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# DEC CVA REAL-TIME RESPONSE REVIEW: SOMALIA AND SOMALILAND

# COUNTRY REPORT

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# LIST OF ACRONYMS

| | |
|---|---|
| COVID-19 | Disease caused by the SARS-CoV-2 virus |
| CHS | Core Humanitarian Standard |
| DEC | Disasters Emergency Committee |
| FGM | Female genetic mutilation |
| HQ | Headquarters |
| MEAL | Monitoring, Evaluation, Accountability and Learning |
| MoH: | Ministry of Health |
| OCHA | Office for Coordination of Humanitarian Aid |
| RTRR | Real Time Response Review |
| PPE | Personal Protective Equipment |
| WHO | World Health Organisation |
| URD | Urgence Rehabilitation Développement |
| UK | United Kingdom |
| WASH | Water Sanitation and Hygiene |

# SUMMARY OF ANALYSIS & RECOMMENDATIONS

## ANALYSIS

| No. | Commitments | Quality Criterion | Analysis |
|---|---|---|---|
| 1 | Communities and people affected by crisis receive assistance appropriate and relevant to their needs. | Humanitarian response is appropriate and relevant | As there was great uncertainty about how the pandemic would evolve, DEC Member Charities were right to adopt a 'no regrets' approach |
| 2 | Communities and people affected by crisis have access to the humanitarian assistance they need at the right time. | Humanitarian response is effective and timely | DEC funding complemented other sources of funding, but took long than expected to arrive |
| 3 | Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action | Humanitarian response strengthens local capacities and avoids negative effects | Instructions to local staff and local partners on how to deal with Covid-19 were clear, and often predated the arrival of DEC Covid-19 funding, which is evidence of a very responsible attitude on the part of the DEC Member Charities |
| 4 | Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them | Humanitarian response is based on communication, participation and feedback | During a pandemic, a certain number of top-down measures are necessary. Communication through local leaders and community members was key. |
| 5 | Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints | Complaints are welcomed and addressed | Mechanisms were in place. However, their effectiveness was far from obvious, despite the efforts made. |
| 6 | Communities and people affected by crisis receive coordinated, complementary assistance | Humanitarian response is coordinated and complementary | All the DEC Member Charities were fully involved in different coordination systems in Nairobi and in the field |
| 7 | Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection | Humanitarian actors continuously learn and improve | The timeframe of this programme is not long enough to see whether DEC Member Charities are learning. However, their eagerness and engagement with the DEC RTRR underlines a strong desire to learn and improve |
| 8 | Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers | Staff are supported to do their job effectively, and are treated fairly and equitably | There was clear evidence of this. However, the unknown nature of the threat and how it will evolve has created some stress. Further engagement will be required on the part of management to deal with this. |
| 9 | Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically. | Resources are managed and used responsibly for their intended purpose | Efforts were made to complement existing programmes and create new ones where needed based on a rigorous approach that DEC Member Charities already apply with many other donors. |

# KEY RECOMMENDATIONS

### RECOMMENDATION N°1

Actively pursue efforts to understand the evolution of the pandemic in order to remain relevant in all activities and in order to remain alert and able to react in the event of a new wave. In addition to regular sources of information (e.g., the WHO web site, special sites such as ihttps://ourworldindata.org/coronavirus-data?fbclid=IwAR3J4TLJjPrcHWOyOM3jUvCOQl4v3JwJaRLoCBirUPFV449ADhLMCCxHibc, etc.), it may be useful to also use a series of other less common sources of information in contexts where there is a lack of data, the main one being information from cemeteries. In Islamic countries, any wave of extra mortality is immediately perceived as it leads to an increase in burials.

### RECOMMENDATION N°2

As most health measures and hygiene messages are valid for many different contagious risks, ensure that they are fully incorporated into routine protocols (in health structures and schools, for instance) and in the creation of rapid response deployment in case there is a resurgence of Covid-19 or for any other epidemic outbreak. The most relevant measures concern personal hygiene and the establishment of hand washing stations as soon as there is a public health alert. All measures designed to protect health workers will remain important in other health crises as they are both critical actors of the response and are frequently agents of contamination.

### RECOMMENDATION N°3

For the population, the dedication of DEC Member Charities and their local partners created a sense of "togetherness", despite the lockdown and limitations to mobility in the field. The trust that has been established during the Covid-19 response should be exploited to prepare the ground for the vaccination phase. This means engaging early with health structures, local leaders and opinion makers (including religious leaders). With the discussions at WHO, the Access to COVID-19 Tools (ACT) Accelerator and the international decision to make resources available for worldwide access to vaccines, there is hope that vaccines will soon be available to the Somali Ministry of Health.

### RECOMMENDATION N°4

Pursue efforts to support food security through CVA and the injection of cash into the economic system (cash for work, etc.) with a specific focus on the elderly.

### RECOMMENDATION N°5

Reinforce monitoring systems on protection issues and develop response capacities. Efforts to improve feedback and complaints mechanisms are necessary. However, there is a need to improve understanding of what 'feedback' is and what a 'complaint' is. In both cases, however, local social scientists could help to understand and deal with issues.

### RECOMMENDATION N°6

Explore opportunities to provide assistance in the Education sector either through support to teachers, the development of remote teaching systems or by supporting children who are at risk since the school closures.

# 1. INTRODUCTION

## 1.1. GENERAL CONTEXT OF THE REVIEW

### 1.1.1. GLOBAL CONTEXT

In the context of the Covid-19 pandemic, the Disasters Emergency Committee (DEC) launched a specific COVID Appeal on 14 July 2020. By the end of August 2020, the campaign had raised over £22.5 million, including UK Aid Match.

Contrary to other DEC appeals in response to emergencies already unfolding, this appeal adopted a proactive approach, based on the idea that responding as early as possible with preventive measures was the most effective way of stopping the pandemic. Selecting countries based on forecasts of the humanitarian needs that would be created by the COVID-19 epidemic was challenging and decisions had to be made with a 'no regrets' approach.

In the end, the funds raised by the Coronavirus 2020 Appeal were allocated to 14 DEC members already working in 7 fragile states in Asia (Afghanistan and Bangladesh for the Rohingya crisis), the Middle East (Yemen and Syria) and Africa (DRC, Somalia and South Sudan). These were selected as priority countries facing a critical situation exacerbated by the Covid-19 crisis. The funds were used to adapt on-going projects and to develop new projects to respond to the anticipated health and non-health impacts of the pandemic, as well as to cope with the impacts of the measures taken to stop it. Special attention was given to specific due diligence and protection measures for staff and partners.

A first allocation of £13m was made in July 2020, of which DEC Member Charities budgeted £10.9m for Phase 1 programmes (14th June 20 - 31st January 21). A second allocation was confirmed in early November 2020 to be used either for Phase 1 or Phase 2. Phase 2 programmes will run from 1 February 2021 - 31 January 2022. The Real-Time Response Review is part of DEC's accountability policy. It contributes to meeting the high demand for accountability from the British population, who donated very generously to the DEC Coronavirus 2020 Appeal, and it aims to increase learning and contribute to the continuous improvement of humanitarian practices.

## 1.2. OBJECTIVES AND SCOPE OF THE REVIEW

In line with the DEC's strong commitment to transparency, continuous learning and accountability, and for the first time across the entire funding period, Groupe URD has been selected and granted to provide MEAL services for the humanitarian programmes funded by the DEC Covid-19 Appeal.

The main tasks will be:

- Carrying out the real-time Response Review of the DEC-funded programmes. Making recommendations for improvements in aid delivery based on the main findings of the review;
- Providing technical advice and guidance on MEAL related activities through a collaborative approach (including some collective learning interventions);
- Conducting a one-day learning and evaluation workshop in phase 2 in order to reflect upon the improvements made since the Response Review, and inform potential themes for evaluations;
- Carrying out a meta-synthesis of evaluations, MEAL reviews and other activities.

#### 1.2.1. OBJECTIVES

As a first step of the multi-year learning process, the Response Review supports real-time collective learning in order to identify lessons and adjustments for the second phase of the response. Based on key documents and interviews with key stakeholders, there are three main objectives:

- **Objective 1**: Improve understanding of the **impacts of the Covid-19 pandemic on contexts** (evolving and diversified needs, access constraints, etc.), and on Member Charities, their partners and key stakeholders;
- **Objective 2**: Analyse **adjustments** that have already been made or that are still needed in humanitarian programming in each country and globally;
- **Objective 3**: Facilitate **collective thinking** between Member Charities about lessons and innovative ideas with regard to responding to the coronavirus pandemic. The primary purpose of this exercise is to generate real-time learning in particular for the DEC Member Charities who may benefit from it during Phase 2. The secondary purpose is to share lessons learnt which might be profitable to all DEC Member Charities in similar global pandemic situations.

This approach includes both a strong focus on context and agencies' specificities (similar programmes by different agencies in a given context) and a comparative analysis between the responses in these different situations (how contexts influence responses).

The lessons learned are aimed at four **main groups**:

- The field staff of each DEC Member Charity and their partners who will be preparing for Phase 2
- The community of DEC Member Charities and their partners in a given country
- The global DEC community
- The DEC secretariat preparing decisions for Phase 2

The Response Review also aims to inform the wider humanitarian community and contribute to knowledge about responding to the coronavirus pandemic in humanitarian settings.

Recommendations are made with a specific focus on the country level and a secondary focus on the global level. These aim to:

- At operational level: assist DEC charity members in improving their response to the pandemic during Phase 2;
- At strategic level: assist decision makers in identifying the main lessons learned that can be helpful for both Phase 2 of the DEC appeal and more broadly for a global crisis situation similar to the Covid-19 pandemic.

#### 1.2.2. SCOPE OF THE REVIEW

**The reference framework**: the review assessed programmes according to the CHS commitments, with a special focus on the relevance of responses and processes - due diligence, safe management of resources, coordination, the involvement of the population, and accountability. Effectiveness will be assessed as much as possible as activities are still on-going.

**Geography**: the review took place in each of the seven countries selected by the DEC for the COVID-19 Appeal. Programmes to be visited were selected through close consultation between the in-country staff

of Member Charities and the Groupe URD team. The selection was based on representativity and feasibility, taking into account access and time constraints. Distance interviews were organised with staff from other Member Charities, including the ones not visited.

**Time:** the review focused on the programmes that were implemented as part of Phase 1 with the aim of identifying key lessons and recommendations.

# 2. METHODOLOGY AND LIMITATIONS

## 2.1. ANALYSIS FRAMEWORK AND KEY QUESTIONS

Firstly, each context is analysed in terms of politics, conflicts, economic aspects, the capacity of national institutions, the level of decentralisation, etc. This is essential to contextualise programmes, the constraints affecting them and their possible impacts. The analysis then focuses on the programmes and any lessons that can be drawn from them.

The learning process involved a **participatory approach**, with several exchange and feedback sessions and the co-construction of recommendations.

The review, collected information from a variety of sources, including quantitative data and **qualitative** information to respond to the following three key questions:

- **Key Q 1:** What has been the impact of COVID-19 on DEC Member Charities (as organisations) and their operational environment (context and needs)?
- **Key Q2:** What measures have already been taken or still need to be taken to adapt to the new working environment?
- **Key Q3:** What lessons and innovative ideas in each country can help to prepare Phase 2, and which can be of use to DEC member charities more broadly, and to the DEC Secretariat in their efforts towards accountability.

## 2.2. SOURCES AND TOOLS

The team collected relevant information through:

- A desk review of relevant literature, evaluations and data sources provided by the DEC secretariat and gathered at country and global levels[1];
- Global-level interviews with key stakeholders from DEC Member Charities;
- Country- and field-level interviews with relevant stakeholders including field staff, local partners, government entities, local authorities, and international aid agencies;
- Discussions with affected people; through individual interviews with local Key Informants (village chiefs, local health responders, etc.), and focus group meetings (organized in a way that allowed gender disaggregated information to be collected). It is very important that the views of the population are taken into account in the Response Review.
- Direct observation of programme activities; The focus groups were conducted in urban and rural areas. In Somaliland, a total of 6 focus groups were conducted in Hargeisa, Burao and Gabiley.
- A survey of relevant stakeholders at the global / headquarters level.

The information collected and analysed falls into four categories:

[1] The DEC team already gave access to the review team (international consultants) to COVID 19 appeal background information and projects documentation via a tailored access to Box.

- Global issues behind the DEC COVID-19 Appeal (timing, discussions with main medias, difficulties in front of this specific situation and its uncertainties)
- General information about the COVID-19 pandemic in each of the countries concerned (time of first detection, information about virus circulation, measures taken by the national authorities)
- Specific information linked to the different projects (duty of care, health specific responses, the adaptation of existing projects, projects addressing new issues) in terms of population targets and accountability mechanisms (towards population and local authorities), adaptative management, etc.
- Key lessons and adaptations that have been recorded by each of the DEC member charities in their operations.

## 2.3. CHALLENGES AND CONSTRAINTS

This Real-Time Review has the following specific characteristics:

- Somalia/Somaliland is part of a complex zone that has been affected by numerous conflicts, droughts, floods, and locust infestations in recent decades. Thus, the vulnerability of the population has multiple causes and Covid-19 has simply added another layer.
- The programmes that have been funded are both preventive and reactive, based on a 'no regrets' approach, with decisions made on the basis of scarce information.
- Covid-19 has had, and continues to have, multiple primary and secondary health impacts, but all the measures that have been taken to control it or to limit contamination have also had significant impacts.

This situation is challenging for aid practitioners and for the team undertaking the review.

**Access constraints**: In the Somali region, where access was already difficult, the combination of the conflict and the pandemic have made it even more challenging. The option of having two consultants (one for Somaliland and one for South and Central Somalia) should have been explored despite limited time and funding. Field visits were thus not as extensive as expected.

**Limited involvement of affected people.** Though the review was supposed to gather feedback from communities about programmes and about their priority needs, the involvement of affected people remained limited due to access constraints.

**Information gaps / problems of data quality / no generation of new data.** The review team collected and compiled relevant available information. But situations and trends are evolving quickly and vary significantly between countries. Numerous unknown factors remain regarding the way the virus spreads and the most efficient way to prevent it from spreading and to treat infected people. Qualitative information was prioritized as it is often best suited to identify difficulties, challenges, solutions and good practices.

**Time constraints /no in-depth evaluations:** Time dedicated to this Real-time Response Review was limited. The main findings / lessons learned and recommendations had to be shared in advance to be incorporated during phase 2. The team conducted the Somalia/Somaliland country study, prepared a stand-alone short country report (10 to 20 pages + annexes) and presented country-specific lessons learned and recommendations.

**Organisational difficulties:** With the inexperience of the lead consultant in organizing 'zoom' conferences and the last-minute administrative constraints posed by Djibouti University (the consultant's principal employer) to allow him to go to Mogadishu, there was a certain level of difficulty in organizing the logistics and the communication for the mission, leading to delays.

# 3. THE POLITICAL AND SECURITY CONTEXT IN SOMALIA: A PANDEMIC IN A WAR CONTEXT

## 3.1. POLITICS

The political situation in a country is one of the key parameters that determine whether or not a crisis can be mitigated: Somalia is a very good example of this paradigm.

### SOUTH AND CENTRAL SOMALIA: PROGRESS, BUT FAR FROM STABILIZED PEACE

In South and Central Somalia, the situation evolved rapidly after the 2005-6 drought with the transformation of the Islamic Courts Union (ICU) into the AS movement. AS rapidly took over large parts of the country and by June 2006, they had established control of the capital. This was immediately perceived as a possible way for Radical Islamist movements, in particular Al Qaida, to establish bases on the African territory. In early 2007, the African Union (AU), with the approval of the United Nations (UN), established the African Union Mission in Somalia (AMISOM), with an initial six-month mandate[2]. Political changes in Mogadishu took place in August 2011, and ended up with the formation of the Federal Government of Somalia (FGS) in September 2012, and the first presidential election for decades. Mogadishu subsequently went through a slow but noticeable recovery, but bombing and attacks against FGS structures and troops and against AMISOM remained a constant threat (Novak, 2013). Clan-based power relations unfortunately contributed to continued political uncertainty. Repeated Security Council Resolutions allowed for the continuation of the AMISOM in order to support dialogue and reconciliation. But AMISOM then found itself caught up in a hard combat situation against an enemy that used Improvised Explosive Devices (IED), suicide bombers and explosive vehicles. Nevertheless, since 2014, security gains, combined with a significant decrease in pirate attacks off the coast of Somalia, have raised hopes of change. Several donors (EU, USA, UK) have provided significant military and financial resources to AMISOM, and have supported anti-piracy operations and the reform of the security system to strengthen the Somali Army and Police (Keating, 2018). Since 2013-2014, efforts to rebuild state institutions have had relatively positive results. Following a decentralisation process, the FGS is now made up of five Member States who nevertheless continue to have many weaknesses and limited capacities. Although AS has been driven out of Mogadishu, assassinations and suicide bombings remain a constant threat[3].

### THE SPECIFIC CASE OF SOMALILAND:

With a constitution and an elected government and parliament since 2003, the Republic of Somaliland, which broke away from Somalia in 1991, has a much more democratic system. The shift from a clan-based system to one based on political parties has meant that the country has been relatively peaceful over an extended period. Somaliland has not had any major security incidents in years. However, the current deterioration of the situation with Puntland in the Sool Sanaag plateau is a source of concern as it is currently developing into a real military confrontation (ICG, 2018)

## 3.2. THE ROLE OF NATIONAL INSTITUTIONS

In 2005-06, there was hardly any functioning central administration. In 2011, the Transitional Federal Government (TFG) exerted little authority apart from in a small part of Mogadishu. Significant progress has taken place since 2014 (HRP, 2015), with the creation of the Federal Government and the establishment of member state institutions, despite their very limited outreach capacity. The creation of agencies dedicated to

[2]http://amisom-au.org/amisom-background/
[3]http://blogs.icrc.org/somalia/2018/07/26/somalia-back-back-staff-security-incidents-see-icrc-scale-back-operations/

disaster management and humanitarian action (HADMA and SODMA) as well as a ministry of humanitarian affairs and disaster management are significant changes. These are beginning to have both positive and negative effects on humanitarian response, such as improved coordination and increased bureaucracy.

While South and Central Somalia has continued to be wracked by political instability, Somaliland has continued to build stronger and more effective institutions, with the inclusion of very competent individuals from the Diaspora. It has also made considerable democratic gains, including a peaceful and democratic presidential election in 2017. The reform of the national crisis management system, which gave birth to the NADFOR, has created significant interest and raised expectations that Somaliland institutions will improve their coordination and engagement with the international aid system (NADFOR, 2018).

## 3.3. SECURITY AND ACCESS

The country has continued to be in a situation of protracted and complex crisis, with humanitarian organisations in permanent danger[4], and Somalia is still seen as one of the most dangerous places to work. Human Resource management has been a sensitive issue in Somalia since the early 90s. Many security incidents (hostage taking, killings) affecting humanitarian agencies have been linked to "HR issues"[5] (the recruitment and firing of staff). However, since 1991, the Somali conflict has created its own set of security risks and access challenges (GRUNEWALD, 2008).

By mid-2006, with the rise of Al Shabbab in large parts of South and Central Somalia, access to the population became difficult. In November 2011, Al Shabbab refused to recognise that a famine was taking place. They also banned humanitarian agencies and expelled several agencies from Middle and Lower Juba, Bay and Bakool, thus aggravating the situation. To receive assistance, many people, often from low-ranking clans or minority groups (Bantous), had to move into geographic areas controlled by more powerful Somali clans. Many were displaced to the Afgoye Corridor and IDP camps/sites in Mogadishu (Grunewald op. cit., Maxwell op. cit.) making the situation chaotic, volatile and even more dangerous for humanitarian agencies. The situation was better in 2015-16-17 than in 2011, though access to some badly-affected people remained problematic. The territorial gains made since 2013 by AMISOM and the Somalia Army have provided the Federal Government of Somalia with a more significant presence on the ground, increasing the area that is accessible to humanitarian aid. The situation has been used by the international community to extend its presence in the South and Central region. However, the situation resembles an archipelago, with islands of stability surrounded by largely hostile seas. In fact, in many of these areas, aid organisations are unable to move further than a few kilometres from their well-secured bases. Mobility is thus critically constrained and airborne means are absolutely key. The United Nations Humanitarian Air Services (UNHAS), the air service financed by the Directorate-General for European Civil Protection and Humanitarian Aid Operations (known as ECHO flight), EU flights, and International Committee of the Red Cross (ICRC) aircrafts are vital to the security of aid actors and their access to the field.

**Key considerations related to the global situation in the Somalia area:**

- Analysis of the political parameters of the crisis and their evolution is essential to identify the room for manoeuvre that exists for humanitarian operations;
- Understanding the characteristics and risk factors of the context is key to the design and understanding of an operation. This means understanding the political situation and the strategies of armed groups and the international community. For instance, in the current

[4] https://www.ngosafety.org/country/somalia
[5] Humanitarian Outcome/Transparency, 2018

context, where so much accent is put on coordinating with the Government, analysis is required of the risk of compromising humanitarian principles?
- It is particularly important to analyse existing institutions, their history, their strengths and their weaknesses and to develop a strategy for engaging with them.

## 3.4. PROGRESS IN AID DELIVERLY PRIOR TO THE PANDEMIC

There was a great deal of discussion in the aftermath of the 2011-12 drought about how to address the Somali context, where crisis had become the "new normal". This opened the way for a series of resilience initiatives that represented a significant shift in the aid landscape in the country. A number of development and resilience programmes were funded by a few 'risk-taking' donors (with UKAID at the forefront). These programmes had some significant effects:

- The regular and predictable injection of cash into communities for a protracted period makes them a little less vulnerable. In several areas, communities that were not part of the programme took shelter in the "Resilience villages" where there were more resources available[6].
- As the development of water resources was an important component of these Resilience programmes, their areas of operation were much better equipped to deal with reduced water availability than other areas (BRICS 2017)[7].

**Key considerations to take into account:**

- All the efforts to build resilience after each crisis event can pay off in making communities better equipped to deal with the next crisis. Though clear progress has been made on the food security front, very little has been achieved on the health front, leaving health institutions very much in disarray after each health crisis.
- Post-crisis development and resilience efforts should aim to develop the capacity to rapidly adopt "crisis mode". This should include work on information flows, disaster management capacity at the community level and mechanisms able to scale up fast when needed.

[6] Interviews with Key Informants, *iati.dfid.gov.uk/iati_documents/4979329.odt*
[7] Interviews with Key Informants,

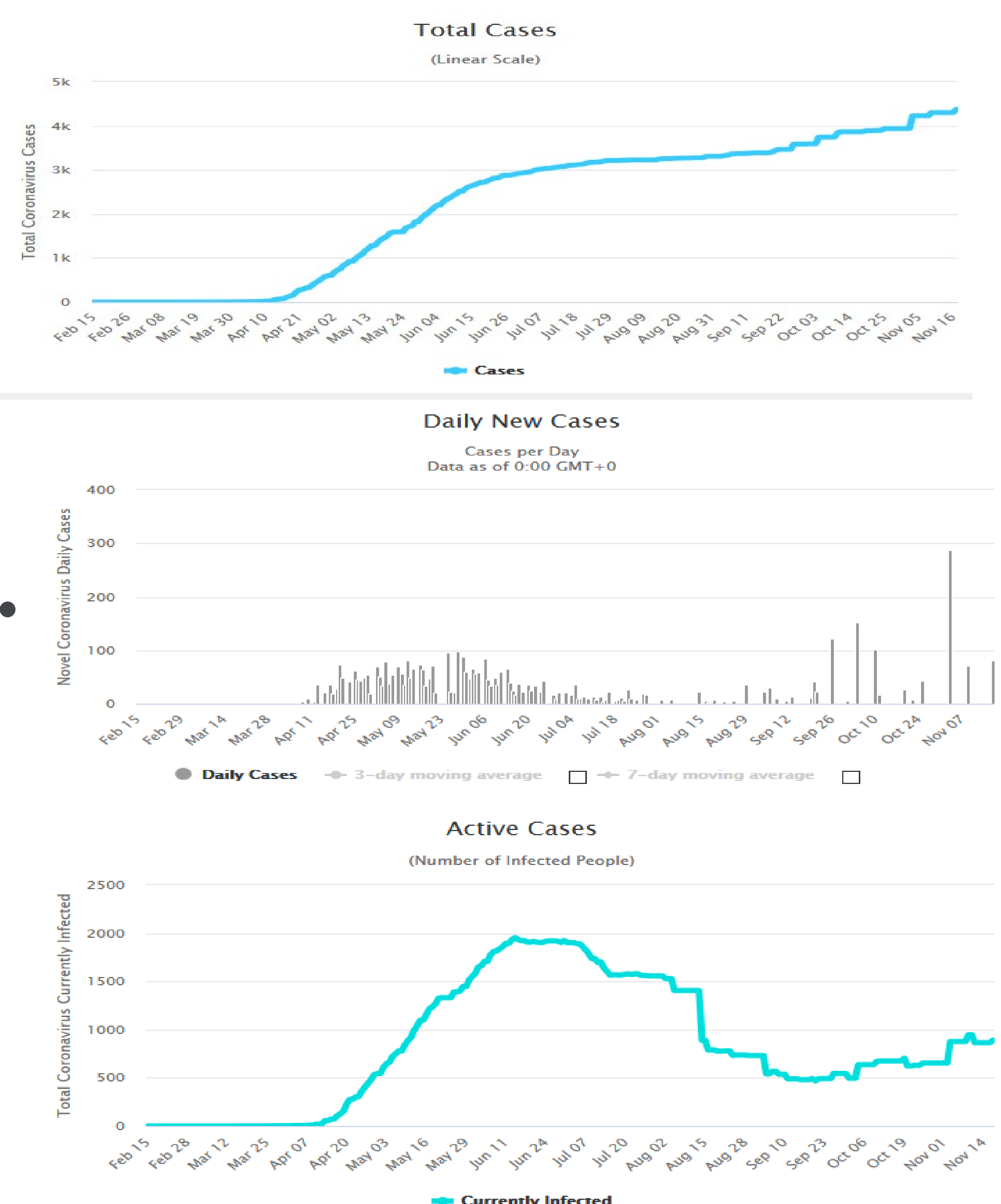
## 3.5. CHARACTERISTICS OF COVID-19 IN SOMALIA/SOMALILAND

Three decades of civil war and instability have weakened Somalia's health system and contributed to it having some of the lowest health indicators in the world. The situation varies from region to region but between 26-70% of Somalia's 15 million people live in poverty and an estimated 2.6 million people have been internally displaced, many of them living in overcrowded IDP settlements where hygiene and health conditions are below basic standards. In addition, an ongoing extremely damaging locust invasion and significant floods during the Gu season made the situation very precarious for many people. Though efforts are being made to rebuild the extremely weak Public Health system, healthcare throughout the Somali region is increasingly being privatised. In May 2014, the Somali Federal Government launched the Essential Package of Health Services (EPHS) initiative with the goal of establishing standards for national health services vis-a-vis governmental and private healthcare providers, as well as for international partners. Cholera, malaria, water-borne diseases and other communicable diseases as well as malnutrition are key targets of EPHS; with the objective of improving health and nutritional control and surveillance. Over the years, efforts to ensure that health facilities are better equipped and staffed, and have more resources, have gone hand in hand with providing support to build institutional capacity. It is important to recall that Somalia is a country of hard-working staff, who are used to operating in difficult conditions in degraded mode, with significant experience in cholera management, especially in the health structures in Mogadishu. But the fact is that at the start of 2020, with low levels of access to healthcare, limited government capacity, and healthcare services that were either unaffordable, unavailable, or not trusted, the health system was not ready to deal with the pandemic.

The Covid-19 pandemic was confirmed to have reached Somalia on 16 March 2020 when the first case, a Somali citizen returning home from China, was confirmed in Mogadishu. A few weeks later there were signs that the virus was spreading in the country, but it did not have a single laboratory capable of diagnosing it. Tests therefore had to be transported to Kenya, with long waiting times before obtaining the results. This immediately raised a lot of concerns: with limited capacity to cope with serious Covid-19 cases, fears grew that the pandemic would have a huge impact on the country. Immediately, the government set aside financial resources (five million dollars) to deal with the disease and formed a Covid-19 task force, mainly for updating the public about how the pandemic was evolving. However, hospitals did not have the capacity to deal with high numbers of serious cases. Emergency care unit beds, isolation facilities and respiratory equipment were all limited. The living conditions in overcrowded IDP settlements in Mogadishu and other cities triggered another level of fear that there would be uncontrollable Covid-19 outbreaks.

In addition to the health impact, there were also concerns that the economic and social impacts of the pandemic could be huge. Indeed, as large segments of the Somalian population rely heavily on remittances from the Diaspora, the economic impact of the lockdown and the slow pace of the international economy, particularly in countries with a significant Somali population, significantly reduced the flow of resources to Somalia. In the political realm, there was speculation that President Mohamed Abdullahi Mohamed would use the pandemic as an excuse to postpone the elections and limit freedom of the press after several journalists covering the pandemic were arrested or intimidated.

Based on current knowledge about Covid-19 cases in Somalia, most key indicators have reached a plateau and the situation is nothing like the disaster that had been feared in spring 2020. However, there are a lot of unreported cases due to the fear of stigmatization, concern about hospitals being sources of contamination and other rumours.

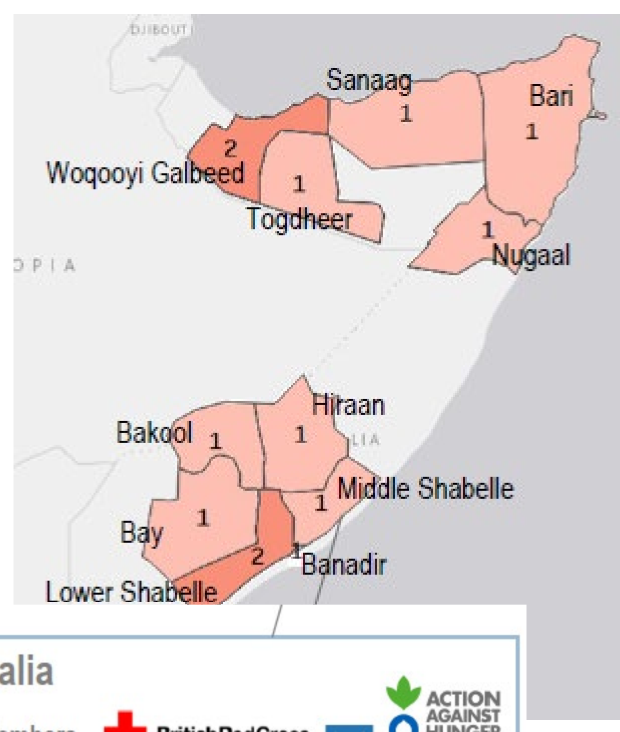



(source: WHO Dash board)

# 3. SUMMARY OF DEC SUPPORTED ACTIONS IN SOMALIA

Most DEC Member Charities have been present in Somalia for years and have implemented various types of programmes in different sectors, such as drought management, nutrition/health and cholera reponses.

Map 1 – DEC-funded projects in Somalia and Somaliland



The projects funded by DEC are located:

- along Shabelle water course in central South Somalia;
- In Northern Somaliland and Puntland.

**Funded programmes/activities**: The priority sectors funded by the COVID-19 Appeal are:

- Health,
- Water Sanitation and Hygiene,
- Economic Security (Food, Livelihoods and multipurpose cash assistance)
- and Protection.

| NGO | Type of programme | Sector | Modalities | Areas |
|---|---|---|---|---|
| Islamic relief | Adaptation of existing programmes to Covid-19 | WASH, Health, CVA,<br>AAP | Direct implementation | Somaliland<br>South Central |
| | New programmes | WASH and emergency relief in hard-to-reach IDP camps | | |
| Action against Hunger | New programme in an existing geographic operational area | Integrated Health/Nutrition support<br>Awareness and information campaigns,<br>WASH in Afghoye stabilisation centre | Through local partners, especially Juba Foundation | Lower Shabelle<br>Support to flood IDPs in Afghoye |
| Plan International | Continuation of existing programmes with new target groups and extended locations | Protection of IDPs | Local NGO partners<br>Takulo for MPC assistance and WASH<br>NAFIS for protection and awareness | Hargeissa and Togdheer |
| British Red Cross | Continuation of existing programmes with adaptation to Covid-19 situation | Agro Recovery programme through Cash transfer | Through ICRC and Somali Red Crescent | Belet Wene, Lower Shabelle; Bakool and Sanaag |
| Action aid | Continuation of an existing programme | Community-based Covid-19 response through WASH, Health, Protection and Food Assistance | Direct implementation | Somaliland |

### 3.1.1. DUTY OF CARE

In the context of the early phase of the pandemic, a key operational responsibility for all aid actors was their duty of care to their staff, colleagues, counterparts and partners;

This led to the large-scale procurement of all different types of Personal Protection Equipment (PPE). Importing and distributing masks, gloves and other equipment was complicated due to the logistical difficulties of operating in this context. All DEC Member Charities showed a significant level of commitment to their staff, developing operational protocols for activities in sectors such as Health, Nutrition and Community Mobilisation where physical presence is necessary. For areas of the aid chain where remote working is possible, working from home, limited presence in offices and systematic use of zoom, WhatsApp groups, etc., were the rule.

As it is often difficult and costly to keep the level of vigilance high, the additional resources made possible through the DEC COVID Appeal turned out to be extremely useful.

### 3.1.2. HEALTH IMPACT

While the health impact of the Covid-19 pandemic in Somalia has not been as catastrophic as feared, the pandemic may have consequences that are as yet unknown. During the field visits in Somalia, two potential Covid-19 cases were identified in Gabiley. This led to lockdown conditions being imposed in the city, and Gabiley hospital being paralysed because all healthcare personnel were mobilized in the response, leaving all other essential services under-staffed. Many programmes implemented prevention measures:

- Protocols to break transmission chains were implemented in existing aid programmes: physical distancing, the distribution of masks, and the establishment of hand washing facilities.
- Measures were implemented in health centres to reduce the risk of contamination in order not only to manage possible cases, but also, and more importantly, to provide normal health and nutrition services.

Although there is no real way of checking whether these measures had any impact on their own, it is important to state that they are part of good practice in such contexts. DEC Member Charities all adopted and adhered to the protocols suggested by the WHO and the Somali Ministry of Health and adhered to them in a relatively systemic way. Many of these measures were not part of DEC Member Charities' programmes before the start of the pandemic. As a result, many of them started to find resources by negotiating with their existing donors to prepare and cope with the unknown health risks. However, the resources from the DEC Appeal were very welcome to consolidate existing efforts. But, as the pandemic did not evolve as dramatically as feared, the implementation of many activities linked to the health response and to the development of preventive measures was slower than expected, leading to a slow pace of expenditure.

The strengthening of WASH activities in the broadest sense also had a health impact:

- Ensuring that water and soap were available in all areas where hand washing was deemed necessary to break transmission chains;
- Ensuring that there was a sufficient number of watering points to facilitate access to water without creating long queues and congestion around pumps and wells;
- The systematic and regular dissemination of prevention messages via boards, radio, telephone messaging, etc. as part of WASH programmes.

A large number of people received training in preventive measures. For example, 40 residents of Gabiley, including police officers, agents of health structures and traditional and religious leaders, received training in order to raise awareness among the city's population.

The measures taken to tackle the Covid-19 pandemic have had both direct and indirect impacts on people's health in urban and rural areas. The increase in the number of cases of malnutrition in certain regions of the country is the direct result of measures taken by NGOs due to lockdown conditions and restricted mobility, which have had a negative impact on nutrition programs. The beneficiaries of nutrition programs implemented

prior to the pandemic have therefore seen their health situation deteriorate, particularly vulnerable people, such as the elderly, children and pregnant women. In the areas where we carried out the Response Review, we observed a decrease in health assistance throughout the period of confinement. Nevertheless, some NGOs maintained their activities, particularly those who received dedicated resources from the DEC Covid-19 Appeal, such as Action Aid in Somaliland. The urgency of the situation has even prompted the continuation of the activities of these NGOs, despite the restrictions that have been imposed by the local authorities on the delivery of assistance.

Most local health actors focused on preventing the spread of Covid-19 and raising awareness among vulnerable people. As a consequence, other basic health services were neglected, especially maternal and child health services. Gaps in Covid-19 diagnostic systems were identified due to a shortage of testing equipment. In some areas, a lot of attention was focused on establishing isolation centres for Covid-19 cases. These isolation centres were not equipped to look after patients properly, particularly in terms of food and water. Thanks to the financial support provided via the DEC COVID Appeal, local partners were able to provide food in centres, which increased their acceptability.

The Covid-19 pandemic weakened the already fragile health system, removing hard-won gains from recent decades. Hospitals and health centres throughout the country are short of qualified personnel and are underfunded. The city of Gabiley has a shortage of health centres and clinics. Those that exist lack facilities and human resources, and are usually highly dependent on assistance from NGOs to conduct their day-to-day operations. As a result, the reduced mobility of NGOs negatively affected the functioning of these health centres.

### 3.1.3. NON-HEALTH IMPACT

**Food and economic security:**

The disruption of global trade and its 'trickle-down effect' on the Somali economy was felt particularly hard in urban areas and for those who depend on daily work related to trade, construction and local services (water supply, etc.). This took place in a context where food security had been weakened by years of drought and a devastating locust plague that affected the entire Horn of Africa. Further losses and displacement were caused by flash floods throughout 2020 (https://reliefweb.int/disaster/ff-2020-000221-som). In addition, the slowing down of international trade reduced the flow of remittances from the large Somali Diaspora, further exacerbating economic difficulties for the many families who depend on them.

The Covid-19 pandemic has caused disruption to the local economy. It has resulted in a deterioration of the living conditions of urban and rural populations. The lockdown and the restrictions on mobility imposed by the authorities caused a reduction in economic activities. In rural areas, there has been a reduction in exports and the marketing of animal and agricultural products. Rural households involved in livestock farming were unable to market dairy products and their livestock which resulted in a considerable loss of income. The lockdown also had a significant impact on the agricultural sector with farmers struggling to market and export their products. The closure of roads and the restrictions imposed on mobility by the local authorities resulted in major losses of income for this category of the Somali population. The impacts of Covid-19 on the agricultural and livestock sector reduced sources of income for rural populations. This led to a reduction in the availability of foodstuffs and therefore a deterioration in food security. Our discussions with people allowed us to understand the extent of the impacts of Covid-19 on food security. Some people only eat once a day due to the scarcity of food products. This adaptation strategy has negative consequences for people's health with an increase in cases of malnutrition.

In urban areas, the situation created by the political and climatic events of recent years was made worse by the measures implemented to prevent the virus from spreading, and resulted in a food shortage. The transportation of agricultural and animal products to local markets in cities across the country became difficult. Sellers of these

products lost their jobs as they were no longer able to work during the lockdown period and had great difficulty providing for their families. The entire informal sector was deeply affected by the pandemic and the containment. In addition to traders in agricultural and livestock products, street vendors also lost their jobs. These economic difficulties contributed to the deterioration of family solidarity as individualism and selfishness increased. As was the case for rural households, remittances fell sharply. This situation made it very difficult for both urban and rural families to access food and thus led to a deterioration of the food situation in these different areas. This situation is likely to lead to a deterioration of their health situation with an increase in cases of malnutrition. Faced with this precarious situation, certain categories of the population have expressed their anger, such as the khat vendors who demonstrated in front of government institution headquarters in Hargeisa and Gabiley.

One of the areas where DEC Member Charities have been particularly useful has been in pursuing their existing food security/ economic security programmes, or expanding them to new populations in their operational areas. DEC Member Charities have strengthened their engagement in economic activities, through enhancing their existing cash transfer programmes, creating new ones or developing further their engagement in agriculture and food security. Cash and Voucher Assistance (CVA) is already very common and was used by most DEC Member Charities to inject money directly into family budgets among vulnerable groups. In the Covid-19 context, CVA was widely used for agricultural programmes (seed distribution, support to land preparation, etc.). These programmes are likely to have rapidly impacted the food security of the targeted families.

The impact of agro-livestock programmes and income-generating activities and related training is less obvious at this stage as they are not short term and will need more time to effectively affect food and economic security.

**Education:**

Covid-19 has led to a deterioration in the Education sector’s situation. Teachers have not been paid and there have not been any operational grants for schools. Schools and universities were closed throughout the lockdown period. After it ended, classes reopened but the number of children per class was reduced. Despite the extra work this has induced, teachers have still not been paid and have therefore been unable to provide for their families. There have even been cases of teachers evicted from their apartments by the owners for non-payment of rent, who have therefore abandoned their classes to find new sources of income. As a result, many children of different ages have lost a significant part of the year and have been partly de-socialized by the lockdown, the closure of schools, the absence of their teachers and the economic difficulties experienced by their parents. One can note that contrary to a few cases in other countries studied by the RTRR, no DEC Member Charities implemented projects in the Education sector. This may have been a missed opportunity and could be something to explore in Phase 2.

**Female genital mutilation**

During the lockdown period, local authorities noticed an increase in FGM (Female genital mutilation) in both urban and rural areas. Unfortunately, this increase can be explained in terms of local cultural norms and the status of women in society. The school closures created an opportunity to revive the practice in certain neighbourhoods. FGM and child marriage are often regarded as a source of income for a particular category of the population even though they are negative coping strategies. Due to the context, the local authorities have been unable to take action to stop the practice. In the city of Berbera, 10 cases of FGM have been identified. In Hargeisa, in the State House camp, 20 cases have been identified by local associations. FGM has also been widely revived in rural areas of the country. In these highly sensitive areas, awareness and education are essential. Plan International's radio awareness campaign on FGM is an example of innovative good practice.

**Protection:**

Significant amounts of information on Covid-19 related to protection issues, including gender-based violence, have emerged from several sources, including DEC Member Charities. The Covid-19 crisis has caused social fragmentation, with an increase in domestic violence, family separations and divorce. Some of the people we met in the field emphasized the close interconnection between family poverty and family breakdown. It is sad that the precarious financial situation of families has become a source of conflict between spouses. Besides family conflicts, the crisis has also resulted in the deterioration of the security situation. There has been an increase in violence against women. Cases of rape and attempted rape have been reported in several urban and rural areas of the country. A high level of insecurity has continued since the lockdown. As a result, most parents are still afraid to send their children to school due to the risk of violence or rape.

Several activities have been set up, largely on the basis of existing programmes, to address these difficult issues. The impact of these activities is not yet clear, but in contexts like Somalia, where GBV is extremely frequent, these activities are always useful.

#### 3.1.4. LOCAL PARTNERS

Several DEC Member Charities are directly implementing their programmes through extremely dedicated teams of local staff. Others are working through partners with whom they have established long-term relations. DEC Member Charities' commitment to their partners was evident from the rapid supply of protective equipment (PPE) and the dissemination of clear preventive measures, often before the arrival of DEC COVID Appeal money.

Local partners are aware that they have an increasingly important role to play and have therefore intensified their efforts in providing timely and appropriate humanitarian assistance to those affected by the crisis. This has led to a change in their response strategies to humanitarian crises in order to follow guidelines imposed by local authorities and donors. Local partners worked on improving communication tools by using online meetings and participating actively in international efforts to measure progress. Local NGOs have become the primary actors of humanitarian interventions during this crisis.

Concerning the delivery of aid, the main challenge was how to reach people. Mobility and programme implementation were significantly limited due to protective measures to avoid the spread of Covid-19. In order to continue their activities in all sectors, local partners adopted alternative solutions that limited direct contact with beneficiaries. This was relatively easy with regard to food security given the well-established practice of mobile money transfers. In other sectors, such as Nutrition or WASH, which require direct field presence, local partners found it quite difficult to carry out their activities, especially those where social distancing is impossible. They therefore adopted precautionary measures such as building hand washing facilities and distributing gloves, disinfectants and soap.

#### 3.1.5. COORDINATION

Significant efforts were made to coordinate with:

- WHO, local Health Ministries and other NGOs through the Health Cluster
- UNICEF, local authorities and local NGOs through the WASH cluster
- All agencies involved in Food Aid, CVA and Livelihoods interventions through the Food Security Cluster
- IOM, local authorities and NGOs involved in IDP programmes through the CCM Cluster
- HCR, ICRC and other NGOs involved in Protection activities through the Protection Cluster, in particular the GBV sub-cluster.
- All DEC Member Charities were involved in the global overview and coordination process under OCHA, including in the preparation and the use of the OCHA Global Covid-19 process.

Involvement in the different coordination mechanisms related to the Covid-19 emergency was highly time consuming, as most adopted new working methods that avoided direct contact: conference calls, video-conferencing, etc. The prominence of "screen-based exchanges" was regularly mentioned as being very frustrating, even though remote management has been a permanent feature of aid operations in Somalia for many years. Nevertheless, these new modalities have allowed the system to function despite the difficulties.

#### 3.1.6. ACCOUNTABILITY & COMMUNICATION

As required in almost all aid programmes, DEC Member Charities have established mechanisms to promote Accountability to Affected Populations (AAP) for their Somalia programmes. These "feedback and complaints mechanisms" take various forms. They can be hotlines, which have been widely developed as part of remote management systems in Somalia for more than 10 years. Or they can be Skype or WhatsApp groups, which allow photographs to be shared, and 'Kobotoolbox'-type tools which allow geo-referenced data to be shared. Based on systems where information is recorded, before being sent to dedicated teams in charge of its analysis and then acted upon, these AAP mechanisms are relatively cumbersome and do not necessarily allow a rapid

response. Agencies also use more direct systems, with complaints and feedback boxes, and interaction with local MEAL teams deployed in the field to monitor activities and listen to views expressed by the population and their leaders. However, these systems have had to follow Covid-19 protocols and are therefore more complicated to implement.

In the specific context of Somalia, using these different AAP systems requires a lot of skills as wrongly understood messages and inadequate responses can easily lead to tension, or even security incidents. The fact that the DEC Member Charities all either developed new programmes in known areas or simply expanded programmes in their existing operational areas meant that they were able to work with populations and local leaders with whom a certain level of confidence had already been established.

# 4. LESSONS AND RECOMMENDATIONS

## 4.1. LESSONS LEARNT

Although the virus did not have the catastrophic impact that had been feared early in the year, the decision to allocate resources raised by the DEC COVID-19 Appeal to Somalia made sense as part of a 'no regrets' approach given the complexity of the situation and its potentially devastating evolution.

Faced with the pandemic, DEC Member Charities in Somalia proved to be creative and capable of adjusting to the situation. The DEC funding helped to adapt and respond to the challenges brought by the pandemic.

Adaptation strategies included:

- Adapting working methods to ensure that activities were safe and were able to run smoothly and sustainability. Remote working and increased emphasis on remote activities were the main strategies adopted.
- Adapting programmes to include activities focusing on 'making the environment and behaviour safer'. However, this came at a price. Behaviour that aimed to limit transmission of the virus prevented many people from gaining access to a whole range of basic health and nutrition needs, leaving them with a deteriorated health situation.
- Developing new programmes that addressed specific needs related to the pandemic (in terms of health and the economic security/livelihoods sectors),

Among the essential lessons learnt from of this Covid-19 response, the following should be underlined:

- Conducting awareness-raising, community engagement and sensitization activities in conjunction with local leaders and opinion makers, particularly religious leaders, is critically important. This allows staff to operate in security, and ensures that the right messages are disseminated while fake news/negative rumours are managed in the most appropriate way. This was particularly import in countering fake news and restoring confidence in health institutions and screening centres which were often accused of being sources of contamination.
- The fact that the response to this 'health crisis' was designed with a more inclusive and holistic approach, taking into account not only the health consequences of the pandemic, but also its impact on other sectors, proved essential. Indeed, the major impact of the crisis in Somalia was socio-economic rather than health-related.
- The importance of supporting women leadership in the response, due to their role in the health system and at the family level, once again demonstrated its importance but also the difficulties to implement it.
- The high level of agility and the rapid communication that took place between the field and the UK, and between the DEC Member Charities and the DEC Secretary, proved very useful and were highly appreciated by all the stakeholders involved.

## 4.2. KEY RECOMMENDATIONS

**RECOMMENDATION N°1:**

Actively pursue efforts to understand the evolution of the pandemic in order to remain relevant in all activities and in order to remain alert and able to react in the event of a new wave. In addition to regular sources of information (e.g., the WHO web site, special sites such as ihttps://ourworldindata.org/coronavirus-data?fbclid=IwAR3J4TLJjPrcHWOyOM3jUvCOQl4v3JwJaRLoCBirUPFV449ADhLMCCxHibc, etc.), it may be useful to also use a series of other less common sources of information in contexts where there is a lack of data, the main one being information from cemeteries. In Islamic countries, any wave of extra mortality is immediately perceived as it leads to an increase in burials.

**RECOMMENDATION N°2**

As most health measures and hygiene messages are valid for many different contagious risks, ensure that they are fully incorporated into routine protocols (in health structures and schools, for instance) and in the creation of rapid response capacities in case there is a resurgence of Covid-19 or for any other epidemic outbreak. The most relevant measures concern personal hygiene and the establishment of hand washing stations as soon as there is a public health alert. All measures designed to protect health workers will will continue to be relevant in other health crises as they are both critical actors of the response and are frequently agents of contamination.

**RECOMMENDATION N°3**

For the population, the dedication of DEC Member Charities and their local partners created a sense of "togetherness", despite the lockdown and limitations to mobility in the field. The trust that has been established during the Covid-19 response should be exploited to prepare the ground for the vaccination phase. This means engaging early with health structures, local leaders and opinion makers (including religious leaders). With the discussions at WHO, the Access to COVID-19 Tools (ACT) Accelerator and the international decision to make resources available for worldwide access to vaccines, there is hope that vaccines will soon be available to the Somali Ministry of Health.

**RECOMMENDATION N°4:**

Pursue efforts to support food security through CVA and the injection of cash into the economic system (cash for work, etc.) with a specific focus on the elderly.

**RECOMMENDATION N°5**

Reinforce monitoring systems on protection issues and develop response capacities. Efforts to improve feedback and complaints mechanisms are necessary. However, there is a need to improve understanding of what 'feedback' is and what a 'complaint' is. In both cases, however, local social scientists could help to understand and deal with issues.

**RECOMMENDATION N°6**

Explore opportunities to provide assistance in the Education sector either through support to teachers, the development of remote teaching systems or by supporting children who are at risk since the school closures.

# 5. ANNEXES

## ANNEX 1: AGENCIES CONSULTED

### DEC MEMBER CHARITIES

Action against Hunger
Action Aid
Islamic Relief Worldwide
Plan International

### OTHERS

OCHA
WHO
Ministry of Health

# ANNEX 2 – ANALYSIS FRAMEWORK

| RTE key questions | Lines of enquiry / Sub-questions | | | Related CHS criterion | indicators/info to collect | Desk R. | Ext. S. | KII | Field obs. | FGD |
|---|---|---|---|---|---|---|---|---|---|---|
| **Objective 1 /** | **Better understand the impacts of Covid 19 pandemic on contexts and needs (+global level on organisations- no flight, HR problems, etc.)** | | | | | | | | | |
| **Objective 2 /** | **Analyse adaptations already done and still needed in humanitarian programming in each country (and at HQ level?)** | | | | | | | | | |
| ***Key Q 1 / What has been the impact of covid 19 on DEC members (as an organisation) and their operational environment (context and needs)?*** | **Context & needs** | **L1** | Main measurable / commonly agreed consequences of the pandemic on each context (health - e.g. situation of the health system, caseload - and non-health related - e.g.specific focus on food security, livelihood, domestic violence, etc. impact on air traffic, on mobility, on supply chain, logistics). More broadly - political / economical consequences of the pandemic / how it has influenced key stakeholders and perhaps influenced power dynamics. | C1 | nb of covid cases (country/camp levels) + mortality and morbidity rate if available | X | x | | | |
| | | | | | Impact on the country health system and staff | X | X | | | |
| | | | | | economic indicator at HH level | | X | | | |
| | | | | | dynamics in food markets | | X | X | x | |
| | | | | | dynamics in access to labor | | X | X | x | |
| | | | | | level of domestic violence | X | X | X | | |
| | | | | | Evolution of level of poverty / food insecurity / malnutrition? | x | x | x | | |
| | | | | | other health related indicator ??? | | x | | | |
| | | | | | monitoring system in place | x | | x | | |
| | | **L2** | Monitoring mechanisms in place to follow the sanitary situation. Who with what system in place. Data accessibility and reliability - to what extent is the information trusted by key stakeholders? Level of visibility of aid agencies. | C1 | Official and non-official Information sources | | x | x | | x |
| | | | | | Covid related data collected (at macro and micro levels) | | x | x | | x |
| | | | | | Reporting frequency and reliability | | | | | |
| | | | | | Existing covid specific info sharing coordination forums | | | | | |
| | | **L3** | Measures taken by local authorities and their impact on aid actors and their ability to deliver. What coping mechanisms developped by aid agencies? What consequences on their programme? For the pop.? | C1, C2, C3 & C6 | Official communication from health authorities, or else providing detailed information - reports related to impact of covid 19 and protective measures on aid activities (if available) - interview with local actors on mitigating measures taken to reduce the impact of such measures. Interview with local actors (aid workers and beneficiaries) on measurable / perceived consequences. | | x | x | | |
| | **Coordination** | **L4** | Impact of the covid 19 crisis on coordination (3 levels to look at - a. with national authorities; b. with the wider aid community; c. among DEC members) - What level of integration with gov. response? How has it influenced humanitarian programming at country level. | C6 | Presence of covid specific coordination mechanisms regrouping all key stakeholders (Nat. authorities, Aid community, DEC members) / Minutes of coordination meetings - joint analysis and response - integrated vision and action plan - Joint M&E | | | X | X | |
| | **Inclusiveness & Accountability toward local pop.** | **L5** | impact on access to the field and level of participation of local populations in the design, the decision process the follow up. Adaptation of accountability mechanisms toward the local pop. Communication mechanism to support feedback and regular exchanges between aid agencies and local communities / is it stronger? Weaker? What lessons learnt? | C4 & C5 | Level of interaction with local actors / involvement in the primary assessment / needs analysis and response design; Communication means employed between communities and aid agencies / frequency and nature of exchanges; result of this interraction. | | | X | X | X |
| ***Key Q2 / What are the measures already taken or still needed to adapt to the new working environment?*** | **Duty of care** | **L6** | Measures taken to protect aid workers (int. & nat.). Home based work - temporary contract suspension - training, equipment, etc. | C3 & C8 | Internal guidance / manual for staff | x | | x | | |
| | | | | | specific measures for international & national staff (work location, workload, work suspension, specific training, equipments, etc.) | x | | x | | |
| | | | | | observed changes in behaviour | | | | x | |
| | | | | | Observed changes in the relationship with communities (access, monitoring, project design, etc.) | | | x | x | x |
| | | | Due diligence measures applied fort local implementing partner. Evolution of the role played by local actors / has it increased? In what ways? Do they play a bigger role? Assume more responsibilities? How is this impacting on their exposure to risks? How is this handled? | C8 | Specific information, addendum to contractual agreement, training, specific monitoring, communication support, equipment provided, etc. | X | | X | | |
| | | | Specific measures taken to protect the local population / beneficiaries. | C4 | Specific guidance | X | | | | |
| | | | | | Remote management | X | | X | X | |
| | | | | | Communication support and initiatives | X | | X | X | x |
| | | | | | Specific equipment | | | X | | |
| | **General Adaptation** | **L7** | What are the changes brought (or yet to be brought) to existing humanitarian programmes in relation to the covid 19 pandemic? What has changed the most in the way humanitarian actors work? What impact on the localisation agenda if any? | C1 | changes in caseload (new refugees? Increased nb of vulnerable p.?) | x | x | | | x |
| | | | What are the changes on more developmental programmes? | C2 | changes in intervention logic (Obj., Timeline, Activities, …) | x | | x | | |
| | | | | C4 & C5 | changes in accountability mechanisms | x | | x | | x |
| | | | | C3 & C6 | changes in roles and responsibilities for local staff/partner, if any (localisation) | x | | x | | |
| | **Impact on health response** | **L8** | Specific changes brought to health interventions in connection with covid 19. Main challenges and opportunities faced. Consequences of these changes (in terms of relevance, efficiency, effectiveness of the projects). | C1 | Targeted needs of covid-specific programmes | x | | x | | |
| | | | | | Response timeliness | | | | | |
| | | | | C2 | Logistic & financial implications | | | x | x | x |
| | | | | | Risk identification and management | | | | | |
| | | | | | HR implications | | | | | |
| | **Impact on non health response** | **L9** | Specific changes brought to non-health interventions in connection with the covid 19. Main challenges and opportunities. Main consequences of these changes (in terms of relevance, efficiency, effectiveness of humanitairan interventions). | C1 | Targeted needs of covid-specific programmes | x | | x | | |
| | | | | | Response timeliness | | | | | |
| | | | | C2 | Logistic & financial implications | | | x | x | x |
| | | | | | Risk identification and management | | | | | |
| | | | | | HR implications | | | | | |
| | **MEAL** | **L10** | Covid specific M&E related challenges faced by DEC members and their local partners. How did they address those challenges? Innovative solutions found. | C7 | Adapted solution to limited access and remote management approach. Role played by local partners. Collected data reliability. Ability of the M&E system in place to fulfil its function and be trusted enough to be used as decision tool. | X | X | X | | X |
| | **Risk management** | **L11** | Covid 19 related risk identification and mitigation measures adoption. Was it accurate? Was it adapted? Any lessons learnt on risk management? | C1 & C2 | Comparative analysis with other sources of information / risks matrix provided by the UN, donor agencies, official sources; Relevance of identified mitigation measures. Identified short comings. | X | X | X | | |
| | **Cross-cutting issues** | **L12** | Covid specific measures taken regarding gender and environmental issues. Any lessons learnt that can benefit the group? | C1 & C3 | Environment and Gender policy in place. Level of awareness of local teams and local population. Level of implementation / integration in the project. | X | | X | X | X |
| **Objective 3 /** | **Facilitate collective thinking about lessons and innovative ideas between members in each country + at global level** | | | | | | | | | |
| ***Key Q3 / What are the lessons learnt and innovative ideas in each country that can benefit the group?*** | This part of the RTE is more prospective than retrospective - the response to the two first key questions (1 & 2) should provide the elements that will then feed the collective learning process. The country exercises (Restitution / consolidation workshop and reporting) should be primarily operation focused - The consolidation and co-construction part, involving the tactical level, should however be more strategic focused to meet expectations.<br>While looking at lessons learnt the RTE will answer the following questions too.<br>• What differences has it made to members to access the DEC funding (and ultimately to people)? What difference has it made / financial / programmatic?<br>• Was DEC proactive enough or reactive enough? Was it a struggle for partners to access DEC funding or respond to this appeal? DEC funding mechanism is flexible – but do members realise that? Do they know how to optimise this flexibility?<br>• How ready were DEC and its members as a collective to respond?<br>• Any multiplying factor(s) that might have been generated/initiated (any leverage effect) by DEC appeal?<br>• What consequences the delay to respond (from March to July) might have had? Was it a bad or a good thing? | | | | | | | | | |

## ANNEX 3 – GENERAL QUESTIONNAIRE

| RTE key questions | DEC Sec | DEC members - strategic level | DEC members - country level | DEC members local partners | Local actors (authorities and pop.) | Other IA organisation | General questionnaire |
|---|---|---|---|---|---|---|---|
| ***Key Q 1 / What has been the impact of covid 19 on DEC members and their operational environment (context and needs)?*** | | | X | X | | X | 1.1 What are the main consequences of the pandemic in your country/region (Political, economical, in terms of power dynamics?) What are the main consequences in terms of health and non-health related - e.g. food security, livelihood, domestic violence, etc.? What was the impact in terms of mobility, on human resources, on supply chain & logistics? On Security? |
| | | | X | | X | X | 1.2 How is the sanitary situation being monitored - who with what system in place and what resources - how accessible and reliable the information is at country level? |
| | | | X | | X | X | 1.3 What are the measures taken by the Authorities and their impact on aid actors and their ability to deliver? How did aid agencies cope with the safety measures and movement restrictions? What consequences on their programme / for the pop.? |
| | | | X | X | | X | 1.4What was the impact of the covid crisis on humanitarian programming and coordination (3 levels to look at - a. with national authorities; b. with the wider aid community; c. among DEC members) - What leassons learnt? |
| | | | X | X | X | X | 1.5 What is covid 19 impact on participation of local population to the project cycle? What is covid 19 impact or influence over accountability mechanisms? Over access to information / communication with aid actors? |

| RTE key questions | DEC Sec | DEC members - strategic level | DEC members - country level | DEC members local partners | Local actors (authorities and pop.) | Other IA organisation | General questionnaire |
|---|---|---|---|---|---|---|---|
| ***Key Q2 / What are the measures already taken or stiil needed to adapt to the new work environment?*** | | X | X | | | | 2.1 What are the measures in place for the safety of aid workers (int. & nat. staff)? |
| | | | X | X | | | 2.2 What are the measures in place for the safety of local implementing partners? Has the role of local partners evolved during the pandemic? If yes to what extent? What has changed? |
| | | | X | | X | | 2.3 What are the measures in place for the safety of the local populations / beneficiaries? |
| | | X | X | X | | X | 2.4 What are the main changes brought or still required to existing humanitarian programming as a consequence of the covid 19 pandemic? What has changed the most in the way humanitarian actors work? Has the pandemic contributed to encourage or reinforce the localisation process for example? |
| | | | X | X | | X | 2.5 What are the most important changes to health interventions in connection with covid 19? What are the main challenges and/or opportunities due to these changes? What impact in terms of relevance, efficiency, effectiveness of humanitarian interventions? |
| | | | X | X | | X | 2.6 What are the specific changes brought to non-health interventions in connection with the covid 19? What are the main challenges and/or opportunities due to these changes? What impact in terms of relevance, efficiency, effectiveness of humanitarian interventions? |
| | | | X | X | | | 2.7 What are the main M&E challenges faced by DEC members as a consequence of the pandemic? Was a solution found? Did it provide deliver according to expectation? What lessons learnt if any? |
| | | | X | X | | X | 2.8 Were covid 19 related risks well identified and were mitigation measures adpated / efficient? What are the key lessons learnt during this pandemic situation from an operational point of view? If any. |
| | | | | X | X | | 2.9 What does exist in terms of complaints and feed back mechanisms |
| | | | X | X | | | 2.10 What were the main specific measures taken regarding gender and environmental issues in relation to the covid crisis? Any lessons learnt worth sharing? |

| RTE key questions | DEC Sec | DEC members - strategic level | DEC members - country level | DEC members local partners | Local actors (authorities and pop.) | Other IA organisation | General questionnaire |
|---|---|---|---|---|---|---|---|
| ***Key Q3 / What are the lessons learnt and innovative ideas in each country that can benefit the group?*** | | X | X | | | | 3.1 What differences has it made to members to access the DEC funding (and ultimately to people)? What difference has it made / financial / programmatic? |
| | | X | X | | | | 3.2 Was DEC proactive enough or reactive enough? Was it a struggle for partners to access DEC funding or respond to this appeal? DEC funding mechanism is flexible – but do members realise that? Do they know how to optimise this flexibility? |
| | | X | X | | | | 3.3 How ready were DEC and its members as a collective to respond? |
| | | X | X | | | | 3.4 Any multiplying factor(s) that might have been generated/initiated (any leverage effect) by DEC appeal? |
| | | X | X | | | | 3.5 What consequences the delay to respond (from March to July) might have had? Was it a bad or a good thing? |

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