

Final **Evaluation** Summary Report



of the Christian Aid component of the Disaster Emergency
Committee Ukraine Crisis Humanitarian Appeal

Christian Aid

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1. Evaluation Overview

Christian Aid (CAID) launched its Ukraine response in the aftermath of the February 2022 full scale invasion, mobilising 16 partners to support over 600,000 crisis-affected individuals across 24 oblasts. Guided by principles of localisation, inclusivity, and community leadership, CAID's interventions spanned Assess and Assist (A&A), Safe Spaces (SS), psychosocial support (PSS), food parcels (FP), and a community-led grant mechanism (sclr). This evaluation, conducted by Crest Point for Consultancy and Development (CPCD), assessed performance across three oblasts—Ternopil, Lviv, and Kharkiv—with findings structured around the nine Core Humanitarian Standards (CHS). Data was collected via 140 household surveys (HS), 11 focus group discussions (FGD), and 13 key informant interviews (KII).

2. Evaluation Findings per CHS and Locations:

CHS 1 – Community feedback incorporation into project design

Across all three oblasts, CAID's partner-led model enabled community voices to shape humanitarian programming. In **Ternopil**, needs assessments were led by partners Light of Reformation (LOR) and Blythswood (BLY) using a blend of KOBO surveys, Telegram consultations, FGDs, and field visits. These tools ensured feedback was prioritised, with program planning based on repeated needs expressed by over 60% of participants. Changes such as reducing food parcel weight and modifying delivery times reflected a direct response to this feedback.

In **Lviv**, APH's Safe Spaces team, composed mainly of IDPs, applied mixed methods (social media monitoring, online surveys, FGDs, personal consultations) to gather insights. Community feedback influenced the expansion of youth courses and replacement of food suppliers. Priority was given to veteran support and underserved towns. In **Kharkiv**, needs assessments were implemented through Blago Foundation staff who relied on QR-coded surveys, written forms, and face-to-face consultation—especially vital for older participants. Community demands led to targeted responses, such as maternal health packages.

Despite these participatory practices, only 25% of participants across locations understood their selection criteria. Kharkiv had the highest awareness at 36.7%, followed by Lviv (22.5%) and Ternopil (10%). Still, 100% of those who were consulted affirmed that their input was acted upon.

CHS 2 – Timely and informed delivery of services

All three locations demonstrated strong performance in ensuring timely and well-communicated assistance. In **Ternopil**, participants reported that even minor registration issues were resolved immediately, contributing to high satisfaction. Staff flexibility, empowered by CAID's decentralised approach, was instrumental in meeting distribution schedules. The use of Telegram for announcements and chatbot support improved responsiveness.

In **Lviv**, the integration of hotline numbers, printed materials, and SMS enabled communication to reach participants with limited internet access. Events were relocated to accessible venues when needed, and staff adjusted travel support for vulnerable individuals. FGDs highlighted swift responses to emergencies, including medical support for children.

In **Kharkiv**, communication was tailored through posters with QR codes, direct engagement by dormitory commandants, and consistent updates via social workers.

Nearly all participants (98.6%) across modalities confirmed no delays, with Kharkiv respondents frequently describing the services as “very prompt” and “well-organised.”

The flexibility of DEC funding allowed partners to integrate new needs, such as firewood provision, and implement logistical solutions like alternate routes and flexible procurement. Delays were minor and typically linked to sclr projects involving renovation, mitigated through seasonal scheduling and vendor coordination.

CHS 3 – Community resilience and project ownership

The evaluation found that CAID's localised model enhanced both individual and community resilience. In **Ternopil**, psychosocial support and volunteerism were noted as drivers of stability for displaced families. Participants emphasised the confidence gained from new responsibilities and the continuity of services enabled by municipal support.

In **Lviv**, camps and civic activities for youth promoted long-term recovery. The involvement of veterans in programming and business development was linked to empowerment. Informal support structures like self-help groups persisted post-intervention.

In **Kharkiv**, public infrastructure upgrades (e.g. playgrounds, gyms) through sclr enabled safe environments for children and fostered community pride. Public committees formed during implementation showed potential for continued local leadership.

Despite these gains, perceived sustainability varied. While 55% of PSS recipients believed emotional coping skills would endure, only 50% of A&A and 25% of Safe Space participants expected continued benefit.

CHS 4 – Services impact

In all regions, the core modalities of A&A, FP, SS, PSS, and sclr demonstrated strong positive outcomes. In **Ternopil**, A&A reduced financial stress and supported family stability. PSS sessions helped participants address trauma and regain control over their emotional wellbeing.

In **Lviv**, Safe Spaces provided educational, emotional, and social benefits for children and parents. Participants noted transformative experiences from creative sessions and career-exploration camps. One participant recalled, however, venue inaccessibility for PwDs remained a limitation, prompting event relocation.

In **Kharkiv**, sclr projects like gyms and community centres delivered visible infrastructure gains. Food parcels contributed to improved nutrition and psychological comfort. Unmet needs like cancer treatment highlighted ongoing gaps, though partners responded to most issues through referrals and partner coordination.

Overall, satisfaction was high: 100% of PSS respondents and 92.5% of Safe Space users reported positive impacts. Few unintended effects were noted. Concerns about program dependence were mitigated through referrals to employment and retraining.

CHS 5 – Community understanding of safe reporting and safeguarding

Safeguarding frameworks were present across partners, but their visibility and uptake varied. In **Ternopil**, staff implemented codes of conduct, complaint boxes, and anonymous surveys. Participants acknowledged strong protections, yet only a fraction used feedback tools due to unclear procedures prior to service receipt.

In **Lviv**, safeguarding centred on SEA prevention, with semi-annual training and anonymous CRM protocols. Materials were disseminated in both print and digital formats. However, few participants recalled safeguarding sessions. Volunteers, while trained, were not always included in refresher courses. In **Kharkiv**, safeguarding training covered ethics, safe space management, and staff conduct. While the atmosphere was generally perceived as safe, only 30% of survey respondents were aware of SEA-specific reporting channels. Social workers were often viewed as informal mediators.

100% of survey respondents denied personal experiences of SEA, and only 11% of all respondents used the formal complaint systems, and of those, just three (4.1%) received a response. These findings underscore the importance of visibility and interpersonal trust in encouraging safe reporting. Future programming must reinforce community sensitisation, particularly in transient populations.

CHS 6 – Coherence with other projects and systems

Across all sites, CAID's approach prioritised alignment with local and humanitarian systems. In **Ternopil**, coordination with municipal structures and churches facilitated shared procurement and joint planning. Respondents described creating a unified beneficiary database to track and manage distributions, minimising duplication.

In **Lviv**, coordination extended to regional councils and social services. Partners held regular meetings with the Lviv Regional Council and worked with the tourism department on public rehabilitation initiatives.

Veteran families and PwDs were supported through coordinated services.

In **Kharkiv**, operational coherence was sustained via digital planning tools and shared work schedules with territorial centres. Partners signed memoranda with public institutions, ensuring effective referrals and service coverage. Staff emphasised active planning and routine check-ins with community committees. While partners avoided duplication through geographic segmentation, survey data showed only 44.4% of participants receiving multiple aid types were asked about overlapping support, indicating room to formalise coherence checks at the participant level.

CHS 7 – Diversity, inclusion, and partner-led approach through CAID

CAID's partner-led approach fostered inclusion and local ownership, with distinct adaptations across locations. In **Ternopil**, inclusion of PwDs was facilitated through Telegram bots and tailored services, such as home delivery and modified distributions. Initiative groups led by women and caregivers highlighted gains in leadership and project management.

In **Lviv**, partner APH actively adjusted programming based on feedback from youth, veterans, and disabled individuals. Adaptations included age-specific psychosocial activities and relocation of inaccessible events. Informants described how elderly feedback led to creation of targeted psychosocial spaces. In **Kharkiv**, inclusion was enabled through consistent home-based outreach and services tailored to children, older adults, and people with disabilities. PwDs received home visits, and dormitory residents benefitted from personalised guidance.

However, some participants highlighted gaps in venue access and follow-up. Overall, 50% of PwD participants said services were accessible, and 73% were satisfied with service delivery. Despite strong inclusion efforts, some participants remained unaware of these adaptations, indicating a need to reinforce visibility of inclusive practices.

CHS 8 – Respectful Treatment of Communities

Staff conduct was widely praised across all three oblasts. In **Ternopil**, psychosocial service providers were valued for patience and attentiveness. Respondents described a welcoming and supportive environment. PSS and A&A recipients highlighted the relational dimension of support as central to their recovery. In **Lviv**, Safe Space facilitators built strong emotional rapport with children and families. Participants appreciated being treated with dignity and as equals. Staff were also praised for enabling connections between displaced children and host communities.

In **Kharkiv**, the presence of social workers and psychologists provided both logistical and emotional security. These relational aspects of service delivery contributed to trust, inclusion, and satisfaction. Survey data confirmed these observations, with over 90% of respondents rating staff attitude and competence as good or excellent.

CHS 9 – Effective use of resources and risk mitigation

Across all three regions, resources were generally viewed as sufficient and used effectively. In **Ternopil**, weekly team monitoring and simplified procurement contributed to strong performance despite limited resources. PSS participants praised the availability of materials and prompt assistance. However, staff noted difficulty recruiting male workers for labour-intensive tasks.

In **Lviv**, budget constraints were managed through flexibility and cost-sharing with volunteers. Medical and transport support was provided during outbreaks at children's camps. MEAL officers used regular financial analysis to guide allocation.

In **Kharkiv**, resource sufficiency was high, but unmet medical needs persisted. Peer mentorship and external partnerships filled gaps when needed. Staff adjusted plans through cross-regional reallocation and donor coordination.

Although 91.4% of survey respondents said resources were sufficient, unmet needs among vulnerable subgroups (e.g., cancer patients) point to the importance of flexible funds and targeted risk mapping.



Lessons Learned

CHS 1 – Participation and Transparency: The sclr model and other participatory approaches enabled partners to act on real-time community feedback. Adjustments to food kits and delivery schedules reflected community priorities, with 100% of consulted individuals confirming their input was used. However, only 25% of participants understood why they were selected for aid, indicating that while engagement was deep, coverage and transparency were limited. Programs must ensure that participatory tools are paired with systematic communication strategies that clearly explain eligibility and procedures to all groups.

CHS 2 – Timeliness and Flexibility: 98.6% of participants reported timely delivery, enabled by flexible funding, staff autonomy, and proactive adjustments to health and logistical needs. The funding allowed for responsive measures like winter firewood provision. However, sclr projects requiring construction or equipment faced seasonal and procurement-related delays. These challenges highlight the need for phased implementation, early vendor engagement, and procurement planning for asset-heavy interventions.

CHS 3 – Resilience and Sustainability: Community-led planning and emotional support activities contributed to resilience, with over 44% of respondents reporting improved financial independence. Yet sustainability varied: while Ternopil saw continued support through local authorities, many in Kharkiv feared service termination. Only half of A&A recipients expected lasting benefit. Early integration of sustainability planning—including handover strategies and municipal alignment—is crucial to reduce service dependency.

CHS 4 – Positive Impact, Limited Continuity: All core modalities were praised for relevance and usefulness: 100% of PSS users and 92.5% of Safe Space users reported positive outcomes. However, many beneficiaries, particularly of A&A and Safe Spaces, reported no lasting impact. This reflects the need for clearer exit strategies, consistent messaging about service duration, and integrated follow-up pathways such as livelihood support or referrals to public services.

CHS 5 – Feedback and Safeguarding Gaps: Although partners offered multiple CRM channels and safeguarding protocols, usage was low: only 11% used feedback tools, and just 4.1% received a response. Awareness of PSEA mechanisms was also limited. This gap—especially in transient populations—shows that one-time sensitisation is insufficient. Safeguarding and accountability systems should be co-designed with communities, made easily accessible, and reiterated throughout the program cycle.

CHS 6 – Coordination and Verification: Coordination with municipalities and flexible partner networks avoided duplication and enabled effective referrals. Shared databases and planning tools were used in some areas. However, only 44.4% of participants receiving multiple aid types were asked about other assistance, suggesting a need for formalised, participant-level coherence checks. Future efforts should standardise shared registries and referral mechanisms across partners.

CHS 7 – Inclusion Requires Systematic Application: Partners introduced inclusive practices—home visits for PwDs, age-specific psychosocial spaces, and youth-focused activities. Still, only 50% of PwD participants agreed that services were accessible, and others noted gaps in physical access or service visibility. Inclusion must be actively monitored, resourced, and evaluated across the response. Capacity-building for partners is essential to meet inclusion and safeguarding standards without compromising local adaptation.

CHS 8 – Staff Conduct and Trust: Staff were consistently described as empathetic, respectful, and supportive, with over 90% of participants rating their conduct positively. Trust in staff contributed to psychosocial recovery, particularly in sensitive services like PSS and Safe Spaces. However, a few inconsistencies in communication highlighted the importance of ongoing staff training, supervision, and performance management.

CHS 9 – Resource Use and Risk Mitigation: Participants viewed resource use as sufficient and appropriate (91.4% satisfaction), thanks to cost-sharing, localised procurement, and partner flexibility. Risks such as disease outbreaks and capacity gaps were addressed through peer mentorship and anticipatory planning. However, some specific needs (e.g., cancer treatment) remained unmet. Future programming should incorporate targeted needs mapping and flexible contingency funding to address emerging vulnerabilities.

Recommendations

1. **Clarify Selection and Eligibility Criteria** Develop a unified communication strategy that includes visual and verbal explanations of inclusion criteria. Conduct orientation sessions at registration and distribute printed materials to increase transparency.
2. **Plan for Exit and Sustainability from Program Onset** Incorporate sustainability milestones and phased transition models into project timelines. For modalities like A&A and SS, consider linking support to vocational training or municipal service integration.
3. **Increase Awareness and Accessibility of Feedback Systems** Reintroduce safeguarding and complaints channels routinely throughout the project lifecycle. Use trusted intermediaries to explain use and confidentiality and ensure SEA-specific channels are clearly promoted.
4. **Ensure Inclusion is Monitored, Visible, and Adapted** Implement minimum accessibility standards for venues and materials. Regularly monitor satisfaction among marginalised groups and communicate adaptations made in response to their input.
5. **Enhance Technical Accompaniment for Smaller Partners** Continue peer mentoring for sclr groups and small NGOs, with optional refresher sessions on financial and reporting procedures. Maintain grant simplicity and build localised support networks.
6. **Formalise Coordination Protocols Across Partners** Develop interoperable registration and referral platforms, including formal agreements for data sharing. Mandate inquiry about other forms of aid during initial assessments.
7. **Maintain Staff Excellence Through Mentorship and Recognition** Provide periodic staff coaching, integrate participant feedback into performance reviews, and maintain staff well-being initiatives.
8. **Anticipate Emerging Needs via Structured Risk Mapping** Conduct quarterly subgroup-specific vulnerability assessments. Establish a flexible fund to address medical and seasonal risks and integrate needs mapping into MEAL systems.

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