COUNTRY REPORT / YEMEN

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ABDULLAH ALI GAMAL AL KAFF
VÉRONIQUE DE GEOFFROY

Groupe URD
Urgence . Réhabilitation . Développement

DEC CVA REAL-TIME RESPONSE REVIEW: YEMEN

:

COUNTRY REPORT

DISASTERS EMERGENCY COMMITTEE

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LIST OF ACRONYMS

COVID-19	Coronavirus 19 Disease
CHS	Core Humanitarian Standard
DEC	Disasters Emergency Committee
FSL	Food Security and Livelihood
HQ	Head Quarter
HH	House Hold
IDP	Internally Displaced Person
MEAL	Monitoring, Evaluation, Accountability and Learning
MHPSS	Mental Health and Psycho Social Support
MoPIC	Ministry of Planning and International Cooperation
MSP	Minimum Service Package
RTRR	Real Time Response Review
PPE	Personal Protective Equipment
SCUK	Save the Children UK
SCMCHA	Supreme Council of Management and Coordination of Humanitarian Affairs
WHO	World Health Organisation
URD	Urgence Rehabilitation Développement
UK	United Kingdom
WASH	Water Sanitation and Hygiene

SUMMARY OF ANALYSIS & RECOMMENDATIONS

SYNTHESIS OF ANALYSIS BASED ON THE CHS COMMITMENTS & CRITERIA

	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	Although information about humanitarian needs in Yemen is incomplete, it is widely recognised that they are huge and diverse, related to the war situation, to direct impacts of Covid-19 on public health and to the indirect impact of Covid-19 on the economy and food security. In this context, humanitarian support provided by DEC Member Charities is crucial, even though insufficient.
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	One of the main issues in Yemen is the effectiveness of aid, linked to the capacity of humanitarian actors to overcome the multiple administrative, logistic and security constraints. In the north, some programmes have not been able to start and many are facing delays. In the south, and despite all the constraints, all projects are on course to achieve the targets specified in the program proposals. Working with a local partner facilitates access and helps to overcome some of the difficulties international actors face.
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	No negative impact of aid has been recorded during the Response Review but longer-term impacts of aid in terms of community resilience are difficult to achieve given that the country is near collapse. Preparedness efforts could be strengthened if funds were available/adapted, e.g., for pre-positioning stocks.
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	Most of the DEC partners rely heavily on community approaches for their programmes, and even more so given travel restrictions. Nearly all distribution activities have applied a community-based targeting and delivery approach. DEC Member Charities have used alternative means to deliver information and awareness messages to beneficiaries using social media, radio, text messages, etc.
5	Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.	Complaints are welcomed and addressed	The mechanisms for receiving complaints from beneficiaries have been affected during the Covid-19 crisis as direct communication lines have stopped, leaving only the hotline and WhatsApp messages, which has led to a decrease in the number of complaints received from beneficiaries.
6	Communities and people affected by crisis receive coordinated, complementary assistance.	Humanitarian response is coordinated and complementary	Coordination with the local authorities both in the north and the south is a prerequisite in Yemen. Coordination with the wider aid community is functional and DEC partners are active players in the cluster system, but there is very little coordination among DEC Member Charities working in Yemen, leading to missed opportunities for better complementarity and mutual support.
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	DEC Member Charities' engagement with the DEC RTRR underlines their willingness to learn and improve. Changes already introduced for phase 2 prove their ability to do so.
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	Duty of care, as implemented by DEC Member Charities in this response, has been central in order to minimise the risk of Covid-19 transmission amongst staff and partner organisations. As in other countries, working from home and using new distance-learning or distance-supporting approaches has introduced new ways of working that will certainly last much beyond the Covid-19 pandemic.
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	The RTRR did not collect any information about misuse of resources. However, in this case, where the Covid-19 pandemic has coincided with the decline in global support for the humanitarian response in Yemen, it is imperative for humanitarian partners in Yemen to intensify their coordination and cooperation to exploit resources economically for the benefit of the largest possible number of affected people.

KEY RECOMMENDATIONS

STRENGTHENING COMMUNICATION WITH COMMUNITIES

- Strengthening the capacities of local community organizations, community committees and volunteers and increasing their participation in the planning and implementation of humanitarian projects is key to ensuring that humanitarian aid is delivered quickly, efficiently and on time.
- Strengthen awareness-raising and communication within communities about safe access to available services and about containing, preventing and responding to Covid-19, as well as positive coping mechanisms. This should be coordinated between Clusters and partners to ensure timely and safe information sharing. Alternative methods of delivering humanitarian assistance should be considered for all activities to avoid social gatherings, such as using phones for outreach and using megaphones and community focal points to disseminate messages.
- Ensure different forms of media are used to promote awareness about hygiene and health services, such as radio announcements, TV announcements, text messaging, social media, and mass awareness campaigns via megaphones, posters and leaflets in public places.
- Increase community outreach to disseminate key health and Covid-19 messages on symptoms, prevention and transmission methods. Key messages should be established by means of a needs assessment to determine the knowledge gaps and rumours among the affected population.
- Establish mechanisms with teachers, parents and youth leaders to communicate Covid-19 risk, prevention and mitigation messaging, in language tailored to different age groups and literacy levels. This includes supporting mobilized youth to play a positive role in this regard.
- Continue to strengthen and improve new monitoring approaches with communities in the context of Covid-19 and restricted social interaction.

ADVOCATING FOR HUMANITARIAN ACCESS & FUNDING

- In order to work in Yemen, it is necessary to negotiate access at local and national levels. It is also necessary to have support from donors, states and the international community. Many NGOs, including DEC Member Charities, advocate permanently in order to be able to implement their programmes in such a complex context, even though DEC funding does not include so-called advocacy activities.
- To ensure that the humanitarian response is successful, humanitarian partners must advocate and convince local authorities of the importance of awareness-raising activities and transferring vital information to affected people to help them cope and protect themselves from the spread of Covid-19.
- Advocate vis-à-vis the relevant authorities and stakeholders for supply chain lines to remain open and uninterrupted, to ensure that key commodities remain available in local markets. Advocacy can also be taken to a higher level regionally with concerned parties to ensure that barriers to the supply chain are minimized and/or eliminated.
- Special attention should be given to the situation in the north. As Covid-19 is no longer recognized by the authorities, it has become much more challenging to negotiate agreements with the SCMCHA to implement Covid-19-related programmes. DEC Member Charities could use their leverage through the Foreign, Commonwealth and Development Office (FCDO) to raise this concern globally and at the national level with the OCHA Humanitarian Coordinator as well as with the SCMCHA.

STRENGTHENING SUPPORT TO IDPS

- Coordinate with other sectors to provide holistic and comprehensive services to displaced communities who are the worst affected by Covid-19. In particular, advocate for health agencies to increase their presence and operations especially within IDP sites. Support isolation/quarantine centres and promote equal access for all groups and health cases without discrimination in all health facilities.
- Support vulnerable IDPs in camps, quarantine centres and other locations without any water source with either in-kind water trucking or cash/vouchers. These activities should take place in addition to the rehabilitation of existing water schemes to facilitate access to safe and adequate water sufficient for personal and domestic purposes, and incorporate Covid-19 precautionary measures.
- Lobby health partners to extend health services to all IDP sites and enhance the capacity of health facilities across the country.

CONTINUING TO MONITOR AND ADAPT TO THE EVOLVING SITUATION

- Continuously monitor key economic indicators, such as the depreciation of the Yemeni riyal against the US dollar, replenishment rates, foreign reserves, importers' access to letters of credit, trends in remittances and prices of key food commodities, to ensure humanitarian interventions are relevant and linked to the overall economic context, and engage in contingency planning in case the situation deteriorates further, making it difficult to operate.
- Increase funding and resources for livelihoods recovery to address the secondary impacts of Covid-19 on jobs and incomes and promote alternative income-earning opportunities that can be sustained even during the Covid-19 pandemic. Such actions should be simple, appropriate and should support local markets.
- Education partners need to think of a variety of new and innovative strategies that can help children continue learning and mitigate the risk of increased dropouts and support children to re-enrol in schools. Outreach activities need to be undertaken to ensure students return, educational activities should be complemented with psychosocial support, and education and hygiene materials should be provided to children and teachers.
- Authority approvals/permissions are becoming increasingly difficult and very lengthy processes in Yemen which, on reflection, has meant that the fact that Phase 1 is a fixed 6-month period is quite challenging for implementation in Yemen.
- Ensure contingency planning and flexible funding (e.g., crisis modifier) help to adapt and respond in a timely manner to evolving needs and unpredictable situations. This is particularly important in the context of Yemen and is encouraged by the DEC secretariat.

1. INTRODUCTION

1.1. 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[1].

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[2].

In the end, the funds raised by the Coronavirus 2020 Appeal were allocated to 14 DEC Member Charities 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 (14 June 2020 - 31 January 2021). A second allocation was made in November and can be used for either Phase 1 or Phase 2, or both. Phase 2 programmes will run from 1 February 2021 to 31 January 2022. The DEC insists that the operations that it funds should be accountable to the British public, who donated generously to the Appeal, and should contribute to learning and the continuous improvement of humanitarian practices.

1.1.2. THE CONTEXT IN YEMEN

At the time of the country prioritization for this appeal, Yemen was ranked 9 out of 189 countries in the INFORM Covid-19 Risk Index[3] as the risks of an outbreak were considered very high due to a series of vulnerabilities.

The internal conflict between Houthi / Ansar Allah forces and forces loyal to the government of Abdrabbuh Mansour Hadi has led to a critical situation for the Yemeni population. For many humanitarian actors, the population is suffering more now than at any time in recent history, with over 24 million Yemenis, 80 per

[1] Commitment from the UK government to contribute £1 of UK aid for every £1 donated to a UK Aid Match charity appeal by an individual living in the UK, up to £2 million.
[2] As data about the prevalence of Covid-19 were not available and/or accurate in most of the countries when the decision was made, the DEC secretariat used the INFORM COVID-19 Risk Index and the Global Health Security Index in order to identify the countries most at risk from the health and humanitarian impacts of Covid-19.
[3] https://publications.jrc.ec.europa.eu/repository/bitstream/JRC120799/jrc120799_pdf.pdf

cent of the entire population, in need of humanitarian assistance and protection to cope in their day-to-day lives.

The country's health system has been weakened and has very limited capacity to cover basic health needs. Only half of Yemen's pre-war health facilities are functional, and there is a widespread shortage of essential medical equipment. Over 3 million individuals are displaced, including 1.3 million living in IDP camps. More than half the Yemeni population, 17.5 million people, are in need of enhanced access to water, sanitation and hygiene (WASH) services. 54 districts have acute WASH deficits; and 46 districts are at high risk of cholera.

The first Covid-19 case was detected in Yemen on 10 April 2020, and between April and July, when decisions were being made about programmes, there were 484 deaths and 1,695 confirmed cases (WHO, 28 July). In November 2020, at the time of the Review, the total number of deaths is 605 for 2,077 confirmed cases (WHO, 26 November).

Covid-19 mitigation measures have included movement restrictions between governorates and along the borders with neighbouring countries (Saudi Arabia and Oman), closed seaports and airports, as well as partial lockdowns and curfews in Sana'a, Aden and other affected governorates.

The economic downturn following the conflict has resulted in the destruction of social protection networks and basic services. This situation, combined with the misuse of many key agricultural and household resources for khat production and consumption is contributing to critical conditions of food security and nutrition, which have been worsened by the Covid-19 mitigation measures.

Despite this critical humanitarian situation, delivering aid in Yemen is extremely challenging. Numerous constraints already existed before the Covid-19 pandemic, ranging from insecurity to administrative restrictions and logistics problems. Humanitarian workers have been denied travel permits to different cities and the parties to the conflict impose arbitrary and excessive restrictions. The UN Panel of Experts on Yemen has criticised all parties to the conflict for increasing the suffering of civilians by impeding the delivery of humanitarian assistance. The question of access to communities has become even more complex in the current Covid-19 situation.

1.2. OBJECTIVES AND SCOPE OF THE REVIEW

1.2.1. OBJECTIVES

The RTR aims at supporting real-time collective learning in order to identify lessons and adjustments for the second phase of the response. The three specific objectives of the RTR are:

- **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 that have emerged from the response to the Covid-19 pandemic.

At country level, the RTR is directed at DEC Member Charities and their partners in order to support the improvement of their response to the pandemic during Phase 2. Each of the country reports will then feed

into a global analysis directed at DEC HQ Member Charities and the wider humanitarian community, which will aim to identify the main lessons learned for the response to the Covid-19 pandemic or similar crises.

1.2.2. SCOPE OF THE REVIEW

In Yemen, projects funded by the DEC are spread across the country in 9 different locations, both in Northern and Southern parts of the country. Six DEC partners, already working in the country prior to the pandemic, are being funded by the Covid-19 Appeal and are implementing programmes directly or through local partners.

Map 1 – DEC-funded project in Yemen

Table 1: Funded organisations and sectors

Organisations	Sectors	Location
Action against Hunger	Health & nutrition	Abyan
British Red Cross	Wash & Livelihoods	Sana'a city
CARE International	Health & Wash	Amran
OXFAM	Health & Wash	Sa'ada and Hajjah
Save the Children	Health, Nutrition, Protection, Wash	Lahj and Hajjah
Tearfund	Food and Wash	Abyan, Aden & Taiz

The funded programmes are providing a wide variety of humanitarian assistance, including WASH, Health, FSL, CVA and Nutrition, implemented by 6 DEC Member Charities, with four out of six being implemented directly, while the other two are being implemented via local partners. The Covid-19 Appeal has placed major emphasis on WASH and Health activities aimed at mitigating the primary impact of Covid-19; they represent 56% of all activities. Other activities have been implemented to reduce the secondary impact of Covid-19, including Multipurpose Cash Assistance (17%), Food (15%), Nutrition (8%) and Protection (3%).

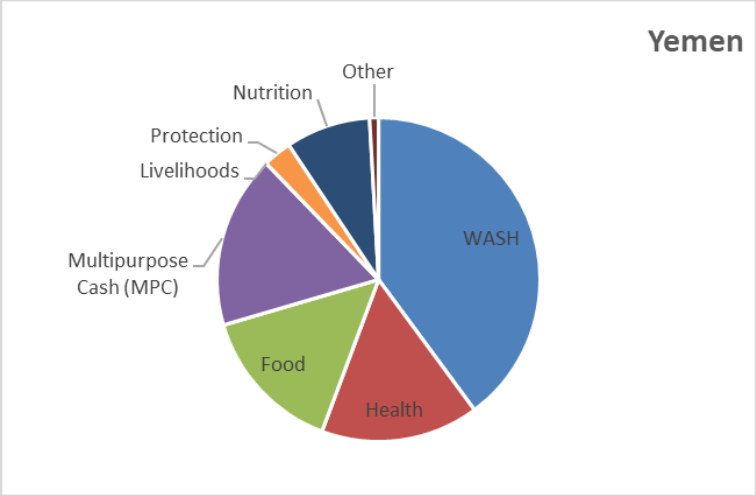


Chart 1 – Budget allocation per sector in Yemen

The activities implemented by DEC Member Charities in Yemen include:

- Health & Nutrition; preventing and treating Severe and Moderate Acute Malnutrition, supporting health facilities with training, delivery of PPEs, medical supplies, incentives for health workers, operational costs, maintenance and providing health facilities with primary health care services.
- WASH; providing WASH supplies (disinfectants and cleaning materials) to HHs as well as health facilities, distributing hygiene kits to affected HHs and IDP camps, rehabilitating and maintaining WASH facilities including water scheme networks, quarantine centres and health facilities, conducting Covid-19 awareness campaigns and installing latrines and wash stations.
- FSL; providing cash assistance and distributing food baskets to the most vulnerable families impacted by the crisis.
- Protection; providing case management services and mental health and psychosocial support (MHPSS) for Covid-19 affected children and caregivers in the health facilities.

1.3. METHODOLOGY AND LIMITATIONS

1.3.1. SOURCES OF INFORMATION

The team collected information through:

- A desk review of relevant literature, evaluations and data sources provided by the DEC secretariat and gathered at country and global levels[4];
- Country- and field-level interviews with relevant stakeholders, including field staff (15) and local authorities (5);
- Discussions with affected populations (5) in Lahij governorate
- Direct observation of Save the Children programme activities in Lahij governorate where Al-Anbouh health centre was visited.

Table 2: Typology of interviews in Yemen[5]

Type of interviewees	Nb	Type of interview
Staff of DEC members		Face to face interview
	15	Remote interview
Representatives of local authorities	3	Face to face interview
	2	Remote interview
Community members	5 Lahij	Focus group discussion Face to face interview

The preliminary results of the RTR were shared during an on-line meeting on 2 December where lessons learnt were discussed and co-constructed[6].

[4] The DEC team gave the review team access to Covid-19 appeal background information and project documentation via a tailored access to Box.
[5] See list of interviewees in Annex 3
[6] See attendance list in Annex 4

1.3.2. CHALLENGES AND CONSTRAINTS

Limited direct observation due to travel constraints: The combination of conflict and a pandemic has made access to the field in Yemen even more challenging than before the pandemic. Getting travel permits for the North would have taken too long and travelling to the South was possible only in Lahij, AL-Maqatrera district, where Al-Anbouh Health Centre (supported by Save the children with DEC funds) was visited. The plan had been to conduct a field visit to Abyan governorate, Khanfar district, but due to the escalation of the conflict between Hadi's forces (IRG) and the Southern Transitional Council (STC), the visit had to be cancelled and the interviews were carried out via phone.

Limited involvement of affected populations. Field visits and interactions with communities were therefore very limited, which affected the quantity and quality of information gathered. The consultant gathered feedback from communities about programmes and about their priority needs only in one place, limiting the representativity of results.

Information gaps / problems of data quality / no generation of new data. The review team collected and compiled relevant available information. But no information about Covid-19 cases is available for the Northern governorates and numerous unknown factors remain regarding the actual figures for Covid-19 cases and deaths in Yemen. Qualitative information has been prioritized as it is often best suited to identifying difficulties, challenges, solutions and good practices.

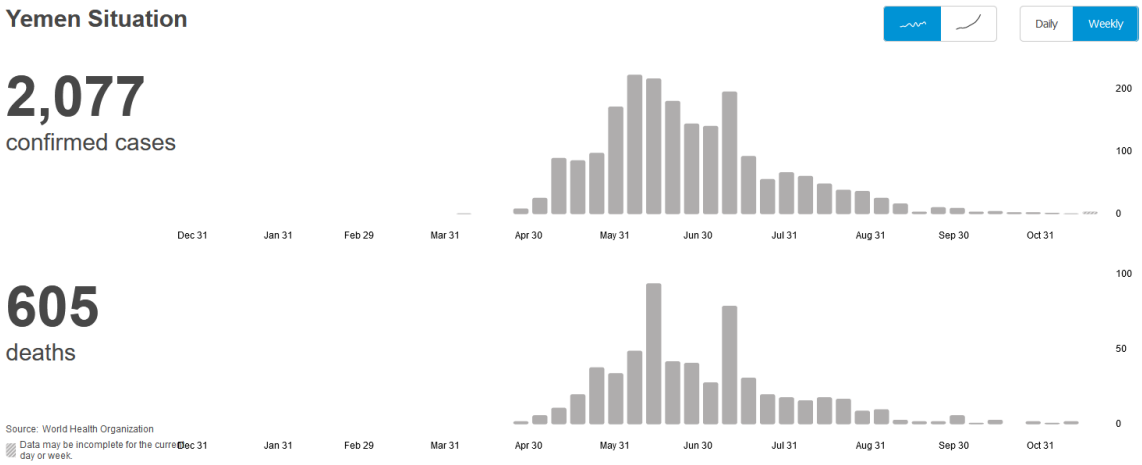
2. MAIN FINDINGS

2.1. KEY QUESTION 1 / IMPACTS

2.1.1. HEALTH IMPACTS

The pandemic's impact on Yemen was expected to be severe. Projected figures, based on models derived from China and Europe initially predicted some 85,000 virus deaths, approaching the number reported killed during the country's ongoing armed conflict[7].

Chart 2 – Confirmed cases and deaths in Yemen



The total number of reported and confirmed deaths (605 deaths for 2,077 confirmed cases on 28 November 2020, WHO) is far below predictions. Measures taken by the authorities and support from aid actors in disseminating prevention messages probably helped to contain the outbreak. But the lack of data from the Northern part of the country, where the authorities did not report any cases, as well as the lack of accurate country-wide reporting, shortages in testing, and barriers to accessing healthcare have certainly led to underreporting of the Covid-19 caseload.

The case fatality rate is among the highest in the world (almost 30%), nearly four times higher than the global average. But if more cases were reported, the ratio would proportionally decrease. This ratio can also be explained by the fact that people are delaying seeking treatment until their condition is critical because of fear of stigma, difficulties in accessing treatment centres, and the perceived risks of seeking care.

A study aiming to quantify excess mortality in Aden Governorate using geospatial analysis techniques on cemeteries[8] estimated around 1,500 excess burials from April to July, and 2,120 up to 19 September, corresponding to a peak weekly increase of 230% from the counterfactual (the same period in previous years). The actual figures of the Covid-19 caseload (deaths and cases) are therefore probably much higher than the figures that have been reported.

[7] ACAPS. COVID-19 -Impact on Yemen. (2020).
[8] Excess mortality during the COVID-19 pandemic in Aden governorate, Yemen: a geospatial and statistical analysis, Koum-Besson et al., London School of Hygiene and Tropical Medicine, London, United Kingdom.

As reported by various interviewees, the pandemic has had other impacts on health. Some health facilities were closed in May-June and many of them have experienced shortages of medicines and personal protection equipment for health staff. This, combined with the fear of being infected in health facilities, led to a drop in attendance and consultation, which, in turn, has had an impact on the level of immunization, delays in the diagnosis or treatment of chronic diseases, etc.

2.1.2. NON-HEALTH IMPACTS

Restrictions of movement between governorates and across the borders with neighbouring countries, the closure of seaports and airports, as well as partial lockdowns and curfews in Sana'a, Aden and other affected governorates have had a direct impact on the economy, limiting exchanges within and outside the country.

Remittances from the Yemeni diaspora are vital to the survival of millions. With many Yemeni expatriates affected by the drop in oil revenues due to the oil crisis and by the impact of Covid-19 on labour markets in many countries, remittances are projected to fall by up to 70 percent[9]. Various interviewees already mentioned this drop in remittances as an indirect but critical impact of the pandemic at the household level.

As a result, the ability of households to cope with new and intensifying shocks has been weakened. The erosion of households' purchasing power has affected access to food and agricultural inputs. A high percentage of households are highly reliant on humanitarian food assistance to meet their daily food needs.

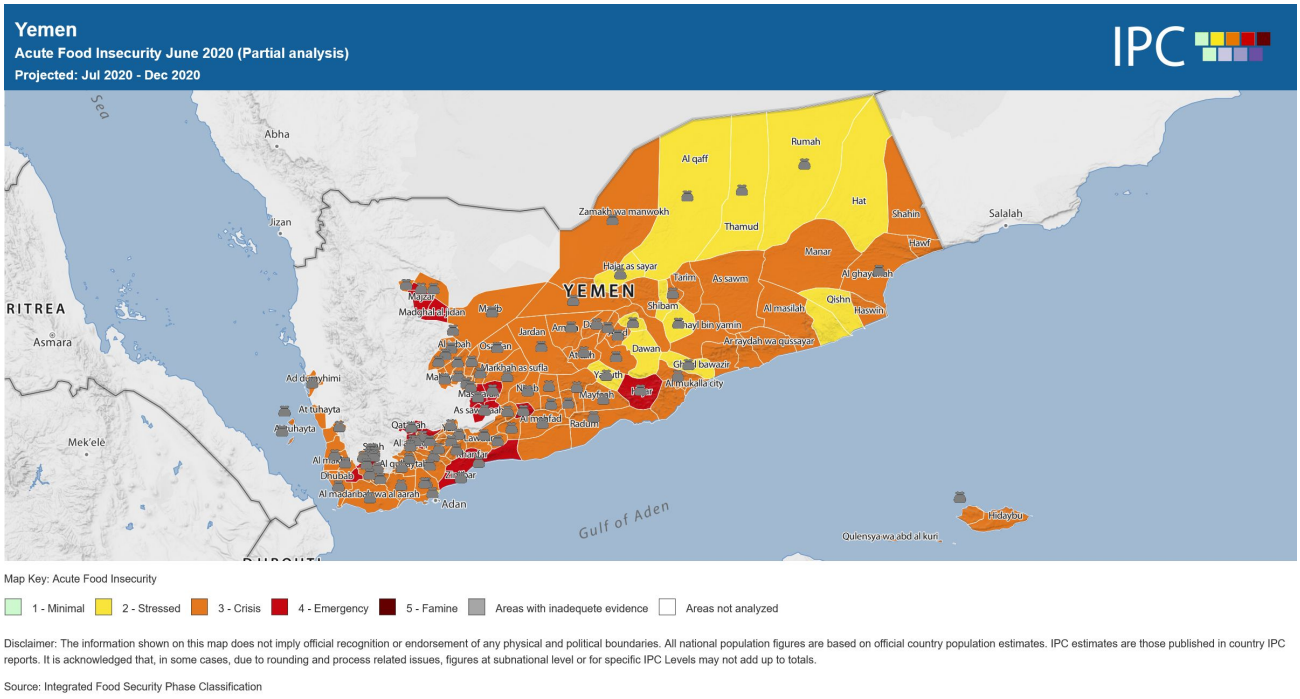
The Covid-19 crisis has contributed to the weakening of the local currency against the US dollar. The Yemini riyal has significantly depreciated since the beginning of 2020, negatively impacting prices and households' purchasing power along with humanitarian programmes. According to reports by ACAPS on the volatility of the Yemeni riyal, there is a direct correlation between currency depreciation and price inflation, especially when it comes to the cost of imported staple foods. This is due to Yemen's dependency on imported goods and the market's dependency on USD. Significant price increases have been more pronounced on imported commodities. Although markets have remained open and fairly functional, Covid-19, together with the depreciation of the riyal and the fuel crisis, has negatively impacted the ability of households to access adequate and safe water as the price of water trucking has increased significantly, which has caused an increase in the overall cost of the Survival Minimum Expenditure Basket (SMEB).

Displaced households and households living in IDP collective sites are faced with challenges and vulnerabilities distinct from those who live in standard housing settings. These challenges and vulnerabilities are exacerbated in the Covid-19 context due to disparate health access and a heightened socio-economic impact on displaced populations. At the same time, it is challenging for them to adhere to appropriate Covid-19 precautionary measures, such as self–isolation to reduce the transmission of the virus. Covid-19 has increased the fear of shelter insecurity amongst households, associated with the fear of eviction due to their increased inability to afford rent. Many IDPs have lost (at least part of) their income due to the Covid-19 pandemic and have no access to humanitarian assistance, leading to open and unsafe living conditions or the threat of forced eviction.

[9] UNDP, 2020

During the first period of the year (February to April 2020), 25% of the population analysed through the IPC were estimated to be highly food insecure (IPC Phase 3 and above). In June it was predicted that the percentage of the population facing high levels of acute food insecurity (IPC Phase 3 and above) would increase to 40% of the analysed population (3.2 million people) between July and December 2020 if humanitarian food assistance was kept at the same levels.

Map 2 – Projected food insecurity in Yemen



Map Key: Acute Food Insecurity

1 - Minimal | 2 - Stressed | 3 - Crisis | 4 - Emergency | 5 - Famine | Areas with inadequete evidence | Areas not analyzed

Disclaimer: The information shown on this map does not imply official recognition or endorsement of any physical and political boundaries. All national population figures are based on official country population estimates. IPC estimates are those published in country IPC reports. It is acknowledged that, in some cases, due to rounding and process related issues, figures at subnational level or for specific IPC Levels may not add up to totals.

Source: Integrated Food Security Phase Classification

Education, like other public services in Yemen, is facing collapse under the weight of Covid-19 due to shortages, budget cuts and defunding. One-third of all school-aged children were already out of school before 16 March 2020, when schools nationwide were closed to prevent the spread of the virus, impacting at least 5.5 million children. Dropout rates are expected to escalate sharply in the months ahead as families struggle to deal with the consequences of the pandemic. Extended school closures may cause not only a loss of learning and child wellbeing in the short term, but also a further loss in human capital and diminished economic opportunities over the long term.

2.1.3. COORDINATION WITH THE AUTHORITIES

Due to the conflict, coordination with the authorities takes two forms: with the government in Aden, which is internationally recognized, and with the de facto authorities in Sanaa from the Houthis/Ansar Allah.

At the beginning of the Covid-19 crisis, the Ministry of Health and Population in the North recognized the existence of the Covid-19 pandemic and formed rapid response teams, prepared places for isolation and treatment and provided them with the medical equipment and medicines necessary to operate these centres. It also issued, in coordination with the Prime Minister, preventive measures at the level of the government and the private sector, such as preventing movements between governorates and districts except for the most urgent necessity, closing schools and universities, reducing employment in government and private facilities, and moving from offices to home working, applying a remote management approach. Despite all of this, the Ministry of Health did not announce any cases of Covid-

19. At the beginning of August, things had returned to normal, and the Ministry denied that there was a Covid-19 outbreak in the North.

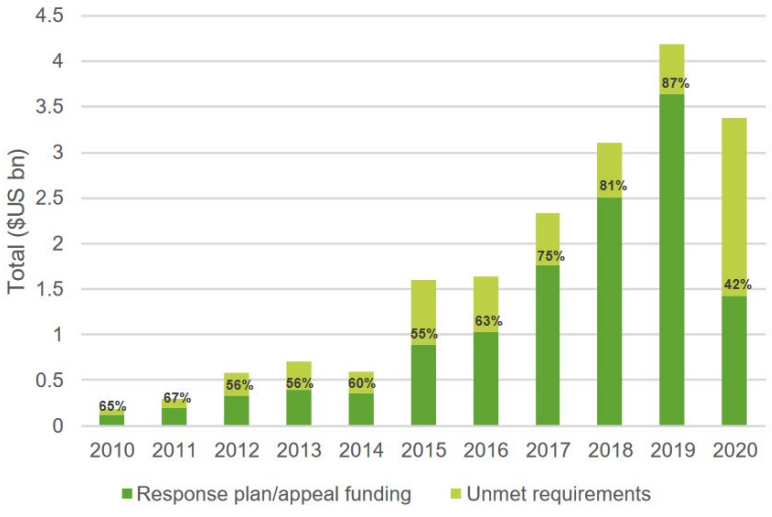
Approvals in the north of Yemen need to be obtained from the central Supreme Council of Management and Coordination of Humanitarian Affairs (SCMCHA), district level offices of the SCMCHA, National security, District authorities, and line ministries, such as the Ministry of Health. Getting a sub-agreement– which is compulsory for any project implementation - usually takes months. As SCMCHA no longer recognises Covid-19 as a public health concern in the North of Yemen, any activities or request for approval related to Covid-19 is being questioned by SCMCHA, and as activities of this kind are no longer considered a priority, sub-agreements are taking longer than originally anticipated.

As for southern Yemen, coordination with the authorities is less challenging than it is in the north. However, obtaining program approval has to go through several channels; first through the central government in Aden, then it can be submitted to the Ministry of Planning and International Cooperation (MoPIC) to gain final approval. Moreover, a new governor took up their position, causing further delays, with requests for additional paperwork. On average, according to OCHA reports, project approval periods were estimated at between 80 and 90 days compared with between 140 and 150 days in the north. Some positive examples were also reported, for example, CARE, who coordinated closely with the Rural Water Authority and the local authority in Amran Governorate for the design of the Covid-19 project.

2.1.4. HUMANITARIAN FUNDING

In late July 2020, the United Nations humanitarian chief, Mark Lowcock, informed the UN Security Council that Yemen's aid operation, which focuses primarily on the north, was, "frankly, on the verge of collapse," and that aid agencies had "already seen severe cuts to many of [their] most essential services. "

Chart 3 – Trends in response plan compared to appeal requirements



Source, OXFAM, 2020[10]

By the end of September, only $1.3 billion of the $3.2 billion needed in 2020 had been received. The drop in donor funding was due in part to the increasingly restrictive operating environment in the second half of 2019, which made it difficult to assure donors that aid was being delivered in accordance with humanitarian principles. As a result, between April and August, agencies were forced to reduce food

[10] Funding The Humanitarian Response In Yemen, Are donors doing their fair share? OXFAM, October 2020

distributions, cut health services in more than 300 facilities and halt specialized services for hundreds of thousands of traumatized and highly vulnerable women and girls. About 9 million people have been impacted by reductions in food assistance since April. A reduction in nutrition services in July affected more than 334,000 pregnant and breastfeeding women. As of September, WHO ended the Minimum Service Package (MSP) in 121 facilities, which affected 1 million people. This is in addition to 1.3 million people deprived of access to life-saving health care services through the MSP due to cuts to the health sector as reported on 28/11/2020 on the WHO official Facebook page which stated that health partners and WHO had been unable to continue their financial support to the healthcare workforce in Yemen. Up to 10,000 health workers were affected.

In July, the UN reported that "the Yemen humanitarian response, including for Covid-19, remains hugely underfunded, risking an increase in the spread of Covid-19 and jeopardizing the ability of humanitarian partners to respond". In conclusion, the funding crisis has had a dire impact on the Yemeni people putting millions of lives at risk. "It's an impossible situation," said Lise Grande, Humanitarian Coordinator for Yemen, in a statement on 23 September. "This is the worst humanitarian crisis in the world yet we don't have the resources we need to save the people who are suffering and will die if we don't help. The consequences of underfunding are immediate, enormous and devastating," she added. "Nearly every humanitarian worker has had to tell a hungry family or someone who is ill that we can't help them because we don't have funding."

2.2. KEY QUESTION 2 / ADAPTATION

At the beginning of the spread of Covid-19 in the world, DEC Member Charities in Yemen began planning and preparing strategies at the global level and adapting them to the current situation in Yemen. As soon as the first case of Covid-19 was recorded in Yemen, the necessary measures were taken.

2.2.1. DUTY OF CARE

All DEC Member Charities in Yemen adhere strictly to duty of care for their staff, local partners, community committees, volunteers and the affected population. Duty of care during the Covid-19 crisis has concentrated on reducing risks to the health, safety and security of employees, not only from a health aspect, but also to avoid having staff stranded or quarantined while on mission or in transit.

In order to guarantee staff safety despite the pandemic and reduce the risk of infection, all DEC Member Charities' staff have to use Personal Protective Equipment (PPE) (gloves and mask) and are required to maintain physical distancing and respect hygiene measures (e.g., regular hand washing, avoiding sharing personal belongings or devices etc.). At the beginning of the Covid-19 crisis in Yemen, a large quantity of PPE was used, which led to a shortage on the local market and a huge increase in prices (up to 200-300 times the normal price). Some organisations had prepositioned stocks they used, others had to purchase PPE from abroad, which took time and made it impossible to distribute PPE during the first months because of delays in the procurement process.

In addition, key preventive measures were introduced in workplaces - such as sanitizing at points of entry, temperature checks by guards, cleaning of surfaces, maintaining a minimum distance of 2m and using facemasks.

Most of the DEC Member Charities in Yemen have developed guidelines that include measures to limit the risk of Covid-19 infection in Health interventions, and non-health interventions, including FSL, WASH, Education, Protection and Nutrition. For the organizations working in the Health sector, such as ACF and Save the Children, they have developed specialized guidance for the triage and referral of symptomatic Covid-19 patients, and PPE operational guidance for health workers, cleaners and community health workers. An SOP for quarantine and isolation has also been produced to define the practical aspects of managing quarantine and isolation, including potential Covid-19 cases amongst humanitarian staff. Moreover, frontline staff have been trained on transmission routes, prevention measures, symptoms, and referrals.

Relief distributions and other activities are being done in accordance with WHO guidelines on physical distancing. Other measures to minimize exposure for staff and beneficiaries include spreading out distributions over a longer period of time to reduce the number of people gathering in one place. For instance, CARE International has extended the period of food basket distribution from 3 to 13 days to prevent the spread of infection among beneficiaries. It has also requested extra funding and shifted some activities to cover the expenses of the Covid-19 preventive measures.

2.2.2. PROGRAMME ACTIVITIES

Despite all the constraints, more than half of the DEC programs in Yemen have made good progress and are on track. Only one organisation has not obtained its sub-agreement approval, which, combined with the late agreement from the DEC (proposal acceptance in late September), has delayed the start of implementation. Other organisations are behind schedule in some activities in the north. Otherwise, all projects, particularly those implemented in the south, are on course to reach the targets specified in the program proposals.

DEC Member Charities' projects in Yemen - progress report summary by the end of November:

Member	Sector	Project status North	Project status South	Reason for delay	Governorates	Comment
Action Against Hunger	Health & Nutrition		On track		Abyan, Khanfar district	Direct implementation Targeting five health facilities and one mobile team in Abyan, Khanfar district. Started from October
Tearfund	FSL(CVA) WASH (Distrib of HKs)		On track		Abyan, Aden & Taiz	A local partner will deliver food and hygiene kits to 750 HHs in Taizz. And another local partner will deliver food and hygiene kits to 500 HHs in Abyan and IDPs from Abyan in Aden
CARE	WASH	Pending		Delay in obtaining sub-agreement with SCMCHA	Amran	Direct implementation
Save the children		In progress (some delay in Hajah)		Delay in obtaining sub-agreement with SCMCHA	Lahij and Hajjah	Direct implementation
OXFAM		In progress (some delay in Sada'a)		Delay in obtaining sub-agreement with SCMCHA	Sa'ada and Hajjah	Direct implementation
British Red Cross		On track			Sana'a city	Through ICRC and through Yemen Red Crescent Society

2.2.3. RELATIONSHIPS WITH LOCAL PARTNERS

Most of the DEC Member Charities in Yemen (4 out of 6) are implementing DEC-funded projects directly with the exception of the Red Cross, which is working through the Yemeni Red Crescent and the ICRC, and Tearfund, which has contracts with local partners.

Working with/through a local organisation requires time and cannot be decided on short notice as they need to subject the partner to a due diligence process and training. However, some DEC Member Charities said that they were planning to integrate local partners into the implementation of the activities of the second phase of the DEC grant, given the importance of local partners in reaching affected communities, especially those located on the front lines, where access is even more difficult for international organizations. Strengthening the capacities of local partners is the main factor to ensure the sustainability and continuity of the provision of humanitarian aid. One respondent in the field argued that local partners represented by civil society organizations, community committees, and volunteers have a more comprehensive understanding of the situation and humanitarian needs in these areas.

2.2.4. ENGAGEMENT WITH COMMUNITIES

Most of the DEC Member Charities who we interviewed engage with community committees, volunteers and local authorities in the beneficiary registration and verification process, in awareness activities and in the distribution of hygiene kits and food baskets, especially since most organizations have reduced their visits to the field due to restrictions imposed by the authorities and the long delays for security clearances. One interviewee stated that volunteers played an important role in communicating awareness messages on how to prevent and limit the spread of Covid-19 in remote communities, which were difficult to reach without the participation of volunteers.

From the interviews, it was revealed that nearly all distribution activities, such as food baskets and hygiene kits, as well as cash and in-kind assistance, selected and verified recipients through the adoption of a community-based targeting approach. This ensured that the targeting criteria were clearly communicated and adhered to. Project information was also communicated about the amount of items to be received and the number of distribution rounds. One interviewee stated that during the Covid-19 crisis, the participation of the local community in the project cycle had increased significantly.

DEC Member Charities used alternative means to deliver information and awareness messages to the beneficiaries, by employing social media, radio and cars with microphones. Text messages were also activated and used on a large scale.

Mechanisms for receiving complaints from beneficiaries were affected during the Covid-19 crisis, as the majority of beneficiaries usually communicated their complaints directly to aid workers in the field or went directly to their offices in the governorates. But with the Covid-19 crisis, most of the channels for receiving complaints stopped, leaving only the hotline and WhatsApp messages, which led to a decrease in the number of complaints received from beneficiaries.

2.2.5. COORDINATION

All DEC Member Charities in Yemen have strong relationships with the wide range of humanitarian actors on the ground, as well as with the local authorities, both in the north and in the south of the country. However, there is no organised coordination among the DEC Member Charities working in Yemen: some are not aware of the other members' projects or targeted places, which may lead to missed opportunities for mutual support.

On the other hand, DEC partners are active players in the cluster system. For example, Oxfam is an active member of the Protection and FSL clusters in Yemen and co-leads the WASH cluster and the Cash and Markets working group while Save the Children is an active member of the Health, WASH, and Protection clusters at the national level and the sub-national level. They lead the Child Protection sub-cluster and they are a member of the Yemen WASH Cluster Strategic Advisory Group, the highest decision-making body, and a lead agency in the Cash in WASH Technical Working Group. They coordinated with the various humanitarian clusters when designing project proposals to respond to Covid-19, in order to obtain information about needs (where? What? For how many people?) and in order to avoid overlapping with others' activities.

As for coordination with clusters, there are no difficulties or problems for DEC Member Charities to communicate with them, as all meetings went from face-to-face to virtual by using remote communication applications such as Skype and Zoom. In spite of this, coordination with the clusters was not as effective as it should have been. For example, a DEC Member Charity reported that the humanitarian clusters took a long time to provide information about which regions required assistance. This delay led to a delay in the response.

From the beginning of May, all interviews and meetings adopted remote and telephone communication mechanisms, whether to communicate with the government, humanitarian agencies or the local community, and this has continued till now.

3. LESSONS AND RECOMMENDATIONS

STRENGTHENING COMMUNICATION WITH COMMUNITIES

At the beginning of the Covid-19 crisis, internal curfews were imposed by the government, and airports and external ports were closed. This prevented international aid workers from travelling to Yemen and halted the provision of suitable aid. It also hindered movement between governorates and the delivery of aid to affected locations. In such contexts, ensuring that humanitarian aid is delivered quickly, efficiently and on time depends on building the capacity of local community organizations, community committees and volunteers, and increasing their participation in the planning and implementation of projects.

Strengthen awareness-raising and communication within communities on safe access to available services and information in relation to the containment, prevention and response to Covid-19 and positive coping mechanisms. This should be coordinated among Clusters and partners to ensure timely and safely information sharing, and alternative modalities for delivering humanitarian assistance should be considered for all activities to avoid social gatherings, including, for example, outreach through phones and messaging disseminated through megaphones and community focal points.

Ensure different forms of media are utilized to spread hygiene promotion awareness messages and awareness of health services. For example, radio announcements, TV announcements, text messaging, social media, and mass awareness campaigns via megaphones, posters and leaflets in public places.

Increase community outreach to disseminate key health and Covid-19 messages on the symptoms, prevention and transmission methods. Key messages should be determined by conducting a needs assessment to determine the knowledge gaps and rumours among the affected population.

Establish mechanisms with teachers, parents and youth leaders to communicate Covid-19 risk, prevention and mitigation messaging, in language tailored to different age groups and literacy levels. This includes supporting mobilized youth to play a positive role in this regard.

Continue to strengthen the newly-adopted remote approach for service monitoring with community-based structures.

ADVOCATING FOR HUMANITARIAN ACCESS & FUNDING

In order to work in Yemen, it is necessary to negotiate access at local and national levels. It is also necessary to have support from donors, states and the international community. Many NGOs, including DEC Member Charities, advocate permanently in order to be able to implement their programmes in such a complex context, even though DEC funding does not include so-called advocacy activities.

To ensure a successful humanitarian response, humanitarian partners must advocate and convince the local authorities of the importance of awareness-raising activities and transferring vital information to affected people to help them cope and protect themselves from the spread of Covid-19.

Advocate vis-à-vis the relevant authorities and stakeholders for supply chain lines to remain open and uninterrupted, to ensure that key commodities remain available in local markets. Advocacy can also be taken to a higher level regionally with concerned parties to ensure that barriers to the supply chain are minimized and/or eliminated.

Special attention should be given to the situation in the north. As Covid-19 is no longer recognized by the authorities, it has become much more challenging to negotiate agreements with the SCMCHA to implement Covid-19-related programmes. DEC Member Charities could use their leverage through the Foreign, Commonwealth and Development Office (FCDO) to raise this concern globally and at the national level with the OCHA Humanitarian Coordinator, as well as with the SCMCHA.

STRENGTHENING SUPPORT TO IDPS

Coordinate with other sectors to provide holistic and comprehensive services to the displaced communities who are the worst affected by Covid-19. In particular, advocate for health agencies to increase their presence and operations especially within IDP sites. Support isolation/quarantine centres and promote equal access for all groups and health cases without discrimination in all health facilities.

Support vulnerable IDPs in camps, quarantine centres and other locations without any water sources with either in-kind water trucking or cash/vouchers. These activities should take place in addition to the rehabilitation of existing water schemes to facilitate access to safe and adequate water sufficient for personal and domestic purposes, and incorporate Covid-19 precautionary measures.

Lobby health partners to extend health services to all IDP sites and enhance the capacity of health facilities across the country.

CONTINUING TO MONITOR AND ADAPT TO THE EVOLVING SITUATION

Continuous monitoring of key economic indicators, such as the depreciation of the Yemeni riyal against the US dollar, replenishment rates, foreign reserves, importers' access to letters of credit, trends in remittances and prices of key food commodities, to ensure humanitarian interventions are relevant and linked to the overall economic context as well as conducting contingency planning in case the situation deteriorates further, making it difficult to operate.

Increase funding and resources for livelihoods recovery to address the secondary impacts of Covid-19 on jobs and incomes and promote alternative income-earning opportunities that can be sustained even during the Covid-19 pandemic. Such actions should be simple, appropriate and should support local markets.

Education partners need to think of a variety of new and innovative strategies that can help children to continue learning, mitigate the risk of increased dropouts and support children to re-enrol in schools. Outreach activities need to be undertaken to ensure students return, educational activities should be complemented with psychosocial support, and education and hygiene materials should be provided to children and teachers.

Authority approvals/permissions are becoming increasingly difficult and very lengthy processes in Yemen which, on reflection, has meant that the fact that Phase 1 is a fixed 6-month period is quite challenging for implementation in Yemen.

Ensure contingency planning and flexible funding (e.g., crisis modifiers) help to adapt and respond in a timely manner to evolving needs and unpredictable situations. This is particularly important in the context of Yemen and is encouraged by the DEC secretariat.

4. ANNEXES

ANNEX 1 – LIST OF INTERVIEWEES FROM DEC MEMBER CHARITIES

Organisation	Name and title	Date
Save the children	Humanitarian Ops Manager	15/11/2020
Save the children	WASH coordinator	11/11/2020
Save the children	Health and Nutrition manager	11/11/2020
Save the children	Nutrition coordinator	11/11/2020
CARE	Deputy Director – Program Development and Coordination	18/11/2020
CARE	PQU Coordinator	18/11/2020
CARE	Deputy Area Manager	17/11/2020
CARE	Program/Saftey& Security	17/11/2020
Oxfam	Humanitarian Programme Coordinator	12/11/2020
Oxfam	Head of WASH	12/11/2020
Oxfam	EFSL Team leader	10/11/2020
Oxfam	PHE Officer	10/11/2020
Oxfam	WASH Coordinator	12/11/2020
ACF	Head of Department Health and Nutrition	18/11/2020
ACF	Staff project officer	18/11/2020

ANNEX 2 – ANALYSIS FRAMEWORK

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?)**									
RTE key questions	**Lines of enquiery / Sub-questions**			**Related CHS criterion**	**indicators/info to collect**	**Desk R.**	**Ext. S.**	**KII**	**Field obs.**	**FGD**
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.		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	
				C3 & C8	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.		Specific guidance	X				
					Remote management	X		X	X	
					Communication support and initiatives	X		X	X	x
				C4	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
				C2	changes in intervention logic (Obj., Timeline, Activities, ...)	x		x		
			What are the changes on more developmental programmes?	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. While looking at lessons learnt the RTE will answer the following questions too. • What differences has it made to members to access the DEC funding (and ultimately to people)? What difference has it made / financial / programmatic? • 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? • How ready were DEC and its members as a collective to respond? • Any multiplying factor(s) that might have been generated/initiated (any leverage effect) by DEC appeal? • 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
							Position / Organization
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? — Humanitarian Ops Manager / Save the Children
			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 ? — WASH coordinator / Save the Children
			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?
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?
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?

Siège du Groupe URD
La Fontaine des Marins
26170 Plaisians – France
Tel : +33 (0)4 75 28 29 35

urd@urd.org

www.urd.org

SUIVEZ-NOUS SUR