution operations with MOH.

The institutional right-holders considered that the operation was successful, and the regional directors and the president of the donation commission at the MoH especially appreciated the work done by IR Tunisia. The challenges mentioned by informants related to poor infrastructure in some regions, the distance between the sub-region and the regional hospital and the problems of public transport that made it difficult for some vulnerable population to access the hospitals easily. Due to the global crisis, the supply of health equipment needed for the Covid-19 crisis is also becoming worse from day to day and the suppliers do not respect the delivery dates. The MOH also mentioned that it will be very helpful to create a framework which establishes a durable and structured cooperation relationship in order to facilitate the implementation of the project in the future. The response was timely and without interruption in the context of Covid-19.

Thus based on the information from different sources, the evaluation team concludes that participation of communities and institutional right-holders was high under **CHS Commitment 4**. This success was based on the use of different approaches, including committees, community mobilizers, local authorities, faith leaders and remote means when travel was not possible and was supported by previous work and links in these committees. The main challenge was ensuring the participation of people who were away from communities due to work and finding ways to involve people busy in daily work locally.

Figure 5: Complaint mechanisms



CHS Commitment 5: Complaints are welcomed and addressed

The majority (above 50%) of both male and female respondents in Mali and Somalia felt fully or partially that the projects had adequate complaint mechanisms that were accessible and understood by all community members and addressed complaints made (Figure 5). However, in Sudan, while females were largely satisfied, nearly 60% of males said that they were inadequate. Around 40% of both males and females in Mali gave no response to these questions. In Tunisia, all respondents skipped these questions which may reflect a lack of knowledge about them or how to use them. Finally, the average score assigned for this commitment in the global survey was 8.5 out of 10. The main challenges reported in the global survey were unrelated local community conflicts getting reflected in the complaint mechanisms, and cultural barriers against making complaints. Still, all the responding countries said that the mechanisms worked well overall and provided useful information.

A wide range of complaint mechanisms across the countries were used including face to face meetings, complaint hotlines and complaint boxes. In all communities visited, the complaint procedure was observed to be in place in prominent places like community or health centres. Satisfaction levels with compliant mechanisms during FGDs were generally higher where multiple methods were used as different methods have their advantages and disadvantages. In all countries, the limited cell phone access in some project areas limits the efficacy of the telephone helpline as right-holders have to travel far to public call offices in

town to make complaints or where cell phone coverage is available, which is especially difficult for women. The low literacy level, especially among women, restricts the use of complaint boxes. The regular meetings by staff during project implementation help overcome the problems associated with the first two methods. But the issue here was that meetings were often held when people were busy with their livelihoods and household activities. For communities, the best timings are early in the morning or late in the afternoon so as not to conflict with their own work priorities. But those times are not possible for project staff due to security issues and distances. Thus, the use of a variety of methods increases the chances of most people being able to make complaints using one method or the other. The FGDS show that complains made largely related to not being included in beneficiary lists, delays in provision of services or issues related to quality of services. However, summary of detailed information from compliant registers were not immediately available from country offices that would reflect the percentage of complaints in different categories and how and how quickly they were handled.

In Pakistan, FGDs revealed satisfaction with complaint mechanisms, though some women groups were not familiar with them in far-flung areas. The female participants said that they were provided a register and telephone number to register their complaints; while those who do not have the means to file a complaint due to poverty or illiteracy, lodge their complaints through the community elders. They maintained that their complaints related to provision of water or livelihoods support or in delays in TACVA project complaints had not been answered. FGD results from Mali indicate that a phone number was made public for complaints registration. Since not all localities are covered by telephone networks, local complaint committees were established in Gourma Rharous, composed of two men and one woman in each village/site based on their community engagement, availability, integrity, transparency, and credibility as identified by the community itself. However, some of the FGD participants were not aware of these formal complaint mechanisms highlighting the need for more explanations during meetings. FGD participants in Somalia also said that the complaint mechanisms information boards were in English instead of local languages which made it difficult for community members not familiar with English to use them. However, extensive explanations given in meetings about the mechanisms still ensured a high degree of satisfaction with complaint mechanisms in Somalia. In Sudan, FGDs and KIIs show that the presence of a MEAL Officer working with the team in the field and holding the responsibility of handling complaints made it easy to have a strong link with right-holders and stakeholders on complaints though problems still persisted. The good knowledge of the complaints process through engagement in previous IR Sudan programs made it easy to manage complaints within the communities. The programs used complaint boxes and direct mobile numbers through which right-holders give their complaints and feedback. The communities were not so familiar with giving written complaints and just prefer using the mobile phones to send their complaints and feedback which were received by the dedicated staff, registered, and dealt with accordingly. In Tunisia, complaints and concerns were handled in direct communication with institutional partners.

Thus, based on triangulation from all the different sources of information, the evaluation team concludes that complaint mechanisms under **CHS Commitment 5** were present and are overall satisfactory but need some improvement in terms of use of multiple methods, use of instruction in local languages, summarizing and analysing complaints and ensuring their use by the most marginalized sections of the community like illiterate persons women and older persons and PWDs.

Table 6: Summary of Responses on Relevance Questions*

Evaluation Question on Relevance, Participation and Complaint Mechanism	Percentage agreeing fully or partially					
	Mali		Somalia		Sudan	
	M	F	M	F	M	F
CHS 1-Relevance						
Q4. Has the project provided services that meet the most important needs of your household during the Covid-19 crisis?	100%	100%	100%	99%	78%	85%
Q5. Has the project provided household services to the most affected households in the community suffering most from Covid-19 crisis?	99%	98%	100%	98%	75%	81%
Q6. Have any less affected people been provided services by the project?	4%	14%	N/A	N/A	38%	20%
CHS 4- Participation						
Q1. Did the project consult all sections of the community properly about its needs in the design phase before starting the project?	87%	76%	95%	99%	83%	91%
Q2. Did the project properly involve all sections of the community during the implementation of the project	93%	85%	100%	99%	89%	83%
Q3. Was your household consulted properly for this matter?	85%	68%	100%	100%	75%	90%
CHS 5-Complaints						
Q7. Did the project give adequate opportunities to make complaints to project staff in case of problems in implementation?	67%	56%	88%	95%	41%	65%
Q8. Were such complaints promptly solved?	63%	65%	86%	94%	38%	65%

*Small-scale Tunisia survey, global survey and FGD results from Pakistan and other countries support these summary findings from household survey in three countries and those presented later for effectiveness, impact and sustainability.

Conclusions on Relevance

Overall, the performance on relevance was highly satisfactory. Most of the complaints from FGDs and KIIs related to issues of budget constraints i.e., request for additional assistance and increasing the number of right-holders. Some other gaps existed in terms of i) delays in addressing income and livelihoods needs in some places, ii) the inclusion of some less affected persons in Somalia, iii) the lack of complaint mechanism instructions in English in some places, and iv) the need to use multiple complaint mechanisms that cater to the needs of all community members. However, overall, good participation of communities and institutional right-holders ensured a focus on relevant needs and worst-affected persons.

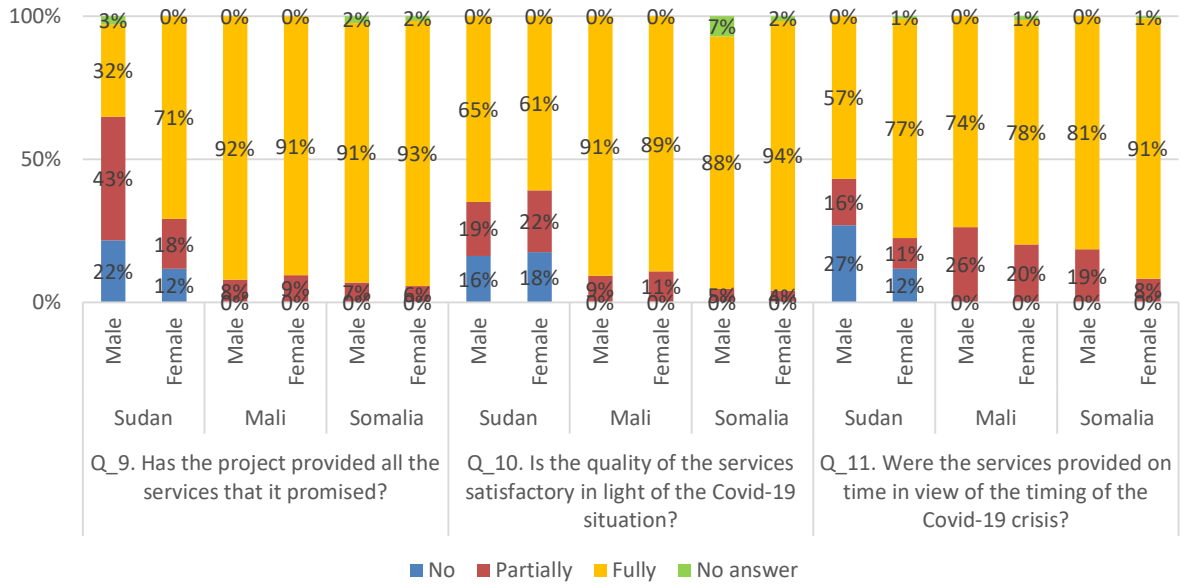
2. EFFECTIVENESS

CHS Commitment 2: Humanitarian response is effective and timely

The household survey reflects a high degree of partial or full satisfaction (at least 75%) among respondents with service commitment fulfilment, quality and services. Over 90% of male and female respondents reported that the projects fully met all the promises made about services in Mali and Somalia (Figure 6). The corresponding figure in Sudan was above 70% for females but only 32% for males, though another 41% of the males reported that the project met the promises at least partially. Satisfaction levels with services quality were also high and nearly 90% of male and female respondents reported full satisfaction in Mali and Somalia. In Sudan, more than 80% of the male and female respondents expressed full or partial satisfaction. Finally, satisfaction with the timing of the services was also high with at least 70% of male and

female respondents expressing full or partial satisfaction in all three countries. The corresponding figures from the Tunisia survey expressing full or partial satisfaction for the three questions were 88%, 77% and 77%. The average score on this commitment in the global survey was 8.5 out of 10. Respondents in this survey mentioned travel restrictions due to Covid-19 and the need to realign budgets as the major challenges under this commitment. However, some countries still reported success in meeting critical needs at the right time, e.g., before the planting or major hunger seasons.

Figure 6: Effectiveness of Services



FGD information supplemented the survey information. FGD participants in Pakistan expressed high levels of satisfaction on the first two questions. However, there were major complaints about the delays in the TACVA project. In fact, some delays were evident in all the Phase 2 projects related to livelihoods in Mali, Pakistan, Tunisia and Sudan largely related to the travel restrictions, security situations, government permissions and the need to realign budgets for Covid-19 purposes where existing non-Covid-19 projects were adjusted to provide Covid-19 related services. Interviews with hospital staff in Pakistan indicated that IRP has provided medical equipment, including portable X-ray machines, ventilators but despite a formal request, it has not provided any capacity building in the use of the medical equipment.

FGD right-holders in Mali were satisfied with different services, especially cash. The money was spent on food, small businesses, repayment of loans, and health expenses. Some mentioned that wash kits were not sufficient in terms of coverage and that they would have appreciated IR's permanent support throughout the epidemiological surveillance period for continuous needs assessment and response. Religious leaders said that the training provided to them allowed them to learn more about COVID-19 prevention and disseminate the information through their sermons. In Bamako, religious leaders requested wash kits, masks and hydro-alcoholic gel for mosques. Health workers in Mali were satisfied with the quality and initial timing of health equipment provided but also requested continuous provision as supplies later ran

out. The host community FGD participants in Sudan said that the services provided are insufficient (distributed only once and to a very small number of individuals). The IDPs were satisfied despite the insufficiency of the services but said that the timing of distribution clashed with the farming season when they were busy. Some people had a problem in using Covid-19 materials because they did not attend the awareness lectures. No FGDs were conducted in Tunisia.

TABLE 7: SUMMARY OF PROJECT ACHIEVEMENTS

Country/Project	Number of targets	Targets Achieved Fully	Targets Achieved Partially	Targets Unachieved	Duration
Mali					
Bamako COVID-19 Response	7	7			April-July 2020
Mali COVID-19 Response-II -GR	6	6			July-December 2020
Supporting Economic Recovery in Douentza,	5	5			July 2020 to July 2022
Pakistan					
CAPER	12	12			June 15, 2020 to December 31, 2020
TAQVA	18	2	2	14	August 1, 2020 to July 31, 2022
Somalia					
DEC	8	8			July 2020-January 2021
CORPS	5	5			May 2020-June 2021
Sudan					
RCPP	4	4			September 2020-February 2021
INDPIABS	3	2	1		January 2021-June 2022
Tunisia					
Emergency Response 1	9	9			October 2020-May 2021
Emergency Response 2	4			4	On-going
Rural Women Empowerment	4	1		3	February 2021-February 2023
Total	85	61	3	21	

Table 7 shows the achievements of different projects against targets. The table shows that for all projects already over, 100% of the targets have been fully achieved. The non or partially targets relate to projects still on-going in Phase 2. However, some such projects, as in Pakistan, started in July-September 2020, but

have not done much implementation to-date, creating frustration particularly in Pakistan even though the July 2020-March 2021 period saw a reduction in Covid-19 cases globally before the current intense phase started. This problem may have been overcome by having short-term early recovery projects after the relief phase and before the development phase. Further details of achievements are provided in the appendix after each project's description.

TABLE 8: SATISFACTION WITH SECTORAL SERVICES

	Country	Gender	No	Partially	Fully	No answer
WASH Kits	Sudan	Male	11%	41%	49%	0%
		Female	15%	32%	53%	0%
	Mali	Male	1%	13%	86%	0%
		Female	1%	12%	86%	0%
	Somalia	Male	49%	0%	51%	0%
		Female	14%	2%	84%	0%
Information/Sensitization on COVID 19 prevention	Sudan	Male	68%	19%	11%	3%
		Female	48%	15%	37%	0%
	Mali	Male	1%	11%	88%	0%
		Female	3%	15%	82%	0%
	Somalia	Male	35%	2%	63%	0%
		Female	18%	2%	79%	1%
Cash Transfer	Sudan	Male	38%	49%	14%	0%
		Female	21%	48%	31%	0%
	Mali	Male	3%	7%	90%	0%
		Female	0%	0%	100%	0%
	Somalia	Male	N/A			
		Female	N/A			

Respondents were also asked to express satisfaction the quality and quantity of three major services that were provided in all three countries (Table 8). More than 80% of the respondents, both male and female, in the three countries expressed satisfaction with WASH kits, except males in Somalia where the percentage was still above 50%. On information and sensitization on Covid-19 prevention, the percentage expressing partial or full satisfaction was above 80% for both males and females in Mali, while in Somalia nearly two-thirds expressed similar satisfaction. In Sudan, the majority expressed dissatisfaction due to a lack of repeat messaging. Finally, on cash transfers, partial or full satisfaction was above 60% for males and nearly 80% for females and above 90% for both males and females in Mali. Cash transfers were not done in Somalia and Bamako in Mali. In Sudan, there was some dissatisfaction with the amount of cash transfers. Information/sensitization on Covid-19 prevention was listed as the most useful service by both males and females in Sudan followed by WASH kits. In Mali, cash transfers and WASH kits were seen as the two most useful services by males and females. In Somalia, distribution of hygiene kits and NFIs were the most popular services (Table 9). Overall, distribution of wash kits was picked as the most useful service by the

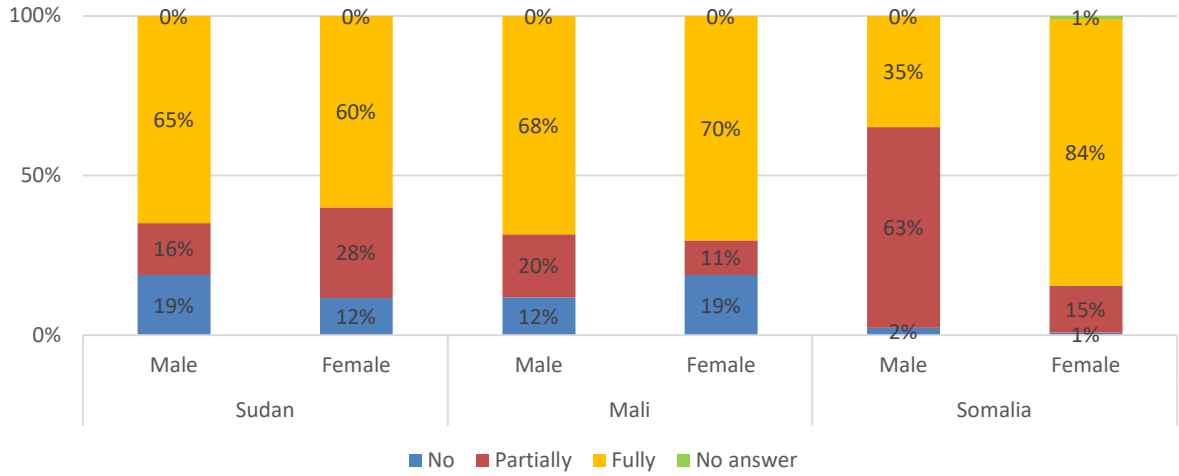
highest percentage of respondents across the three countries followed closely by hygiene kits. However, this was solely due to the high popularity of hygiene kits only in Somalia. This was followed closely by cash transfers. Hand washing facility placement was seen as the least useful service in all three countries by both males and females.

TABLE 9: MOST USEFUL SERVICE

Country	Gender	WASH Kits	Information/Sensitization	Cash Transfers	Distribution of NFI	Distribution of hygiene kits	Hand wash facility placement
Sudan	Male	43%	49%	8%	0%	0%	0%
	Female	26%	38%	37%	0%	0%	0%
Mali	Male	32%	14%	54%	0%	0%	0%
	Female	47%	12%	41%	0%	0%	0%
Somalia	Male	0%	0%	N/A	35%	65%	0%
	Female	1%	1%	N/A	20%	76%	2%

Thus, overall performance on **CHS Commitment 2** is good, especially with the issue of promises kept and quality of services, though there were complaints about late delivery of services in some countries due to Covid-19 restrictions and other constraints. Other complaints related to lack of delivery of services that went beyond the scope of the project budgets. The most satisfaction was expressed with regard to WASH and informational services.

Figure 7: Capacity-building by Pre-Covid IR services



CHS Commitment 3: Humanitarian response strengthens local capacities and avoids negative effects.

In many current project areas, IR country programs were already providing services to the communities before the start of the Covid-19 crisis. More than 80% of both males and females in the three countries agreed fully or partially that such services had built their capacities to cope with the Covid-19 crisis (Figure 7). FGDs show that in some countries, these services included hygiene promotion services that had helped increase awareness about cleanliness and vector and virus transmission. Elsewhere, WASH services had helped improve clean water supply. In addition, new RCCE-related project services started after Covid-19 that related to avoiding negative effects during Covid-19 were also highly appreciated in the three countries (Figure 8). Thus, more than 80% of both males and females in the three countries felt partially or fully that IR had provided services which had helped them avoid negative impact and remain safe during Covid-19. In Tunisia, 100% respondents said so.

KIIs with the right-holders in Tunisia show that they are well-trained health professionals who did not need much training. Thus, IR Tunisia delivered materials only, even though training was offered. The project strengthened the capacities of the public hospitals through equipment that will last for years. The risk of the spread of the virus was avoided by respecting the physical distancing and masking prevention measures during the health supply distributions at hospitals.

Similarly, more than 95% of the males and females reported no negative impact from project activities across the three countries (Figure 9). In Tunisia, the corresponding figure was nearly 70%. In the global survey, the average score on this commitment was close to 9 out of 10. The main successes in both building capacities and avoiding negative impact were attributed to working with local administrations which had good idea about local situations and were able to travel easily and to working through local community members.

Figure 8: Project Information on Covid-19 Precautions

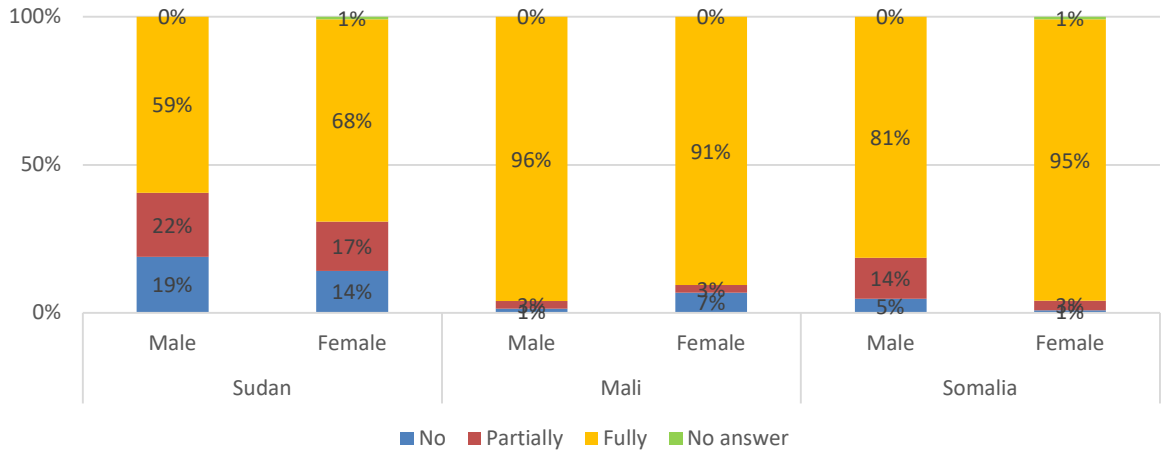
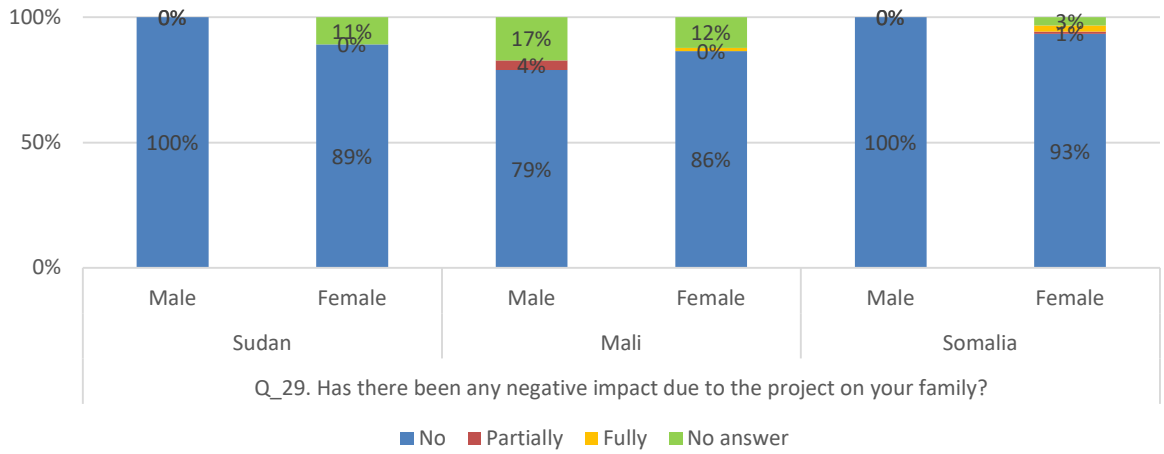


Figure 9: Negative Impact from Project Services



The communities in TACVA project in Pakistan who had received IRP's support prior to Covid-19 were better prepared and organized to deal with the crises because: (a) the formation of community groups helped the communities in addressing the pandemic in an organized manner; (b) the water related projects helped the communities in accessing clean water for washing and drinking; (c) and the kitchen gardening projects helped the communities economically as a safe and free source of food. The majority of male and female FGD participants in Pakistan indicated that the provision of awareness sessions, masks and soaps had helped them stay safe from Covid-19. However, they also said that IRP has not built their capacity after Covid-19 to deal with their own problems which are primarily economic, though the female participants said that it had taught them how to save money, which has helped them in increasing their savings. However, FGD participants appreciated the tips on Covid-19 prevention.

In Mali FGDs and KIIs, the most important step identified to provide services safely to communities during the Covid-19 crisis was accountability of project staff, which played the role of models in Covid-19 prevention by respecting SOPs. In addition, awareness raising sessions conducted by staff were also appreciated as well as the establishment of 'screening teams' of volunteers (cordon sanitaire), screening those in transit and providing referral if needed, a key strategy used during the Ebola outbreak too. FGDs show that the training sessions, wash kits, awareness raising sessions through posters, religious leaders' sermons, radio all contributed to build the capacity of communities to cope with COVID-19 during and even after the end of the Project and helped them stay safe. The many useful awareness sessions made by religious leaders and project staff contributed to slowing down the spread of COVID-19. Health workers in Bamako regretted the fact that they were not trained on infection prevention control, COVID case management and referral. In Bamako, key informants in Health Referral Centres reported that they would have appreciated a closer collaboration with Islamic Relief until the end of the Covid-19 pandemics and support to repair their scanner device. Thus, addressing these issues or referring right-holders to other agencies able to address them would have been helpful. The projects involved a limited number of mosques and religious leaders as right-holders. It may also be useful to provide advocacy or training to the High Council for Muslim to help them relay similar information to other religious leaders at grassroots level nationally.

FGDs in Sudan show that the communities in Sudan are very social and people are used to living and eating together. The new reality being forced by C-19 precautions like lockdown and social distancing were very hard to adopt for the communities, especially in the rural areas. Hence IR Sudan exerted much effort to deliver the message. Using the Radio as means of delivering messages on Covid-19 precautions proved to be an effective method to reach the targeted right-holders. However, host, refugee and IDP communities emphasized the need for continuous messaging as people forget while some people are away from communities. IRS has assisted Southern Sudan refugees and IDPs through multipurpose cash assistance to meet their basic needs after they became underemployed during the lockdown period in 2020. Given the current COVID19 situation, IRS ensured that preventive measures are taken while disbursing cash. IRS disbursed the cash through the banks to ensure that limited number of right-holders are served per day to mitigate further risks of infection in line with IRW cash transfer standard operating procedure. Moreover, IRS shared the distribution plan with the banks and right-holders to allow them to have planned disbursement dates as a control measure. KIIs in Tunisia show that institutional right-holders were kept safe through remote working modalities and adherence strictly to SOPs during equipment distribution.

Thus, overall, performance on **CHS Commitment 3** was satisfactory. Previous projects had successfully built the informational and income capacities to deal with the current crisis, thus somewhat alleviating misery after Covid-19. New services helped communities avoid harm from Covid-19 to a great extent while project activities did not cause harm to communities.

CHS Commitment 8: Staff is supported to do their job effectively, and are treated fairly and equitably.

The key issues under this commitment related to keeping staff safe from Covid-19 while they undertook their jobs and providing them with adequate support from head offices to deal with this novel crisis. IRW developed broad guidelines to keep staff safe during the crisis which covered i) important facts about Covid-19, ii) physical distancing measures, iii) tips for working with communities, iv) Protective equipment for community facing staff, Guidance for religious institutions, events and practices and useful links to external resources on Covid-19. These sections included useful information. However, key issues were absent such as guidance for offices on work-from-home possibilities, leave and absence policies, work measures within offices, staggering of work schedules, options for Covid-affected employees etc. The document also could do with better presentation and layout editing and could be more detailed.

In addition, each country program developed their own policies. In Pakistan, IRP constituted a Covid-19 steering committee, which ensured regular monitoring of and communication with the staff. Other steps included restricting the number of employees in offices, disinfecting offices & vehicles, provision of PPEs, encouraging work from home, traveling during daylight, two passengers per car policy, compulsory wearing of masks, development and propagation of 'distant but not disconnected' theme. Staff was invited to become role models in the prevention of Covid-19 through the use of masks, gels, respect for distance, washing hands, keeping a safe distance, gathering small groups, and meeting in open places during interactions with the communities. Due to IRP's strict observance and monitoring of Covid-19 related SOPs and policies, there are no reports of incidents during the Covid-19 response involving staff nor

complains from communities about unsafe interactions, even though the communities were more concerned about their economic situation compared to the risks associated with Covid-19.

BOX 2: IMPLEMENTATION CHALLENGES DURING COVID-19 CRISIS

Interviews with staff in Pakistan were particularly helpful in understanding the implementation challenges that affected effectiveness. The biggest challenge was to understand the pandemic in a holistic manner due to the ever changing information from the health focused organizations, especially since IR is not a health focused organization. At the start of its emergency response, it also lacked sufficient health and other human resources. IRP met that gap by regularly communicating with the concerned organizations, health practitioners, and WHO doctors. Procurement of medical equipment, especially portable ventilators and X-ray machines, was a big challenge due disruptions in the global supply chains. Thus, this assistance materialized more than 3 months after the pandemic broke out in Balochistan. Carrying out behavioural change communication and awareness activities was also a challenge because almost 70% of the target communities are illiterate. IRP countered these challenges by engaging subject matter experts. IRP also faced challenges in acquiring NOCs from district administrations which it overcame through persistent follow-up. Travel restrictions were a big challenge too. IRP's monitoring and evaluation staff in Quetta, MEAL staff in Islamabad, and Project Monitoring and Tracking System (PMTS) successfully ensured remote implementation, monitoring and accountability of its activities whenever its staff could not visit the hospitals and communities due to Covid-19 restrictions. IRP also used remote implementation and monitoring of its activities occasionally through the beneficiary committees formed at the community level. The IRP field staff indicated that it had stopped its operations during the Covid-19 lockdowns as IRP imposed work from home SOPs. Later, the project field team implemented and monitored all the project activities in person with strict observance of Covid-19 SOPs. Since IRP implements its own projects directly, this became a gap because the local partners would have had better access to the communities compared to the project staff located in the district headquarters. The following gaps were identified by IRP staff in their ability to fully engage communities: (a) Limited resources restricted outreach to cover other areas equally in need of support; (b) Highly vulnerable groups cannot spare time for project activities from their menial jobs working as daily wagers; (c) Donors do not provide sufficient time for submitting project proposals to involve communities in the planning and implementation stages. However, IRP manages this issue by using data gathered from relevant government departments, prior/ongoing baseline and end-line surveys, and dialogue with the communities after project approval of a project to ascertain and prioritize needs and problems of the communities.

In Sudan, the lockdown affected the ability of the project to conclude its activities within the planned period, which necessitated a request for no-cost extension as most markets were closed which delayed procurement of the project inputs in time. Cash scarcity also affected timely implementation as many times the banks was not giving the needed cash as per plans. To mitigate this issue, IR had an agreement with the Bank of Khartoum to release cash amounts as requested. This agreement assisted in continuing the program relatively smoothly. High inflation contributed to an increase in all costs. The scarcity of fuel and increase in prices affected the monitoring of the project and resulted in fewer field visits.

Staff in Mali was also supported to do their job effectively. They were provided with PPE, given detailed SOPs on working during Covid-19 and were invited to play role models in the prevention of Covid-19 (use of masks, gels, respect for distance). In Sudan, when the crisis occurred, the decision was made to work remotely and to respect the Covid-19 protection measures. Some staff was affected by the Covid-19 but not at the office. The Sudan office was very proactive in dealing with the COVID-19 threat to its staff. A Security & Incidence Management Committee was established to provide advice on action and precautions concerning COVID-19 to staff and distributed safety items including PPE. IRS Staff were fully

oriented with C-19 related issues and how to keep safe. Staff was advised to wear masks all through working hours, use hand sanitizers, check the body temperature when attending office, attending meetings virtually, and limit gathering while in office. The office management provided all needed supplies and materials that helped staff to cope with the situation which controlled staff from being contracted with C-19 and enabled business continuity. In Somalia, IR gave staff safety the utmost priority. Program staff were trained on risk communication and community engagement (RCCE) and given PPE, masks and gels for them to remain safe from Covid-19. The organization has also compensated when staff worked extra hours in the field due to Covid-19 issues. In Tunisia, besides other measures above, the use of technologies facilitated the implementation of the projects during the crisis while keeping the staff safe given that institutional right-holders had online facilities. To reduce the risks and to work safely, the team used their personal Facebook pages and shared information online. The procedures and authorizations were sent by email for staff working from home. Countries in the global survey assigned an average score of nearly 9 out of 10. The main challenges were completing the deliverables while keeping staff safe (as much of the work cannot be done remotely) and the lack of awareness within communities. The countries identified the use of strict protocols related to physical distancing and use of face masks and gels as the main success factors in keeping staff safe.

Table 10: Summary Responses on Effectiveness Questions

Percentage agreeing fully or partially about effectiveness			
	Countries	Gender	Partially or Fully
CHS 2			
Q_9. Has the project provided all the services that it promised?	Sudan	Male	75%
		Female	89%
	Mali	Male	100%
		Female	100%
	Somalia	Male	98%
		Female	99%
Q_10. Is the quality of the services satisfactory in light of the Covid-19 situation?	Sudan	Male	84%
		Female	83%
	Mali	Male	100%
		Female	100%
	Somalia	Male	93%
		Female	98%
Q_11. Were the services provided on time in view of the timing of the Covid-19 crisis?	Sudan	Male	73%
		Female	88%
	Mali	Male	100%
		Female	98%
	Somalia	Male	100%

		Female	99%
WASH Kits (for COVID prevention)	Sudan	Male	90%
		Female	75%
	Mali	Male	99%
		Female	98%
	Somalia	Male	51%
		Female	86%
Information/Sensitization on COVID 19 prevention	Sudan	Male	30%
		Female	52%
	Mali	Male	99%
		Female	87%
	Somalia	Male	65%
		Female	81%
Cash Transfer	Sudan	Male	63%
		Female	79%
	Mali	Male	57%
		Female	42%
	Somalia	Male	N/A
		Female	N/A
CHS 3			
Did the project provide any information that helped your family remain safe from Covid-19 virus?	Sudan	Male	81%
		Female	85%
	Mali	Male	99%
		Female	94%
	Somalia	Male	95%
		Female	98%
If IR was providing services in your community before the Covid 19 crisis, did those services help you cope better with the Covid-19 crisis?	Sudan	Male	81%
		Female	88%
	Mali	Male	88%
		Female	81%
	Somalia	Male	98%
		Female	99%
Q_29. Has there been any negative impact due to the project on your family?	Sudan	Male	0%
		Female	0%
	Mali	Male	4%
		Female	1%
	Somalia	Male	0%
		Female	3%

Thus, overall, the agency performed a good job of keeping staff safe through development of Covid-19 working guidelines under **CHS Commitment 8**, resulting in few Covid-19 infections among staff. However, the IRW global guidelines could be made more detailed and presentable.

Conclusions on Effectiveness

Overall performance on effectiveness was satisfactory. The projects were rated highly on keeping promises and the quality of services though there were complaints about timeliness in several countries. The agency succeeded in achieving these high levels of effectiveness while keeping staff and communities safe during the Covid-19 crisis.

3. EFFICIENCY

CHS Commitment 6: Humanitarian responses are coordinated and complementary

In all five countries, IRW country programs coordinated actively with external stakeholders such as the relevant government agencies and UN agencies.

Islamic Relief's Covid-19 approaches in Mali were guided by updates from the United Nations' Humanitarian Office for the Coordination of Humanitarian Action, the COVID-19 Multi-sectoral Humanitarian Plan for Mali; The Inter-Agency Standing Committee (IASC) COVID-19 Global Humanitarian Response Plan (GHRP); The World Health Organization (WHO) COVID-19 Preparedness and Response plan in Mali; and the WHO Strategic Plan for Preparedness and Response to COVID-19 (SPRP). In its implementations approach too, Islamic Relief focused on the Covid-19 prevention measures given by WHO. Thus, the use of faith based approach IEC sessions through sermons or the establishment of screening team (cordon sanitaire) are strategies which complement UN strategies. KIIS with government and UN officials show that Islamic Relief Mali is an active participant in all coordination forums in Mali at national, regional and local levels and actively participates in meetings of all sectoral clusters, disaster management structures of the Mali government and humanitarian forums. The project is therefore implemented in consultation UN bodies, national and local authorities, while guaranteeing complementarity with food security, livelihoods, and wash actions implemented of other NGOs and UN bodies (e.g. UN World Food Program).

Similarly, Interviews with IRP staff and external stakeholders in Pakistan indicate that IRP worked closely with government, the UN and other international agencies during the pandemic. As a result, IRP made use of the best Covid-19 practices and approaches applied by the international community and complemented them by passing those approaches to the organizations working at the provincial and district levels. IRP complemented the approaches of UN and other agencies in its Covid-19 response by following the UN Covid-19 response plan, and coordinating its efforts with all relevant stakeholders and UN agencies. Interviews with IRP's external stakeholders indicated that IRP's Covid-19 approaches cannot be compared with UN and other agencies due to the small size and scale of its operations. However, one marked

difference is that unlike UN and other agencies, IRP implements its own projects directly, which makes it more flexible in making midcourse corrections and re-appropriating funds. IRP coordinated and collaborated with other stakeholders through the WASH, health, and livelihoods working groups chaired by the relevant agency. The gaps were felt in terms of the frequency of the working group meetings, which were carried out monthly instead of weekly. IRP ensured its active participation in the Covid-19 working group meetings headed by PDMA and attended by all stakeholders. However, there were gaps in the occurrence of these meetings in Balochistan. IRP also attended the monthly meetings of the Pakistan Humanitarian Forum besides the regular meetings arranged by the Deputy Commissioners and District Health Officers at the district level. Interviews with staff of district hospitals, BHUs and education department in Quetta and Chagai indicated that the delivery of services from IRP was according to their needs, satisfactory and without interruptions. Interviews with IRP's external stakeholders, UNICEF and FAO, indicate that they are familiar with IRP's projects, have collaborated with it before and during the Covid-19 emergency, and appreciate IRP's work as very effective. The areas of improvement include, having more staff and expertise in the health sector and effective report writing and showcasing its work. Interviews with IRP staff indicate that it did not work in isolation and was part and parcel of the UN and other international agencies during the pandemic; as a result, IRP made use of the best Covid-19 practices and approaches applied by the international community and complemented them by passing those approaches to the organizations working at the provincial and district levels. IRP complemented the approaches of UN and other agencies in its Covid-19 response by following the UN Covid-19 response plan, coordinating the efforts of all relevant stakeholders and UN agencies, and by filling in the gaps and needs according to its resources.

In Somalia too, IR has established close collaboration and coordination with UN health clusters during the Covid-19 response. One example of this is the training participated by IR DEC and CORPS project staff on Risk communication and community engagement (RCCE) package designed by UNICEF for Covid-19 workers. IR have also been an active member for the Covid-19 Taskforce committees established by the Government and actively participated in relevant meetings with UN and other international and national agencies. There was good coordination with authorities and other partners and stakeholders working in the same field. IR Sudan was working within the unified coordination mechanism with the Humanitarian Aid Commission (HAC), health ministry, UN, and other partners and stakeholders. There was a forum of information sharing through the health sector which helped IR Sudan to share and also receive different related information that facilitated the implementation. IRS Coronavirus program approaches complement and compares with the Covid-19 approaches of UN and SMoH, Plan Sudan, and WFP stakeholders in Greater Kordofan.

In Tunisia, the coordination was mainly with the MOH and hospitals, as explained earlier, and less so with the UN system. These partners felt that the IR interventions were more timely than UN agencies due to the very good relationships with partners. The implementation of the Covid-19 response started before the UN agencies which started one month after the IR finished the first phase in May 2020. However, IR Tunisia operations focused mainly on the strengthening of capacity of the health ministry. However, the UN operations were more diversified. UN Women worked on violence against women during the lockdown. UNICEF distributed a huge quantity of masks and sanitizers. IR Tunisia is perceived as being more efficient since it distributes the donations itself, which also give it more visibility.

Countries in the global survey assigned an average score of nearly 9 out of 10 on this commitment. Respondents identified getting required coordination and cooperation from government agencies as the main challenge followed by lack of adequate staff to coordinate adequately. However, the respondents still felt that they were successful in coordinating their work with others.

Thus, the agency performed a good job at coordinating its work with government and UN agencies and other partners during the Covid-19 crisis despite the restrictions on meetings to meet **CHS Commitment 6**. This resulted in improved quality of work and reduced bottlenecks and challenges.

CHS Commitment 7: Humanitarian actors continuously learn and improve

All five countries had their own unique learning approaches and outcomes. In Mali, program staff identified Project accountability (information/communication/consultation and participation of right-holders from project design to evaluation through implementation, including post distribution monitoring) as the main process adopted to ensure continuous learning and improvement during Covid-19 response and beyond. In this process, lessons on practices which work or those which do not work are identified to improve decision making and refine project in a view of maximizing impact within communities. The key lesson learnt identified by the Mali team include:

- Putting the right-holders at the heart of the decision-making process by consulting them during the entire project implementation process encourages their support and full participation in the project, maximize results/achievements, mitigates risks of negative impact;
- The selection of local suppliers namely rental of local vehicle in an insecurity context reduces vehicles attacks and contributes to staff security;
- The sustainability strategy must be based on the involvement and strengthening of grassroots stakeholders (involvement of technical health services, capacity building for religious leaders and traditional therapists);
- The intervention strategy must emphasize a participatory approach by involving, from the start, stakeholders (political and administrative authorities, Health Centres, technical services, communities including representatives of women, people living with disability, widows, IDPs, etc.) not only during needs assessment but also during the selection of right-holders and project implementation process;
- Covid-19 affected the livelihoods of communities as prices for elementary needs increased (food items and NFI); hence the necessity of designing and implementing a resilience program which will complement other humanitarian and development actions in the project areas in short, intermediate and longer terms. A project taking into account the Socio-Economic Recovery Framework (SERF) of Islamic Relief for the Covid-19 crisis *(namely protecting livelihoods, rebuilding livelihoods and enhancing livelihoods)* would have better met the needs of communities.
- On the other hand, a faith based approach was considered as a one of the good practices to reach and sensitized communities through sermons. The link between the Quranic verses and the Covid-19 prevention measures has been helpful in terms of community awareness. Such a practice should be maintained.

- The establishment of "screening team" to detect suspect cases was also selected as a good practice. The provision of households with wash kits, timely delivery of services, cash transfer and IEC on Covid-19 were the four best parts identified par participants in FGDs.
- The main weakness was the limited scope of the project (in terms of geographic coverage and number of right-holders) and the duration of the project (only six months) as well as the limited number of equipment (wash kits, PPE) right-holders provided due to budgetary constraints.

Interviews with IR Pakistan staff indicate the following most important lessons learnt:

- Collaboration, communication, coordination and cooperation of the all actors in disaster response is crucial in fighting disasters;
- The respective governments need to be supported in building their capacities for fighting disasters. The disaster response is most effective if implemented by involving and supporting the frontline government organizations, such as the NDMA and PDMAs in case of Pakistan. The district health facilities need to be prepared and equipped to deal with a pandemic;
- The humanitarian response must be timely to be effective; which in case of IRP was not because the processes for approval and funding of project proposals are slow at the IR headquarter level;
- Since IRP is not a health focused organization it lacked expertise and experts in the health sector and relied on other organizations to design its activities;
- Development of a pool of all relevant responders in a disaster at the regional and national levels is helpful
- Chart out the level of a particular country's ability and resources to counter disasters to ensure support through advocacy for those countries that are the weakest and at risk; Ensure that the humanitarian response is based on equity as some of the hardest hit countries were left out from receiving humanitarian assistance during Covid-19 crises;
- Need to develop SOPs to address a pandemic in future and should have plans to carry out its activities;
- IRW needs to be prepared for a pandemic and must include it in IRW's 2022-2027 strategy.

IRS interventions in Kordofan got high appreciation from the authorities and as well the local communities. Project information was shared with different government bodies to learn from the experience. However, limited time did not allow the proper documentation of learning. IRS has also been actively participating in the health sector meetings which is a good forum for sharing learning and learning from others' experiences. One good lesson is that cash disbursement proved to be of high impact as it helped weak and vulnerable families to get some money for their livelihoods during a very harsh period when many people lost their income because of the lockdown. IR Tunisia organized an evaluation which was coordinated with all the government stakeholders and the team is now working on the lessons learnt. Some key lessons learnt so far include the need to do a mapping of the suppliers who are reliable and the necessity to create a Covid-19 response supply chain.

Respondents in the global survey gave an average score of 6.75 out of 10 on this dimension which was the lowest score across all the nine commitments, mainly due to the low score of 3 assigned by one country. The main challenge in learning was identified as the travel restrictions and the difficulty in doing learning

activities through remote modes. The respondents identified the use of volunteers for feedback purposes as the reasons for success in this dimension.

Overall, the following key common lessons emerge from the ones identified by different countries individually:

- Ensure the participation of all key stakeholders in both planning and implementation is essential
- IRW must place more emphasis on dealing with pandemics in its disaster preparedness work and building capacity to deal with the health aspects
- Develop an efficient supply chain system that can immediately be activated after the crisis
- Advocate for building the capacity of countries with weak capacities and ensure that they get adequate support
- Develop a comprehensive response plan based on SERF that emphasizes both immediate aid as well as support for ensuring recovery within communities
- Ensure timely approval and implementation of projects

The support from IR HQ and regional staff was deemed adequate in terms of developing the initial response framework and developing the consolidated proposal approval process which led to quicker approval of proposals. Later, IRW released the SERF in September 2020, by which it was too late for many countries to incorporate it in their planning. The only exception was the Douentza project in Mali which builds fully on SERF. It is a comprehensive framework which can help guide both immediate and recovery responses and recognizing the linkages between the two sets of work in all types of emergencies. Thus, it should be made part of the global Disaster Response Manual to develop a basis for identifying different types of programs in different sectors and emergencies. However, some changes are recommended. Firstly, the summary diagram has three layers, with the outer two circles both emphasizing the type of programming to be done by IRW. However, there is no linkage shown on how they relate to each other. Thus it would be better to merge them and have the outer circle focus instead on showing how disasters affect various components of community life. The inner programming circle could then link with each of these components to identify the type of programming needed to deal with the damage in each component of community life. Second, it should be differentiated according to the types of impacts of different types of disasters and the different types of sectors and services needed.

The technical units in UK and beyond also organized a number of webinars to enhance learning among field staff. This included webinars on Protection, Inclusion and RCCE. However, in terms of encouraging bottom-up learning from program implementation, the UK units played a less active role, even though the global M&E framework recommends learning events for countries during emergencies. However, this recommendation was not adopted by most countries. As such, more follow-up on this recommendation by the Program Learning Unit in UK would have been helpful in capturing and documenting learning. This could have included organizing mid-term learning workshops in each country, encouraging the development of learning documents and more sharing of information across countries which could have then been used to inform the remaining period of implementation of early projects. Since IRW adheres to the OECD-DAC criteria and the CHS commitments, these could have served as the guiding framework while the regular M&E and accountability processes structured to provide information for these criteria and commitments. However, this end-line evaluation serves to fill the gap as IRW's Covid-19 response is

continuing in many places, especially Phase 2 programs. There was feedback from one country that at the global level the Disaster Risk Management Department could have done more in terms of helping or scaling up responses for specific countries and monitoring their responses. For future, since the agency adheres to the CHS commitments, they should serve as the analytical framework for its planning, implementation and monitoring processes during emergencies. All planning, implementation, monitoring and reporting templates should reflect how each commitment will be met, monitored and reported upon. Adequate training should be given to staff on these commitments and how to incorporate them in their work.

The various planning, implementation, monitoring and reporting templates, processes and documents must be updated to incorporate elements from SERF and CHS commitments. In particular, there is a need to revise the 2012 Disaster Response Manual by updating and incorporating some of the following features:

- Latest guidelines for doing and joining interagency rapid assessments developed in industry
- Team composition for different types of emergencies and assessments.
- Methodological guidelines on assessments
- ICT applications, devices and toolkits to assist data collection during humanitarian needs assessments.
- Guidance to develop emergency programs that address key components of SERF
- Guidance to develop technically sound emergency programs in sectors like livelihoods, water, sanitation etc. for different emergencies, especially during pandemics based on SERF
- Logistical and management issues during emergencies
- Checklists for key actions to be taken during first 24 hours, 72 hours, 30 days and 90 days during emergencies by countries, regions and global teams
- Incorporation of CHS commitments in different sections and templates

The agency is also encouraged to have an internal discussion on the feasibility of developing more technical expertise for key sectors for both immediate and recovery work based on its country-level and regional sectoral strengths. The head office must also look at developing greater technical capacity in these emergent country and regional level expertise. More emphasis must also be placed in increasing capacity to attract more funding from external donors so that the funding for sectoral work during the immediate phase is covered as much as possible by external funding while the more recovery oriented work along economic strengthening for which less external funding is available can be funded from internal funding from fund-raising IRW offices. Greater technical capacity in key sectors can help attract more external funding.

Thus, performance along **CHS Commitment 7** must be improved by ensuring adherence to the common learning framework for emergencies, aligning its planning, implementation, monitoring and reporting templates in line with the CHS commitments and SERF, and updating its emergency manuals and other toolkits.

CHS Commitment 9: Resources are managed and used responsibly for their intended purpose.

Each of the five countries has achieved this commitment in different ways. Interviews with IR Pakistan staff indicated that the main way IRP ensured responsible use of resources was gathering data for the most vulnerable and worst-affected communities from the most relevant organizations, such as the PDMA, DDMAs and district health departments to ascertain the gaps in the relief and response efforts so as to target its resources most efficiently and with best value for money. IRP's success was that it reached out to some of the most vulnerable, remotest and neglected communities in Balochistan and ensured that these communities received Covid-19 related assistance. IRP also ensured that it did not go beyond the level where its human and financial resources and systems would have been compromised. The gaps were in terms of resources, which were not sufficient to reach out to other equally worst-affected communities and areas in Balochistan. IRP also lacked resources to engage external subject-experts in the areas where it was deficient in-house, specifically in the health sector. Such expertise would have increased the most judicious use of resources.

IR Sudan has strict policies and business processes that were being applied during this project regardless of the Covid-19 situation. Hence the work went smoothly and with full coordination to achieve goals. In general, IR has a robust financial system that helps the budget holders to track budget utilization. IR Sudan tries its level best to attract the right calibre for given posts and hiring is on a merit basis. Resources allocated for the COVID-19 response are utilized responsibly in all its operational areas. There were many virtual meetings held and also different feedback and comments received from the regional office. The Operational and Financial Report (OFR) is an effective mechanism whereas the country office has its meeting monthly to identify operational and financial issues affecting the program in general and suggest solutions/recommendations/actions to be reported to the regional office. Then a regional OFR meeting is conducted every month for each country with the attendance of the Head of Region and his team and also the CD and his team where issues of IRS are discussed with the regional team ending up with having clear actions to resolve any issues. Copies of OFR meetings could be found with CD.

Efficient processes also ensured high cost-benefit ratio in Somalia in spite of the extremely spread-out area of implementation and relatively small number of staff for the project. The FGDs participants appreciated the efficient mode which IR followed to implement the project through continuous IR staff presence in the field and the need-based approach followed by IR. However, IR staff felt that in general the NGO systems were bureaucratic, especially when the organization is procuring items. The field team complained that delays sometimes hinder the smooth implementation of the project. Islamic Relief Mali works in synergy and complementarity with internal projects (internal coherence). Teams of the different internal projects generally hold planning meetings together. During these planning meetings, opportunities of collaboration, synergies and complementarities are always identified. For example, when staff from

different projects have a mission in the same area, they usually hire/rent one car instead of two. On the other hand, procedures used by the project by putting local suppliers in competition for the supply of goods and services made it possible to save money and have more results. The key process adopted in Tunisia to ensure the responsible use of resources was the coordination between the different IR units and external stakeholders over the procurement and distribution plan. Continuous coordination and communication on the plan helped in both time and cost efficiency.

Respondents from the global survey assigned and average score of nearly 9 out of 10 on this commitment. The main challenge was the increased cost imposed by the Covid-19 SOPs such as travel restrictions and physical distancing guidelines. Countries ensured good use of resources by fully implementing good practices such as using local suppliers who could provide goods locally more easily, increasing synergies with existing projects and building Covid-19 activities into them to obtain Covid-19 as well as original project outcomes.

While performance on **CHS Commitment 9** was adequate, with each country using its own approach to use resources well, a clearer approach developed by IRW head office on ensuring, measuring and reporting the efficient use of resources would have been helpful. Such an approach could use approaches such as Value for Money andcost-benefit analysis to evaluate the efficient use of resources. (a possible framework is provided in the appendix).

Conclusions on Efficiency

The agency has done an excellent job at coordinating with external stakeholders in all countries, especially with government partner agencies. this has helped in increasing relevance, effectiveness, impact and sustainability of project work. However, the work on learning and support to country programs and ensuring good use of resources lacks global harmonization and has been done on an ad-hoc basis by each country. Thus, there is the need to develop more globally harmonized approaches on these issues and aligning its emergency work more closely with the CHS commitments.

4. IMPACT AND SUSTAINABILITY

The discussion under impact and sustainability falls beyond the CHS Commitments framework, which in itself is reflective of the problems involved in measuring impact and sustainability in the context of emergencies given the high and compressed needs, the implementation challenges, the short-duration of projects focused mainly on alleviating suffering and the difficulties involved in documenting impact and sustainability during the dynamics of emergencies. All these problems were heightened further during this crisis due to mobility restrictions and risks to the staff from the medical nature of the crisis. These issues must be kept in mind while reviewing the information in this section and some of the short comings found in the impact and sustainability of projects.

Impact and sustainability information was collected according to the four main SERF program components in the household survey and the FGDs. Under social protection, this related to water services, hygiene knowledge, food security and health and nutritional status. Projects were successful in increasing water access (Figure 10). In Somalia nearly 100% of both males and females agreed fully or partially that their water supply had increased due to IR projects while over 75% of both males and females felt so in Mali. The corresponding figure in Sudan was around 60% for females and around 40% for males. Among those who reported an impact on water supply, more than 80% of both males and females agreed fully or partially that this increase will be sustainable for at least 2-3 years, except among males in Somalia for whom the figure was around 60%.

In terms of improvement in hygiene knowledge (Figure 11), more than 80% of both males and females in the three countries agreed fully or partially that their knowledge had increased. Also, more than 80% who said so also felt that the impact will be sustainable and last for at least 2-3 years. The impact on family food security was high in Mali with both males and females and females in Somalia, where more than 80% agreed partially or fully that their food security had improved due to IR work (Figure 12). Full or partial impact was reported by 51% males in Somalia. More than 70% of the respondents in Mali and Somalia agreed fully or partially that the impact is sustainable in terms of lasting for at least 2-3 years.

Figure 10: Social Protection-Water Supply

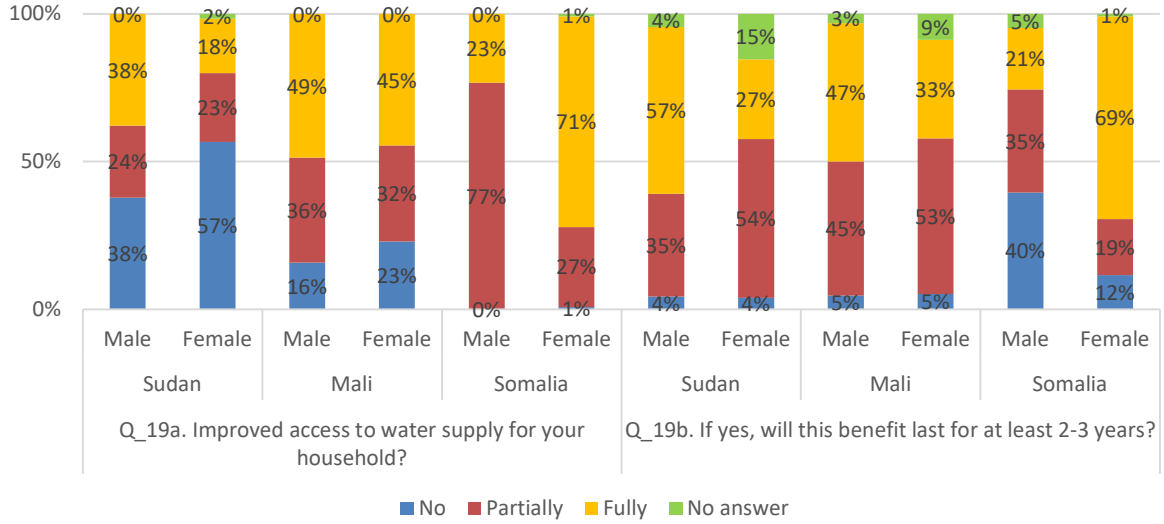
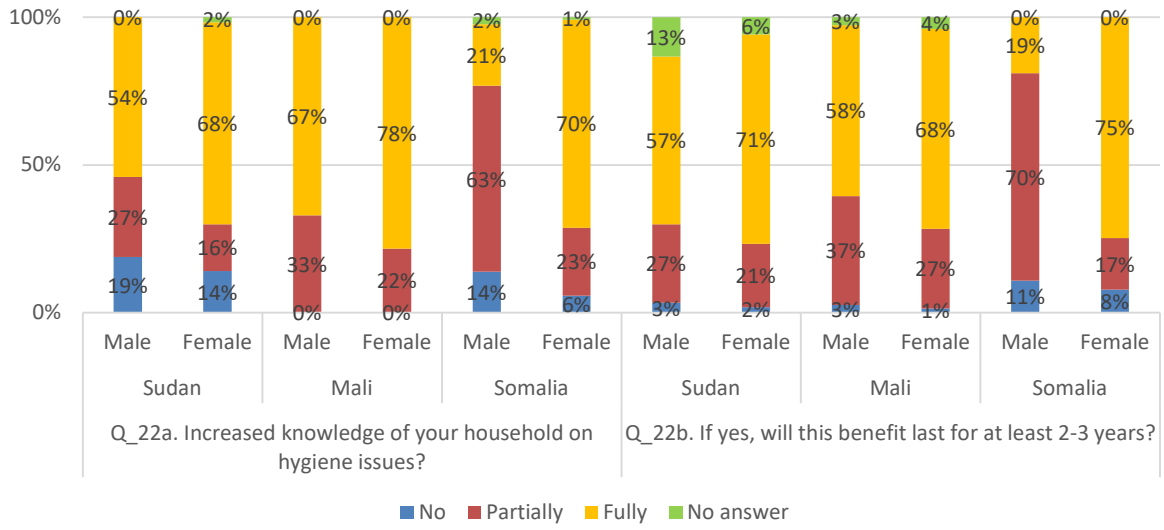


Figure 11: Social Protection-Hygiene Knowledge



The improvement in water supply, hygiene information and food security has helped improve the health and nutritional status of communities (Figures 13 and 14). More than 80% of male and female right-holders in Somalia and Mali and females in Sudan agreed partially or fully that the IR work had helped improve the health status of their household and around 60% of males in Sudan said so. More than 70% of those males and females who reported impact felt that it will last sustainably for at least 2-3 years in all three countries.

Figure 12: Social Protection-Increased food security

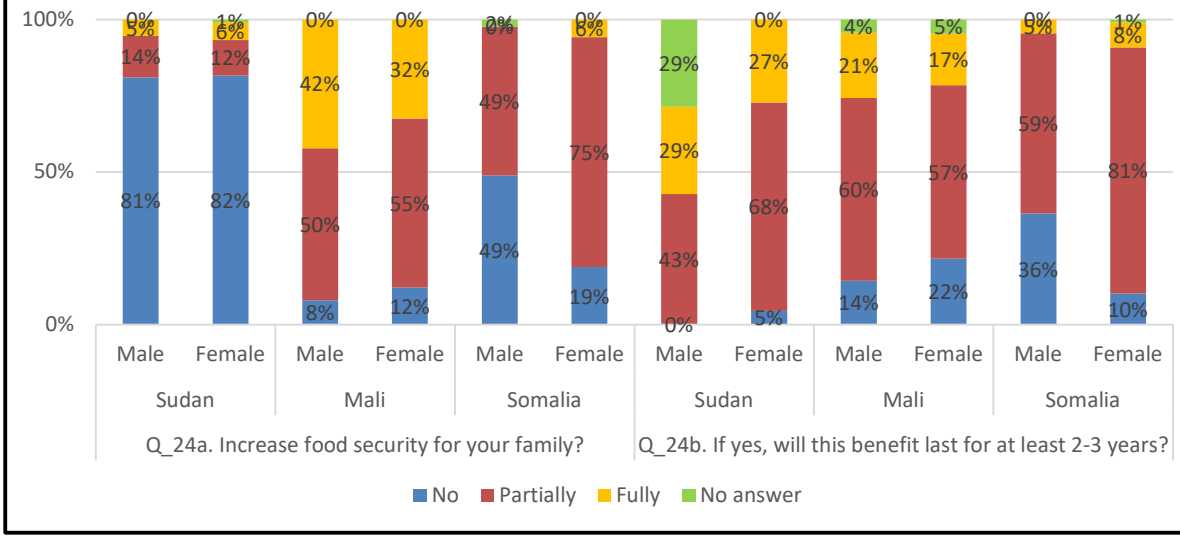
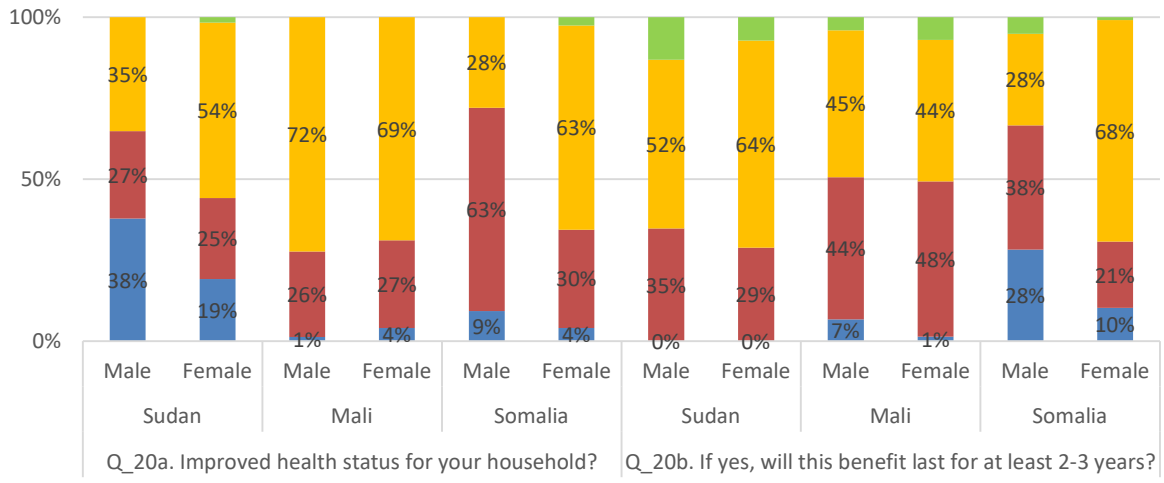


Figure 13: Social protection-Health status



On nutritional status (Figure 14), more than 75% of males and females in Somalia and Mali and females in Sudan agreed fully or partially that the projects had helped improve the nutritional status of their families. The corresponding figure for males in Sudan was 51%. More than 80% of males and females in all three countries who reported some impact also reported fully or partially that it will last sustainably for at least 2-3 years.

Figure 14: Social Protection-Nutritional Status

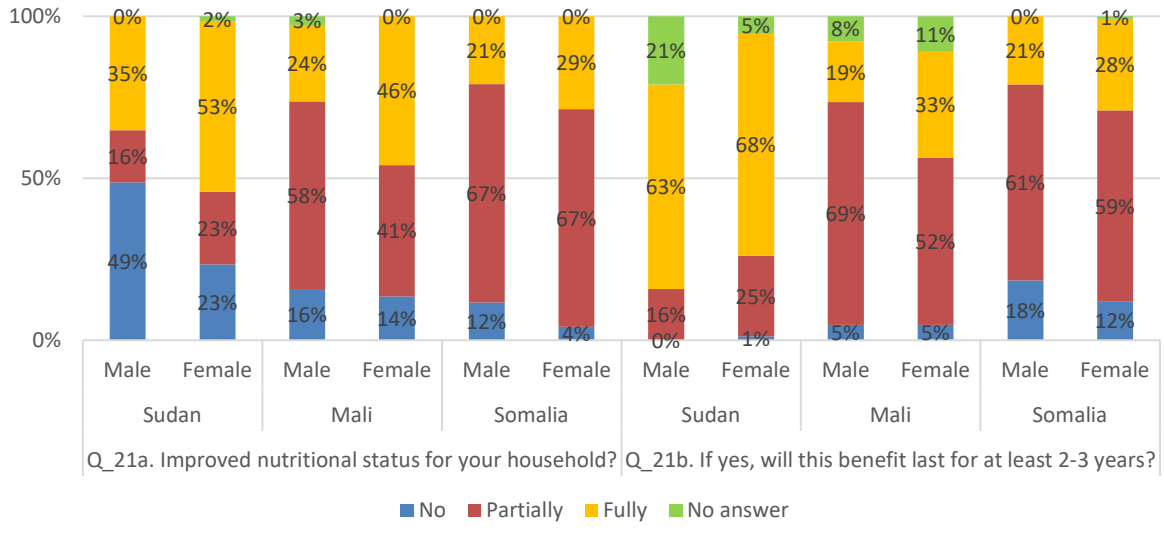
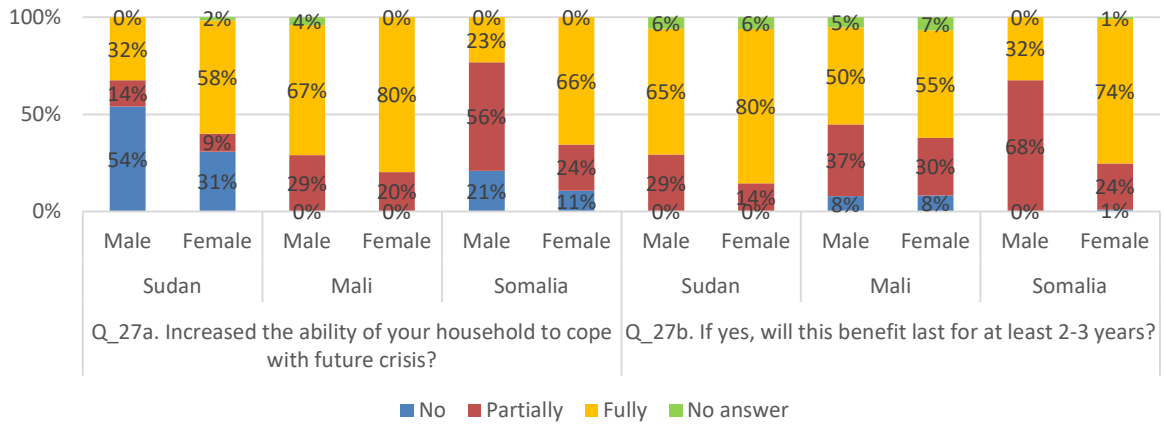


Figure 15: Social Inclusion: Increased Resilience



In social inclusion, respondents were asked about the impact on their resilience and community cohesion. On resilience (Figure 15), around 80% or more of the males and females in Mali and Somalia agreed fully or partially that the projects had increased their household resilience to future shocks. In Sudan, the corresponding figure was nearly 70% among females and around 45% among males. Around 70% or more of those who reported some impact, also agreed fully or partially that it will last sustainably for at least 2-3 years among both males and females in all three countries. On community cohesion (Figure 16), around 70% or more males and females in the three countries agreed fully or partially that the projects had enhanced community cohesion. Around 80% or more who said so also agreed fully or partially that this impact will last sustainably for at least 2-3 years. In Tunisia small-scale survey, 100% of respondents reported partial or full impact on both resilience and community cohesion and also agreed partially or fully that the impact will last sustainably for at least 2-3 years.

Figure 16: Social inclusion-Community Cohesion

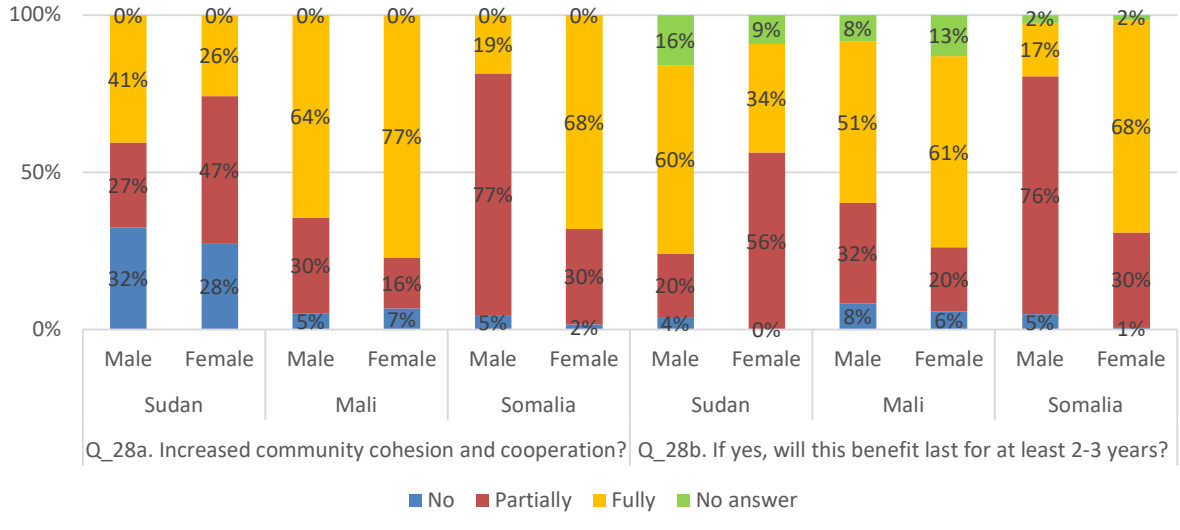
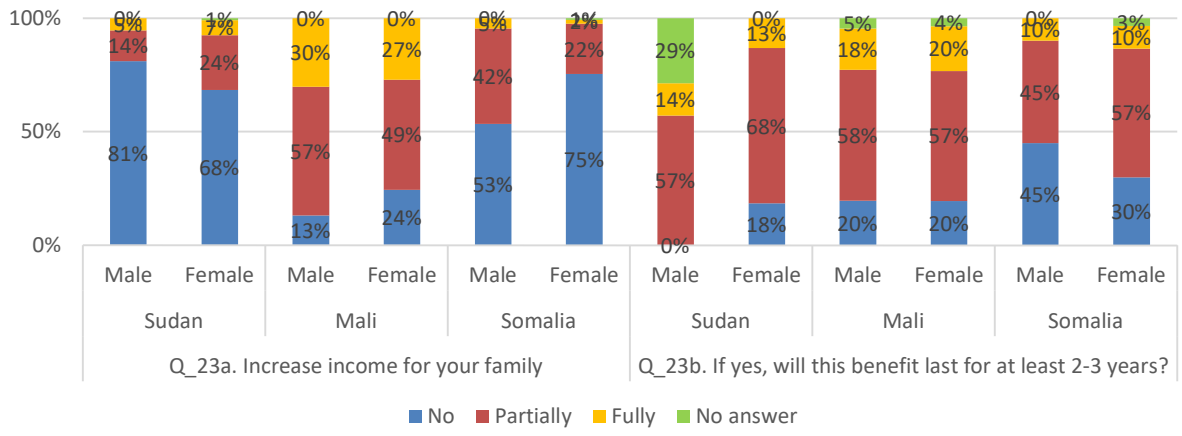
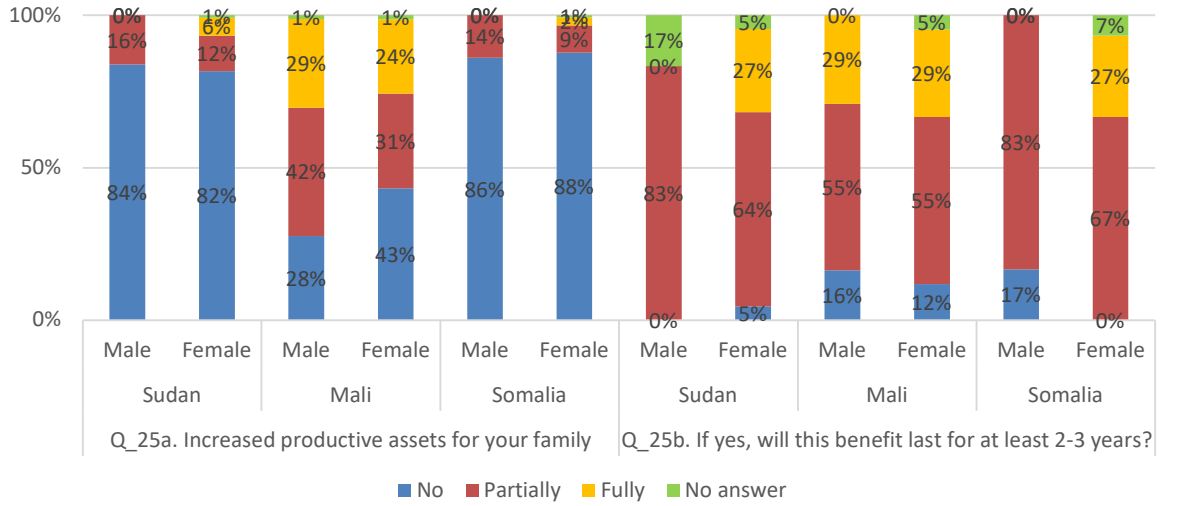


Figure 17: Economic Strengthening-Increased Income



Within economic strengthening, respondents were asked about increased income and assets. Despite the fact that Phase 1 projects had mainly focused on social inclusion and protection and very little on economic strengthening while Phase 2 projects focused on economic strengthening were in very early phases, sizeable impact was reported in Mali on economic strengthening directly or indirectly due to improved social inclusion and protection activities and much lesser levels in Sudan and Somalia in terms of increased incomes and assets (Figures 17 and 18).

Figure 18: Eonomic Strengthening-Increased Assets



In the Tunisia small-scale survey, 67% of women reported improved water supply and all of them expect it to last for several years. 100% each reported some improvement in health and hygiene status and 67%

and 77% respectively expected it to last several years. Few reported any improvement in food security or income although almost all reported an increase in assets due to the project. In the global survey too, the main impact was reported under social protection, especially health outcomes, and social inclusion.

Results from FGDs and KIIs in Mali indicate that the training of health workers, religious leaders and traditional therapists has helped prevent Covid-19. The health centres prevention and patient care kits and community WASH kits have too. This impact will be sustainable if people continue to respect hygiene measures. In addition, cash transfers also contributed to improving the food and nutritional security of ultra-poor households. However, these results will only be sustainable if Islamic Relief puts in place a resilience program in view of the deteriorating socio-economic situation and the loss of livelihoods. This program could be implemented while including cross-cutting issues such as social cohesion and peace building in communities in Timbuktu and Douentza. This is due, among other things, to the Covid-19 crisis with its corollaries such as price increase, insecurity and closure of certain schools by jihadist groups. The current situation will worsen if there is no work done against malnutrition, food insecurity and the deterioration of living conditions (health, education, etc.). Result from FGDs and KIIs indicate communities democratically agreed on vulnerability criteria before the project start. They identified themselves in the process of project implementation from its start to end; which has strengthened cohesion and cooperation between them. However, some villages felt that they had been excluded. Communities reported that they have developed an increased capacity for resilience in the face of future crises. Indeed, knowledge acquired in COVID-19 prevention as well as changes in attitudes will help them to cope better with future crises. But the project had less impact in terms of protection, rebuilding and/or strengthening livelihoods. Cash transfer to vulnerable and ultra-vulnerable right-holders barely allowed them to meet food and non-food needs beyond the short term. Following the border closures due to Covid-19, prices of basic food and non-food items increased at a time when the purchasing power of communities has been affected.

Impacts for IRP's projects are yet to be determined formally for the TACVA project as it is still in early phases of implementation. However, FGDs and KIIs show that the impact of the Covid-19 related risk awareness imparted to the communities was high and will most likely sustain beyond the project's life. The sustainability of portable ventilators and X-ray machines provided to the hospitals have great value for the hospitals, which ensures their sustainability. IRP's provision of medical equipment and WASH facilities in hospitals and construction of toilets for education department in Chagai and Quetta are assisting these institutions in carrying out their activities and facilitating the patients and students in a better way. FGDs show that IRP successfully fulfilled the health, FSL and WASH related needs of district hospitals and target communities and increased the knowledge and ability of communities to stay clean, protect themselves from the virus, and pass on this knowledge beyond the project. According to the communities the strongest part of IRP's Covid-19 response was: (a) provision of seeds to grow crops; and (b) Covid-19 awareness sessions while the weakest part was: (a) delays in provision of seeds; (b) non-provision of food items; and (c) delay in the delivery of services under the TACVA project. For future projects the communities need assistance in the following areas: 1. Fencing for their goats to prevent them from getting killed by vehicles on the highway; 2. Basic health unit; 3. Tube well to access water for crops and household use; 4. Green tunnels to grow their fruits and vegetables; 5. Economic support because the earnings have stopped due to Covid-19 lockdowns; 6. Sewage system; 7. Assistance in agricultural inputs; and 8. Medicine for animals.

BOX 3: BENEFICIARY VOICES

Mr. Z is 50 years old, and is the father of a 9-member refugee household from South Sudan and two of them are PWDs. He is staying in a refugee Camp in the Sheikan, North Kordofan. The project provided Covid-19 services, namely sterilizers and masks during the distribution of food aid. The project listened to our complaints and problems, and some of them were solved. The project served both men and women. However, the services provided by the project did not include financial support. The project helped us by providing some information to stay safe from Coronavirus. IRS used to provide us with services before the Corona pandemic, consisting of cornbread, oils, awareness and guidance and monthly financial aid, which helped a great deal in improving the current health status. It is expected that it will continue for the coming years. There is no improvement in the family's nutritional status. There is no negative impact of the project, but insufficient services are provided.

"I am 45 years old with eight children and I am illiterate", explains Ms A in Pakistan. "I came to know about IRP's work in our village back in 2019 and became a member of the female community group of our village. IRP back then was organizing and forming community groups in her village and trying to find out about the problems and needs of the community. She said that her community faces extreme shortages of water due to the drought and their needs are primarily due to drought limited income generation opportunities. She said that back in 2019, IRP assisted the male community members with agricultural seeds and toolkits to help with better crop production and female members of the community were provided kitchen gardening support to produce healthy vegetables. She said that, "When the pandemic broke out in Quetta, my husband, who is also illiterate and works as a labourer on daily wages, lost his job due to the lockdowns. My family's basic necessities of life which were already strained became extremely difficult to fulfil after my husband, as the sole breadwinner for the family, could not find work". IRP during the Covid-19 peak time in Quetta started distributing face masks, soaps and sanitizers amongst her community and held Covid-19 related awareness sessions. "Although my family was going through extremely harsh economic situation and we needed economic support instead of awareness sessions, we nonetheless attended the Covid-19 awareness sessions". She said that during this time her family started focusing more than usual on the kitchen gardening. Although her husband cannot spare time from her menial job to attend the IRP community meetings, he still makes an effort to attend these meetings whenever he can afford to do so. She said that the agricultural seed provided to her husband also contribute in raising her family's income.

In Somalia, Islamic Relief launched the Covid-19 prevention project in three areas of Daynile, Balcad and Bondhere. Ms. F was among the right-holders of this project with her young daughter, AA, who was suffering from Epilepsy for the last 2 years. The doctors at IRS health clinic supported this family by providing some supportive medicine. "I am a mother of four kids, going to the private hospital is not an easy job for us as we do not have money to pay the hospital. We really send our thanks to the donor and those brought to us this wonderful support to us in Somalia", says F. "Now, my young daughter feels well. We receive free care and treatment while my daughter is very happy now as she can go to school without feeling faintness-Alhamdollilah. This kind of funding is mainly needed by mothers like me who have orphan children and live in the IDPs camps. I want to send my gratefulness to everyone who contributes this marvellous aid and may Allah reward them the day after".

My name is RT, 78 years old. I am an Internal Displace Person (IDP) living in Gourma Rharous, Mali. I benefited from IR's support. Islamic Relief in Mali provided me with Wash Kits. In addition, I benefited from two cash transfers (42.000 CFA x 2). When I received this money, I paid my debts, and bought food (rice) for my household. I used the rest of money to start a business. Indeed, I used half of the money to pay and resell condiments. I also received information on how to prevent Covid-19. Life with Covid-19 and insecurity issues means that livelihoods are so much affected that it is sometimes difficult to get one meal per day particularly for vulnerable people like me. I was ultra-vulnerable and jobless. Thanks to the money I received, I started a business. Even though I would have wished a more important amount, I successfully started my business and I am able to cover immediate elementary needs for my family. I am still requesting IR's support so that my business can grow with a view of becoming independent, my family and I. You know I am old and I need economic and food support. My business, if I am supported, can help me take care of our household elementary needs. I want economic and food support from IR. If I can get more support, this will help me do business and I will feel independent in terms of covering the needs of my family.

FGDs in Somalia have indicated that hand washing facilities placed in the IDP camps have enabled people to frequently wash their hands which has helped reduce the spread of Covid-19. This service and the hygiene promotion will have sustainability according to people. The project approaches were seen as efficient, especially the use of the predeveloped beneficiary's selection criteria. The methods used to sensitize, mobilize and share information with the communities and government were appreciated, in addition to the accountability mechanisms. IR reached some of the more vulnerable populations in the IDPs settlements, such as elderly and PWD right-holders. The project has achieved its purpose of contributing to COVID 19 prevention, preparedness, and hygiene practice behaviour change, according to communities. The visited IDPs settlements seemed well aware of Covid19 preventing measures. Almost everyone in the sites was wearing masks and the social distancing practice was clearly visible. While the project cannot claim full attribution, it is a positive finding for the densely populated area of Banaadir. However monitoring activities were weak and absence of baseline and monitoring data restricted analysis.

FGDs in Sudan too reported higher impact on social inclusion (resilience and community cohesion), social protection (provision of basic services but less impact on economic strengthening, as expected given the focus of the programs. KIIs in Tunisia show that the provision of health equipment has significantly increased the capacities of hospitals to provide better Covid-19 services and much of the impact related to durable equipment will continue for several years. The project related to women's empowerment in Tataouine is still in the inception phase. But it has generated sustainable results from the work earlier implemented in 2017 and 2018, which augurs well for the current phase. IR Tunisia provided them with materials to generate income. The women groups rely on marketing via internet and Facebook pages sponsored by IR Tunisia which also helps to minimize physical contact and the impact of the Covid-19.

Thus, overall, as expected the greatest **impact and sustainability** in all four countries was on social inclusion and protection components of SERF given that Phase 1 projects largely focused on basic needs related services while Phase 2 projects that focused on livelihoods work were in very early stages of implementation.

Table 11: Summary Responses on Impact Questions

	Percentage agreeing fully or partially about impact					
	Mali		**Somalia**		**Sudan**	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Social Protection						
Water	85	77	100	98	**62**	**41**
Hygiene	100	100	84	93	81	84
Health	99	96	91	93	62	79
Nutrition	81	86	88	96	51	75
Food Security	92	88	49	81	19	18
Social Inclusion						
Cohesion	94	93	95	98	68	72
Resilience	96	100	79	90	46	67
Economic Strengthening						
Increased income	87	76	**47**	**24**	19	31
Increased assets	71	56	**14**	**11**	16	18

Table 12: Summary Responses on Sustainability Questions

	Percentage agreeing fully or partially about sustainability					
	Mali		Somalia		Sudan	
	Male	Female	Male	Female	Male	Female
Social Protection						
Water	92	86	**55**	88	82	81
Hygiene	94	95	89	92	84	92
Health	89	92	67	89	65	71
Nutrition	87	84	82	87	79	94
Food Security	81	74	64	89	72	95
Social Inclusion						
Cohesion	83	81	87	98	80	90
Resilience	87	85	100	98	94	94
Economic Strengthening						
Increased income	76	77	**55**	**67**	71	81
Increased assets	84	83	83	93	88	84

Responses on sustainability questions only include of those persons who reported partial or full impact.

CHAPTER 4: CONCLUSIONS

1. RELEVANCE

CHS Commitment 1: Humanitarian response is appropriate and relevant

The evaluation team found performance on this commitment to be satisfactory. The services provided were largely very relevant and the focus was on highly affected persons. The regions selected were among the most isolated and worst-affected. The main complaints related to provision of services and addition of more right-holders that went beyond budgets available. Other more valid complaints related to inclusion of less affected persons and the need for some ancillary services closely to current services such as health equipment. The coverage of women and PWDs was deemed appropriate. Health and hygiene information and food, livelihoods and income related needs were generally mentioned as the most important ones. The health and hygiene needs were generally provided in all the projects. However, in projects that only focused on basic needs like health and water, people also expressed the need for food, income and livelihoods support. There were no complaints in FGDs from any of the countries about highly affected persons being left behind, though a general comment in several countries was that more persons should have been helped as almost everyone in the communities was affected .

CHS Commitment 4: Humanitarian response is based upon communication, participation, and feedback

The evaluation team concludes that participation of communities and institutional right-holders was high. This success was based on the use of different approaches, including committees, community mobilizers, local authorities, faith leaders and remote means when travel was not possible and was supported by previous work and links in these committees. The main challenge was ensuring the participation of people who were away from communities due to work and finding ways to involve people busy in daily work locally. The main challenges reported were the travel restrictions which made it difficult to consult communities and the inability to incorporate the feedback given by communities during consultations due to limited funds. The major successes were being able to still consult communities using local administration and faith leaders who had mobility and remote techniques like cell phones.

CHS Commitment 5: Complaints are welcomed and addressed.

Based on triangulation from all the different sources of information, the evaluation team concludes that complaint mechanisms were present but need some improvement in terms of use of multiple methods, use of instruction in local languages and ensuring use by the most marginalized sections of the community like illiterate persons, women, older persons and PWDs. A wide range of complaint mechanisms were used including face to face meetings, complaint hotlines and complaint boxes. In all communities visited, the complaint procedure was observed to be in place in prominent places like community or health centres. Satisfaction levels with compliant mechanisms during FGDs were generally higher where multiple methods were used as different methods have their advantages and disadvantages.

Overall, the performance on relevance was highly satisfactory. Most of the complaints from FGDs and KIIs related to issues of budget constraints i.e., request for additional assistance and increasing the number of right-holders. Some other gaps existed in terms of i) delays in addressing income and livelihoods needs in some places, ii) the inclusion of some less affected persons in Somalia, iii) the lack of complaint mechanism instructions in English in some places, and iv) the need to use multiple complaint mechanisms that cater to the needs of all community members. However, overall, good participation of communities and institutional right-holders ensured a focus on relevant needs and needy persons.

2. EFFECTIVENESS

CHS Commitment 2: Humanitarian response is effective and timely.

Overall performance on **CHS Commitment 2** is good, especially with the issue of promises kept and quality of services, though there were complaints about late delivery of services in some countries due to Covid-19 restrictions and other constraints. Other complaints related to lack of delivery of services that went beyond the scope of the project budgets. The most satisfaction was expressed with regard to WASH and informational services. For all projects already over, 100% of the targets have been fully achieved. The non or partially targets relate to projects still on-going. Information was not available for Mali and Tunisia.

CHS Commitment 3: Humanitarian response strengthens local capacities and avoids negative effects.

Overall, performance on **CHS Commitment 3** was satisfactory. Previous projects had successfully built the informational and income capacities to deal with the current crisis, thus somewhat alleviating misery after Covid-19. New services helped communities avoid harm from Covid-19 to a great extent while project activities did not cause harm to communities. Most of the males and females in the countries reported no negative impact from project activities while the majority said that past project activities had prepared them well for dealing with Covid-19 through hygiene promotion, water work and income projects. Current project work focused on awareness raising also reduced people's risks.

CHS Commitment 8: Staff is supported to do their job effectively, and are treated fairly and equitably.

Overall, the agency performed a good job of keeping staff safe from infection through the development of Covid-19 working guidelines and related awareness-raising under **CHS Commitment 8**, resulting in few Covid-19 infections among staff. The agency developed global guidelines for staff safety during Covid-19. However, the IRW global guidelines could be made more detailed and presentable. All countries also developed detailed SOPs for working during Covid-19 and mandated remote work in the beginning.

Overall performance on effectiveness was satisfactory. The projects were rated highly on keeping promises and the quality of services though there were complaints about timeliness in several countries. All projects met their targets in time though there were delays in starting Phase 2 projects in several countries. The agency succeeded in achieving these high levels of effectiveness while keeping staff and communities safe during the Covid-19 crisis.

3. EFFICIENCY

CHS Commitment 6: Humanitarian responses are coordinated and complementary.

The agency performed a good job at coordinating its work with government and UN agencies and other partners during the Covid-19 crisis despite the restrictions on meetings. This resulted in improved quality of work and reduced bottlenecks and challenges. External stakeholders expressed satisfaction with the nature of IRW work and their own involvement in it where required.

CHS Commitment 7: Humanitarian actors continuously learn and improve.

Performance along **CHS Commitment 7** must be improved significantly by developing a common learning framework for emergencies, aligning its planning, implementation, monitoring and reporting templates in line with the CHS commitments and updating its emergency toolkits. Most countries did not undertake any formal learning processes during or after Phase 1 projects.

CHS Commitment 9: Resources are managed and used responsibly for their intended purpose.

While performance on **CHS Commitment 9** was adequate, with each country using its own approach to use resources well, a clearer approach developed by IRW head office on ensuring, measuring and reporting the efficient use of resources would have been helpful. Such an approach could have used approaches such as Value for Money, cost-benefit analysis and Social Return on Investment to evaluate the efficient use of resources.

IR work on efficiency needs improvement. It has done an excellent job at coordinating with external stakeholders in all countries, especially with government partner agencies. This has helped in increasing relevance, effectiveness, impact and sustainability of project work. However, the work on learning and support to country programs and ensuring good use of resources lacks global harmonization and has been done on an ad-hoc basis by each country. Thus, there is the need to develop more globally harmonized approaches on these issues and aligning its emergency work more closely with the CHS commitments.

4. IMPACT AND SUSTAINABILITY

The discussion under impact and sustainability falls beyond the CHS Commitments, which is reflective of the problems involved in measuring impact and sustainability during emergencies given high and compressed needs, practical challenges, short-duration of projects focused on alleviating suffering and the difficulties involved in documentation, especially in a pandemic. Still, the agency created impact and sustainability from Phase 1 projects. As expected the greatest **impact and sustainability** was on social inclusion and protection components of SERF given that Phase 1 projects largely focused on basic needs while Phase 2 projects that focused on livelihoods work were in very early stages of implementation.

Thus major work is needed under efficiency on Commitment 7 and 9 and to a lesser extent on Commitment 5 under relevance and Commitment 8 under effectiveness. In summary that means good performance on core commitments focused on relevance, participation, quality, coordination and to a lesser extent impact and even sustainability but improvements needed in capturing and sharing learning, ensuring efficient use of resources, complaints handling and timely delivery of Phase 2 projects.

The summary is as follows:

Table 13: Summary Performance on OECD-DAC and CHS Criteria[2]

OECD-DAC and CHS criteria	Summary performance
Relevance	**Satisfactory**
• CHS Commitment 1: Humanitarian response is appropriate and relevant.	**Satisfactory**
• CHS Commitment 4: Humanitarian response is based upon communication, participation, and feedback	**Satisfactory**
• CHS Commitment 5: Complaints are welcomed and addressed.	**Satisfactory though complaint mechanisms must be strengthened for better implementation and analysis**
Effectiveness	**Satisfactory**
• CHS Commitment 2: Humanitarian response is effective and timely.	**Satisfactory quality but delay in Phase 2 projects**
• CHS Commitment 3: Humanitarian response strengthens local capacities and avoids negative effects.	**Satisfactory**
• CHS Commitment 8: Staff is supported to do their job effectively, and are treated fairly and equitably.	**Satisfactory, but better guidelines needed from HQ on Covid-19 precautions for staff**
Efficiency	**More work needed**
• CHS Commitment 6: Humanitarian responses are coordinated and complementary.	**Satisfactory**
• CHS Commitment 7: Humanitarian actors continuously learn and improve.	**More globally harmonized approach is needed**
• CHS Commitment 9: Resources are managed and used responsibly for their intended purpose.	**More globally harmonized approach is needed**
Impact and Sustainability	**Satisfactory given it is emergency work--Mainly in the areas of social inclusion and protection given the nature of Phase I project and delays in Phase 2 projects**

[2] An overall judgment of "satisfactory" and "needs improvement" are given on each CHS commitment. Performance on a commitment is considered satisfactory when beneficiary satisfaction was above two-thirds for field-level commitments and where strong systems exist in case of commitments related to agency systems and processes.

CHAPTER 5: RECOMMENDATIONS

2. OVERALL

The overall recommendations relate to steps that IRW HQ units like Program Quality and DRMD are advised to take to strengthen adherence to the CHS commitments and preparation for future pandemics and other disasters

CHS Commitment 1: Humanitarian response is appropriate and relevant.

1. Develop programming guidelines as part of SERF that encourage countries to adopt a programming continuum for emergency work consisting of relief, early recovery and development that covers not only basic needs in the areas of social inclusion and social protection but also livelihoods opportunities in the areas of economic strengthening (Lead role: DRMD)

CHS Commitment 2: Humanitarian response is effective and timely.

2. Streamline HQ procedures to ensure more timely approval of proposals and budget changes to allow work to start quickly at the field level and keep communities informed about the reasons for delays to manage expectations (Lead role: PFPD)
3. Help countries develop an efficient supply chain system that can immediately be activated after the crisis to ensure timely delivery of inputs (Lead role: Global Procurement)

CHS Commitment 3: Humanitarian response strengthens local capacities and avoids negative effects.

4. Develop the capacities of country offices and partners to undertake pandemic-related work in case international deployments are not possible during pandemics and also consider developing remote deployment options (Lead role: DRMD).

CHS Commitment 4: Humanitarian response is based upon communication, participation, and feedback

5. Develop external stakeholder partnership guidelines that encourage countries to build on the successes achieved in ensuring participation by working with faith leaders at both local and national level, community leaders and local authorities while ensuring that the broader values and agendas of such actors do not conflict with the faith-based or global humanitarian values of IRW (Lead role: PFPD).

CHS Commitment 7: Humanitarian actors continuously learn and improve.

6. Include pandemic work as a priority in the next Strategic Plan and align planning, implementation, monitoring and reporting templates in line with pandemic work, CHS commitments and SERF and update emergency manual and other toolkits accordingly (Lead role: Program Quality/DRMD).
7. Develop more expertise in core sectoral areas that build on existing capacities and can help attract more funding from external donors, e.g., cash transfers, WASH and early recovery livelihoods

work, for basic needs sectors so that its own resources can be freed up to focus on economic strengthening work which is less funded by external donors (Lead role: Program Quality/DRMD).

8. Undertake emergency training on new frameworks above for country-level emergency staff (Lead role: Program Quality/DRMD).

CHS Commitment 8: Staff is supported to do their job effectively, and are treated fairly and equitably.

9. Develop more detailed and presentable guidelines on staff safety during pandemics to provide more guidance on HR issues such as leave compensation, overtime, hazard pay, Covid-19 precautions, remote work and physical work with sufficient SOPs etc. (Lead role: Global Security/HR).

CHS Commitment 9: Resources are managed and used responsibly for their intended purpose.

10. Develop a clearer approach on ensuring, measuring and reporting the efficient use of resources would have been helpful. Such an approach could use approaches such as Value for Money and cost-benefit analysis to evaluate the efficient use of resources (Lead role: Program Quality/DRMD).

3. COUNTRY-SPECIFIC

PAKISTAN

1. IRP donors should provide sufficient time before call for submission of project proposals to ensure relevance through complete and comprehensive involvement of the project right-holders in the planning stage.
2. IRW needs to focus its humanitarian work in Balochistan in the pattern of IRP's TACVA project, which is most relevant in addressing the crucial needs of the poor local communities besides providing them with sustainable income generation opportunities. The project addresses the critical issues of climate variabilities affecting the livelihoods of communities through adaptive livelihoods, agriculture and livestock, water resource management, advocacy, and DRR.
3. IRW in future needs to ensure effectiveness of its global humanitarian response by: (a) focusing on a few instead of many countries; (b)developing a pandemic specific contingency plan for responding across the globe; (c) employing a proactive communication strategy during a pandemic instead of a reactive one; and (d) including health sector in its operations.
4. IRW needs to develop a formal system for continuous learning and improvement, which was missing during the Covid-19 emergency response in Pakistan.

MALI

1. Combine the Covid-19 response project with 3-5 years resilience program (with a particular focus on women) in line with Islamic Relief Socio-economic recovery framework (SERF), namely: 1) protecting livelihoods, 2) rebuilding livelihoods and 3) enhancing livelihoods – all of which aim to

achieve humanitarian, development and peace outcomes which are considered to be fundamentally inter-related;

2. Set up a mobile device (wash kits, gel) which can be loaned to communities in the event of an event such as weddings, baptisms, funeral ceremonies or any other mass event;
3. Sensitize communities for the establishment of a WASH committee on issues related to hygiene during events:
4. Provide schools and mosques with prevention kits against covid-19;
5. Raise awareness among NGOs so that Covid-19 prevention measures become cross-cutting issues in all their interventions mobilizing masses;
6. Review the vulnerability criteria by selecting households that cannot afford more than one meal per day or inactive people due to Covid-19 (e.g. Restorer, small retailers);
7. Train members of complaint committees on their roles and responsibilities in relation to all the process (selection of right-holders, distribution, and management;
8. Strengthen the capacities of community relays and children / young people by adopting a strategy similar to peers' education;
9. Bringing a continuous support to health centres in terms of equipment and capacity building till the end of COVID-19.

SOMALIA

1. **Introduce monitoring database for collecting Realtime project information to Maximize use of monitoring data:** The monitoring framework that IR used was solid, and they collected data regularly. However, they did seem to achieve a regular analysis of disaggregated data systematically. The trends of the pandemic in the project target areas was not collected hence it will be difficult to identity the extent in which IR have contributed to overall reduction of the pandemic. Therefore, it's advisable for RI to establish this trend database to better introduce robust and meaningful monitoring mechanism.
2. **To build wider resilience of the communities, focus on programs beyond health and food security**: The strategic projects objectives set the tone for a health focused project. IR should look how to introduce multi-dimensional programming in order to achieve and build the wider resilience of the target communities for future shocks and disasters.
3. **Supporting community level assets**: The project sought to help communities in adopting the covid19 pandemic. With minimal consideration of building community assets to resist shocks better. Despite the primary hazards in which communities are currently experiencing is Covid 19 pandemic —IR should look more closely into shared resources such as water points and building settlements. Resilience cannot be built by focusing at the individual level projects but must span to systematic change and multi sectoral intervention.
4. **Ensure protection and inclusivity:** IR has the intention to follow and prioritize protection issues. To put the intention into action and with appropriate indicators and tools in place, it needs to take steps to mainstream key protection considerations within the programs this includes conducting comprehensive and participatory assessments of protection risks, undertaking robust protection monitoring, and adapting it into the program design and implementation as needed. IR should look community level protection issues and more importantly the inclusion of women,

disable, children and elderly people in to the programs so as to ensure their actual needs are addressed.

5. **Apply Socio-economic recovery framework for the Covid-19 crisis.** To ensure that IR programs are in line with SERF a multidimensional approach for programming should be applied which addresses SERFs Key pillars like Economic Strengthening (Improved assets, skills, income, production and market access). Social Protection (Improved food security, health, nutrition, literacy). Resilience Strengthening (Improved adaptive capacities to response to crises) Financial Inclusion (Improved savings, credit, insurance and financial service) Social Inclusion (Enhanced rights awareness, decision making, community participation and governance).

SUDAN

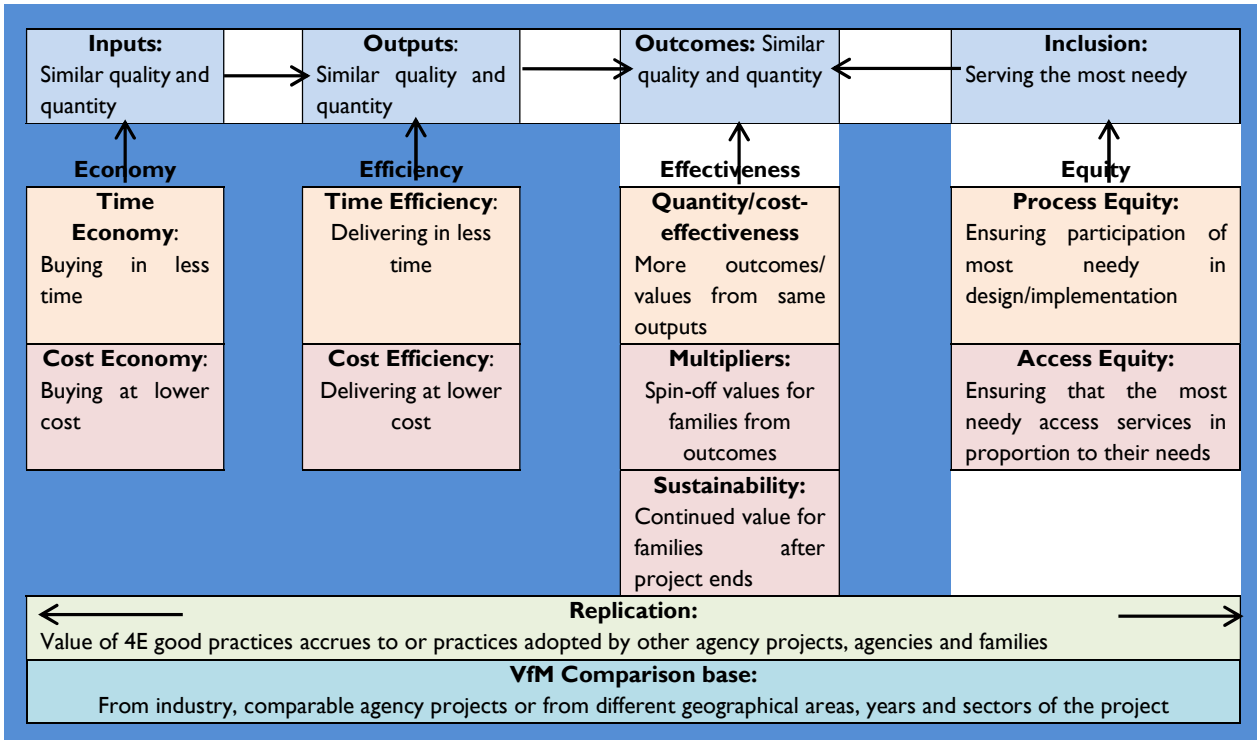
1. Provide income support to help increase income, preferably monthly, and target women working in the market (tea sellers - small income-generating enterprises - food processing for sales). Increase financial support to increase capital to start small income-generating projects and raining in the fields of handicrafts to increase income.
2. Provide adequate quantity of Covid-19 services in terms of WASH kits, hygiene kits and awareness-raising spread over the duration of the project.
3. Provide food subsidies and financial and in-kind benefits to vulnerable groups (people with disabilities, orphans, the elderly and widows)
4. Increase water sources and access to Primary Health Care Centres

TUNISIA

1. Undertake a mapping of the suppliers who are reliable and can deliver the items on time to create a Covid-19 response supply chain.
2. Tackle any environmental issues such as toxic waste in the women empowerment project for the future given their increased salience in Tunisia.
3. Reinforce the capacities of public hospitals keeping in mind that one of the gaps encountered is that many patients affected by the Covid-19 can't reach the regional hospital because it is far from small cities. Thus divide the quantity of items between regional hospitals and local hospitals.
4. The cooperation with ministries must be institutionalized by signing partnership agreements to set the areas of intervention of each association to better manage donations and facilitate the procedure with customs and administrations.
5. Publish the reports of project activities and collaboration with state institutions and the annual accounts and audits and have certificates on this from the central bank or the financial analysis commission in order to improve perception with the state institutions.

ANNEXES

A. VALUE FOR MONEY FRAMEWORK



Under this framework, agencies can collect data on procurement-related savings under Economy at the country and global levels. Under Efficiency, they can collect information on how delivery improvements led to savings. Under effectiveness, the focus is on how the same outputs delivered results in better outcomes. Finally, under Equity, data collection focuses on success in reaching out to the most needy persons and communities. The analysis is largely done by collecting examples of for each categories with some cost estimates for economy and efficiency, outcome information for Effectiveness and inclusion information for Equity. The framework can be implemented gradually over time, starting with economy and efficiency.

B. PROJECT DETAILS

I. MALI

1. Bamako COVID-19 Response Project

The first case of COVID-19 was reported in Mali on March 24, 2020 and as of August 16, 2020, official figures showed 2,640 people affected, 75 deaths and 1,987 cases of recovery. The regions of Koulikoro, Kayes, Sikasso, Ségou, Mopti, GAo, Kidal, Timbuktu and the district of Bamako are all affected with the city of Bamako at the epicentre of the pandemic with 72% of confirmed cases. The emergence of the COVID-19 pandemic adds to an already worrying humanitarian situation, aggravating previous

vulnerabilities and increasing humanitarian needs in Mali. Communes 2 and 4 in Bamako were heavily affected by flooding in May 2019 and communities had not fully recovered from the negative effects of this disaster. COVID-19 heightens their vulnerability where community members have little access to basic facilities such as WASH services that are essential to the prevention and mitigation of the effects of the virus. Due to the current living conditions in these densely populated areas, preparedness and prevention are essential measures to prevent the spread and to strengthen the coping capacities of already vulnerable populations who have few resources on which to rely for prevention. Communes 2 and 4 account for 75% of commercial activities in the district of Bamako, with the government's restrictive measures put in place at the onset of the virus, particularly the curfew, according to the local service of Social Development, 80% of the population was placed into heightened vulnerability. Whilst government National Response Plans include a focus on community engagement and prevention, measures are limited and support of actors is required to support vulnerable communities. Services and social systems in Mali were weakened and the health care system was unprepared for a COVID-19 outbreak which would rapidly overwhelm and exhaust existing capacities.

Implemented within Bamako Districts 2 and 4, the project had two main objectives; 1) Provision of support to at risk and vulnerable populations with immediate support in mitigating/prevention of covid-19 transmission through immediate WASH support and 2) To support government institutions in the response to covid-19.

The project successfully carried out the following activities:

5. Distribution of WASH Kits to 317 Households vs 300 planned HHs in Communes 2 and 4 of Bamako:
6. The organization of 20 awareness sessions across Communes 2 and 4 by the Community Response Teams on prevention and identification of COVID;
7. The training of 40 faith leaders on prevention and identification of COVID and faith based messaging related to COVID (Agents of knowledge, attitude and practice change to disseminate faith-based messaging on COVID-19);
8. Broadcast of awareness sessions on prevention, routes of contamination and means of protection (to reach HCs sites and wider);
9. Displaying of 120 posters vs 100 planned in public places relating to best practices to follow for prevention of virus spread;
10. The provision of hygiene and WASH kits and protective clothing (gloves and masks) to 22 health centres in Bamako commune 2 and 4.

PROJECT ACHIEVEMENTS AGAINST ALL OUTPUTS AND OUTCOMES
BAMAKO COVID-19 RESPONSE PROJECT PROGRESS

Outputs	Indicators	Planned Targets	Actual Targets Achieved
300 households identified to receive WASH kits	# of households identified to receive WASH kits	300	317
300 kits distributed to HCs across 2 communes	# of households receiving WASH items	300	317
22 provided to targeted health centres in Bamako commune 2 and 4	# of health centers receiving WASH items	22	22

4 Community Response Teams hold 4 sessions sensitising community members on prevention and identification of COVID	# of sessions held on prevention and identification of COVID	20	20
Faith leaders disseminate faith based messaging related to COVID	# of religious leaders trained	40	40
100 awareness sessions broadcasted on prevention, routes of contamination and means of protection (to reach HCs sites and wider)	# of sensitizations conducted by faith leaders	100	105
100 posters displayed in public places relating to best practices to follow for prevention of spread	# of posters displayed in public places relating to best practices to follow for prevention of spread	100	120

2. Mali Covid-19 Response II Project:

The pandemic in Mali is occurring in a context already marked by critical humanitarian needs with almost a quarter of the population depending on humanitarian assistance. Services and social systems are weakened and the health care system in Mali is unprepared for a COVID-19 outbreak which would rapidly overwhelm and exhaust existing capacities. Low levels of knowledge on COVID-19, lack of ability of communities to observe critical measures associated with mitigating spread of the virus; social distancing, isolation and access to WASH infrastructure and items, closed health centres and low capacities of existing centres are some of the factors expected to exacerbate an outbreak in Mali, particularly in already vulnerable Northern Regions impacted by ongoing and worsening conflict.

Through a series of activities, this 6-month intervention implemented within 40 villages across 4 Communes of Gourma Rharous (Northern Mali), aimed to:

- Strengthen technical and operational capacities of health workers in 4 communes of the Gourma Rharous river band
- Strengthen community awareness on covid-19, prevention and best practices to adopt in response to the pandemic through community-led and faith-based risk communication
- Enhance capacity of the most vulnerable to meet basic needs in the covid-19 context through increased access to food and non-food items.

Communities targeted by this intervention are along the River Band. Due to insecurity in the region, the river is used as a key transit route for community members and IDPs moving within Mali as it is considered safer than using roads in an unstable security environment. Discussions with Health Authorities have highlighted these areas as concerns with regards to vulnerability to covid-19 spread because of fluid movement.

The project completed the following activities;

1. The training of 30 Government Health Workers (16 Community Health Centre Staff and 14 District Health Centre Staff) on infection prevention control, COVID case management and referral (The history of COVID-19 and its character, Impacts of COVID on different parts of society (older persons,

pregnant women, children), PPE and practical exercises in using PPE, Government systems for management of COVID-19 and relationships between different health structures within this, Management of COVID cases in the health care setting (patients and the health centre environment), Precautions to adopt to prevent and mitigate the spread of covid and How to manage cases of COVID mortality

2. The provision of PPE and WASH Kits 4 to targeted community health centres and 1 to district health centre
3. Support to the reinforcement of 4 'screening teams' (cordon sanitaire) teams through employment of 8 additional volunteers and support in staffing costs of health agents;
4. The provision of WASH kits to 200 vulnerable HHs (including 100 IDP HHs);
5. The provision of PPE & disinfectant to trained local religious leaders (Imams), traditional healers and community influential;
6. Broadcasting of COVID-19 risk communication and sensitization awareness sessions from local radio channels;
7. Displaying of 100 posters with COVID-19 and protection messaging from a faith based perspective;
8. Awareness sessions among communities from a religious/ traditional perspective through local religious leaders (Imams), traditional healers and community influential (IECs);
9. Broadcasting of 20 radio debates between faith leaders on COVID-19 and protection (messaging to be age, gender and ability appropriate);
10. Training of 120 people across 40 villages (faith leaders, influential community stakeholders and traditional healers) on COVID-19 awareness and prevention and protection, including faith-based messaging;
11. Cash transfer to 200 vulnerable HHs (100 IDP HHs) to enable minimum food needs to be met for 2 months.

GOURMA RHAROUS COVID-19 RESPONSE PROJECT PROGRESS

Outputs	**Indicators**	**Planned Targets**	**Actual Targets Achieved**
Government health workers improved their knowledge of infection control, COVID case management, and referral.	# of Staff from the Community Health Centers and the Reference Health Center trained in the prevention and infection control	44	44
Improved screening, testing and treatment of COVID-19 in 4 target communes	# of volunteers screening/monitoring at the level of sanitary cords	8	**15**
Community Leaders are strengthened on covid-19 and equipped with PPE.	# of Community Leaders strengthened on covid-19 and equipped with PPE	120	120
Improved handwashing practices among target households.	# of households provided with wash kits including ultra-poor vulnerable households and households of displaced persons.	200	320

Target populations have increased access to information on COVID-19 prevention, containment measures, practices and protection messages.	# of villages reached by IECs disseminated through different mechanisms	40	40
Cash transfer to 200 vulnerable HHs (100 IDP HHs) (42,000 xof per month) to enable minimum food needs to be met for 2 months	# of households receiving Cash transfer	200	200

SUPPORTING ECONOMIC RECOVERY AND RESILIENCE PROJECT IN DOUENTZA

Working across 5 villages, this initiative intends to contribute to enhanced resilience and socio-economic recovery of vulnerable HHs within the Circle of Douentza, in working towards this the intervention seeks to achieve the following:

Outcome 1: This outcome is dedicated to component 1 of SE Recovery Framework; 'Protecting Livelihoods'. As highlighted in the situation analysis, vulnerable households are resorting to negative coping mechanisms including the sale of productive assets to ensure food security. Through this outcome, social protection will be targeted to secure livelihoods and food consumption of targeted households:

Outcome 2: This outcome is focused on 'rebuilding livelihoods'; the restoration or realisation of livelihood opportunities, diversification of livelihoods as part of building resilience, and strengthening of market linkages and engagement:

Outcome 3:

This outcome focuses on enhancing livelihoods and strengthening strategies that can ensure sustainable livelihoods improvements, including strengthening influential community groups based on best practices and proven approaches by IR Mali.

Outputs	**Indicators**	**Planned Targets**	**Actual Targets Achieved**
Improved access to food for 200 HHs during the lean season	# of HHs receiving cash during the lean season	200	200
Increased cereal availability in intervention communities	# of cereal banks established	5	5
	# of management committees members trained on management	15	15
Increased access of producers to productive assets	# of productive asset restoration needs assessment & environmental impact study	1	1
	# of micro dams constructed	1	0

PAKISTAN

Project 1: Covid-19 Awareness and Protection Emergency Response (CAPER) Project

This was a short term emergency response project (June 15, 2020 to December 31, 2020) implemented in districts Quetta and Chagai Balochistan province. The project had a budget of USD 250,000 and it was implemented with the close coordination of the Balochistan Provincial Disaster Management Authority (PDMA) and district health departments of Quetta and Chagai. The project primarily provided direct support to the health departments in terms of medical equipment, personal protective equipment (PPE), installation or fixing of movable water and WASH facilities and awareness-raising through hygiene sessions and media campaigns. The medical equipment was provided to the district hospitals on a need basis in collaboration with the PDMA and district administrations.

The project completed the following activities:

1. Installation of 50 portable hand wash basins in 50 major public places of both the districts of Chagai and Quetta;
2. Provision of 25 fixed filter water coolers installed at 12 hospitals in Chagai and 13 in Quetta;
3. Provision of Covid-19 virtual awareness videos and messages through FM radio programs in 4 different languages spoken in Balochistan
4. Provision of 1 mobile X-ray machine at DHQ Hospital Chagai and 2 at Civil Sandman Hospital Quetta
5. Provision of 2 portable ventilators for DHQ Hospital Chagai and 3 for Civil Sandeman Hospital Quetta;
6. Provision and installation of incinerator at DHQ Hospital Chagai
7. Provided 42 awareness raising sessions and PPEs (Masks, Soaps, and sanitizers) within communities of Quetta & Chagai districts.
8. Provided need based technical assistance (awareness raising) for PDMA at quarantine centres and public places;
9. Provided Covid-19 related education and awareness to front line responders in districts Chagai and Quetta;
10. Conducted research on the socio-economic impacts on most at risk from Covid-19;
11. Engaged with youth for use of technology to spread Covid-19 awareness;
12. Engaged with faith institutions/ faith leaders for awareness and faith based psychological support.

CAPER PROJECT ACHIEVEMENTS VS TARGETS

Outcome 1. Two districts of Balochistan Quetta and Chagai communities were affected by Covid-19 pandemic and as a result of this project, government Health department Balochistan will be able to cope up with Covid-19 response				
Outputs for Outcome 1	**Indicators**	**Planned Targets**	**Targets Achieved**	**Reason for any Variance**
Promotion of hand washing and space for sanitation through portable wash basin facilities and wash rooms	# of portable hand washing facilities and Wash rooms will be provided to PDMA and Health department for Hospitals / health facilities / Quarantine centres	1.1 Provision of 50 Portable hand wash basins	50 portable hand washing basins installed at targeted districts (25 at Chagai and 25 at Quetta	Target achieved no variance
Safe and clean water at quarantine centres and hospitals	# people at quarantine centres and hospitals will have access to safe and clean water	1.2 Provision of 25 portable filter water coolers for HCFs & school (initially the planned activity was portable water coolers which was changed due to closure of quarantine centres)	25 portable filter water coolers for HCFs and School installed (13 Quetta and 12 at Chagai)	The activity was changed from portable to fix water coolers, the revised target changed.
Improved Health and hygiene awareness around Covid-19	Communities at affected districts will reach with awareness messages and PPE on COVID-19	2.1. Provision of 100 Patient protection Kits (covid-19 response focused)	Provided 100 patient protection kits, 50 kits at DHQ Hospital Dalbandin Chagai and 50 at Civil Sandman Hospital Quetta	Target achieved
		2.2. Virtual awareness videos and messages through FM radio programs	1 animated video developed. Video was aired in 14 different district of Balochistan including Quetta and Chagai and SMDs (surface mounted device) at Quetta	Target over achieved (It was planned to air videos at 2 targeted districts but it was aired at 14 districts)
Provision of testing and treatment equipment for hospitals dealing with Covid-19	Affected people will be access to testing and treatment	Provision of 3 Mobile X-ray machine	Provided 2 mobile x-ray machines (01 at Civil Sandman Hospital Quetta and 01 at DHQ Dalbandin Chagai	Target achieved

		Provision of 5 portable ventilators	Provided 4 portable ventilators (3 at Civil Sandman Hospital Quetta and 2 at DHQ Dalbandin Chagai	Target achieved
Provision of protective material for staff managing quarantine camps and wards	Staff taking caring of quarantine centre and other isolation wards will be protected from potential threats of Covid-19 emergency threat	500 Hand Sanitizers 1000 Disposable medical masks	500 hand sanitizer 1000 Surgical Mask	Target achieved
Engagement of departments and communities through awareness and advocacy activities	The departments and communities are sensitized and aware about the potential of Covid-19 pandemic and able to contribute in stopping it from potential spread by engagement of potential stakeholder through technology	3.1 Community awareness drives for Behaviour Change through networks and alliances (5 units)	Conducted 42 awareness activities (9 at Quetta 33 at Chagai) benefitting 1,801 people	The target over achieved, extra activities were conducted on the demand and request of communities
		3.2. Need based technical assistance (awareness raising) to provincial government	1 need based awareness activity on importance of hand washing was conducted at Quetta	Target achieved
		3.3. Education and awareness to front line responders (6 Units)	Awareness activities conducted 1 at broader level while 5 for small groups with Quetta Municipal Corporation	Target Achieved
		3.4. Engagement with youth for use of technology focusing Advocacy and BCC (10 Units)	Engagement with youth through media was conducted. For 45 days	Target achieved, the target was 10 units however, through this activity the awareness campaigned through media was launch for 45 days with two different youth

				social media groups
		3.5. Engaging Faith institutions/ faith leaders for awareness and faith based psychological support (10 Units)	12 sessions by faith leaders conducted. (Muslim, Christian and Hindu faith leaders conducted sessions)	Target over achieved, as the target was 10 sessions but 12 sessions were conducted one extra in each district

Project II: Transformation & Adaptation Against Climate Variability Affected-Areas (TACVA) Project:

This is a long term project (August 1, 2020 to July 31, 2022) being implemented in Quetta and Harnai districts of Balochistan province. The project has a budget of CAD 1million and its objectives include drought resilience through water use efficiency, access to food security needs, and reaching out in the fight against Covid-19 outbreak. These objectives are backstopped by policy advocacy for developing mechanisms within the public structures for climate adaptive and Covid-19 planning, budgeting and implementation through integrated programs and policies. The project right-holders include 1,200 families (16,800 persons). The short term outputs of the project include:

1. Clean water sources for domestic use established in the communities and public institutions;
2. Water schemes for climate-adaptive agricultural use established;
3. Climate-adaptive agricultural support provided to small farm holders;
4. Poultry and livestock support provided to small farm holders;
5. Climate-adaptive food security trainings/workshops conducted for communities and government line departments, including women and men;
6. Capacity building and advocacy on inclusive, COVID sensitive and climate-adaptive planning and implementation conducted for staff, communities, and government line departments;
7. Policies developed/revised on inclusive climate-adaptive approaches.

TACVA PROJECT ACHIEVEMENTS VS TARGETS

(Based on 1st Interim Report)

Outcome 1. Increased access and Improved utilization of clean water resources among community members, including women, men, girls, and boys in Quetta and Harnai, Balochistan				
Outputs for Outcome 1	**Indicators**	**Planned Targets**	**Targets Achieved**	**Reason for any Variance**
1.1 Clean water sources for domestic use established in the communities and public institutions	Community consultation conducted, with particularly women and girls, on the location and accessibility to water sources	6 community consultation meeting were planned	11 community consultation meetings conducted.	We found that this activity is a need based therefore, we have exceeded our target. Also number of meetings and right-holders increased due to engagement of more community members

	Provision of water for hand washing for regular cleaning and disinfection purposes in vulnerable public spaces and Health care facilities.	Planned target is 8	Achieved target is 0	This activity was not planned for initial phase and is still to come. Need resolutions are submitted. Technical survey has been started.
	Drinking Water Supply scheme) Provision of clean drinking water through innovative techniques (Solarized schemes, water filtration plants etc. as per WHO standards.	Planned target is 5	Achieved target is 0	This activity was not planned for initial phase and is still to come. Need resolutions are submitted. Technical survey has been started.
	Provision of appropriate Personal Protective Equipment (PPEs) for staff of responding institutions.	Planned target is 12	Achieved target is 11	Achieved in both districts. We consider this activity as achieved/completed in both districts. The reason of variance is that because the number of right-holders has been exceeded in district Quetta. Also because in district Harnai not more than 5 health institutions are functional.
	Improved awareness around COVID-19 prevention and hand washing practices.	Planned target is 64	Achieved target is 64	Completed in both districts
1.2 Water schemes for climate-adaptive agricultural use established	Community consultation conducted with women and men on the agricultural water resource construction	Planned target is 5	Achieved target is 4	Completed. Variance created because number of right-holders in Quetta was exceeded.
	Agricultural irrigation schemes installed	Planned target is 7	Achieved target is 0	Activity yet to begin. Need resolutions are submitted. Technical survey has been started.
	Agricultural water channels and ponds constructed.	Planned target is 14	Achieved target is 0	BOQ & Proposal are made for one water pond. Activity is in progress.
	Agricultural water reservoirs constructed	Planned target is 5	Achieved target is 0	Activity is in progress.
Outcome 2. Improved food security among community members, particularly women and girls, in Quetta and Harnai Districts, Balochistan				
Outputs for Outcome 2	**Indicators**	**Planned Targets**	**Targets Achieved**	**Reason for any Variance**

2.1 Climate-adaptive agricultural support provided to small farm holders	Laser land levelling for agriculture conducted, Drought-tolerant seeds distributed among women and men, Kitchen gardening inputs (i.e. seeds) distributed among women, Kitchen Gardening training, Kitchen Gardening Seeds, Biogas technology distributed, Green tunnels built for off-season vegetables production	200 Hrs for laser land levelling, Drought-tolerant seeds distribution among 100 right-holders, 100 females are planned to entertain for kitchen gardening activities, 8 Biogas and technology distribution and 8 Green tunnels are planned	This activity was not planned in 1st Interim	As the project is in initial phase therefore team has started working on the preparations to achieve the planned targets. After the completion of preparations, the team will be able to execute the plan and will be able to accomplish the planned targets.
2.2 Poultry and livestock support provided to small farm holders	Poultry distributed, primarily to women. Animal health vaccination camps conducted. Shade for animals in communally selected locations constructed	100 poultry distribution, 20 Animal health camps and construction of 6 shades for animals are planned to achieve	This activity was not planned in 1st Interim	Team is engaged for the assessment of right-holders, meetings and consultations with livestock departments of both the districts for the finalization of schedule of Animal Health Vaccination Camps and need resolution. During this initial phase of TACVA project, team is mostly focused on the preparations for the successful achievement of planned targets before the end of next reporting period
2.3 Climate-adaptive food security trainings/workshops conducted for communities and government line departments, including women and men	Agricultural management training developed and conducted. Livestock management training developed and conducted. Exposure visit conducted for sheep farmers, organized around Wool Value Chain.	10 Agricultural management training, 10 Livestock management training and 2 exposure visits for sheep farmers are planned.	None as of yet	Project is in initial phases.

Outcome 3. Enhanced policy dialogue on inclusive COVID sensitive and climate-adaptive planning and implementation among communities (women and men) and government line departments				
Outputs for Outcome 3	**Indicators**	**Planned Targets**	**Targets Achieved**	**Reason for any Variance**
	# of Engagement sessions conducted with stakeholder Increase in the level of sensitization at the stakeholders level	5 Multi-stakeholder consultations, including women and men & 500 Staff capacity building and training for staff and communities 1 at CO and other at Quetta	None of the targets achieved	Project is in initial phase.
	# Advocacy workshops held on IWRM, gender inclusion, and climate-adaptive livelihoods Increased level of capacity around IWRM, gender inclusion, and climate-adaptive livelihoods	2 Advocacy workshops are planned.	None as of yet	Project is in initial phase.
	# of sessions conducted with PCRWR, ARID, ARI, and universities conducted	8 Structured individual and joint sessions are planned	None as of yet	Project is in initial phase.
	# Gender action plan and policy developed with key stakeholders	2 Gender Action Plans are planned to develop.	None as of yet	Project is in initial phase.
	Percentage of policies revised in the light developed GAP	Development of 1 Gender Policy of "Gender & Child Cell" with PDMA is planned.	None as of yet	Project is in initial phase.
	# of women sensitised / aware on their rights.	10 Awareness raising campaign and advocacy on Gender inclusion in Livelihood at district /provincial level are planned.	None as of yet	Project is in initial phase.

SUDAN

Project 1: IR- USA Response to Coronavirus Precautions and Preventions (RCPP) Project

The RCCP project had a budget of USD 300,000 and it was implemented from September 2020 till March 2021. The project aimed at providing COVID-19 services and cash assistance to the most affected 10,000 individuals in South and North Kordofan states (refugees, IDPs, and host community) through distribution of hygiene/ sanitary kits and PPEs (face masks, hands sanitizers, soap, radio messages, and IES materials). The target groups were at significant risk of contracting and transmitting Coronavirus among the refugees from Southern Sudan and host communities. The target communities were living in crowded urban areas, which put them at risk to Coronavirus transmission; additionally, lack of facilities providing COVID-19 services further impacted their ability to deal with preventive measures. Consequently, the goal of RCPP project was to reach out to the target groups through awareness and advocacy related activities, including site visits, public meetings with right-holders, dissemination of preventive measures, and distribution of posters and sterilization of public places through joint campaigns with the State Ministry of Health (SMoH) and media campaigns. The project also supported SMoH staff with face masks, gloves, and uniforms.

The cash assistance was provided to the targeted households, mainly IDPs and refugees, which rely on casual labour and small-scale businesses. The preventive measures announced by the local authorities had restricted the activity of targeted groups and limited their movement and source of livelihoods. The multipurpose cash assistance provided flexibility to the unemployed right-holders to meet their basic needs. IRS disbursed cash in person and through the banks in line with IRW cash transfer standard operating procedures.

RCCP PROJECT ACHIEVEMENTS VS TARGETS

Project Strategy & objectively verifiable Indicators			Progress towards Results					
Output: What types of activities are planned?	**Outcome: What are the planned outputs of these activities?**	**Impact: KPI of short-term/ medium-term effects**	**Level in 1st PIR (self-reported)**	**Midterm Target**	**End-of-project Target**	**Midterm Level & Assess-ment**	**Achieve-ment Rating**	**Justification for Rating**
Cash disbursement to affected families	Cash transfer of USD300/HHD	Livelihood resilience for vulnerable households facing C-19	640 (405 female & 235 male)	50%	1600 HHDs	960 HHDs	MS	Due to inflation the transfer is too low, and coverage is 60%, Distributed 320 for Um Rawaba, 320 for Sheikan, and 320 for the other 3 localities
Awareness campaigns	Organized awareness & Advocacy peer education sessions	10 school Sessions	0	5 session	10 sessions	10 school session	S	Though it started late due to locked schools, it is observed satisfactory
Training sessions provided.	Conduct training for volunteers to disseminate hygiene	60 ToT trained on hygiene messages	45 (22 female &23 male)	NA	60 trainees	60 trainees	HS	Done on time for the 6 targeted localities in GK State.
Support to the SMOH in terms of supplies and equipment	Organize training for medical staff and workers in isolation centres.	At least 40 training session conducted in GK State	0	NA	40 training sessions	40 training	S	Though it started late due to locked down GKS, it is observed and judged satisfactory by the evaluation

Project II: Integrated Development Project to Improve Access to Basic Services (InDPIABS) Project

InDPIABS is an 18 month development project (November 1, 2020 to May 30, 2022, which covers the thematic areas of FSL, Education, Protection, WASH, and Health. The project aims at providing the affected vulnerable communities with sustainable basic services through improvements in food security at the household level, enrolment and retention of school-going children, gender and culturally sensitive WASH and protection services, and sustainable environmental practices.

The project complements and is linked to existing IRS projects providing rehabilitation of health and WASH facilities, supporting community based protection networks, rehabilitating school facilities and infrastructure including hygiene and sanitation facilities, providing smallholder farmers with seeds and tools, capacity building of community members and healthcare staff on hygiene and sanitation, and carrying out Covid-19 awareness and prevention. The project aims at improving and increasing the access of affected vulnerable men, women, boys, and girls to basic services while creating resilience and sustainability of rural livelihood. IRS coordinates the project activities with other partners and respective government departments in the project sites including UNICEF, WFP, UNOCHA, WHO, and UNHCR.

InDPIABS PROJECT ACHIEVEMENTS VS TARGETS

Project Strategy & objectively verifiable Indicators			**Progress towards Results**					
Output: What types of activities are planned?	Outcome: What are the planned outputs of these activities?	Impact: KPI of short-term/ medium-term effects	Level in 1st PIR (self-reported)	Midterm Target	End-of-project Target	Midterm Level & Assessment	Achievement Rating	Justification for Rating
Provision of soap pieces to insure applying good practices	1000 pieces of soap distributed to Health Facilities ensure prevention measures in place	80% target population prevented from C-19 transmission in North & South Kordofan states	2798	1000	1000	2798	HS	277% of End of project plan quantity of soap is distributed which sufficient to surpass the target population
Provision of sets of face masks and hand gloves	1000 face mask sets to Health Facilities provided	80% of critical government gaps improved	1500	1000	1000	1500	HS	150% of End of project plan quantity of masks sets is distributed which sufficient to surpass the target population
Provision of dilute disinfections and sanitizers	1000 hand sanitizers (bottles) to Health Facilities provided	75% target people increased awareness and have access to C-19 services in GKS	1000	1000	1000	666	MS	67% of End of project plan quantity of sanitizers is distributed which less sufficient to meet the target population

SOMALIA

Project 1: COVID-19 Prevention Response in Somalia (CORPS) Project

The CORPS project works in close collaboration with local authorities and community leaders. The project is targeting Daynille and Bondhere IDP camps in Banadir region and Balcad IDP camp in Middle Shabelle region through sustainable access to handwashing facilities, provision of hygiene kit and community health education. The project activities include provision of: (a) Hygiene kits, mobile handwashing stands, facemasks, and hygiene promotion campaigns to 1,000 poor and vulnerable IDP households, 400 in Daynille, 400 in Bondhere, and 200 in Balcad; (b) Temperature screening facilities at health centres; (c) Six mobile communal handwashing stands to promote good hygiene practices and conduct handwashing demonstration and COVID awareness campaigns in IRS operated primary health care facilities in Daynille, Bondhere and Balcad; (d) N95 facemasks to the health staff working at the primary health care facilities to minimize exposure and hospital based transmission; and (e) Recruitment and training of five health educators to promote good hygiene practices and behaviour changes and complement the IEC materials.

CORPS PROJECT ACHIEVEMENTS VS TARGETS

Thematic Area	Activities & Location	Planned Targets	Targets Achieved
WASH	Provision of hygiene kits	1,000 households	7,500 persons
	Mobile handwashing facilities	6 facilities	6 facilities
Health	Establishment and equipment of 3 screening centres in Bondhere, Balcad and Daynille	21,374 persons	21,375 persons
	Trained community health promoters	5 persons	5 persons
	Trained health educators	18 persons	18 persons

Project II: COVID-19 Emergency Response in Somalia (CERS) DEC Project

The CERS project provided humanitarian support to the most affected, needy and vulnerable population, including children and women in IDP camps in Daynile, Mogadishu; Baidoa and Garowe. Overall the project provided immediate support for the vulnerable and high risk population, strengthened preparedness of health facilities in Covid-19 prevention and treatment, provided immediate support to vulnerable people, and strengthened the purchasing power of the target right-holders (666 households or 3,996 individuals) through both conditional and unconditional cash grants in Qardho/Burtinle and Baidoa. The project carried out the following activities:

- Improved sanitation and hygiene practices of the IDP camps through COVID awareness in seven districts of Somalia, through: construction of 24 hand washing facilities targeting 7,500 right-holders (6 in Mogadishu, 6 in Baidoa, 4 in Balcad, 4 in Qardho, and 4 in Burtinle);
- Carried out Covid-19 mass awareness through multiple communication channels, including, radio, SMS, and IEC, targeting 3,500 IDP households;
- Distributed hygiene kits, including laundry soap, bath soap, 20 litre Jerrycans, and facemasks to 3,500 households in Daynile district of Benadir region-Mogadishu and 1,750 households in Qardho/Burtinle in Puntland, totalling 5,250 households;

- Carried community mobilization and awareness campaigns through radio programme for 3,500 households in Daynile IDP camp;
- Installed 11 screening centres (3 in Mogadishu, 3 in Baidoa,1 in Balcad, 3 in Burtinle and 1 in Qardho) to strengthen essential health care service delivery in the health facilities and maintaining the continuity of essential lifesaving services to minimize risks to for patients and health staff. IR reached a total of 22,000 individuals through these activities;
- Trained 100 community health workers and volunteers on Covid-19 risk reduction and strengthened the capacity of health facilities in infection control interventions, waste management and essential protective equipment;
- Provided PPE kits and trainings to 100 frontline health workers. The PPEs included gloves, goggles, face shields, gowns, hand sanitizers, infrared thermometers, and liquid soap;
- Provided medicines to health facilities on a monthly basis and lifesaving health care services and awareness to reduce mortality and morbidity rate among the affected population;
- Strengthened health staffing, drugs and supplies, screening, case management and referrals, disease surveillance and community participation.
- Reached out to 45,830 people with curative consultations, including 18,812 under five year old children and 27,018 adult patients;
- Trained 24 frontline health workers on Covid-19 management and RCCE. The local containment of transmission was taken into greater consideration through the establishment of screening units within existing health facilities, which included infection control training and measures across all health facilities.
- Carried out risk communication and community engagement, one of the main component of the project, through behaviour change interventions by CHWs and frontline health workers who were trained to emphasize on prevention measures. This included handwashing practices, social distancing and wearing of facemasks when necessary in the public places;
- Trained faith and young community leaders trained on Covid-19 impact and risk reduction at community level reaching 75 individuals;
- Provided 666 households (3,996 individuals) with multi-purpose cash grants through 333 unconditional cash transfers in Baidoa and 333 conditional cash transfers in Nugal/Bari (167 households in Qardho and 166 households in Burtinle);

CERS PROJECT ACHIEVEMENTS VS TARGETS

Thematic Area	Activities & Location	Planned Targets	Targets Achieved
WASH	Constructed Wash facilities: 6 in Mogadishu, 6 in Baido, 4 in Balcad, 4 in Gardo, and 4 in Burtinle	7, 500 persons	7,500 persons
	Covid 19 awareness	3,500 persons	3,500 persons
	Distribution of hygiene kits	5,250 persons	5,250 persons
Health	Establishment of screening centres: 3 in Mogadishu, 3 in Baidao, 1 in Balcad, 3 in Burtinle, and 1 in Gardo		
	Trained community health workers	29 persons	29 persons
	Trained frontline health workers	24 persons	24 persons

	Trained faith and young community leaders	75 persons	75 persons
Livelihoods	Provided unconditional cash transfer in Baidao	333 households	333 households
	Provided conditional cash transfer in Gardo and Burtinle	333 households	333 households

TUNISIA

Project 1: Emergency Response to Fight the Spread of Corona Virus in Tunisia "Spread Hope Tunisia"

The project reinforced capacity of the Ministry of Health to fight the spread of Corona virus through infrastructure improvement of 13 public health hospitals. The IR Tunisia (IRT) response was launched to assist the poor infrastructure of and lack of equipment in Tunisian hospitals. There were only 240 equipped ICU beds in Tunisian hospitals, divided in 11 out of the 24 governorates. In this regard, the Ministry of Health launched a campaign to collect donations to support the medical facilities which were running out of protective and medical equipment. The project was designed to support the Ministry of Health in fighting the spread of the pandemic. The project provided the following medical equipment and supplies: ICU electric syringe pumps; Monitors for ICU beds; Suction Machines; ICU Machines; Beds; Laboratory equipment; Automated Biochemistry Machines; Protective masks(helmet), Gant vinyl, Gel hydroalcolique, and Surblouse

Project II: Rural Women Empowerment in Tataouine

The COVID-19 pandemic has affected all sections of society, but in the rural, remote and disadvantaged regions, the impact was severe, especially on vulnerable groups such as rural women. The project aims at empowering rural women in Tataouine economically, socially and in terms of health. The project is providing a decent source of income for 50 female headed households through the creation of 50 micro-projects. The project was being implemented before the Covid-19 crisis and has since consolidated its activities. The project has created 6 women groups, structuring them into cooperatives and empowered them economically, socially and in terms of health and environmental awareness. Due to the Covid-19 restrictions two of the six groups have left the project. The women groups are supported through technical and administrative trainings, work tools and equipment, and marketing of their products. The project also provides awareness of the target rural women groups on issues, including reproductive health, women basic rights, GBV, first aid techniques, and how to prevent domestic accidents. The health aspect of the project was executed through the organization of Health Caravans in eight target villages comprising of specialized doctors, mid-wives and nurses to detect cases with breast or uterus cancer, diabetes, high blood pressure etc. The environmental aspect of the project was carried out by conducting awareness sessions on the importance of environmental protection and installation of plastic bottle recycling containers in each targeted village.

PROJECT ACHIEVEMENTS VS TARGETS-3 PROJECTS

Project Name	Project Status	Sector	Related Covid 19 Indicator	Project achievement
Emergency Support to Prevent the Spread of Second Wave of COVID-19 in Tunisia	ongoing	Health	Number of Hospitals supported with Medical equipment #Number of Cases provided with lifesaving support equipment	The project is still in progress
Rural Women Empowerment Tataouine. Phase 2	starting up	Livelihood and income generation	Number of Hospitals supported with Medical equipment #Direct number of right-holders	Distribution of the following equipment took place: 1. Moniteur de surveillance (5 pcs) 2. Pousse seringues simple voies (7 pcs) 3. Masques VNI sterilisables à usage multiples (20 pcs) 4. Canule 6mm pour appreil optiflow (10 pcs/100: 90 pcs will be received in 10 days) 5. Circuit de ventilation avec humidificateur pour Optiflow (10 pcs/100: 90 pcs will be received in 10 days) 6. Combinaison de protection à usage unique (1000 pcs) 7. Blouses de protection à usage unique (700 pcs) 8. Inkind donation: Combinaison de protection à usage unique (396 pcs)
Phase 1: Emergency response to minimize the spread of Corona Virus in Tunisia	completed	Emergency response		Provision and installation of 15 surgical aspirators, 15 electrical syringe pumps, 7 modular monitors and 1 automate biochemistry machine in 11 hospitals added to a training conduction on the automate biochemistry machine utilization in 1 hospital

C) STAKEHOLDERS CONSULTED

GLOBAL IRW STAFF

NAME	DESIGNATION & ORGANIZATION
Leo Nalugon	Global FSL Adviser
Mohammed Afsar	Head of Disaster Risk Management Division
Haroon Altaf	Humanitarian Programme and Policy Manager

Saba Mahmood	Humanitarian Coordinator
Naveed Ul Haq Mirza	Global Programme Accountability and Learning Lead
Mohammed Moniruzzaman	Senior MEAL Coordinator
Haroon Kash	Head of Region - Asia
Yusuf Roble	Head of Region - East Africa
Ismail Safi	Head of Programs, IR USA
Catriona Addleton	IR Canada

MALI

NAME	DESIGNATION & ORGANIZATION
Mr. Moussa Traoré	Country Director IR Mali
Mr. Sambou Camara	Programmes Coordinator IR Mali
Mr. Abdoulaye Sow	Head of Sub-office, IR Gourma Rharous
Mr. Abdoul Wahab Touré	Head of Project, IR Gourma Rharous
Mr. Youssouf Traoré	Local Social Development Director, Commune 2, Bamako
Dr. Mama Sy Konaté	Head Doctor, Commune 6 Health Referral Center, Bamako
Dr. Dicko	Head Doctor, Commune 4 Health Referral Center, Bamako
Mr. Ahmed Abdoulaye Maïga	Representative of International Medical Corps in Gourma Rharous
Mr. Djibril Elhadj Diallo	Representative of World Food Program in Gourma Rharous
Mr. Loubabata Maiga	Head Doctor, Banikane Health Referral Center; Gourma Rharous

PAKISTAN

NAME	DESIGNATION & ORGANIZATION
Umair Hasan	Country Director IRP
Raza Narejo	Head of Programmes IRP
Sajid Ayyub Jadoon	Manager MEAL IRP
Dr. Dawood Riaz	PO WHO
Alamgir Khan or Falak Naz	PO UNICEF
Rizwan Ahmed	Agribusiness Specialist, FAO
Ghafoor Agha	DD M&E PDMA
Dr. Ahamad Zaman Jamali	DHO Quetta
Rizwan Kasi	PO IRP
Ahtasham Kubdani	PO IRP
Dr. Zahoor Ahmed Baloch	Surgeon Prince Fahad Hospital Chagai
Wahab Baloch	DSM PPHI /(Facilitation at BHUs) Chagai
Aman Ullah Notezai	District Education Officer Chagai
Dr. Imdad Ali	Project Officer IRP, Chagai
Muhammad Tahir	Engineer IRP
Abdul Salam	CDO IRP
Dr. Syed Muzzafar Ali Shah	DHO Haranai
Muhammad Ashraf	CDO IRP

SUDAN

NAME	DESIGNATION & ORGANIZATION
Mr. Elsaddig El-Nour	Country Director IR Sudan
Mr. Zahid Jalbani,	Head of Programmes IR Sudan
Mr. Shihab Ali	Senior Programme Manager IR Sudan
Ms. Duretti Haji	Project Manager IR USA
Mr. Haitham Salah	Project Coordinator IR USA
Mr. Adam Edris	MEAL Manager IR Sudan
Mr. Mohammed Abu Shanab	Office Manager GK IRS
Mr. Bakri Awad	Nutrition Officer from SMoH
Mr. Nagi Elmaryood	Director of Kordofan & Radio Station
Mr. Ahmed Ibrahim	Senior staff, Plan Sudan
Mrs. Mona Ibrahim	Program Officer from WFP
Mr. Hamid Fathallah	Deputy Assistant HAC – Elobied Office

SOMALIA

NAME	DESIGNATION & ORGANIZATION
Sahara Mohamed Abdi	Health Officer, Ministry of Health, Somalia
Awil Ibrahim Hussein	Health Officer, Islamic Relief Somalia
Ibrahim Abdi Hussein	Emergency Officer, Islamic Relief Somalia
Mohamed Aded Ali	MEAL coordinator, Islamic Relief Somalia
Siciid Nuuriye Abshir	Emergency Officer, World Health Organization (WHO)

TUNISIA

NAME	DESIGNATION & ORGANIZATION
Hadji Khaled	Bizerte Regional Hospital, Bizerte
Toumi Belgacem	EL Kef Regional Hospital, EL Kef
Temtem Taib	Medenine Hospital, Medenine
Mr. Taha	Regional Health Director, Tataouine
Nasri Imed	Gafsa Regional Hospital, Gafsa
Arbi Bachir	Kbelli Regional Hospital, Kbelli
Mohamed Meftehi	Ministry of Health
Walid ben hamida	Acting Program Manager, IRT
Ali Jemai	Project Coordinator, IRT
Rym Chariag	Project Officer, IRT
Oumayma Idoudi	Wash Specialist, IRT

D) DOCUMENTS CONSULTED

IRW GLOBAL DOCUMENT LIST

1. Anticipatory Alert Template
2. Categorization of Emergencies
3. Disaster Preparedness Plan Template
4. Emergency Alert Template
5. Emergency Process Flowchart
6. Emergency Response Plan/Strategy Template
7. Emergency Templates & Guidance
8. Emergency Update Template
9. Final Report: Desk Review & Mapping of IRW Livelihood Programme Outcomes & Impact, 2018
10. GEF and 24/7 Fund Guidelines
11. GEF Application Form
12. Inclusive Protective Programming Framework
13. Interim Humanitarian Surge Deployment Guidelines
14. Islamic Relief List of External Publications: https://www.islamic-relief.org/wp-content/uploads/2020/05/Covid-19-Response-9Jun2020.pdf https://www.islamic-relief.org/wp-content/uploads/2020/09/Covid-recovery-framework-pdf.pdf; https://www.islamic-relief.org/fighting-covid-19s-economic-impact-at-the-micro-level/; https://www.islamic-relief.org/wp-content/uploads/2020/06/Islamic-Relief-COVID-19-MENA-EE-Regional-Impact-Analysis.pdf'
15. Islamic Relief Worldwide Guidelines for field based staff, April 2020
16. IRW Disaster Response Handbook (2012)
17. IRW External Publication, Covid-19 Response, June 2020
18. IRW Cash Scoping Final Report, 2020
19. MEAL Framework Tools & Guidelines
20. Needs Assessment Key Informant Template
21. Needs Assessment Template
22. Partner Implementation- Emergency Project Checklist
23. Protection & Inclusion in COVID-19 Response Planning, Webinar 1-3, March 2020 and Webinar 4, May 2020
24. Protection, Inclusion and Context Sensitivity in COVID-19 Response, A brief guidance for IR
25. Socio-economic Recovery Framework for the Covid-19 crisis, August 2020
26. Supporting Documents for Project Templates
27. Surge Roster- Post Deployment Form
28. Surge Roster- Staff Request Form
29. The Start Fund Learning Grant: Report Form
30. Unified Project Cycle Documents Issue Log
31. Unified Project Proposal Documents
32. Unified Project Reporting Documents

MALI

1. Bamako Covid-19 Response Project concept note
2. Gourma Rharous Covid-19 Response Project concept note
3. Final report of Bamako Covid-19 Response Project
4. Baseline and Final reports of Gourma Rharous Covid-19 Response Project

PAKISTAN

1. CAPER Project Concept Note
2. Grant Agreement between Islamic Relief USA & IRW for CAPER Project
3. CAPER Full Project Budget
4. CAPER Re-appropriated Full Project Budget
5. CAPER Programme Schedule Change Request Form v5
6. CAPER Programme Schedule Change Request Form v3
7. CAPER Final Progress Report
8. CAPER Project Activities Progress Report
9. TACVA Project Proposal
10. Grant Agreement between Islamic Relief Canada and IRW for TACVA Project
11. TACVA Full Project Budget
12. TACVA Project Logic Model
13. TACVA MEAL Plan
14. TACVA First Interim Progress Report
15. TACVA Interim Narrative Report
16. TACVA Proposed Activities Breakdown
17. TACVA Project Activities Progress Report
18. TACVA Full Project Budget

SOMALIA

1. DEC project proposal
2. DEC project interim reports
3. DEC project workplan
4. DEC project distribution plan
5. DEC project MEAL framework
6. DEC project Log frame
7. Corps project MEAL framework
8. Corps project reports
9. CORPs project distribution plan
10. CRM reports
11. ALNAP. (2016) Evaluation of Humanitarian Action Guide Bibliography

SUDAN

1. Project Document
2. Monthly Progress Report and Project Updates September 2020
3. Monthly Progress Report and Project Updates December 2020
4. Monthly Progress Report and Project Updates January 2021
5. Midterm Report January 2021
6. Monthly Progress Report and Project Updates March 2021

TUNISIA

1. Project Cooperation agreement between the MoH and IRTunisia
2. Project Risk Assessment
3. Documents related to the technical description and characteristics of the distributed equipment.
4. Logical framework related to Reinforced capacity of the Ministry of Health to fight the spread of a second wave of Covid-19 in Tunisia
5. Monitoring Plan Covid-19 response
6. Implementation Plan Covid-19 response
7. Meeting minutes
8. Monitoring Plan Covid-19 response.
9. Breakdown of deliverables.
10. PV Webinar.
11. Project monitoring plan Rural Women Empowerment Project Tataouine.

E) PROFILES OF THE EVALUATION TEAM

Dr. Niaz Murtaza, Global Consultant

Dr. Niaz Murtaza has more than 20 years' experience in emergency response, DRR activities, early warning systems and implementation of international technical standards in more than 40 countries in Asia, Africa and Americas with reputed agencies such as IRC, Oxfam and ActionAid. In his job as International Program Manager, Emergencies for ActionAid, he was the agency's international lead person for all emergency response and DRR work spread across more than 30 countries globally and was responsible for the implementation of international technical standards, such as SPHERE, Hugo Framework, NGO Code of Conduct, CHS, and global DRM trends, policies and frameworks. He has extensive experience in managing multi-country projects with ActionAid as well as multi-country evaluations with Plan (West Africa food crisis), ACF (Middle-East), HelpAge (Middle-East) and Start Fund (second evaluation). He has a Ph.D. from the University of California at Berkeley in community-level sustainable development issues among disaster-prone communities and is currently affiliated there with a research focus on accountability and impact evaluation issues. These experiences give him a strong background in participatory evaluations and rights-based research with marginalized groups. Over the last six years, he has conducted large-scale, team evaluations, reviews and research studies as Team Leader for more than 20 agencies globally. He recently also undertook the evaluation of the Covid-19 response of War Child Holland across 12 countries globally using CHS and DAC criteria. He is well familiar with IRW's faith-based approach and subscribes to it. He has also undertaken evaluations of IRW's programmes in three multi-agency assignments for DEC and ADCAP. He also has excellent communication skills as well as a track-record of writing high quality, easily readable and constructive evaluation reports delivered 100% on time. He is currently based in Pakistan close by to all the mentioned countries and UK, making communication and travel easy.

Adama Samuel KONE, National Consultant, Mali

Specialist in monitoring-evaluation and capacity building, Mr. KONE holds a Master's degree specializing in Innovations, Development and Societies at the International Institute of Water and Environment Engineering (2iE) in Burkina Faso. He was the linchpin of several studies and monitoring-evaluation

missions carried out by CEFODES, an expertise firm in Project / Program monitoring and evaluation, which he heads in the field of governance, human rights, prevention. / conflict management, education, health (including SRH, food and nutrition security), gender, economic development, etc. Mr. KONE has, on the other hand, acquired several experiences with international organizations such as Right To Play, Save the Children, SNV, ICCO, Oxfam in terms of diagnostics, baseline studies and monitoring-evaluation of Projects in the areas of education, health, conflict prevention and management, human rights, peace building, governance and accountability, economic and social development in full-time jobs. Mr. KONE is currently the associate director of CEFODES with more than 50 consultancy missions in the field of project evaluation. Mr. KONE is one of the leaders in field of training in Project Planning and Monitoring Evaluation in Mali.

Aftab Ismail Khan, National Consultant, Pakistan

Aftab Khan has worked in development for more than 20 years. His experience has revolved around designing, managing and conducting evaluations, assessments, reviews and studies; program development and coordination; project analysis, implementation and management; policy research and development; communications; needs assessments; surveys; report writing; and market research and promotion of local products. Sector and thematic experience includes governance; local state-building (access to justice, rule of law/human rights and local governance); infrastructure; environment; education; WASH; FSL; shelter; trade; social protection; disaster relief and management; reconstruction and rehabilitation; gender mainstreaming; gender based violence; sustainable resource use based enterprise and livelihoods development; community mobilization; agriculture; income generation; and poverty alleviation. He has a Master of Business Administration (IT) from Pepperdine University, Malibu, California, USA and has conducted evaluations for International Trade Centre (ITC), WTO, UN; USAID; FCO, BHC; SDC; UNICEF; GEF; UNDP; Mercy Corps; CARE International; IUCN; AKRSP; Oxfam-GB; Earthquake Reconstruction and Rehabilitation Authority (ERRA), Pakistan; National Disaster Management Authority (NDMA), Pakistan; Ministry of Climate Change, Pakistan; Ministry of Women Development, Pakistan; and Government of Gilgit-Baltistan.

Dr. Eltighani Elamin Hussein, National Consultant, Sudan

Dr. Eltighani Elamin Hussein has done Ph. D. in Agricultural Economics and has more than 30 years of experience in development interventions in food security and nutrition with public administration, and institution development, 10 years in conducting evaluations, using EU methods and templates as well as the OECD-DAC evaluation criteria such as: 15 M&E; 30 of Final and Mid-Term Evaluations; 40 of surveys and assessments, working and evaluating within the rural development and governance sectors on food security and agricultural markets and also worked in various region like Afghanistan, East Africa, North Africa, Central Africa, Iraq and Germany. **Membership of professional bodies: Platform for African – European Partnership in Agricultural Research for Development; expert panel on 'Innovations to build sustainable, equitable, inclusive food value chains'. High-Level Panel Expert with World Committee for Food Security & Nutrition (HLPE);** African Economics Research Consortium, Nairobi, Kenya; Economic Research Forum, Cairo, Egypt; European Evaluation Society.

Dr. Fatma Raach, National Consultant, Tunisia

Dr. Raach is a PhD Professor and Assistant in Public Law. He provides consultancy work for NGO's and International Organizations in projects dealing with training, consultancy, state reforms, justice reforms, prevention of torture in Tunisia, violent extremism in Tunisia, and strengthening of the rule of law and human rights protection during democratic transitions.

Mohamed Jama Hussein, National Consultant, Somalia

Mr. Hussein has more than 10 years of experience working with both governmental and non-governmental organizations in Somalia. His area of expertise is M&E and research and program management. In recent years he has conducted more than 15 different research projects including evaluations, baselines and other researches for different organizations in Somalia. Mohamed holds BA in Community development and MA in Sustainable Development from Sussex University, UK. He has previously worked with Care International as Technical Advisor, M&E, Save the Children, Manager M&E, Relief International, M&E Officer, and Senior Advisor, Somali Government

F) DISAGGREGATED DATA BY OLD AGE AND DISABILITIES

1. Data for respondents having age above 60 years:

Q_3. Was your household consulted properly for this matter?				
	Sudan	Mali	Somalia	Overall
No	14%	24%	0%	17%
Partially	21%	0%	20%	9%
Fully	64%	76%	80%	74%
No answer	0%	0%	0%	0%

Q_4. Has the project provided services that meet the most important needs of your household during the Covid-19 crisis?				
	Sudan	Mali	Somalia	Overall
No	7%	0%	0%	1%
Partially	36%	7%	27%	17%
Fully	57%	93%	73%	81%
No answer	0%	0%	0%	0%

Q_7. Did the project give adequate opportunities to make complaints to project staff in case of problems in implementation?				
	Sudan	Mali	Somalia	Overall
No	43%	17%	0%	19%

Partially	0%	15%	27%	14%
Fully	57%	56%	73%	60%
No answer	0%	12%	0%	7%

Q_10. Is the quality of the services satisfactory in light of the Covid-19 situation?				
	Sudan	Mali	Somalia	Overall
No	7%	0%	0%	1%
Partially	7%	10%	0%	7%
Fully	86%	90%	87%	89%
No answer	0%	0%	13%	3%

Q_11. Were the services provided on time in view of the timing of the Covid-19 crisis?				
	Sudan	Mali	Somalia	Overall
No	14%	0%	0%	3%
Partially	14%	12%	0%	10%
Fully	71%	88%	100%	87%
No answer	0%	0%	0%	0%

Q_13. Has the project met the needs of persons with disabilities well given the Covid-19 crisis?				
	Sudan	Mali	Somalia	Overall
No	21%	0%	0%	4%
Partially	21%	17%	27%	20%
Fully	57%	73%	67%	69%
No answer	0%	10%	7%	7%

Q_17. Did the project provide any information that helped your family remain safe from Covid-19 virus?				
	Sudan	Mali	Somalia	Overall
No	7%	7%	0%	6%
Partially	7%	0%	13%	4%
Fully	86%	93%	87%	90%
No answer	0%	0%	0%	0%

2. <u>Tables for families with disabilities:</u>

Q_3. Was your household consulted properly for this matter?				
	Sudan	Mali	Somalia	Overall

No	15%	31%	0%	17%
Partially	12%	2%	15%	8%
Fully	73%	67%	85%	75%
No answer	0%	0%	0%	0%

Q_4. Has the project provided services that meet the most important needs of your household during the Covid-19 crisis?				
	Sudan	Mali	Somalia	Overall
No	23%	0%	0%	4%
Partially	31%	8%	10%	13%
Fully	46%	92%	90%	83%
No answer	0%	0%	0%	0%

Q_7. Did the project give adequate opportunities to make complaints to project staff in case of problems in implementation?				
	Sudan	Mali	Somalia	Overall
No	38%	30%	8%	24%
Partially	4%	8%	6%	7%
Fully	58%	53%	81%	64%
No answer	0%	9%	4%	6%

Q_10. Is the quality of the services satisfactory in light of the Covid-19 situation?				
	Sudan	Mali	Somalia	Overall
No	12%	0%	0%	2%
Partially	23%	6%	6%	9%
Fully	65%	94%	92%	88%
No answer	0%	0%	2%	1%

Q_11. Were the services provided on time in view of the timing of the Covid-19 crisis?				
	Sudan	Mali	Somalia	Overall
No	19%	0%	0%	4%
Partially	12%	19%	8%	14%
Fully	69%	81%	92%	83%
No answer	0%	0%	0%	0%

Q_13. Has the project met the needs of persons with disabilities well given the Covid-19 crisis?

	Sudan	Mali	Somalia	Overall
No	38%	2%	0%	8%
Partially	19%	2%	21%	12%
Fully	35%	92%	77%	76%
No answer	8%	5%	2%	4%

Q_17. Did the project provide any information that helped your family remain safe from Covid-19 virus?				
	Sudan	Mali	Somalia	Overall
No	19%	5%	2%	7%
Partially	12%	2%	8%	6%
Fully	69%	94%	90%	88%
No answer	0%	0%	0%	0%

H) TERMS OF REFERENCE

Tender document for the evaluation of Islamic Relief Worldwide's Global Covid-19 response and recovery programme 2020/21, March 2021

Islamic Relief Worldwide
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www.irworldwide.org
Registered Charity No. 328158 Company No. 2365572

ISLAMIC RELIEF WORLDWIDE

Islamic Relief is an international aid and development charity, which aims to alleviate the suffering of the world's poorest people. It is an independent Non-Governmental Organisation (NGO) founded in the UK in 1984.

As well as responding to disasters and emergencies, Islamic Relief promotes sustainable economic and social development by working with local communities - regardless of race, religion or gender.

Our vision:

Inspired by our Islamic faith and guided by our values, we envisage a caring world where communities are empowered, social obligations are fulfilled and people respond as one to the suffering of others.

Our mission:

Exemplifying our Islamic values, we will mobilise resources, build partnerships, and develop local capacity, as we work to:

Enable communities to mitigate the effect of disasters, prepare for their occurrence and respond by providing relief, protection and recovery.

Promote integrated development and environmental custodianship with a focus on sustainable livelihoods.

Support the marginalised and vulnerable to voice their needs and address root causes of poverty.

We allocate these resources regardless of race, political affiliation, gender or belief, and without expecting anything in return.

At the international level, Islamic Relief Worldwide (IRW) has consultative status with the UN Economic and Social Council, and is a signatory to the International Red Cross and Red Crescent Code of Conduct. IRW is committed to the Sustainable Development Goals (SDGs) through raising awareness of the issues that affect poor communities and through its work on the ground. Islamic Relief are one of only 13 charities that have fulfilled the criteria and have become members of the Disasters Emergency Committee (www.dec.org.uk)

IRW endeavours to work closely with local communities, focussing on capacity-building and empowerment to help them achieve development without dependency.

Please see our website for more information http://www.islamic-relief.org/

PROJECT BACKGROUND

2020 will remain an unforgettable year for humanity with the exponential spread of Covid-19 across the world and the resultant loss of life, widespread lockdowns, restrictions in social contact and in many countries, compounding humanitarian crisis, on top of pre-existing and new crisis caused by conflict, natural disasters and climate change.

Global humanitarian impacts from Covid-19 during 2020 are summarised below from OCHA's Global Humanitarian Response Plan Update (February 2021):

In less than one year (March-December 2020), more than 82 million COVID-19 cases and 1.8 million deaths were recorded. Beyond the immediate health impacts of COVID-19, the secondary effects of the pandemic were particularly grievous in humanitarian settings. Closures and lockdowns, and market volatility drastically increased food insecurity, pushing over 270 million people worldwide to suffer from acute food insecurity by the end of 2020.

Gender-based violence sharply increased, fueled by the loss of referral pathways, access to information, the closures of schools and safe spaces, and the day-to-day isolation of women and girls during lockdowns. Some countries recorded a 700 per cent increase in calls to gender-based violence (GBV) hotlines in the first months of the pandemic. The pandemic also increased the abuse and neglect of older persons who are the group most at-risk of dying from COVID-19.

Health service disruptions also led to a 30 per cent reduction in the global coverage of essential nutrition services, leaving nearly seven million additional children at risk of suffering from acute malnutrition.

The closure of schools led to the loss of important early intervention opportunities for protection, mental health and psychosocial support, and nutrition programs. The economic contractions worldwide brought about the first increase in extreme poverty since 1998. In January 2021, it was estimated that between 119 million and 124 million people could have fallen back into extreme poverty in 2020 due to COVID-19, with an additional increase of between 24 million and 39 million people in 2021, potentially bringing the number of new people living in extreme poverty to between 143 million and 163 million.

Under this unprecedented challenge, Islamic Relief Worldwide and our country programmes launched significant Covid-19 response efforts throughout 2020 to confront both the primary and secondary impacts of the pandemic. Whilst initial responses were focused on short-term lifesaving needs

including risk communication and community engagement (RCCE), strengthening health systems to take care of Covid-19 affected patients, and providing emergency food security assistance to those impacted by lockdowns, Islamic Relief also recognised the need to act on the secondary impacts. IR's initial response strategy is summarised below:

- **Working with communities to promote good hygiene practices and equip them with the information they need to halt the spread of the virus**
- **Supporting and strengthening healthcare services**
- **Making sure the long-term impacts of the crisis are addressed from the outset.**
  Examples of type of responses in different countries during the first phase are provided in tables below:

Examples of Islamic Relief Worldwide Covid-19 response interventions during the initial response phase (April – September 2020)

Local health authorities are better preparedness and have long term capacity to respond to COVID19 cases	Trainings on COVID-19 case management and containment for health service providers in collaboration with national and provincial disaster management and health authorities.	Health
	Personal Protective Equipment (PPEs) supplies for health centres (per health cluster package and standard) for medical and paramedical staff to ensure their safety leading towards containment and management of COVID-19 in 40 health centres.	Health
	Medical equipment, medicines and medical supplies for health centres and quarantines as per WHO standards to deliver uninterrupted services focused upon limiting losses of life in 40 health centres.	Health
	Provision of non-food (Hygiene kits and necessary daily use items) to national and provincial disaster management and health authorities for quarantine facilities and designated hospital in relation to COVID-19 in 40 health centres	WASH
	Supply of materials for decontamination/Disinfection of quarantine spaces, designated hospitals and localities with the support of local authorities premises where cases of COVID-19 reported	Health
Community led health information awareness campaigns contributes to reduced risk of spread of infection	COVID19 Risk awareness messaging disseminated via different communication mediums, for ex radio/TV, social media and printed IEC materials)	Health
	Mobilise and train volunteers to raise COVID-19 risk awareness information across communities) – check with budget on length of training	Health
	Assistance provided to vulnerable persons to access social safety nets) i/e persons with disabilities, older persons, female headed households	Health
Enhanced capacity of the most vulnerable families and individuals to manage basic (social and economic) needs - food insecurity, livelihoods etc.	Provision of food packages to 40 health centres for vulnerable COVID-19 affected patients)	FSL
	Provision of interest free microfinance support to entrepreneurs in urban peripheries and small landholders /farmers in rural areas with particularly emphasis upon women affected by COVID-19 to restart their work and reduce	FSL
	Establishment of Health Trust Fund by developing risk financing framework	FSL
Health care facilities and authorities have enhanced preparedness and long- term capacity to respond to COVID19 cases	Provision of protective equipment and WASH kits (cluster standards) to 43 community health centres and 2 District health centres	Health
	Strengthen referral mechanisms (from community to health centre and community health centre to District health centre levels)	Health
	Rapid rehabilitation of X water points at health centres	WASH
	Training of health workers at screening posts (cordon sanitary), 43 community health centres and X District health centres	Health
	Provision of equipment to X District decontamination teams	Health
Community led health information awareness campaigns contribute to reduced risk of spread of infection	Train X community health association teams (CHAs) on COVID sensitisation and equip them with sensitisation kits	Health
	Conduct awareness raising sessions on Covid-19 through CHAs	Health
	Establish and train X faith-leader, traditional healer, community leader committees on COVID, protection, burial management and equip with sensitisation kits. Committees will be linked to health centres	Health
	Conduct awareness raising sessions on Covid-19, protection and burial management from a faith based perspective through faith-leader, traditional healer, community leader committees	Health
	Training of women volunteers on COVID-19 and pregnancy	Health
	Mobilise volunteers to conduct awareness sessions on COVID-19 and implications on pregnancy equipped with adapted materials on hygiene, IPC, danger signs and how and where to seek care	Health

Following on from the first phase response, Islamic Relief also developed a 'Socio-economic recovery framework' to guide a more holistic recovery effort focused on secondary impacts of Covid-19. The framework is summarised in the diagram below with some examples in the table further down of the type of interventions in phase 2 'recovery phase' from September 2020 onwards:

Examples of a phase 2 Covid-19 response recovery programme are listed in table below:

	12 months
Strengthened food security of most vulnerable households affected by multiple hazards	X
Increased employment opportunity through VSLA and income generating activities	X
Strengthened capacity of existing health facilities and services to combat Covid-19	X
Improved access to safe water and enhanced coverage of sanitation and hygiene services	X

OBJECTIVES OF THE EVALUATION

This evaluation has been commissioned by Islamic Relief Worldwide (IRW), funded by IR USA, in line with our commitment to learning and accountability to communities and partners. The purpose of this evaluation is to map our global Covid-19 response and recovery programme and assess the effectiveness of IR's response and recovery strategies and approaches with reference to outcomes and outputs as well as draw lessons for future programming and preparedness. We propose that this is done using a sample of **five country-level reviews** with consolidation of findings, incorporating global preparedness and coordination assessment, project mapping and desk review, into one global evaluation report. This evaluation should take into consideration the OECD/DAC Evaluation Criteria to assess the performance

of projects in selected countries and the overall programme approach, as well as use the Core Humanitarian Standard (CHS) to evaluate the quality of the interventions and the aspects of accountability.

The focus is on:

1. Identifying lessons and good practice from the overall Covid-19 response and recovery programme to inform IRW and potentially wider sector to future response to similar health emergencies. This report will be externally published.
2. Assessing the extent to which planned outputs and outcomes have been achieved using the OECD DAC criteria for evaluating humanitarian responses including assessing for relevance, connectedness, coherence, coordination, effectiveness, efficiency, impact and sustainability and recommend priorities and any changes to approach for subsequent phases of Covid-19 recovery.
3. Evaluating the appropriateness and extent of application of quality standards, with a particular focus on the CHS.
4. Examine what level of preparedness at IRW headquarters and country offices had / could have had, what went well in the coordination / management of it, what didn't and what ought to be done differently going forward etc [This section of the report will be internal but may also be published for wider learning purposes]

THE SCOPE OF THE EVALUATION

The scope of the evaluation should cover the activities funded under IR's Global Covid-19 Response and Recovery Programme. The geographical scope of the evaluation includes a desk review and mapping of the overall IR global Covid-19 response and recovery projects as well as targeted in-country reviews of specific identified completed or ongoing projects from across all the following 5 countries:

- **Sudan (Khartoum and Greater Kordofan)**
- **Somalia (Banadir and Middle Shabelle)**
- **Tunisia (Tunis, Tataouine and El Hamma)**
- **Mali (Bamako and Gourma Rharous)**
- **Pakistan (Islamabad & Balochistan – preferred; or AJK)**

Its expected the lead global consultant, responsible for the consolidated final evaluation report, will identify and partner with a national consultant or consultants in each of these 5 countries, including any enumerators required where relevant, for the county level reviews to be conducted in parallel. Where a national consultant cannot be identified or would not have access to communities within any particular country or countries, we welcome proposals that combine in-country and remote reviews and consultation with IRW staff and stakeholders and potentially community members for these specific countries. In case its not possible to do physical in-country review in all 5 countries, physical in-country reviews must be conducted in at least 3 countries and the others reviewed remotely using appropriate 'good enough' methodologies and approaches. National consultants/team members must have been identified and be available during the proposed evaluation by the time the consultancy agreement has been signed – expected to be no later than 31st March 2021. However, bids where national consultants have already been identified by the date of tender submission or interview will score higher in this component. Under the overall leadership and responsibility of the lead consultant, national consultants will need to be responsible, for hiring and supervising any in-country enumerators envisaged and ensuring data quality and integrity.

The technical scope of the evaluation is to:

- Examine the relevance and appropriateness of Islamic Relief's Covid-19 response and recovery programs, with specific reference to the design of project, choices and prioritization of intervention approaches and the progress in achieving the planned objectives (i.e. the outcomes and outputs)
- Review the effectiveness and efficiency of the mode of operation in both initial response and ongoing recovery phases
- Make a brief comparison between IR's response strategies and any UN or government cluster response plans and strategies for the sectors of intervention in each country and the degree of alignment or divergence and rationale for this
- Examine beneficiary and community targeting and selection strategies and whether the most vulnerable and at-risk individuals and communities were targeted and supported, especially those living in extreme poverty and from an age, gender and disability inclusion and protection perspectives. Data gathering and analysis should disaggregate for any differences in relation to access and benefit from a sex, age, disability perspective.
- Uncover the gaps in provision or unintended positive or negative impacts and providing commentary on the primary and secondary effects of the intervention, along with any direct and indirect contributions
- Analyse the connectedness of the response interventions to aiding recovery, including the degree to which or otherwise IR's socio-economic recovery framework was applied, incorporated and found to be relevant and effective in recovery phase programming
- Assess coherence of the response and recovery efforts with other actors and review the extent to which collaboration with stakeholders built and leveraged local capacity and resources and whether IR proactively worked with local actors, leverages them, supports them and strengthens them
- Examine the strategic value addition and distinctive contribution of IRW, if any, including but not limited to faith-based approaches, risk communication and community engagement, protection, inclusion and conflict sensitivity and environmental and resilience considerations
- Assess the appropriateness and effectiveness of adaptations made by each IR country team in light of Covid-19 to ongoing pre-Covid programming and projects and to adapting MEL and accountability processes within country, including remote management, remote MEAL approaches and ensuring inclusive accountability mechanisms for persons most at risk.
- Assess the appropriateness and relevance of IR's 'Socio economic recovery framework' in informing IR's global Covid-19 response and minimising medium and long term risk – in particular how or to what extent the SERF was understood and adopted in programming? Whether SERF catalysed any new elements or innovations in programming and any recommendations to improve it.
- Document and highlight any innovations and key lessons learned from each country as well as those at IRW international office coordinating and supporting overall response and recovery effort
  To the degree feasible, the above should be done with a view to gauging differences in performance and outcomes including level of resilience to Covid-19 primary and secondary impacts, comparing 3 different communities areas in each country (i.e. urban/peri-urban, pre-existing rural working area with established IR facilitated community organizations or self-help

groups and an area where Covid-19 response was to a new target community and/or no prior IR projects).

As IRW is a certified CHS agency and is deeply committed to ensuring accountability to and participation of communities, IRW incorporates the use of the CHS standard within our evaluations as standard. We believe this can be integrated with the DAC criteria in the following way:

Relevance

- CHS Commitment 1: Humanitarian response is appropriate and relevant.
- CHS Commitment 4: Humanitarian response is based upon communication, participation, and feedback

Effectiveness

- CHS Commitment 2: Humanitarian response is effective and timely.
- CHS Commitment 3: Humanitarian response strengthens local capacities and avoids negative effects.
- CHS Commitment 5: Complaints are welcomed and addressed.
- CHS Commitment 8: Staff is supported to do their job effectively, and are treated fairly and equitably.

Efficiency

- CHS Commitment 6: Humanitarian responses are coordinated and complementary.
- CHS Commitment 7: Humanitarian actors continuously learn and improve.
- CHS Commitment 9: Resources are managed and used responsibly for their intended purpose.

The evaluation conclusion should provide an indicative assessment of performance of Islamic Relief's Covid-19 response and recovery programme in each country against each of the CHS Commitments and any actionable recommendations for improvements. This indicative assessment of compliance should be based on findings from consultations with communities and stakeholders and be presented using a RAG indicator, where red signifies non-compliance and significant improvement needed, amber signifies weak or non-systematic compliance requiring some improvement and green signifies adequate or good compliance. A consolidated assessment across the overall response against each of the 9 CHS Commitments should be included with recommendation for improvements and highlighting particular good practice examples.

For more guidance on CHS evaluation questions, please refer to appendix 3.

METHODOLOGY AND APPROACH

A provisional list of projects to be evaluated in each country is provided in **Appendix 2**. However the specific projects to be reviewed in each country can be adjusted in consultation with IRW based on accessibility to the locations and community; or following desk review identifying other projects which may be more relevant or provide a wider perspective on the overall response and recovery programme. Consultation with staff, communities and wider stakeholders is expected to include an assessment of the overall IRW Covid-19 response and recovery programme in country, and adjustments related to Covid-19 to any ongoing pre-covid or newly approved non-Covid related projects, and not just the specific project being reviewed.

As a guide for planning purposes, at least 2 projects should be reviewed per country with a maximum of 5 working days including travel to review and gather community data from communities per project. In countries where locations are closer or there are smaller projects, up to 3 projects may

be reviewed within 10 working days. Total review time per country including consultation and data gathering with communities, interviews and FGDs with staff, wider stakeholders including partners, local government and national level peer/UN cluster leads etc should not exceed more than 15 working days. Its expected that each of the 5 country reviews will be conducted in parallel using a national consultant or consultants per country.
Within each of these 5 countries the evaluation should endeavour to assess our Covid-19 response and recovery support in at least one urban/peri-urban and two rural communities (one of which is should, where present, be a pre-Covid 19 working area with IR established community organisations or self-help groups) .

We are looking for an evaluation team to meet the above objectives and scope through a mixed method (quantitative and qualitative) approach of:

- Desk review of secondary data and information, including rapid review of sector level lessons learned and evaluations of Covid-19 responses by humanitarian agencies available in the public domain e.g. ALNAP and review and mapping from IRW project documentation
- FGD with communities – with proportionate sampling and numbers of FGDs
- Survey and key informant interviews with IR staff (at IRW international office, country offices and potentially fundraising partner offices), relevant peer agencies, local partner organizations, key identified stakeholders in each country, including community leaders, faith leaders, representatives of specialized protection and inclusion focused agencies, relevant UN cluster leads and local or national government authorities
- Remote or physical household surveys (where safe, possible and relevant) with a statistically representative sample, where safe and appropriate to do so, within each of the identified countries. If household survey cannot be done in any particular country or context, we would be happy to hear of alternative approaches to a household surveys to draw out voices of right-holders in representative manner, particularly those that are most at risk or vulnerable,
- Facilitating a lessons learned exercise with key staff from each country programme team (either in-person or via remote means) as well as a separate exercise with selected IRW international office staff to capture learning and opportunities for improvement at the global level including initial surge and coordination of the pandemic response.
- Ensure robust qualitative and quantitative data analysis to ensure findings are triangulated, evidenced and representative

We would like the evaluators to outline their proposed methodology and requirements for this particular consultancy and <u>we also welcome any alternative proposed methodologies or evaluation approaches</u> that may be deemed more suitable and efficient.

REQUIRED COMPETENCIES

The successful team will have the following competencies:

- Demonstrate evidence of extensive experience in evaluating humanitarian action
- Possess sectoral experience and knowledge in evaluating previous public health emergencies, health, WASH, cash and voucher assistance, food security and livelihood interventions

- Possess deep knowledge and practical experience of using quality standards such as CHS and Sphere
- Possess strong qualitative and quantitative research skills
- Have excellent written skills in English
- Have the legal right and ability to travel to or within the identified countries or have national counterpart consultants appointed in those countries
- Be able to fluently communicate in English and can or shall have a team member/s who speaks the local language of the countries to be evaluated (if local translators are required this should be budgeted).

The chosen evaluation team will be supported by IRW Programme Quality (PQ) team, the IRW Disaster Risk Management Department (DRMD), the IRW Regional team and IR country teams.

PROJECT OUTPUTS

The consultant is expected to produce:

- A detailed work plan and inception report developed with and approved by IRW, setting out the detailed methodology and deliverables prior to commencing the evaluation.
- A Covid-19 risk assessment with proposed mitigation measures related to conducting this evaluation, setting out different contingencies in case of challenges to the evaluation due to Covid-19 or other issues.
- A full report with the following sections:

a) Title of Report: **An Evaluation of Islamic Relief's Global Covid-19 Response and Recovery Programme 2020/21**

b) Consultancy organisation and any partner names

c) Name of person who compiled the report including summary of role/contribution of others in the team

d) Period during which the review was undertaken

e) Acknowledgements

f) Abbreviations

g) Table of contents

h) Executive summary

i) Main report – max 40 pages – (Specific reporting structure will be agreed at inception stage, but consultant is invited to propose a suitable report structure layout)

j) Annexes

- Terms of reference for the review
- Profile of the review team members
- Review schedule
- Documents consulted during the desk review
- Persons participating in the review – with appropriate consent for names to be published or specific names should be anonymised highlighting just role, organisation and gender
- Anonymised copy of field data collected during the review
- Additional key overview tables, graphs or charts etc. created and used to support analysis inform findings
- Bibliography

k) The consultant will be required to have a video conference call with IRW international office and provide feedback on and answer questions about the findings. This meeting can be attended remotely by the consultant via Microsoft Teams or Zoom where the consultant is outside the UK or based on request from the consultant.

TIMETABLE AND REPORTING INFORMATION

The evaluation is expected to run for a maximum of **30 working days**, starting by the **1st April 2021** and ending before the **3rd of June 2021**

Date	Description	Responsibility
2nd March 2021	Tender live date	IRW
16th March 2021	Final date for submission of bid proposal	Consultant
17th - 18th March 2021	Proposals considered, short-listing and follow up enquiries completed	IRW
18th – 31st March 2021	Consultant interviews and final selection (+ signing contracts)	IRW
1st – 2nd April 2021	Meeting with the consultant and agree on an evaluation methodology, plan of action, working schedule	IRW
8th April 2021	Submission of Inception Report (at least 7 days before commencing the evaluation)	Consultant
14th April – 7th May 2021	Evaluation/Data collection	Consultant
17th May 2021	Collation and analysis of evaluation data, and submission of the first draft to IRW for comments	Consultant
19th May 2021	Initial Presentation of Findings	Consultant
25th May 2021	IRW responses to draft report	IRW

31st May 2021	Final report submitted to IRW	Consultant
1st – 3rd June 2021	Final Presentation with IR key stakeholders	Consultant

Reporting information;

Contract duration: Duration to be specified by the consultant

Direct report: Programme Impact & Learning Manager

Job Title: Consultant; Global Covid-19 Programme Evaluation

The consultant will communicate in the first instance with and will forward deliverables to the IRW Programme Quality team.

PROPOSAL TO TENDER AND COSTING:

1. Consultants (single or teams) interested in carrying out this work must:
   Submit a proposal/bid, including the following;

   i. Detailed cover letter/proposal outlining a methodology and approach briefing note
   ii. CV or outline of relevant skills and experience possessed by the consultant who will be carrying out the tasks and any other personnel who will work on the project
   iii. Example (s) of relevant work
   iv. The consultancy daily rate
   v. Expenses policy of the tendering consultant. Incurred expenses will not be included but will be agreed in advance of any contract signed
   vi. Be able to complete the project within the timeframe stated above
   vii. Vii. be able to demonstrate experience of humanitarian review for similar work

PAYMENT TERMS AND CONDITIONS

2. Payment will be made in accordance with the deliverables and deadlines as follows:

- 40% of the total amount – submission of the inception report
- 30% of the total amount – submission of the first draft of the evaluation report
- 30% of the total amount – submission of the final report including all outputs and attachments mentioned above

3. We can be flexible with payment terms, invoices are normally paid on net payment terms of 28 days from the time of the invoice date.

ADDITIONAL INFORMATION AND CONDITIONS OF CONTRACT

4. During the consultancy period,
   IRW will only cover:

- The costs and expenses associated with in-country, work-related transportation for the consultant and the assessment team

- International and local travel for the consultant and the local team
- Accommodation while in the field
- Training venues
- Consultancy fees

IRW will not cover:

- Tax obligations as required by the country in which he/she will file income tax
- Any pre/post assignment medical costs. These should be covered by the consultant
- Medical and travel insurance arrangements and costs. These should be covered by the consultant

CONSULTANCY CONTRACT

This will be for an initial period that is to be specified by the consultant commencing from March/April 2021. The selected candidate is expected to work from their home/office and be reporting to the Programme Impact & Learning Manager or team member designated for this study.

The terms upon which the consultant will be engaged are as per the consultancy agreement. The invoice is to be submitted at the end of the month and will be paid on net payment terms 28 days though we can be flexible.

All potential applicants must fill in the table beneath in **Appendix 1** to help collate key data pertaining to this tender. The applicant must be clear about other expenses being claimed in relation to this consultancy and these must be specified clearly.

For this consultancy all applicants are required to submit a covering letter with a company profile(s) and CV's of all consultants including the lead consultant(s).

A proposal including, planned activities, methodology, deliverables, timeline, references and cost proposal (including expenses) are expected.

Other relevant supporting documents should be included as the consultants sees fit.

All applicants must have a valid visa or a permit to work in the UK (if travel is required to the UK) and to the places where this project is required to be undertaken.

TENDER DATES AND CONTACT DETAILS

All proposals are required to be submitted by **Tuesday 16th March 2021** at **1.00pm UK time** pursuant to the attached guidelines for submitting a quotation and these be returned to tendering@irworldwide.org
For any issues relating to the tender or its contents please email directly to tendering@irworldwide.org

Following submission, IRW may engage in further discussion with applicants concerning tenders in order to ensure mutual understanding and an optimal agreement.
Quotations must include the following information for assessment purposes.

1. Payment terms (as mentioned above)
2. Full break down of costs including taxes, expenses and any VAT
3. References (two are preferred)
4. Technical competency for this role
5. Demonstrable experience of developing a similar project

Note: The criteria are subject to change.

APPENDIX 1

Please fill in the table below. It is essential all sections be completed and where relevant additional expenses be specified in detail. In case of questions about how to complete the table below, please contact tendering@irworldwide.org

Cost of a consultancy for the evaluation of Islamic Relief's Global Covid-19 Response and Recovery Programme 2020/21, February 2021	**Full name of all consultants working on this project**
Full company trading name	
No of proposed hours per week	
No. of proposed days	
Preferred days	
Non preferred days	
Earliest available start date	
Expected project finish date	
Day rate (required for invoicing purposes)	**£**
Total cost for consultancy in GBP (less taxes and expenses)	**£**
Expenses (flights)	**£**
Expenses (accommodation)	**£**
Expenses (transfers)	**£**

Expenses (in country travel)	**£**
Expenses (visa)	**£**
Expenses (security)	**£**
Expenses (food)	**£**
Expenses (print/stationary)	**£**
Expenses other (please specify)	**£**
Total expenses	**£**
Total VAT or taxes	**£**
Total cost for consultancy in GBP (inclusive of taxes and expenses)	**£**

Note

The applicant is expected to take responsibility for paying full taxes and social charges in his/her country of residence.