

SPACE Social Protection Approaches to COVID-19: Expert advice helpline



GUIDANCE FOR FRAMING CASE STUDIES ON SOCIAL PROTECTION RESPONSES TO COVID-19

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This Case Study Framing was developed alongside others – most importantly [a Strategy Decision Matrix](#) and a [Delivery System Decision Matrix](#) – as a tool used to structure an independent and unbiased analysis of COVID-19 response options. It does not necessarily represent FCD0 or GIZ own views or policies.

1 OVERVIEW

The COVID-19 pandemic has highlighted the important role of social protection approaches in response to large covariate shocks. There is a lot to be learned from countries' collective experience, including documenting what has happened to date and what this implies for the future. Even before more structured impact and process evaluations are taking place, academics, researchers and practitioners have started the process of 'Case Study documentation'. The learning that this brings will be maximised if such case studies are carried out comprehensively and comparably. Otherwise, there is a real risk that information generated could overwhelm potential users, get lost, and ultimately be ineffective at contributing to learning.

This document offers guidance on how to ensure that information is documented systematically and with a particular focus on the COVID-19 response. It suggests a structure of the key areas and dimensions to consider, and detailed questions to answer under each heading. This template can also help in drawing up terms of reference for future evaluations of social protection responses to COVID-19. This is in order to ensure future learning will:

- be the most useful collective public good possible for policy-makers, practitioners and other researchers.
- be comparable, thorough, and easily accessible, informing further meta-research and systematic insights in the future.
- build on prior country evidence/research/documentation to the extent possible.

This document was developed collaboratively by the Social Protection Approaches to COVID-19: Expert advice helpline (SPACE) expert team, comprising over 25 experts with many years' experience working in a variety of capacities on shock responsive social protection and linkages with humanitarian response. It specifically builds on:

- The SPACE framing documents: the [Strategy Decision Matrix](#) and [Evaluating Delivery Systems Matrix](#)

- The [MAINTAINS COVID-19 and Social Protection responses research framing](#)
- The [IPC database framing](#) (supported by SPACE) and the [Global Social Protection COVID-19 response paper](#) (Gentilini et al, 2020)
- Emerging country Case Studies and regional overviews documenting COVID-19 social protection responses e.g. by G2PX, IPC-IG, the Grand Bargain sub-group on linking Social Protection and Humanitarian Cash Transfers and the ILO
- Our past work as researchers writing/reviewing similar case studies

2 BEFORE YOU START

Learning will be most useful if it can speak to other research being done and if it is based on familiarity with the concepts and terminology of others in the sector. A core set of literature on shock responsive social protection can assist in classifying different responses to COVID-19 and lessons emerging for future preparedness. Useful documents include:

- The TRANSFORM module on Shock Responsive Social Protection [here](#). [ANNEX A](#) includes a long list of relevant resources this was built on.
- The SPACE [Useful COVID-19 and Social Protection Materials](#), focusing on COVID-19. This includes a document that thematically organises relevant literature on Social Protection and the COVID-19 response.

The [socialprotection.org](#) website also lists other case studies have been or are currently being written on the COVID-19 response, and you can use it to reach out to colleagues working in this field in your country. Feel free also to reach out to SPACE (SPACE@dai.com) for further guidance.

3 STRUCTURING YOUR CASE STUDY

By using the suggested Case Study structure, you will ensure that all critical topics and essential questions are covered systematically, and the resulting work is comparable across different contexts and reports. The key area of focus, length, and depth of each Case Study will depend on a wide variety of factors – but the below framing can easily be tailored to your specific needs by removing areas which are outside of your scope of review.

Box 1: FRAMING FOR A COMPLETE CASE STUDY

The following provides an overall framing for a complete case study (yours may necessarily have fewer sections):

Introduction and Background

- Pre-COVID-19 overview
- The socio-economic impacts of COVID-19 on the country

Overall description of the social protection and emergency assistance responses

- What were the social protection policy responses to the crisis?
- What other emergency responses were used to mitigate socio-economic impacts on affected populations?
- What was the policy process behind these choices?
- How were the different elements of the response financed?

The design of the response

- Objectives
- Eligibility criteria and design of overarching targeting strategy
- Setting the benefit/transfer level, frequency and duration

The implementation of the response (along the 'delivery chain')

- Outreach and communications
- Identification of new caseloads, registration and enrolment
- Payments
- Accountability and social inclusion
- Coordination and linkages
- Monitoring & Evaluation (M&E) and learning

Assessing the response against key dimensions

- Coverage
- Adequacy
- Comprehensiveness (scope)
- Timeliness
- Value for money/cost-effectiveness
- Accountability
- Long Term Implications

Challenges, lessons learned and preparedness implications for the future

3.1 Introduction and background

Even if the topic of the case study is very specific, it will be extremely useful to briefly put it into context by describing the situation before COVID-19 and by describing the range of social protection and humanitarian measures being taken to respond, including those outside the focus of the case study.

3.1.1 Pre-COVID-19 overview

What was the state of social protection before COVID-19? Give a quick overview of the system's main interventions. These may be contributory or contributory benefits, across social insurance, social assistance and active labour market policies. Briefly give key design features of the interventions (e.g. benefit levels, duration of benefits, gender and

inclusion aspects, etc.). Who was covered and who were excluded groups? Put this in context: what % of the population was covered by different interventions? What % of poorest quintile? What % GDP invested? What level of 'adequacy' (e.g. transfer value?).

What other complementary systems/sectors were working in country on emergency response, which have been key to the COVID-19 response? Similar to the above social protection section, give a quick overview of the key and related aspects of any ongoing humanitarian responses in target areas of the country, particularly related to design, funding, and coordination features of relevant forms of cash, voucher, and in-kind assistance

3.1.2 The socio-economic impacts of COVID-19 on the country

The responses to COVID-19 were dictated by country-specific impacts and emerging needs. This Section would briefly discuss these, where possible giving preference to rigorous, representative and data-based analysis of impacts, rather than single source localised reporting (or media reports where are not substantiated).

- Severity of the COVID-19 health crisis and stringency of the lockdown over time – [see stringency index](#)
- How was the economy affected, including unemployment trends and income losses (disaggregated by sex, age, urban vs rural or other key demographics where possible)? These will vary depending on the country's economic structure.
- Which populations were the most vulnerable to the COVID-19 economic crisis?
 - Who were the most vulnerable before COVID-19 (e.g. poorest, women, disabled, elderly, children, migrants and IDPs, etc.) and how has COVID-19 affected these people?
 - What groups have *become* vulnerable since COVID-19? How were informal workers and those involved in casual labour and home-based work affected (disaggregated by sex, age or other key demographics if available)?
 - How far can this be broken down by sex, age, geographically, etc.?

For key documentation on COVID-19 socio-economic impacts, see the 'COVID-19 Impact' section of the [SPACE Useful COVID-19 and Social Protection Materials](#)

3.2 Overall description of the social protection and emergency assistance responses

3.2.1 What were the social protection policy responses to the crisis?

In many countries the COVID-19 social protection response consisted of several interventions across social insurance, labour market policies and social assistance – coordinated to greater or less degree. Existing interventions may have been adapted; new interventions may have been introduced; and there may have been changes in the system itself as a result of the public health crisis and the surge in need for assistance. As with the description of the pre-COVID-19 situation, even if the focus of the case study is on just one intervention, it will be helpful to put this in context by briefly sketching out the COVID-19 adaptation as a whole according to the following areas:

- **System resilience - changes in the functioning of routine social protection:** Were any changes made to routine interventions, to enable them to continue functioning, both because of public health considerations or because of a surge in need? Were additional staff taken on? How were they integrated into the system? What safety measures were taken to reduce contagion among staff and among recipients, e.g. changing payment modalities, increasing the number of payment points, etc? How smoothly were these changes effected? Had there been any existing contingency protocols to guide this?
- **System adaptation**
 - Adaptation of existing programming: How were existing interventions adapted to respond to the new crisis? Was there any vertical expansion (i.e. increase in value of assistance given)? Any horizontal expansion (i.e. extension of assistance to new beneficiaries)? Was there any relaxing of enrolment or renewal requirements, or suspension of conditionalities (e.g. work requirement, attendance at school, etc.)?
 - New programming. What new interventions were rolled out, and what were their objectives (E.g. immediate response vs. medium long-term recession; directly affected or indirectly affected; one population sub-group or multiple (which?
 - *For both:* Who was the target population? What was the budget allocated (individually and overall)? Did these interventions work together as a system and if so, how?

See an example visual classification across the social protection response, from the Gentilini et al (2020) mapping. It would be useful to add a final column on emergency assistance responses too, for completeness (see Section 3.2.2. below).

	SOCIAL ASSISTANCE				SOCIAL INSURANCE				LABOR MARKETS			
Countries	Cash-based transfers *	Public Works	In-kind (in-kind/school feeding)	Utility and financial support	Paid leave/unemployment	Health insurance support	Pensions and disability benefits	Social security contributions (waiver/subsidy)	Wage subsidy	Activation (training)	Labor regulation adjustment	Reduced work time subsidy
Afghanistan			✓									

3.2.2 What other emergency responses (e.g. humanitarian assistance) were used to mitigate socio-economic impacts on affected populations?

Even if the focus of the study is only on social protection, humanitarian interventions and other emergency assistance may be an important – or integral – part of the response. It would therefore be useful to address the same questions as above (3.2.1) in relation to the Disaster Risk Management and humanitarian sectors. Without this information, it will be difficult to contextualise trade-offs, objectives and complementarities between different sectors responding to this pandemic and it will be unclear why certain decisions were made or difficult to learn from gaps for future crises.

- How were these responses coordinated with the social protection sector, if at all?
- Was there any deliberate alignment with the social protection sector?

3.2.3 What was the policy process behind these choices?

It is not always easy to find any record of why policies were chosen or why interventions were designed in a certain way. However, the more choices and their rationales are documented, the more can be learned for future crises – avoiding any trap that a certain policy or programming direction will necessarily be set in stone. This information, often neglected in case studies, is critical – even if it is only to document that the reasons for choices have not been made explicit and are not known by key actors.

- Why was this specific social protection response chosen, over other possible options? Which stakeholders had decision-making power in this process? How were the target groups decided? Was it based on any assessment of likely effects of COVID-19 (including consultations with communities, market, risk, gender and inclusion assessment etc.) and/or were decisions based on stakeholder preferences or operational reasons?
- Were there other options considered and then discarded? Which options and for what reasons were these discarded (e.g. lack of feasibility, financing, etc.)?
- What were the main trade-offs considered in the decision-making process and how were those addressed? As discussed in the SPACE Strategy Decision Matrix, there are many trade-offs involved in decision-making for a shock-response – when trying to achieve relevant outcomes under a set of constraints. For example, coverage vs adequacy, inclusive coverage vs timeliness, etc.
- What is known about the reasons why any humanitarian assistance was aligned/integrated in the way it was with social protection?

3.2.4 How were the different elements of the response financed?

- Domestic vs foreign resources (% and absolute amount of each) and through what financing instruments (did these exist prior to the COVID-19 response)?
- **Was there any existing contingency financing?** If so, how did this work and was it according to plan (i.e. did established triggers work)? What % of the response did it cover?
- **Was funding a constraint?** How? Was the response restricted due to available funding? How? Was it delayed because of funding and/or political process tied to approving funding?

3.3 The design of the response

This Section would delve into the design choices underlying the response to COVID-19. Your case study may be focusing on just one or two specific social protection interventions, not necessarily the ‘full response’ outlined above. Where your scope has not already been defined (e.g. by a client), it will be most interesting to study cases of expansions of caseload (horizontal expansion), which pose more challenges than for vertical expansion. Depending on your areas of focus the questions below should be considered in how the COVID-19 response was designed, though all will not be relevant for all case studies.

3.3.1 Objectives

- What were the objectives of the intervention? How far were these specific to COVID-19? How far were these public health objectives (e.g. supporting people to prevent breach

of isolation), meeting acute needs or longer-term objectives of preventing the crisis from creating greater long-term poverty?

3.3.2 Eligibility criteria and design of overarching targeting strategy

- Targeting strategy and criteria:
 - What was the overarching targeting strategy (geographic/ categorical/ poverty targeted, designed how)? Why was this chosen? Did it follow targeting strategies used by pre-COVID-19 interventions or was it designed specifically for the current crisis?
 - Who was included and who was excluded by the eligibility criteria? Would any additional qualifying conditions have prevented certain people from benefiting (e.g. a work requirement and the disabled; a residency requirement and migrants/IDPs)?
- How well did the targeting strategy and eligibility criteria match the stated objectives of the intervention? E.g. if there was limited geographic coverage, did this match areas most affected by COVID-19?
- Was eligibility and/or targeting conducted at the household or individual level? If household, were there stipulations around which individual received or could collect benefits (including stipulations by sex)?
- How was targeting implemented? What successes and problems were experienced? (cross-reference Sections 2.4.1/2 below)
- Where there elements of innovation compared to routine programming? If so, what were they?

3.3.3 Setting the benefit/transfer level, frequency and duration

- What was the benefit level/value, frequency and duration? Did this vary for different population groups?
- How well did the benefit value and duration match the stated objectives of the intervention? For the case of social transfers (cash payments), what were they intended to cover?
- How was the value/duration chosen/determined, in practice (e.g. as a % of a minimum expenditure basket, as a % of poverty line)?
- To what extent was the value/duration modified because of budget constraints (there will be a trade-off between transfer size and coverage)?
- Were benefit values the same as pre-COVID-19 or adapted? If adapted,
 - what % increase was granted?
 - Were there any challenges faced operationalising any changes (change in legislation? Changes to information system? etc.)? Which?

3.4 The implementation of the response (along the 'delivery chain')

This Section should focus on the practical implementation details of the response along the 'delivery chain' (see the [World Bank Sourcebook](#) for useful overall framing for routine social assistance interventions).

3.4.1 Outreach and communications

- What strategies were put in place to communicate who was eligible, how to apply and receive assistance, duration of support etc.? Did problems with communication lead to any delays, misunderstandings or potential conflicts?
- Did anyone have difficulties in accessing this information (e.g. because of literacy, language differences, access to media, etc.)? If so, how was this addressed?

3.4.2 Identification of new caseloads, registration and enrolment

- Describe, step by step.
 - How were new beneficiaries registered (their data collected?)
 - Were pre-existing registries/data used to identify new beneficiaries? Which and how? E.g. social registries of potential beneficiaries, beneficiary registries (e.g. past beneficiaries, those on waiting lists, etc)? Other registries? Also see BOX 1.
 - If not, how was new data collected? e.g. through online platforms/hotlines, USSD/SMS technology, in-person interviews via local offices or door to door, through community groups, etc.
 - Was there any further interoperability with existing registries? How/why?
 - Were multiple options for registration enabled for different caseloads?
 - How was eligibility assessed, in practice (i.e. through what process)? Were there any verification & validation steps?
 - What % of those that 'applied' was deemed eligible? Who was rejected and why? E.g. lack of relevant documentation, validation cross-check showing duplication or misreporting, etc.
 - How was enrolment completed?
- How long did it take to design the mechanism and to complete registration, eligibility assessment and subsequent enrolment? How long was the 'window' to apply?
- Were any other options proposed/tried and dropped because of lack of feasibility (which/why)?
- How effective was this mechanism?
 - Which population groups faced the highest barriers to access and how were these addressed – if at all?
 - What other challenges were faced?
- Did the national ID system and/or Civil Registration and Vital Statistics system (CRVS) play a role to enable registration/enrolment? How?
- What was known about the degree of exclusion error by the intervention? Inclusion error?

Refer to SPACE's note on the different options for rapid expansion of caseloads: [here](#) and blog post [here](#) – stress opportunities, challenges and pre-requisites that enabled the decisions above.

- *For overarching descriptions of scale-up strategies, including digital innovations during COVID-19 responses, also see:*
- *World Bank (2020) [Scaling up social assistance payments as part of the COVID-19 pandemic response here](#):*

- *CGDEV Digital Technology in Social Assistance Transfers for COVID-19 Relief: Lessons from Selected Cases [here](#);*
- *Case study examples on [Pakistan](#), [Brazil](#), [Ecuador](#), [Peru](#), [Colombia](#), [Jordan](#), and [South Africa](#).*

Box 1: DATABASES AND INFORMATION SYSTEMS

If/where existing administrative databases and social protection information systems (e.g. social registries) were used to support registration/enrolment:

Which databases and information systems were leveraged and how?

- What was the coverage of the information system used (% population)? How was data quality and 'fitness for purpose' assessed?
- What data does it contain? How up-to-date was it?
- Was there a mechanism in place to ensure that affected people who were not in the registries could be reached?
- Where there MoUs for data sharing in place? Or a good degree of interoperability? Otherwise, how was the data exchange operationalised? Was data protection guaranteed?

For an overview of using existing social protection data/info systems for shock response and relevant criteria, see [this Paper](#).

3.4.3 Payments

This section is only relevant for social protection measure that involved payments to beneficiary households or individuals.

- Describe step by step. How were benefits delivered/paid? Could beneficiaries choose between different delivery modalities or were these pre-determined based on other factors (e.g. geography)?
- Is the response relying on an existing delivery mechanism? How? How was it adapted?
- Were any other options proposed/tried and dropped because of lack of feasibility (which/why)?
- How effective was the delivery mechanism?
 - Who faced the highest barriers to access and how were these addressed?
 - What other challenges were faced?
 - Was the mechanism tailored to the needs of the target population? How?
 - Was it tailored to the needs emerging from the pandemic (i.e. social distancing)? How?
- Did the payment mechanism require partnerships with the private sector, with humanitarian agencies, with NGOs? How did this work?
- Will this delivery mechanism be used in the future by social protection or somehow feed into future options (sustainability)? Explain future plans.

For a typology, refer to SPACE's note on the different payment options used by governments in response to COVID-19: [here](#). Also refer to the other documents shared above.

3.4.4 Accountability and social inclusion

- Were there grievance redressal/complaints and appeals processes attached to the response?
 - How were these designed and implemented?
 - Were these functioning and effective throughout the response?
 - Were they appropriate for all issues faced?
 - Was systematic monitoring of grievance type, demographics of individuals raising grievances, and case closure rates done?
 - Were any changes made to the implementation and operations of the response made based on this information?
 - Were eligibility decisions overturned through the grievance process? How?
- Were there any other accountability mechanisms set in place for the response? E.g. supervisory bodies, parliamentary oversight, social audits, civil society watchdogs, etc.
- Was the design and delivery of the response transparent and widely understood? E.g. openly shared data on criteria for eligibility and prioritisation, overall caseloads reached and budget, etc.
- Was the design and the delivery of the response tailored to enhance dignity of affected populations? How?
 - Who was consulted for design/implementation? Did it include groups or members of groups who were identified as particularly vulnerable, (e.g. women's groups, coalitions representing people with disabilities, migrants and refugees etc.).
 - Were gender and protection risks mitigated via any implementation or design features (e.g. information on gender-based violence helplines at touch points, communication campaigns on harmful gender-norms, linkages to existing /new case management and referral services)?

Refer to the *SPACE 'Gender and Inclusion Operational Guidance'* for more examples and information. Also see this Open Government Partnership guidance note.

3.4.5 Coordination and linkages

- Were the actions of all agencies providing cash/voucher/food transfers (e.g. across social protection, humanitarian and DRM) effectively coordinated? What was the mechanism used for coordination? Was the response coordinated with other responses by the government and other agencies (e.g. humanitarian)?
- Who led the coordination process and how was this operationalised in practice?
- Was the coordination effective? How far were the objectives shared by different agencies, and especially of the social protection and the humanitarian system? How well did coordination permit different agencies to focus on shared outcomes (see section 3 below)?
- Did the coordination lead to sharing or co-creation of resources, protocols, systems, data, etc? To harmonising criteria of different responses? How?
- What aspects of the above have remained after the emergency phase passed? Which have been or should be integrated into regular ways of working moving forward, or into default preparedness planning for future shocks?
- How have relationships/partnerships changed due to this experience? Has this experience fundamentally changed the working approaches of these stakeholders? How far do participants attribute successes (or blockers) to specific individuals versus

institutionalised processes that can be replicated and what was the risk that those people move on?

See [SPACE Identifying Practical Options for Linking Humanitarian Assistance and Social Protection in the COVID-19 Response](#)

3.4.6 Monitoring & Evaluation (M&E) and learning

- Was any M&E carried out to inform the progress of the response – and future action? Who carried out these activities? Were any products produced (internal or external) and what were the objectives of these outputs (provide links, citations and key findings in the case study narrative as appropriate).
- For monitoring activities: what data was collected? What data was not collected? Was data managed in ways that made it timely, easy to access and use? What data was used? For what?
- Was data collected in a way that protected the identity, dignity and safeguarded participants? What data protection standards were used?
- Was gender and inclusion a component of analysis of the data? E.g. was data disaggregated at basic levels to allow inference for vulnerable populations (e.g. by sex, age, disability etc.). Were data collection systems harmonised across different response efforts (if so, which and how)?
- Was any workshop/learning event organised to consolidate insights and discuss options for future preparedness? Who participated in this event? Were results fed back to communities and beneficiaries?

3.5 Assessing the response against key dimensions

The Sections above are primarily *descriptive*. This Section would be primarily *evaluative* – providing an overall assessment of the extent to which the core outcomes we are collectively trying to achieve with the COVID-19 response, across sectors, have indeed been achieved. The more this information can be presented in a way that enables comparability with other countries, the better.

3.5.1 Coverage

- What was the coverage of the response (across all interventions and relevant sectors, ideally broken down)? (total numbers, and as % of the affected population nationally and % of the total population).
- Did the response support those that were most likely to be affected/in need? How was this established (how were needs determined)? If so how, if not, why not?
- Who was left out of the response?
- Can the most significant causes of inclusion and/or exclusion errors be identified?

3.5.2 Adequacy

- Was the transfer modality (e.g. cash or in kind), value and duration adequate to meet the objectives? Was it adequate to meet the needs of recipients?
- What was the value as a proportion of pre-COVID-19 transfers?
- How does the amount compare to relevant benchmarks: minimum expenditure basket, pre-response social protection value, national poverty line, minimum wages?

3.5.3 Comprehensiveness (scope)

- Were complementary measures implemented to ensure that key multi-dimensional needs of affected populations were addressed? (e.g. to meet health needs, livelihoods' support, psychosocial support needs, protection needs, violence against women and girls, disability inclusion, etc.).
- Did this require any trade-offs? Which? E.g. cost of additional components vs coverage/adequacy.
- How did these build on existing interventions and systems, e.g. linking people to existing services they did not have access to before?

3.5.4 Timeliness

- Was the response timely in relation to its objectives? (e.g. if focused on medium-term recovery a longer timeframe was reasonable; if emergency response before negative coping strategies kick-in, a two-week timeframe would be more appropriate)
- Was it timely 'overall'? It will be useful to draw up a calendar detailing critical dates such as: when the pandemic began (WHO declaration); when control measures were first introduced; when needs were assessed (including by social protection system and by the humanitarian system); when decisions on responses were taken; when funds were sought; when funds were released; when the first payments were made (to what % of beneficiaries?); when all targeted households received their first payments; when any parallel/similar humanitarian assistance was delivered. (These details will enable the identification of any links where delays were caused as well as comparisons across countries)
- Was the response timely for all the beneficiaries? Or were some supported first? Who and why? Who was supported last and when? (e.g. vertical expansions being implemented before the horizontal ones or the new interventions; e.g. 'easy' caseloads reached before others – already registered, already had a bank account etc.)
- What were the main reasons for any delays and what was done to enhance timeliness to the extent possible? (funding, decision making process, operational capacity, etc.)

3.5.5 Value for money/cost-effectiveness

A full treatment of value for money may not be possible within a case study, it is beyond the scope of this guide to provide full guidance for specialist value for money case studies. However, because value for money is so often a part of the rationale behind using social protection, it is useful to give it some consideration. Cost efficiency (the cost per outcome i.e. the value of money received) is more straightforward and can more easily be treated in the case study than cost effectiveness (the cost of achieving outcomes). Even for cost-efficiency, the data needed may not be available. If not, documenting where existing monitoring systems have critical data gaps will be an extremely useful contribution for their future design.

- Cost-efficiency.
 - Is it possible to calculate a Total Cost to Transfer Ratio (TCTR) for the different social protection interventions? Was it possible to disaggregate it by population group? Can this be compared with the TCTR for any comparable assistance through the humanitarian sector? If there was insufficient data readily available to calculate the TCTRs, which data was being collected and which data was missing? Was there any information on the cost to recipients of collecting the

- money? It was significant enough to change the “net TCTR” (the ratio of the total cost to value received)?
 - What elements contributed to cost-efficiency? Did the response rely on existing systems/data / capacity? Which/how, and how did this affect the dimensions above?
- Cost-effectiveness.
 - What range of indicators can be used to measure how well the intervention met its objectives (e.g. maintaining household consumption above a minimum expenditure basket, preventing distress sales of assets)?
 - Is it possible to compare the intervention with others against these same objectives?
- Were systems coordinated and harmonised across different actors, sectors and institutions (within government and beyond - e.g. humanitarian), resulting in reduced costs and enhanced efficiency and effectiveness? How (e.g. eliminating duplicated delivery systems)?

3.5.6 Accountability

- Were humanitarian principles respected in the response, to the extent these are relevant? The term “humanitarian principles” makes it seem that these are principles which apply to the humanitarian sector. In fact, these are principles which should be considered by everyone working in assistance in two kinds of situations: where needs are so acute that they are a matter of life and death; and in conflicts.
 - **Prioritisation of those most in need.** The humanitarian principle of ‘humanity’ is that life-saving assistance must go to those most in need – i.e. in urgent, acute need – which is not necessarily the case in social protection targeting. Were there people who faced life-threatening need? How far did social protection assistance prioritise these people (rather than, for example, those in chronic poverty)?
 - **Impartiality.** It is a fundamental humanitarian principle that life-saving assistance is provided without discrimination. State resources are not always used impartially. Was there any discrimination, whether deliberate or unintended, in the targeting of resources, for example based on geography, ethnicity, on politics or, in the case of conflict, to those in areas supporting the government? If so, were the measures taken by international actors to ensure that life-saving assistance was given through the humanitarian system to populations not targeted for social protection?
 - **Neutrality.** In some conflicts, the state is one of the parties to the conflict and its legitimacy may even be questioned by some. The choice to support state structures and to channel international aid through state social protection systems may, in some (but not all) conflicts, be a very political decision, e.g. increasing the patronage power of one party to a conflict. In such cases, the principle of neutrality may be important. How far was this principle relevant? If so, was it considered by donors and international organisations supporting social protection? If the principle of neutrality was not observed, how far was it mitigated through humanitarian assistance?
- Were accountability mechanisms sufficient, ensuring full respect of core human rights?
- Was the response understandable and accepted by communities?

3.5.7 Long Term Implications

- To what extent was the response embedded in and strengthening long-term government systems? How?
- To what extent did it involve and leverage the strengths of local actors?
- What are the exit / phase-out strategies in place? (for temporary scale ups) What are these? Are any caseloads being incorporated into routine social protection interventions? How?

3.6 Challenges, lessons learned and preparedness implications for the future

- Summarise (based on everything that has emerged in the Sections above) the key challenges and lessons learned that could be shared and relevant to other countries.
 - When doing this, make sure you are targeting different audiences and their needs (e.g. policy makers, practitioners, researchers).
- What are the next steps in your country's social protection agenda – building on the learning from the COVID-19 responses?
- Are there any specific plans for preparedness for future shocks that are emerging, building on available Shock Responsive Social Protection guidance?

See *SPACE [Preparing for Future Shocks](#)* and the *TRANSFORM Shock Responsive Social Protection* module for more examples and information on practical next steps.

4 A FINAL NOTE FOR AUTHORS

The depth and breadth of the questions above should not overwhelm you! It is likely you will not be able to answer each and every question, or address every area, and that is not a problem. However, no matter what you choose to focus on:

- Take this document as an encouragement to be as systematic as possible in your analysis and follow this structure where you can;
- Recognise your Case Study will be more useful if it can be easily compared against others from other countries;
- Aim to inform policy makers and practitioners hoping to do better in their response to future crises (details that may not be important to you will be important to them);
- Take 'research uptake' as seriously as the research itself. Share your findings on socialprotection.org and other relevant platforms and liaise with fellow researchers!

We wish you all the best in this process – hoping we can jointly set the foundations for stronger preparedness for the future.

ACKNOWLEDGEMENTS AND DISCLAIMER

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