HEARTLAND ALLIANCE INTERNATIONAL

# Improving Access to Health: Resilience, Healing, and Protection in Colombia

Baseline report

Prepared by:
Ileana Resendez, MEL Director
Mónica Rodríguez, MEL Specialist
Héctor Rangel, MEL analist
Cindy Ospina, baseline consultant
Miguel Marín, rural facilitator
Martha Meza, rural facilitator
Ana Paola Mora, legal proffessional
December 29.2021

## Table of Contents

## Acronyms and Abbreviations

| | |
|---|---|
| BHA | Bureau for Humanitarian Assistance |
| CAs | Community Agents |
| CSO | Civil Social Organizations |
| HAI | Heartland Alliance International |
| ELC | humanitarian local coordination |
| IDP | Internally Displaced Person |
| ITT | Indicator tracking table |
| FCS | Food Consumption Score |
| GoC | Colombian government |
| HHS | Household Hunger Scale |
| KYR | Know Your Rights |
| LGBTQ | Lesbian, Gay, Bisexual, Transgender, and Queer |
| MAS | Improving Access to Health: Resilience, Healing, and Protection in Colombia |
| MEL | Monitoring, Evaluation, and Learning |
| MHPSS | Mental Health and Psychosocial Support |
| rCSI | Reduced Coping Strategies Index |
| SRH | Sexual and Reproductive Health |
| PU | Purpose |

## Executive Summary

This report outlines the methodology and findings of baseline for Improving Access to Health: Resilience, Healing, and Protection in Colombia (In Spanish, Mejorando el Acceso a la Salud: Resiliencia, Sanación y Protección en Colombia MAS) Project, a twelve-month project currently funded through the Bureau for Humanitarian Assistance (BHA) that began on September 30, 2021.

The goal of *MAS Resiliencia* is: Colombian IDPs, returnees, victims of conflict, and their host communities are better protected, experience improved well-being, and demonstrate greater resilience, specifically on the pacific and north coast and in southwest Colombia in the departments of Chocó, Valle de Cauca, Córdoba, and Nariño.

The MAS project has four Purposes (PUs):

PU 1: Target beneficiaries have improved basic primary health through an integrated service delivery approach
PU2: Target beneficiaries are more aware of their rights under Colombian law
PU3: Targeted communities are better protected against communicable diseases, including water-borne illnesses.
PU4: Targeted communities reduce food insecurity through aid received

The overall purpose of the baseline report was to collect data for all indicators included in the ITT before implementation begins. Baselines should also collect non-indicator information to describe the prevailing conditions of the target communities or population. Baseline values serve as a point of comparison with end line values during the final evaluation. They also provide important information about the affected population that can be used to improve targeting and activity design before implementation begins.

This 12-month project builds from a previous 2-year intervention, therefore, some of the values for output indicators and sometimes for outcome indicators do not have a baseline value of zero. Instead, they are showing the values of the end of the 2-year previous intervention as the baseline value. The baseline was conducted for all new output and outcome indicators and a final evaluation will be conducted at the end of the project that will be inclusive of both the 2-year intervention and the 12-month intervention, to assess the effectiveness, efficiency, impact, sustainability, relevance, and coherence of the intervention.

## Introduction

HAI works in close coordination with government institutions such as the Victims Unit, the Ministry of Health, and Municipal Health Secretaries to align and strengthen programs and interventions to improve health in conflict survivors. HAI has national and regional agreements with the Victims Unit as well as the Ministry of Health to mainstream efforts in this direction. Furthermore, HAI has also cultivated an extensive network of community-based CSOs, especially within marginalized communities. HAI will continue to collaborate with these organizations to strengthen their capacity to prepare them for health-related emergencies and co-design messaging, so it is culturally appropriate and relevant to each context.

PU 1: Target beneficiaries have improved basic primary health through an integrated service delivery approach

The MAS project will continue to respond to significant unmet maternal and reproductive healthcare needs. To provide the most comprehensive care and ensure appropriate referrals, HAI will continue its contractual relationship with the expert Colombian health organization, *Profamilia,* to provide high-quality reproductive healthcare to 2,000 target beneficiary women and LGBTI individuals in line with the 2018 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.
HAI will train staff to provide information and orientation to 4,500 participants, as well as public entities, on reproductive healthcare referral pathways and protocols, with careful attention to age, gender, and sexual diversity, ensuring a survivor-centered approach to GBV cases.
In Y3, HAI will continue to provide individual and group Mental Health and Psychosocial Support (MHPSS services). MHPSS services will continue to be delivered primarily to recently displaced IDPs, victims of conflict, and Colombian returnees.
HAI strengthened the institutional emergency referral pathway and will continue to train key public stakeholders on the impact of forced displacement and exposure to conflict as well as MHPSS treatment and referral systems

PU2: Target beneficiaries are more aware of their rights under Colombian law

In Y3, HAI will continue to train and empower CAs and technical staff to recognize and respond to protection incidents and needs. Trained CAs will educate at least 2,000 individuals about their rights and available comprehensive services, including the legal rights to reparations and procedures to access them for IDPs, Colombian returnees, and victims of the conflict.
HAI will continue to provide legal consultation and assistance in response to specific legal needs of target beneficiaries. At least 800 IDPs and victims of the conflict will receive legal services to establish their eligibility for and access to state services and reparations.
HAI will support indigenous and rural farmer communities to conduct four assessments and design preparedness and risk mitigation plans to respond to conflict and displacement.
HAI will continue collaborating with women and LGBTI organizations to conduct five participatory risk and safety mapping exercises in their communities and identify sources of GBV, potential allies, GBV risk factors, and factors that trigger or facilitate GBV.

PU3: Targeted communities are better protected against communicable diseases, including water-borne illnesses.

HAI coordinates the delivery of information related to hygiene-related diseases with local CSOs and community leaders who actively participate in the design of the delivered hygiene practice messages. Afro-Colombian Community Councils and Indigenous Community Authorities in four departments are close HAI's partners and support the delivery of messaging and distribution of Menstrual Hygiene Management (MHM) materials and hygiene items

PU4: Targeted communities reduce food insecurity through aid received

HAI coordinates the delivery of unconditional food assistance with the local GoC as part of the response to recently displaced communities or communities affected by confinement in targeted areas. Particularly, emergency responses are coordinated in the humanitarian local coordination teams (ELC) where government actors such as the Victims Unit and international agencies prepare the immediate response to the emergencies.

## I. Methodology

HAI starts the third year of intervention using the same methodologies applied in the past two years for PU1 and PU2. Humanitarian aids delivering activities contended in PU3 and PU4 are part of the MAS project experience, too. The same geographic areas will be covered: Departments of Cauca, Valle del Cauca, Córdoba, and Chocó, and the IDP population, attended in the past, will be covered and will be reported on the same indicators. In this sense, HAI considered it appropriate to use the end line values from relevant indicators generated from the previous award as the baseline for their new follow-on award.

HAI emergency activities enroll new participants on a rolling basis throughout implementation rather than all at once at the start of the activity. HAI captures baseline characteristics of each cohort as the participants are enrolled, through a beneficiary census. On first analysis of 3,755 participants attended in Q1 will be provided as the most in-depth and recent study of the target population.

For PU3 and PU4, four rural and indigenous communities were selected. An initial characterization of these communities was applied to identify their principal conditions and take decisions about the intervention design.

For PU4, 409 surveys were applied in two communities in an emergency food assistance intervention in Nariño's department, to identify the values for the indicators: Food Consumption Score FCS, Reduced Coping Strategies Index rCSI, and Household Hunger Scale HHS.

## II. Detailed findings

For the register of the participants in the MAS project, a family characterization form is applied to enroll them. In Q1, 3,779 heads of households were identified, with the following information:

| Age | Buenaventura | Cali | Montería | Quibdó | Tumaco | Total |
|---|---|---|---|---|---|---|
| 18-59 | 197 | 1562 | 441 | 370 | 690 | 3260 |
| More than 60 | 34 | 261 | 37 | 32 | 155 | 519 |
| **Total** | **231** | **1823** | **478** | **402** | **845** | **3779** |

Most of the heads of a household enrolled (86%) are in the age group between 18 and 59 years old, 485 of them are in Cali.

| Ethnicity | Buenaventura | Cali | Montería | Quibdó | Tumaco | Total |
|---|---|---|---|---|---|---|
| Afro-descendants | 178 | 699 | 6 | 256 | 617 | 1756 |
| Indigenous | 21 | 187 | 108 | 82 | 163 | 561 |
| Not defined | 32 | 934 | 364 | 64 | 65 | 1459 |
| Gypsy | | 3 | | | | 3 |
| **Total** | **231** | **1823** | **478** | **402** | **845** | **3779** |

Most of the participants identified (46%) are afro descendants. The biggest prevalence was identified in Cali and Tumaco cities. Indigenous people (15%) will increase in Q2 when rural and indigenous plans start with community work.

| Gender | Buenaventura | Cali | Montería | Quibdó | Tumaco | Total |
|---|---|---|---|---|---|---|
| Men | 66 | 582 | 124 | 47 | 274 | 1093 |
| Other | 1 | 2 | | | 1 | 4 |
| Female | 164 | 1239 | 354 | 355 | 570 | 2682 |
| **Total** | **231** | **1823** | **478** | **402** | **845** | **3779** |

Most of the participants identified are women (71%), so it´s important how the gender approach will be applied in project interventions., Gender-Based Violence (GBV) is increasing; so is maternal mortality. These figures are not reflected in the registers of public authorities. Access to SRH services through the MAS project is intended to prevent unwanted pregnancies, ensure access to safe birthing and maternity care. It is also designed to bring awareness of sexual abuse and provide legal support.

Other characteristics of Q1 participants group: Rural (34%), Urban (66%); OSCs member (2%), NGO/government staff (3%), IDPs (90%), host population (3%), migrants (25); illiterate people (2%) and People with disabilities (8%).

The general statistics about gender and age of family groups are shown as bellows:

| | BUENAVENTURA | | | CALI | | | MONTERIA | | | QUIBDO | | | TUMACO | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AGE | male | female | other | male | female | other | male | female | other | male | female | other | male | female | other | Total |
| **0-2** | 54 | 51 | 0 | 142 | 126 | 3 | 53 | 46 | 0 | 77 | 61 | 2 | 59 | 56 | 0 | **730** |
| **3-5** | 41 | 76 | 4 | 277 | 199 | 1 | 80 | 86 | 90 | 82 | 75 | 2 | 79 | 72 | 0 | **1.164** |
| **6-17** | 100 | 95 | 1 | 718 | 640 | 3 | 231 | 232 | 0 | 216 | 192 | 12 | 366 | 331 | 1 | **3.138** |
| **18-49** | 208 | 453 | 6 | 1524 | 1910 | 5 | 417 | 645 | 3 | 337 | 653 | 6 | 749 | 1094 | 1 | **8.011** |
| **50-59** | 30 | 115 | 9 | 187 | 143 | 3 | 81 | 102 | 0 | 28 | 62 | 2 | 91 | 127 | 1 | **981** |
| **MAS DE 60** | 63 | 52 | 5 | 239 | 292 | 3 | 71 | 71 | 3 | 26 | 85 | 0 | 155 | 231 | 0 | **1.296** |
| | **496** | **842** | **25** | **3.087** | **3.310** | **18** | **933** | **1.182** | **96** | **766** | **1.128** | **24** | **1.499** | **1.911** | **3** | **15.320** |

The MAS project does not have an initial registry of participants to be attended during the year, the emergency context of the intervention means that people register throughout the year. A part of the individual and group interventions is based on a single session and another part requires a greater number of sessions. In this context, the continuous enrolment scenario defined for the MAS project is Scenario 2: Overlap. Each cohort receives short-term assistance, with some overlap between the cohorts. In this case, the activities work with multiple cohorts of participants with short-term interventions and HAI proposes to change the requirement to measure outcome indicators (FCS, rCSI, and HHS) at the bottom line through representative surveys by a robust PDM that include outcomes monitoring.

PU 01 Target beneficiaries have improved basic primary health through an integrated service delivery approach.

HAI considered it appropriate to use the end line values from relevant indicators generated from the previous award as the baseline for their new follow-on award. These baseline values were included in Indicator Tracking Table ITT (Annex 1)

In Y2, the MAS project attended 2,083 people in SHR services through PROFAMILIA. 97% women, 3% men, and another gender. 71% of interventions were developed in brigades and 19% in clinic establishments. About 75% requested help related to contraceptive methods, routine checks, and preliminary consultations. Sexual counseling requested by the age group, age 18-32 years, constituted 67% of the beneficiaries.

For SMAPS services, 896 individuals have had access to mental health services. Though most of the beneficiaries of the MHPSS are women, men and LGTBI have also requested psychological support. Approximately, 61% of recipients are over 33 years old suggesting that middle and older-aged individual do value their mental health. Of the attendees, 73% correspond to internally displaced, 12% are GVB survivors, and 6% were migrants. More than 67% of MHPSS recipients belong to ethnic groups such as Afro-descendants, indigenous, and Rom. There were 229 critical cases where 36% displayed suicidal tendencies. From the 82% of diagnoses made in the first session, the availability of MHPSS has allowed specialists to uncover 130 cases of GBV and 63 cases of familial violence.

### PU 02 Target beneficiaries experience improved psychosocial well-being and protection.

1,165 persons have sued with the support of HAI's legal services, 77% of the cases were related to victims of the armed conflict. 11% of the total were issued by survivors of GBV) and 12% were part of the legalization of migrants from Venezuela (153). Seven LGTBI individuals had access to justice and about half of all the cases were submitted in Valle del Cauca and Nariño. Men were the main beneficiaries of judicial support (878). With the support of HAI, 22% of recipients pursued their legal recourse.

To improve access to the administration of justice, HAI supports the Public Minister issuing applications to the victims of the armed conflict during internal displacement. In Y2, 1,249 applications were submitted: 45% in Valle del Cauca, 21% in Nariño, 14% in Córdoba, 13% in Chocó, and 7% in Cauca.

### PU 03 & PU 04 Targeted communities are better protected against communicable diseases, including water-borne illnesses but also reduce food insecurity.

Actions planned for purpose 03 demanded an important planning process and community work to achieve the goals expected, principally for the reduction of water-borne illnesses prevalence. The team developed a selection of the places which have the required conditions to work integral and continuous actions with these rural and indigenous communities:

- Support Indigenous and rural farmer communities to conduct community assessments and design preparedness and risk mitigation plans to respond to conflict and displacement in their communities.
- Support Indigenous and rural farmer communities to implement community preparedness and risk mitigation plans through technical training for first responders and annual community forums.

- Target beneficiaries increase their knowledge in hygiene practices to prevent water-borne diseases
- Together with community leaders, design communications materials to deliver health messages to prevent disease and promote health.
- Disseminate context-appropriate health prevention communication materials for hard-to-reach populations (healthy lifestyles, mental health, and hygiene) through print, SMS, local radio, and other mediums
- Women and girls have access to Menstrual Hygiene Management (MHM) materials and hygiene items
- Distribute hygiene kits to target beneficiaries
- Targeted communities reduce food insecurity through aid received

Given that each community has a different population, access conditions, ethnicity, and conditions of access to water, it is necessary to identify how the strategies for PU03 and PU 04 will be applied differently in each region. A brief analysis showing the main conditions of these communities is shown below:

### 1. Rural zone of Villa Carmina, Montelíbano city, Córdoba department.

Community overview

Villa Carmina is a returnee community, located on the banks of the San Juan River, which corresponds to an arm of the San Jorge River (Córdoba), located in the municipality of Montelibano Córdoba.
The host community has been harassed/threatened by illegal groups who desecrated ancestral practices and plundered sacred places for natural resources. The locals had to host displaced 52 farming families from nearby areas. They also offered residency to victims of the social conflict made up of 70% indigenous and 30% other ethnicities.

The only available place for social and community interaction is a small school. However, the conditions were incompatible with safety and hygienic practices. The sports facility is a rudimentary earth football field. Community-based radio and WhatsApp are among practical communication means.

Facing food scarcity are 65 households and 248 residents of which 46% are women and 54% are men. This is because of the lack of access and mobility restrictions. Also, the unavailability of farmland has curtailed small farming activity. Armed actors impose restrictions on food transportation. Compounding the paucity of farming opportunities are the mega-projects in the adjacent areas of Villa Carmina.

Gender dynamics

From a total population of 248, 38% are less than age 18. Of the 65 households, 46 are headed by women suggesting that food security and domestic issues in Villa Carmina are controlled by women.

According to the information gathered, informal labor could be the source of income for women beyond farming. Of those 46 household heads, 4 are nursing (one is under 16), 1 woman was pregnant and 10 are over 50. A total of 5 elderly women are responsible for their productive and reproductive work, one being 75 years old. Older men (four, over 65) are also accountable for household economics.

WASH panorama

According to health registers, in 2019 there were 161 cases of acute diarrhoeal disease affecting Villa Carmina's. Environmental conditions adversely impact the physical, mental and emotional health of the residents. The closest health facility is an hour away. Access to clean water is limited only to the school; households avail themselves of this resource from shallow handmade wells that are seasonally functional.

During the period, February-July, the area is drought-stricken making the well-water turbid. Water needs to be transported from afar. The residents accepted this seasonal water shortage as a fact of life. They attribute water scarcity and pollution to coal mining activities in adjacent areas.

There is a public latrine in the school for fecal sludge containment but all residents resort to open defecation because of the lack of in-house facilities. Households have means for handwashing but no other sanitization utensils and methods are available for safe water usage.

## 2. Rural zone of La Guachosa, Quibdó city, Chocó department.

Community overview

La Guachosa is located in the municipality of Quibdó, Chocó and part of the Tutunendo district. The clean water bodies of the tropical rainforest are the main attraction around which all ethnic groups of the area congregate. Local dwellers are becoming increasingly dependent on the tourism economy. The stunning rivers are part of the ethnic cosmovision and are deemed sacred. La Guachosa was initiated 23 years ago by the Embera indigenous group. The origin was driven by climate change and internal displacement.

The small community has 17 households - all 74 residents are related. A small school and communal house are the focus of community-based activities. For higher education and health needs, residents have to travel beyond the perimeter of the village. Without internet and telephone access communication is limited. Despite road access to the main city, inhabitants are living in poverty which restricts their mobility.

Gender dynamics

All residents participate in tourism and farming activities: men, women, and children but there is no evidence yet if economic resources are pooled collectively or controlled by specific gender identity in the household. Approximately 55% of the population is under 18 years old providing youthful vigor to the community.

There is an equal proportion of women and men. Of the 14 adult women, two are breastfeeding, one is pregnant, one is a single mother with a 1-year old and another who lives alone. Two of the total adult women are over 55 and one is a household head, taking care of 4 children under 18. The 4 elders are equally divided along gender lines.

WASH panorama

Due to the lack of WASH services, community members recall that children and adults suffered from waterborne afflictions including diarrhea, intestinal parasites, and skin fungus. Management of stored

rainwater is inadequate to protect water purity. Alternative water resources are two rivers 45 m away. A public water point, 500 m away is out of service.

Women and children serve as water-hauling mules and accidents are not uncommon. Water quality decrease during heavy downpours mainly due to contaminants from illegal mining and tourist waste. Open defecation is also a source of water contamination due to the lack of individual sanitation facilities. For some, hygienic assets are limited to buckets and tanks.

## 3. Resguardo Guelmambí Caraño, rural zone of El Diviso, Barbacoas city, Nariño department.

Community overview

In the Municipality of Barbacoas there are Indigenous Reservations and Cabildos of the AWA people: Cuambí Yaslambí Reservation, Pingullo Sardinero, Cuasbil Skirt, Gran Sábalo (territory in Barbacoas and Tumaco), Saundé Guiguay, Guelmambí Caraño, Tortugaña Telembí, Pulganguardo-Honda -Río Güiza, Alto Ulbi Nunalbi, Pipalta Palbí Yaguapí, Ñambí Piedra Verde and the Cabildos Guasalpi and Guelmalbí El Bombo. The focused Reservation is the Guelmambí Caraño.

Currently, 155 inhabitants live in the community, which makes up 45 families. The houses are distant. Most of the households are made up of extended families in which several family nuclei coexist under the same roof, approximately eight members.

Gender dynamics

Since the consultation with indigenous communities is a long process, it was not possible to previously obtain a census of this group. The first contacts and meetings with the indigenous authorities are being developed and it is expected to have this information in less than a month.

WASH panorama

There is a high risk of contamination of the water sources that supply water to the community, due to the oil spill and the fumigation with glyphosate. The inhabitants are at high risk of contracting diseases or even dying from poisoning. There is a shortage, due to the severe droughts and low amount of water for human consumption that in the whole area does not have treatment systems, the main source that supplies water to the community is a stream that is 1 km from the homes. As an alternative storage source, the community deposits water in gallons. However, the community states that the water quality is good with a crystalline hue. In particular, this community does not have an aqueduct that can provide water service by quality standards.
The families are supplied with water daily in routes that last approximately 1 hour according to the distance at which the home is located from the water source (ravine). They use gallons between 10 and 20 liters that are transported by the inhabitants. Women are mostly those who carry out this task in the community.

## 4. Rural zone of Hatico, Totoró city, Cauca department.

Community overview

Totoró municipality, in the Cauca region, is 30 Km away from the city of Popayán. The Hatico village is surrounded by mountains and streams that feed one of the main rivers of Colombia, the Cauca River. Access to the village takes about 30 minutes from Totoró. Its history is marked by indigenous slavery and religious influence.

Among the meager communal facilities are a small school, a church, and a cemetery. For health and education services residents rely on adjoining towns. Even if the El Hatico's inhabitants are not recognized as poverty-stricken they do lack water, sanitation, healthcare, and fully equipped schools. The agricultural economy feeds 85% of the population. This situation makes them vulnerable to climate change and other natural disasters. Consequently, they face the question of food and water security.

Gender dynamics

About 200 people, 43 families, are currently scattered throughout the community. 46% of the population are women and 29% of them are minors.

WASH panorama

The community depends on two systems for its water supply. During the rainy season, however, the water quality is compromised. The residents depend on two nearby streams (150 m) for their water supply. Mostly, it's the women who serve as water carriers. The water is then stored in buckets, tanks, and bottles.

All Bio-constructed households are usually equipped with latrines or flush toilets; only 23% of the households have wastewater collecting tanks (septic tanks). The others openly discharge their wastewater into the environment.

## PU 04: Targeted communities reduce food insecurity through aid received during emergencies.

The baseline shows that a differential strategy has to be applied depending on the kind of population attended in 4.1.1 activity,

A part of the food assistance kits or vouches will be delivered in the communities described before, where the HAI team will have longer community work. The other food assistance kits or vouchers will be delivered in emergency zones, with shorter activities to attend a specific humanitarian emergency.

For the baseline, 409 surveys were applied in two communities in an emergency food assistance intervention in Nariño's department, to identify the values for the indicators: Food Consumption Score FCS, Reduced Coping Strategies Index rCSI, and Household Hunger Scale HHS.

Household Hunger Score (HHS)

That is a proxy for food insecurity. To collect data for this indicator is asked about the frequency with which three events were experienced by any household member in the last four weeks:

1. No food at all in the house
2. Went to bed hungry
3. Went all day and night without eating

Following the methodology described in USAID BHA Indicator Handbook, the results obtained are:

67 families scored HHS 0-1 which means little to no hunger (11%)
529 families scored HHS 2-3 which means moderate hunger (86%)
21 families scored HHS 4-6 which means severe hunger (3%)

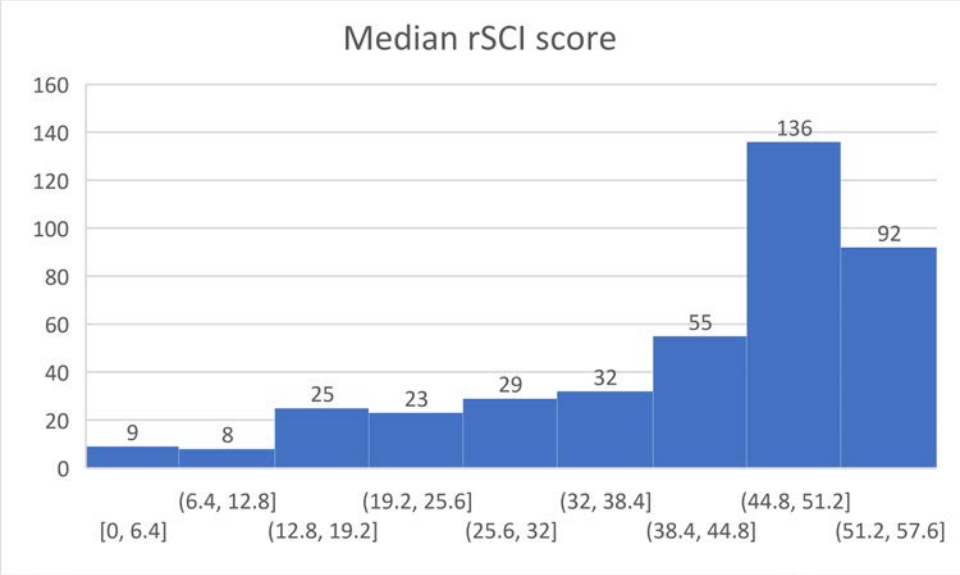
Mean and median Reduced Coping Strategy Index (rCSI) score

The rCSI is a proxy indicator of household food insecurity that is based on a list of behaviors (coping strategies) that people do to manage their food insecurity situation. Following the methodology described in USAID BHA Indicator Handbook, the results obtained are:

| "In the previous 7 days, if there have been times when you did not have enough food or money to buy food, how often has your household had to _____?" | Frequency (# of Days out of 7) | Severity Weight | Weighted Score (Frequency x weight) |
|---|---|---|---|
| 1. Rely on less preferred and less expensive foods | 5,15970516 | 1 | 5,15970516 |
| 2. Borrow food or rely on help from friends or relatives | 4,609336609 | 2 | 9,218673219 |
| 3. Limit portion size at mealtime | 5,606879607 | 1 | 5,606879607 |
| 4. Restrict consumption by adults for small children to eat | 5,361179361 | 3 | 16,08353808 |
| 5. Reduce the number of meals eaten in a day | 5,314496314 | 1 | 5,314496314 |
| TOTAL HOUSEHOLDS SCORE | | | 41,38329238 |

The frequency was obtained by dividing the total sum of days by the number of surveyed households. If 56 is the maximum score if a family applies all five strategies (100% of food security vulnerability), 41.38 equals 74% of food security vulnerability,

However, when analyzing the median of the information, we find that the most representative value is in the range between 44.8 and 51.2, which would represent 91% vulnerability in food security.

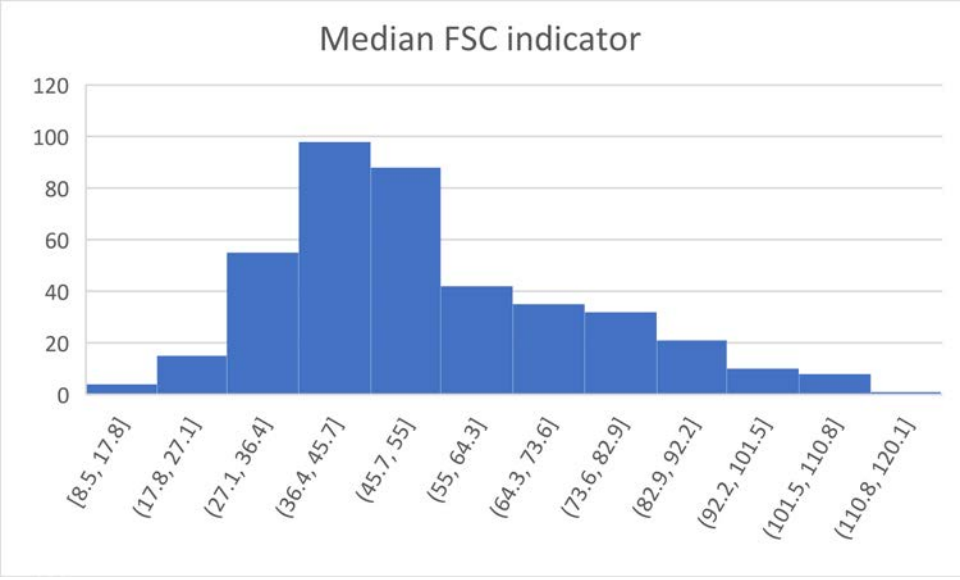



Food Consumption Score (FCS)

FCS is a composite score based on dietary diversity, food frequency, and the relative nutritional importance of different food groups. It is a proxy indicator for food intake. Following the methodology described in USAID BHA Indicator Handbook, the results obtained are:

FCS mean for 407 families was 53.35. Raw scores over 35 which is determined as “acceptable.”
FCS median for 407 families was in the range between 36.4 and 45.7which is determined as “acceptable.”

7 families scored FCS less than 21 which means poor FCS (2%)
52 families scored FCS between 21 and 35 which means border line (13%)
350 families scored FCS more than 35 which means acceptable (75%)



## III. Programmatic implications

Once the information on the intervention for the project in year 3 had been analyzed, the identification of four communities in which an intervention could be carried out from different sectors was proposed as a work strategy, thus allowing the achievement of results for different purposes. Each of these communities has conditions that need to be analyzed to design a tailored intervention. The territories identified and described above are the following:

1. Rural zone of Villa Carmina, Montelíbano city, Córdoba department.
2. Rural zone of La Guachosa, Quibdó city, Chocó department.
3. Resguardo Guelmambí Caraño, rural zone of El Diviso, Barbacoas city, Nariño department.
4. Rural zone of Hatico, Totoró city, Cauca department.

It means a change in the number of participants to be a benefit in the project because an important number of activities will be developed integrally in the communities selected. The new values for beneficiaries in each sector are:

| PU | DIRECTS | | | INDIRECT |
|---|---|---|---|---|
| | Number | Female | Male | |
| **TOTAL PU1** | 8.597 | 6.090 | 3.632 | 5.750 |
| **TOTAL PU2** | 17190 | 10361 | 6829 | 35000 |
| **TOTAL PU3** | 3.850 | 2.550 | 500 | 5.550 |
| **TOTAL PU4** | 3.000 | 1.800 | 1.200 | 9.000 |
| TOTAL | 32.637 | 20.801 | 12.161 | 55.300 |

For PU04, assistance consists in the delivery of a kit or voucher food assistance, it is not a long-term intervention. In this sense, HAI proposes to change the end-line survey for Food Consumption Score FCS, Reduced Coping Strategies Index rCSI, and Household Hunger Scale HHS, implementing an enhanced PDM.

## IV. Conclusions and recommendations

Agreements with ethnic and indigenous communities demand time and capacity building. Some of these communities do not have an internet connection or phone lines, then the only way to have communication is traveling there. The first steps to agree on the intervention with them were implemented and additional information will be supplied soon.

In consideration of the difficulties needed to be addressed, applying the instruments of data collection and analysis becomes a time-consuming undertaking. Despite this, HAI was able to collect meaningful data related to the fourth sector. Using end-line data from the last year, assumptions were made for all the places since they have similar features and demographics. Baseline information will be gathered along with the MAS project implementation.

For MAS Y3, it is a challenge do not to attend migrant population; it was an important number of participants last year. One other challenge is to increase the attention to children and young people because a lot of them have affectations for the war and the conditions than they have to live.

A new model of intervention was designed for SRH services with PROFAMILIA, it will represent a reduced number of services related to the last years. HAI has to look for new ways to cover other services not contemplated in the BHA award.

Incidence of water-borne diseases in the communities assisted based on community health facilities records was not presented as an official number in this baseline because HAI is articulating contacts with heath entities in the communities to establish the official numbers for PU03.

## V. Annex A: Indicator Tracking Table

**BHA ITT**

| | |
|---|---|
| **Award #** | |
| **Awardee** | Heartland Alliance International |
| **Country** | Colombia |
| **Duration** | 12 months |
| **Version Date** | 5/10/2021 |

## I. Annex A: Indicator Tracking Table

| Activity Indicator | Result Statement | Sector | Subsector | Keyword | BHA Indicator | Indicator^ | Disaggregates^ | Indicator Type ^ | Desired direction | Baseline Value | Endline Value | Life of Award (LOA) | Monitoring Data** Target (Semi-annual) | Actual (Semi-annual) | LOA Actual | Data Collection Method^^ | Data Source^^ | Data Collection Frequency | Position Responsible for Collection | Assumptions | Indicator used in PRM project | Same Target group | Same Location | Same Participants |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Goal The needs of Colombian IDPs, returnees, victims of the armed conflict and host communities, particularly in hard to reach and underserved communities, are better met in response to ongoing displacements and conflict in Colombia.** | | | | | | | | | | | | | | | | | | | | | | | |
| | **Purpose** | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | Target beneficiaries have improved basic primary health through an integrated service delivery approach | Health | Basic primary health care (PHC) | N/A | C01 | Percentage of people on the last quartile of well-being score | Location, gender, age group | Outcome | + | 0.85 | | 0.85 | | | | Well-being assessment tool | Well-being assessment tool | Baseline, Endline | MEL Officer | Service enables well-being improvements and do not harm participants | No | | | |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 | Target beneficiaries benefit from high-quality reproductive healthcare. | Health | Basic primary health care (PHC) | N/A | C02 | Percentage of people satisfied with the reproductive healthcare they receive | Gender, location | Outcome | + | 0.91 | | 1.00 | | | | Survey | Healthcare Satisfaction Survey | Monthly | MEL Officer | Profamilia is well recognized health provider and continues to provide quality and timely services under the contract terms through the life of the project | Yes | Yes | Yes | No |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1.1 | Provide reproductive and maternal health with a special focus on women and LGBTI people, in partnership with Profamilia. | Health | Basic primary health care (PHC) | N/A | H08 | Number of pregnant women who attended at least two comprehensive antenatal clinics | Gender, location, type of service | Output | + | 83.00 | | 250.00 | | | | Routine Monitoring | Patients registers | Ongoing basis | MEL Officer, Implementing partner | Comprehensive services include procurement of restrictive commodities for family planning | No | | | |
| | | Health | Basic primary health care | N/A | H05 | Number of outpatients consultations | Gender, age group, consultation type | Output | + | 2083.00 | | 1750.00 | | | | Routine Monitoring | Patients registers | Ongoing basis | MEL Officer, Implementing | | No | | | |
| 1.1.2 | Train CAs and staff to provide information to participants on reproductive healthcare referrals with careful attention to age, gender, and sexual diversity. | Health | Basic primary health care (PHC) | | H04 | Number of health care staff trained | Gender, location, age group | Output | + | 55.00 | | 47.00 | | | | Routine Monitoring | Attendance sheets, | Ongoing basis | MEL Officer, Implementing partner | Local government is supportive of this intervention given the recognition of Profamilia and their limited capacity to provide the services | No | | | |
| | | Health | Basic primary health care | | C03 | Number of healthcare training provided | Gender, location | Output | + | 0.00 | | 4.00 | | | | Routine Monitoring | Training tracking tool | Ongoing basis | MEL Officer | | No | | | |
| 1.1.3 | Disseminate existing local reproductive healthcare and GBV referral pathways and protocols for target population | Health | Basic primary health care (PHC) | | C04 | Number of individuals that receive information about reproductive healthcare pathways and protocols | Location | Output | + | 987.00 | | 4500.00 | | | | Routine Monitoring | Distribution lists | Ongoing basis | MEL Officer | Local government is supportive of this intervention given the recognition of Profamilia and their limited capacity to provide the services | Yes | Yes | Yes | No |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2 | Target participants benefit from high-quality mental health services in response to ongoing displacements | Health | Basic primary health care (PHC) | | C05 | Percent of people satisfied with mental health and psychosocial care they or their families receive | Gender, location, age group | Outcome | + | 0.84 | | 0.99 | | | | Survey | Mental and psychosocial satisfaction survey | Endline | MEL Officer | Services received are sufficient to help participants reduce anxiety, depression, stress, regardless of their specific context/situation | Yes | Yes | Yes | No |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2.1 | Provide group and individual mental health services to target beneficiaries | Health | Basic primary health care (PHC) | | C06 | Number of individuals participating in mental health services | Gender, location, type of service | Output | + | 8669.00 | | 2000.00 | | | | Routine Monitoring | Mental health tracking | Ongoing basis | MEL Officer | In times of COVID-19, direct beneficiaries are available to receive services remotely. Alternatively, they are provided with resources and conditions to mobilize them and receive the services in-person | Yes | Yes | Yes | No |
| 1.2.2 | Refer participants to specialized mental health service providers and guarantee access to service follow up | Health | Basic primary health care (PHC) | | H13 | Number of consultations for any mental health condition | Gender, age group, service type | Output | + | 0.00 | | 30.00 | | | | Routine Monitoring | Patients registers | Ongoing basis | MEL Officer, Implementing partner | Specialized services are available for referred participants, if necessary, HAI will enable access | Yes | Yes | Yes | No |
| 1.2.3a | Train and mentor CSOs and communities to design preparedness and risk mitigation plans to respond to health emergencies | Health | Basic primary health care (PHC) | | C08 | Number of health emergency preparedness and risk mitigation plans developed | Location | Output | + | 5.00 | | 5.00 | | | | Routine Monitoring | Plans | Ongoing | MEL Officer | Health municipal plans will be developed in collaboration with CSOs and local authorities | Yes | Yes | Yes | No |
| 1.2.3b | Train and mentor CSOs and communities to design preparedness and risk mitigation plans to respond to health emergencies | Health | Basic primary health care (PHC) | | C09 | Percentage of persons at risk of immediate harm for whom a crisis response plan is developed and implemented. (Includes persons at risk of suicide, victims of trafficking or severe intimate partner violence, and others at immediate risk of harm.) | Gender, location | Output | + | 0.00 | | 0.30 | | | | Routine Monitoring | Plans | Ongoing | MEL Officer | | No | | | |
| 1.2.4 | Provide emergency community-based interventions, including PFA and psychoeducation, to target beneficiaries | Health | Essential Health Services | | C07 | Number of individuals that receive community-based interventions | Gender | Output | + | 19577.00 | | 4000.00 | | | | Routine Monitoring | Patients registers | Ongoing basis | MEL Officer, implementing partner | | Yes | Yes | Yes | No |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3 | Government staff related with victims attention receive qualification trained for emergency responses | Health | Essential Health Services | | C10 | Percentage of individuals trained who increased their knowledge on PFA, trauma-informed approach and other MHPSS concepts, GBV, and basic competencies for emergency responses | Gender, location, goverment organization | Outcome | + | 0.74 | | 0.80 | | | | Routine Monitoring | Pre and post tests | Ongoing basis | MEL Officer | In times of COVID-19, direct beneficiaries are available to receive services remotely. | Yes | Yes | Yes | No |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3.1 | Train Health providers, Victims Attention Centers (CRAV) staff, and other key public stakeholders on PFA, trauma-informed approach and other MHPSS concepts, GBV and basic competencies for emergency responses | Health | Essential Health Services | | C11 | Number of individuals trained on PFA, trauma-informed approach and other MHPSS concepts, GBV and basic competencies for emergency responses | Affiliation, location, gender | Output | + | 168.00 | | 180.00 | | | | Routine Monitoring | Attendance sheets, agendas | Ongoing basis | MEL Officer | Feasible to coordinate and agree on availability for capacity building | No | | | |
| | **Purpose** | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | Target beneficiaries experience improved psychosocial well-being and protection | Protection | Protection Coordination, Advocacy, and Information | | C12 | Percentage of individuals that receive protections services who have received a favorable resolution of their legal issue | Gender, location, age group | Outcome | + | 0.00 | | 0.60 | | | | Documentation review | Case files | Baseline, Endline | MEL Officer | Contextual factors do not undermine the benefits of services provided through the project | No | | | |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.1 | Target beneficiaries are more aware of their rights under Colombian law | Protection | Protection Coordination, Advocacy, and Information | | C13 | Average score on Colombian law assessment | Gender, location, age group, type o | Outcome | + | 0.95 | | 0.85 | | | | Test | Pre and post test | Ongoing | MEL Officer | Security conditions allow for project service delivery | No | | | |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.1.1a | Train CAs and technical staff on legal issues and procedures to comprehensive support target beneficiaries | Protection | Protection Coordination, Advocacy, and Information | | C14 | Number of staff trained in recognizing and responding to protection incidents and concerns | Gender, location, age group | Output | + | 55.00 | | 47.00 | | | | Routine Monitoring | Attendance sheets, Training agendas | Ongoing basis | MEL Officer | CAs are from the communities and will remain there during the life of the project | Yes | Yes | Yes | No |
| 2.1.1b | Train CAs and technical staff on legal issues and procedures to comprehensive support | Protection | Protection Coordination, | | C15 | Number trainings on legal issues and procedures | Training theme | Output | + | 0.00 | | 4.00 | | | | Routine Monitoring | Training agendas | Ongoing basis | MEL Officer | | No | | | |
| 2.1.2 | Educate target beneficiaries about their rights and available services, including the legal rights to reparations and procedures to access them for IDPs, Colombian returnees, and victims of the conflict. | Protection | Protection Coordination, Advocacy, and Information | | P05 | Number of individuals trained in protection | Gender, location, age group | Output | + | 6003.00 | | 2000.00 | | | | Routine Monitoring | Attendance sheets | Ongoing basis | MEL Officer | Trainings provided by expert HAI staff who also keep up with national legal changes and developments | Yes | Yes | Yes | No |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.2 | Target beneficiaries have improved access to legal support to uphold their rights and secure justice | Protection | Protection Coordination, Advocacy, and Information | | C16 | Percentage of beneficiaries that are satisfied with consultation and/or case representation services received by HAI and partners | Gender, location | Outcome | + | 0.76 | | 1.00 | | | | Survey | Legal service Satisfaction survey | Quarterly | MEL Officer | No limit in the number of consultations to ensure comprehensive service, including access to additional legal resources | Yes | Yes | Yes | No |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.2.1 | Provide legal consultation, assistance, and representation to help IDPs, and victims of the armed conflict to establish eligibility for as well as access state services and reparations | Protection | Protection Coordination, Advocacy, and Information | | C17 | Number of individuals who receive legal services to establish eligibility for reparations as victims of the conflict | Gender, location | Output | + | 1068.00 | | 850.00 | | | | Routine Monitoring | Case files | Ongoing basis | MEL Officer | HAI builds a trusting relationship with communities and their leaders in order to access their territories | No | | | |
| 2.2.2 | Partner with the Ministerio Público to increase their capacity to register victims of conflict declarations after displacements | Protection | Protection Coordination, Advocacy, and Information | | C18 | Number of conflict victims that provide their statement to the Ministerio Público through HAI support | Gender, location | Output | + | 1462.00 | | 500.00 | | | | Routine Monitoring | Case files | Ongoing basis | MEL Officer | Participants trust the Ministerio Publico to provide declarations and seek resolutions | Yes | Yes | Yes | No |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.3 | Indigenous and rural farmer communities in rural areas at risk for displacement enhance their community protection mechanisms | Protection | Protection Coordination, Advocacy, and Information | | C19 | Percentage of surveyed community participants who demonstrate knowledge of community protection mechanisms | Gender, location | Outcome | + | 0.78 | | 0.75 | | | | Survey | Community protection mechanism survey | Baseline, endline | MEL Officer | Communities and their leaders recognize risks and are interested and motivated to engage in establishing long term protection mechanisms | Yes | Yes | Yes | No |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.3.1a | Provide continuous training and supervision to community agents (CAs) to provide comprehensive non-specialized PSS services, GBV case management and referrals for other services to their communities | Protection | Protection Coordination, Advocacy, and Information | | C20 | Number of Community Agents trained | Gender, Location | Output | + | 55.00 | | 30.00 | | | | Routine Monitoring | Attendance sheets | Ongoing basis | MEL Officer | SPSS professionals provide sufficient supervsion to CAs during the life of the project and closely manage the comprehensive training processes provided. | Yes | Yes | Yes | Yes |
| 2.3.1b | Provide continuous training and supervision to community agents (CAs) to provide comprehensive non-specialized PSS services, GBV case management and referrals for other services to their communities | Protection | Protection Coordination, Advocacy, and Information | | C21 | Number of supervision sessions carried out with CA and project staff | Type of participant supervised, Location | Output | + | 0.00 | | 50.00 | | | | Routine Monitoring | Attendance sheets, Training agendas | Ongoing basis | MEL Officer | | Yes | Yes | Yes | No |
| 2.3.2a | Support Indigenous and rural farmer communities to conduct community assessments and design preparedness and risk mitigation plans to respond to conflict and displacement in their communities | Protection | Protection Coordination, Advocacy, and Information | | C22 | Number of preparedness and risk mitigation plans designed/updated | Location | Output | + | 4.00 | | 4.00 | | | | Participatory planning | Plans | Ongoing basis | MEL Officer | HAI builds a trusting relationship with communities and their leaders in order to access their territories and work collaborative with them in developing risks assessments and mitigation plans | Yes | Yes | Yes | No |
| 2.3.2b | Support Indigenous and rural farmer communities to conduct community assessments and design preparedness and risk mitigation plans to respond to conflict and displacement in their communities | Protection | Protection Coordination, Advocacy, and Information | | C23 | Number of communities with designed/updated risk mitigation plan | n/a | Output | + | 4.00 | | 4.00 | | | | Routine Monitoring | Distribution lists | Ongoing basis | MEL Officer | | Yes | Yes | Yes | No |
| 2.3.3 | Support Indigenous and rural farmer communities to implement community preparedness and risk mitigation plans through technical trainings for first responders and annual community forums | Protection | Protection Coordination, Advocacy, and Information | | C24 | Number of Indigenous and rural farmers who complete at least one technical training | Location, gender | Output | + | 414.00 | | 100.00 | | | | Routine Monitoring | Attendance sheets, agendas | Ongoing basis | MEL Officer | Security conditions allow project participants and HAI mobility and service delivery | Yes | Yes | Yes | No |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.4 | Government agencies and humanitarian actors have increased capacity to respond to the MHPSS and GBV response needs of target beneficiaries | Protection | Protection Coordination, Advocacy, and Information | | C25 | Percentage of trained individuals who demonstrate increased knowledge of workshop topics | Affiliation, location, gender | Outcome | + | 0.74 | | 0.80 | | | | Pre post test | MHPSS and GBV assessment | Ongoing basis | MEL Officer | Other capacity factors are not determined to improve government agencies and humanitarian actors capacity | Yes | Yes | Yes | No |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.4.1 | Train emergency response agencies on mechanisms to protect against SEA in humanitarian settings. | Protection | Protection Coordination, Advocacy, and Information | | C26 | Number of individuals trained on mechanisms to protect against SEA | Affiliation, location, gender | Output | + | 74.00 | | 60.00 | | | | Routine Monitoring | Attendance sheets, agendas | Ongoing basis | MEL Officer | HAI maintains recognition as a leader in SEA policies among humanitarian sector agencies | Yes | Yes | Yes | No |
| 2.4.2 | Train local government staff and service providers on victim's law implementation | Protection | Protection Coordination, Advocacy, and Information | | C27 | Number of individuals trained on national victims law implementation | Affiliation, location, gender | Output | + | 104.00 | | 100.00 | | | | Routine Monitoring | Attendance sheets, agendas | Ongoing basis | MEL Officer | Feasible to coordinate and agree on availability for capacity building | Yes | Yes | Yes | No |
| 2.4.3 | In partnership with government units and other NGOS, provide self-care sessions to their frontline humanitarian workers to prevent burnout and secondary trauma and improve work satisfaction. | Protection | Protection Coordination, Advocacy, and Information | | C28 | Number of individuals who participate in at least one care session | Affiliation, location, gender | Output | + | 269.00 | | 200.00 | | | | Routine Monitoring | Attendance sheets, agendas | Ongoing basis | MEL Officer | HAI maintains recognition as a leader in self-care policies among humanitarian sector agencies | Yes | Yes | Yes | No |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.5 | Women, LGBTI community members at risk of GBV, SGBV or survivors improve their wellbeing | Protection | Psychosocial Support Activities | | C29 | Percent of individual beneficiaries who report an increase in their psychosocial wellbeing | Gender, age group | Outcome | + | 0.84 | | 0.60 | | | | Assessment | Wellbeing assessment | Baseline, endline | MEL Officer | Gender disparity is intrinsic to culture, limiting the effects of interventions | Yes | Yes | Yes | No |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.5.1 | Provide case management for victims of SGBV and GBV, in-person or by phone in cases of emergency in accordance with IASC guidelines, and ensure referral to essential services | Protection | Psychosocial Support Activities | | P03 | Number Individual beneficiaries accessing gender based violence (GBV) response services | Gender, location, services, age group | Output | + | 327.00 | | 150.00 | | | | Routine Monitoring | Attendance sheets, case files | Ongoing basis | MEL Officer | Victims feel trust in HAI and receive services regardless of presenting the report to the aggressor | Yes | Yes | Yes | No |
| 2.5.2 | Provide community-based group and individual MHPSS services to target beneficiaries, including victims of GBV and SGBV | Protection | Psychosocial Support Activities | | P06 | Number of individuals participating in psychosocial support services | Gender, age group | Output | + | 1579.00 | | 5000.00 | | | | Routine Monitoring | Attendance sheets, agendas | Ongoing basis | MEL Officer | Victims feel trust in HAI and receive services regardless of presenting the report to the aggressor | Yes | Yes | Yes | No |
| 2.5.3 | Provide legal consultation, assistance, and representation to GBV survivors pursuing justice | Protection | Psychosocial Support Activities | | C30 | Number of survivors of GBV or other crimes who receive legal services | Gender, location | Output | + | 137.00 | | 100.00 | | | | Routine Monitoring | Case files | Monthly | MEL Officer | Victims feel trust in HAI and receive services regardless of presenting the report to the aggressor | Yes | Yes | Yes | No |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.6a | Women, LGBTI community members at risk of GBV, SGBV or survivors have improved protection strategies | Protection | Prevention of and Response to GBV | | C31 | Improvement on safety and protection strategies | n/a | Outcome | + | 5.00 | | n/a | | | | Participatory safety mapping | Participatory safety mapping | Baseline, endline | MEL Officer | HAI builds a trusting relationship with communities and their leaders in order to access their territories and work collaborative with them in developing risks assessments and mitigation plans | No | | | |
| 2.6b | Women, LGBTI community members at risk of GBV, SGBV or survivors have improved protection strategies | Protection | Prevention of and Response to GBV | | P04 | Number of dollars allocated to GBV interventions | n/a | Input | + | 0.00 | | 23000.00 | | | | Routine monitoring | Activity records, budgets | Ongoing basis | MEL Officer | | No | | | |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | |
| 2.6.1 | Collaborate with women and LGBTI organizations to conduct participatory risk and safety mapping in their community, identifying sources of GBV, potential allies, GBV risk factors, and factors that trigger or facilitate GBV. | Protection | Prevention of and Response to GBV | | C32 | Number of risk and safety mapping activities conducted | Location | Output | + | 5.00 | | 5.00 | | | | Routine Monitoring | Risk and safety mapping documents | Ongoing basis | MEL Officer | LGBTI organizations engagement in the project increase the potential for impact and sustainability of project interventions | Yes | Yes | Yes | No |
| 2.6.2 | Collaborate with women and LGBTI organizations to design community action plans to prevent and respond to GBV and support their implementation through | Protection | Prevention of and Response to GBV | | C33 | Number of community action plans designed/updated | Location | Output | + | 5.00 | | 5.00 | | | | Routine Monitoring | Plans | Ongoing basis | MEL Officer | LGBTI organizations engagement in the project increase the potential for impact and sustainability of project interventions | Yes | Yes | Yes | No |
| 2.6.3 | Train women and LGBTI organizations to implement community action plans to prevent and respond to GBV through technical assistance. | Protection | Prevention of and Response to GBV | | C34 | Number of individuals who participate in technical assistance activities | Location, gender | Output | + | 551.00 | | 75.00 | | | | Routine Monitoring | Attendance sheets, agendas | Ongoing basis | MEL Officer | LGBTI organizations engagement in the project increase the potential for impact and sustainability of project interventions | Yes | Yes | Yes | No |
| 2.6.4 | Support Women and LGBTI organizations to develop and conduct awareness campaign about risks and vulnerability factors for GBV, COVID-19 and SEA specific to gender ethnicity, and other social characteristics | Protection | Prevention of and Response to GBV | | C35 | Number of individuals who are reached with information about risk and vulnerability for GBV and SEA | Location, gender | Output | + | 1579.00 | | 4000.00 | | | | Routine Monitoring | Attendance sheets, communicat ions records | Ongoing basis | MEL Officer | LGBTI organizations engagement in the project increase the potential for impact and sustainability of project interventions | Yes | Yes | Yes | No |
| 2.6.5 | Women and LGBTI organizations and other NGOS refer survivors of GBV to MHPSS, reproductive healthcare, legal and other social services for comprehensive care . | Protection | Prevention of and Response to GBV | | C36 | Number of individuals referred for additional services | Location, gender | Output | + | 1690.00 | | 400.00 | | | | Routine Monitoring | Case notes, referral forms | Ongoing basis | MEL Officer | Services are available and accessible to attend referred survivors of GBV | Yes | Yes | Yes | No |
| | **Purpose** | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | Targeted communities are better protected against communicable diseases, including water-borne illnesses. | Water, Sanitation, and Hygiene | Hygiene Promotion | | C37 | Incidence of water borne diseases in the communities assisted based on community health facilities records | | Outcome | - | tbd | | 0.05 | | | | Secondary sources | Community Health Centers records | Baseline, endline | MEL Officer | Target population have sustainable access to clean water and soap to continue implementing project messages after project completion. | No | | | |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | |
| 3.1a | Target beneficiaries increase their knowledge in hygiene practices to prevent water-borne diseases | Water, Sanitation, and Hygiene | Hygiene Promotion | | W10 | Percent of people targeted by hygiene promotion activity who know at least 3 of the 5 critical times to wash their hands | Location | Outcome | + | 0.00 | | 0.80 | | | | Beneficiary-based (household) survey. | Questionnai re | Baseline, endline | MEL Officer | Selected media are the best alternatives to disseminate messages about healthy lifestyles, mental health, and hygiene for hard-to-reach populations | No | | | |
| 3.1b | Target beneficiaries increase their knowledge in hygiene practices to prevent water-borne diseases | Water, Sanitation, and Hygiene | Hygiene Promotion | | W08 | Percent of beneficiary households with soap and water at handwashing station on premises | Location | Outcome | + | 0.00 | | 0.80 | | | | Direct observation (during beneficiary survey) | Direct observation | Baseline, endline | MEL Officer | | No | | | |

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.1c | Target beneficiaries increase their knowledge in hygiene practices to prevent water-borne diseases | Water, Sanitation, and Hygiene | Hygiene Promotion | | W11 | Percentage of households targeted by the hygiene promotion activity who store their drinking water safely in clean containers | Location | Outcome | + | 0.00 | | 0.30 | | | | Direct observation (during beneficiary survey) | Direct observation | Baseline, endline | MEL Officer | [illegible] | No | | | |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | | |
| 3.1.1 | Together with community leaders, design communications materials to deliver health messages to prevent disease and promote health. | Water, Sanitation, and Hygiene | Hygiene Promotion | | C38 | Number of communications materials designed | Media type, target population | Output | + | 51.00 | | 15.00 | | | | Routine Monitoring | Materials developed | Ongoing basis | MEL Officer | Co-development of community messages with local communities, Indigenous authorities to ensure appropriateness/cultural appropriateness and effectiveness of message acceptance | Yes | Yes | Yes | No |
| 3.1.2a | Disseminate context-appropriate health prevention communication materials for hard-to-reach populations (healthy lifestyles, mental health, and hygiene) through print, SMS, local radio, and other mediums | Water, Sanitation, and Hygiene | Hygiene Promotion | | W07 | Number of people receiving direct hygiene promotion (excluding mass media campaigns and without double counting) | Gender, age group | Output | + | 0.00 | | 2000.00 | | | | Routine Monitoring | Registration records | Ongoing basis | MEL Officer | The most hard to reach communities have access to the local media & physical equipment (radios, etc.) | No | | | |
| 3.1.2b | Disseminate context-appropriate health prevention communication materials for hard-to-reach populations (healthy lifestyles, mental health, and hygiene) through print, SMS, local radio, and other mediums | Water, Sanitation, and Hygiene | Hygiene Promotion | | C39 | Number of people reached through hygiene promotion | Location | Output | + | 0.00 | | 4000.00 | | | | Routine Monitoring | Service records, media reports | Ongoing basis | MEL Officer | The most hard to reach communities have access to the local media & physical equipment (radios, etc.) | No | | | |
| | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | | |
| 3.2a | Women and girls have access to Menstrual Hygiene Management (MHM) materials and hygiene items | Water, Sanitation, and Hygiene | NFI | | W26 | Percent of households reporting satisfaction with the contents of the WASH NFI received through direct distribution | n/a | Outcome | + | n/a | | 0.80 | | | | FGD | Post distribution FGD | Endline | MEL Officer | Women receiving dignity kits are literate and can read and benefit from the messaging included in the kits | No | | | |
| 3.2b | Women and girls have access to Menstrual Hygiene Management (MHM) materials and hygiene items | Water, Sanitation, and Hygiene | NFI | | W27 | Percent of households reporting satisfaction with the quantity of WASH NFI received through direct distribution | n/a | Outcome | + | n/a | | 0.70 | | | | FGD | Post distribution FGC | Endline | MEL Officer | | No | | | |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | | |
| 3.2.1 | Distribute dignity kits to vulnerable women and girls | Water, Sanitation, and Hygiene | NFI | In-kind | C40 | Number of individuals who receive dignity kits | Location, gender | Output | + | 1450.00 | | 1000.00 | | | | Routine Monitoring | Distribution records | Ongoing basis | MEL Officer | Most vulnerable women and girls receive the kits assistance | Yes | Yes | Yes | No |
| 3.2.2a | Distribute hygiene kits to target beneficiaries | Water, Sanitation, and Hygiene | NFI | In-kind | C41 | Number of individuals who receive hygiene kits | Location, gender | Output | + | 1216.00 | | 1100.00 | | | | Routine Monitoring | Distribution records | Ongoing basis | MEL Officer | Most in-need individuals receive the kits assistance | Yes | Yes | Yes | No |
| 3.2.2b | Distribute hygiene kits to target beneficiaries | Water, Sanitation, and Hygiene | NFI | In-kind | W25 | Number of individuals receiving WASH NFI assistance through all modalities (without double counting) | Location, gender | Output | + | 1216.00 | | 1500.00 | | | | Routine Monitoring | Distribution records | Ongoing basis | MEL Officer | | No | | | |
| | **Purpose** | | | | | | | | | | | | | | | | | | | | | | | | |
| 4.0 | Targeted communities reduce food insecurity through aid received | Food Assistance | Uncondicional Food Assistance | | **F03** | Percent of food assistance decision-making entity members who are women | Age | Outcome | + | n/a | | 0.50 | | | | Routine Monitoring | review of documents that list the members of decision-making committees and other bodies by gender | Semiannual report and final report | MEL Officer | - | No | | | |
| 4.0 | Targeted communities reduce food insecurity through aid received | Food Assistance | Uncondicional Food Assistance | | **F02** | Percent of households were women/men reported participating in decisions on the use of food assistance | Sex of primary beneficiary receiving food assistance. Nested: modality, sex, age, decision actor | Outcome | + | n/a | | 0.50 | | | | Beneficiary survey | Questionnaire | Baseline, end line | MEL Officer | - | No | | | |
| **4.1** | **Intermediate Outcome*** | | | | | | | | | | | | | | | | | | | | | | | | |
| 4.1 a | Targeted communities receive emergency food assistance during recent displacements or confinements | Food Assistance | Uncondicional Food Assistance | | FS03 | Percent of households with moderate and severe Household Hunger Scale (HHS) scores | Overall, gender household type | Outcome | - | 41.00 | | 43.00 | | | | Beneficiary survey | Questionnaire | Baseline,PDM | MEL Officer | - | No | | | |
| 4.1 b | Targeted communities receive emergency food assistance during recent displacements or confinements | Food Assistance | Uncondicional Food Assistance | | FS02 | Mean and median Reduced Coping Strategy Index (rCSI) score | Sex, age groups | Outcome | - | little to no hunger (11%) moderate | | little to no hunger (14%) moderate | | | | Beneficiary survey | Questionnaire | Baseline, PDM | MEL Officer | - | No | | | |
| 4.1 c | Targeted communities receive emergency food assistance during recent displacements or confinements | Food Assistance | Uncondicional Food Assistance | | FS01 | Percent of households with poor, borderline, and acceptable Food Consumption Score (FCS) | 1. Percent of households with "Poor" FCS scores<br>2. Percent of households with "Borderline" FCS scores<br>3. Percent of households with "Acceptable" FCS scores (Recommended) Level 1 - Data points: mean, median, number of beneficiary households (Recommended) Level 2 - Gendered Household Type: F&M, FNM, MNF, CNA | Outcome | N/A | poor FCS (2%) border line (13%) acceptable (75%) | | poor FCS (0%) border line (15%) acceptable (75%) | | | | Beneficiary survey | Questionnaire | Baseline, PDM | MEL Officer | - | No | | | |
| | **Output** | | | | | | | | | | | | | | | | | | | | | | | | |
| 4.1.1 | Support local governments in emergency response by distributing essential items/ basic food packages to recently affected populations by acute emergencies | Food Assistance | Uncondicional Food Assistance | | F01 | Number of beneficiaries receiving food assistance | Sex, modality type, conditionality | Output | + | 9352.00 | | 6000.00 | | | | Routine Monitoring | Monitoring checklist | Frequency of collection will depend on the frequency of | MEL Officer | Develop partnerships and agreements with local governments | Yes | Yes | Yes | No |
| 4.1.1 | Support local governments in emergency response by distributing essential items/ basic food packages to recently affected populations by acute emergencies | Food Assistance | Uncondicional Food Assistance | | FS04 | Number of individual beneficiaries participating in BHA food security activities | Sex, age | Output | + | 9352.00 | | 6000.00 | | | | Routine Monitoring | Activity Records/ monitoring checklist | Frequency of collection will be ongoing. Frequency of | MEL Officer | | Yes | Yes | Yes | No |

** The sub-purpose and intermediate outcome are optional depending on the complexity of the proposed activity*
*** Additional monitoring columns should be added based on the life of the award, and frequency of collecting routine data, as determined by the PIRS*
*^ The components for each BHA indicator are stated in the Performance Indicator Reference Sheet (PIRS).*
*^^ Data Collection Method and Data Source are generally stated in the Performance Indicator Reference Sheet (PIRS), however, implementing partner should provide specific information based on their context and interventions.*

## I. Annex B: Indicator Estimates Table

### BHA DIRECT AND INDIRECT ESTIMATES

| PU | | | DIRECTS | | | INDIRECT | | |
|---|---|---|---|---|---|---|---|---|
| | | | Number | Female | Male | | | |
| **SO1 Target groups** | Sector | Description | Number | f(60%) | m (40%) | Description | Multiplier | |
| Target population 1 IDPs women & LGBTQ MHPSS | **Basic Primary Health Care** | 1.1.1 Reproductive and maternal health | 250 | 250 | | families | 3 | 750 |
| | | | 2750 | 1800 | 950 | outpatients consultations | 0 | |
| | | 1.2.1 mental health beneficiaries (assumption 50% of campaings receipients) | 1500 | 1425 | 950 | families | 3 | 4,500 |
| | | 1.2.2 specialized mental health (assumption, included in previous) | 0 | | | families | 3 | - |
| Target population 2 CA | | 1.1.2 Training CA staff | 47 | 30 | 17 | psychoeducation beneficiaries (assumption are beneficiaries on 1.1.3) | 0 | - |
| Target poppulation 3 General public | | 1.1.3 campaigns | 4,000 | 2,550 | 1,700 | n/a | | |
| Target population 4 CSO and communities | | 1.2.3 5 CSO's | 50 | 35 | 15 | Community members from each organization (5 CSO) | 50 | 500 |
| **TOTAL PU1** | | | 8,597 | 6,090 | 3,632 | | 59 | 5,750 |
| **SO2 Target groups** | Sector | Description | Number | f(60%) | m (40%) | Description | Multiplier | |
| | **Protection Advocacy and Information** | 2.1.1 CAs included in SO1 | 0 | | | n/a | 0 | - |
| Target population 5 IDPs Legal support | | 2.1.2 legal services- rights | 2000 | 1200 | 800 | | | |
| | | 2.2.1 legal consultation (assumption same from above) | | | | | | |
| Target population 6 Ministerio Public servants | | 2.2.2 conflict victims | 500 | 300 | 200 | | | |
| Target population 1 IDPs women & LGBTQ MHPSS support | | SO 2 2.5.2 people | 5000 | 3000 | 2000 | families | 3 | 15,000 |
| Target population 7 MHPSS recepients | | 2.3.2 MHPSS (assumption- legal and SMAPS included) | 7000 | 4200 | 2800 | | | |
| Target population 8 Rural communities | | 2.3.3 Rural communities assessments 4 (assumption 100 per community) | 100 | 60 | 40 | n/a | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | 2.3.4 rural population conducting training (assumption included in 2.3.3) | 0 | | | | | |
| Target population 9 Health providers | | 2.4.1 trauma-informed, GBV, MHPSS training | 180 | 150 | 30 | Patients | 50 | 9,000 |
| Target population 10 Emergency response Agencies | | 2.4.2 Training on SHEA | 60 | 36 | 24 | Beneficiaries | 100 | 6,000 |
| Target population 11 Local government | | 2.4.3 Local government training on victims law implementation | 100 | 60 | 40 | beneficiaries | 50 | 5,000 |
| Target population 12 Front line humanitarian workers | | 2.4.4 Training on self-care (assumption including 2.4.2) | 200 | 120 | 80 | Beneficiaries (assumption included in 2.4.2) | 0 | - |
| | **Psychosocial Support Activities** | | | | | | | |
| Target population 1 IDPs women & LGBTQ MHPSS support | | 2.5.1 GBV support (assumption include in 1.1.1) (services 150) | 0 | | | n/a | 0 | - |
| Target population 7 MHPSS recepients | | 2.5.2 Community based MHPSS, including GBV (assumption included in 2.3.2) (services 5000) | 0 | | | n/a | 0 | - |
| Target population 7 MHPSS recepients | | 2.5.3 Legal consultation (assumption included in 2.3.2) (services 100) | 0 | | | n/a | 0 | - |
| | **Prevention and Response to GBV** | | | | | | | |
| Target population 4 CSO and communities | | 2.6.1 5 CSO's conduct participatory risk and safety mapping(service 5 CSO, assumption 10 staff each) | 50 | 35 | 15 | n/a | 0 | - |
| Target population 13 women & LGBTQ CSOs | | 2.6.3 Training women & LGBTQ CSOs (Included in 2.6.5) | 0 | | | Beneficiaries | 50 | - |
| Target population 14 Campaing outreach vulnerability GBV, Covid | | 2.6.4 campaign about risks and vulnerability factors (assumption 50% from other campaing) | 2000 | 1200 | 800 | n/a | 0 | - |
| Target population 7 MHPSS recepients | | 2.6.5 Referrals to health, legal (assumption included in 2.5.2) (service 400) | 0 | | | n/a | 0 | - |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **TOTAL PU2** | | | 17190 | 10361 | 6829 | | | 253 | 35000 |
| **SO3 Target groups** | Sector | Description | Number | | | Description | Multiplier | | |
| | Hygiene promotion | | | | | | | | |
| Target population 15 healthy lifestyles campaing recepients | | 3.1.2 hard to reach groups healthy lifestyle campaing (assumption 50% from other campaings) | 2000 | 1200 | 800 | n/a | | 0 | - |
| | Wash NFI | | | | | | | | |
| Target population 1 IDPs women & LGBTQ MHPSS support | | 3.2.1 dignity kits (assumption: included in 1.1.1) (service 1000) | 750 | 750 | 0 | families | | 3 | 2,250 |
| Target population 1 IDPs women & LGBTQ MHPSS support | | 3.2.2 hygiene kits (assumption: included in 3.2.1) (service 7000) | 1100 | 600 | 500 | families | | 3 | 3,300 |
| **TOTAL PU3** | | | 3,850 | 2,550 | 500 | | 0 | 6 | 5,550 |
| **SO4 Target groups** | Sector | Description | Number | | | Description | Multiplier | | |
| Target population in emergency campaigns | | 4.1.1 | 3000 | 1800 | 1200 | | | 3 | 9,000 |
| **TOTAL PU4** | | | 3,000 | 1,800 | 1,200 | | 0 | 3 | 9,000 |
| TOTAL | | | 32,637 | 20,801 | 12,161 | | 0 | 321 | 55,300 |