Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa

Regional Analysis

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Preface

UNICEF's Eastern and Southern Africa Regional Office (UNICEF ESARO) has commissioned Oxford Policy Management (OPM) to carry out a real-time assessment (RTA) of UNICEF's response to COVID-19 in countries in the region.

This report outlines the findings from the regional analysis and draws predominantly on a desk review of secondary information and data relating to all 21 countries provided by the Evaluation Section, a questionnaire administered to all UNICEF country offices (COs) in the region, and a second questionnaire administered to UNICEF partners in 15 countries. In line with the 'light-touch' nature of the overall RTA and respecting the maximum page length of 15 pages (excluding the Executive Summary), the report provides an overview of the findings, emerging themes, and lessons to be learned. The report format follows the outline provided by UNICEF ESARO for regional reports.

The RTA team includes the following members: Jayne Webster (Team Leader), Emma Jones (Project Manager), Bilal Hakeem (RTA coordinator), Elizabeth Harrop (Adviser, Gender and Social Protection), Georgina Rawle (Adviser, Education), Kandi Shejavali (Monitoring & Evaluation (M&E) Expert), Deogardius Medardi (M&E Expert), Lauren Mueenuddin (M&E Expert), Denis Tiren (M&E Expert), and Nicola Wiafe (Research Analyst). Nicola Wiafe drafted this report, which was then reviewed by other members of the project team.

We are grateful to UNICEF ESARO's Evaluation Section, specifically to Urs Nagel, Bikul Tulachan, and Yasmin Almeida, for their invaluable collaboration and guidance on the conceptualisation, design, and technical delivery of the RTA work. In addition, UNICEF consultant Karen Hickson provided useful inputs.

Executive summary

Introduction

This light-touch regional analysis of the UNICEF response to COVID-19 in the Eastern and Southern Africa region (ESAR) was undertaken between October 2020 and January 2021. It has involved a desk-based review of secondary information and data provided by UNICEF ESARO Evaluation Section and analysis of results of surveys administered to UNICEF COs and their partners. It aimed at answering **four overarching questions**: (i) how have UNICEF COs adapted to the COVID-19 pandemic and to evolving needs?; (ii) how can the implementation and quality of the COVID-19 response be characterised?; (iii) what are the emerging themes?; and (iv) what are the early lessons?

Findings

Adaptation in the COVID-19 response: the region partially met expectations related to adaptation, with most countries developing adaptations in some programme areas. COs adapted to the pandemic by enhancing coordination with government counterparts, reprogramming resources, hiring new staff and redeploying existing staff, scaling up the use of digital platforms, and increasing the use of local solutions.

Implementation of the COVID-19 response: the region partially met expectations relating to the implementation of the response. There was evidence of successful efforts to maintain most or all essential services in most countries. For most COs, interventions appear to target only some of the populations identified as vulnerable and, while all COs are implementing gender equality- or gender-based violence (GBV)-related programming, fewer countries appear to be making efforts to mainstream gender. Most COs are collecting feedback on the COVID-19 response from affected populations, but it is not always clear how this feedback is used to inform programming. Similarly, COs are using a variety of methods to determine population needs but, for some countries, it is not clear how this data has fed into the response. There is limited evidence of successful preparedness and contingency planning in COs without past experience of mounting an emergency response.

Ability to assure quality in the COVID-19 response: Despite the negative impacts of the crisis on UNICEF's ability to deliver quality, the region has met expectations related to quality-related indicators. COs have made efforts to adjust monitoring and reporting systems to the COVID-19 context. There are also perceptions that, overall, the response has been delivered in a timely manner, even though there are suggestions that processes for making partnerships and procuring supplies during emergencies could be further streamlined.

Positives and challenges

Notable positives from UNICEF's response include the following:

- **Partnerships:** strong partnerships with government, civil society, UN agencies, donors, and the private sector have been instrumental in reaching targeted populations, including the most vulnerable, in order to mitigate the secondary impacts of the response.

- **Access to funding:** continued access to funding, including through successful applications for reprogramming funds, has contributed to timeliness of the response and enabled the implementation of child protection and social protection programmes; this has been made possible due to strong relationships and early engagement with donors.

- **Innovative solutions:** the use of digital and mobile phone platforms for communication, training, and service delivery and local procurement have been successful and have demonstrated efficiency benefits.

- **Supplies:** support from the Supplies Division and use of local procurement have been key in mitigating shortages in personal protective equipment (PPE) and lifesaving commodities.

- **Risk Communication and Community Engagement (RCCE):** this is considered to be one of the most successful and timely aspects of the response, and has helped in generating demand for essential services.

The **challenges** encountered in the response to COVID-19 included:

- **Lack of preparedness** in countries without previous experience mounting an emergency response.

- **Movement restrictions** affecting essential services delivery, programme monitoring, and procurement.

- **Access to supplies:** especially for PPE due to high global demand and low/non-existent local production, which was exacerbated by movement restrictions, customs delays, insecurity, etc.

- **Access to funding:** delayed funding was one of the main hinderances to a timely response.

- **Lack of reliable data** on some aspects of programme performance (e.g. access to distance learning), gender inequality, and vulnerable populations, which was exacerbated by travel restrictions and poor-quality routine data from government.

Lessons/Suggested action points

The major lessons that can be drawn from this light-touch analysis are:

1. **Use the COVID-19 response to strengthen preparedness and emergency response**, especially in COs with limited experience of responding to emergencies.

2. **Continue to advocate for additional funding** that can be used flexibly and improve the speed of disbursements to prevent programming delays.

3. **Strengthen and expand partnerships** with UN agencies, government, technical agencies, civil society, donors, and suppliers, including developing long-standing partnerships, simplifying the procedures to make new partnerships in an emergency, and ensuring that COs are supported to use and adapt these simplified procedures.

4. **Continue testing and use of innovative approaches**, including use of digital platforms, local procurement of supplies, and new modes of service delivery; invest in electronic systems and advocate for improved connectivity and Information Communication Technology (ICT) infrastructure.

5. **Improve the availability of data**, including disaggregated data and data on vulnerable populations, and ensure data is used to adapt programming to country needs.

6. **Improve access to supplies**, including making it easier for COs to leverage local suppliers and increasing the use of contingency planning.

7. Increase **prioritisation of child protection, social protection, and RCCE** by continuing to advocate for additional resources and ensuring COs have adequate numbers of staff with the relevant expertise.

8. **Improve gender programming**, including accountability for results on gender, reporting of sex-disaggregated data, availability of gender experts, and funding.

9. Improve **accountability to affected populations (AAP)** by building on existing feedback platforms and ensuring the availability of necessary skills and systems to collect and analyse data; ensure all COs are implementing activities to address the **risk of sexual exploitation and abuse (SEA)**.

10. **Improve coverage of vulnerable groups**, ensuring that activities are targeted at all groups that have been identified as vulnerable and that COs and partners have a shared understanding of who the vulnerable groups are.

List of abbreviations

AAP	Accountability to Affected Populations
C4D	Communication for Development
CO	Country Office
ESAR	Eastern and Southern Africa Region
ESARO	Eastern and Southern Africa Regional Office (of UNICEF)
GBV	Gender-Based Violence
HAC	Humanitarian Action for Children
ICT	Information Communication Technology
IDP	Internally Displaced Person
IPC	Infection Prevention and Control
M&E	Monitoring & Evaluation
MHPSS	Mental Health & Psychosocial Support
NGO	Non-Governmental Organisation
OPM	Oxford Policy Management
PPE	Personal Protective Equipment
PSEA	Prevention of Sexual Exploitation and Abuse
SEA	Sexual Exploitation and Abuse
RCCE	Risk Communication and Community Engagement
RTA	Real-Time Assessment
ToR	Terms of Reference
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

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1 Introduction

1.1 Background

In March 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a pandemic. Since then, the UNICEF COs and regional office in ESAR have been working with governments, United Nations Country Teams, development partners, non-governmental organisations (NGOs), and private sector partners to respond to the pandemic with the aim of reducing transmission and mitigating the negative secondary impacts of the spread of the disease. By August 2020, UNICEF ESAR countries had received nearly US$ 350 million, approximately 18% of UNICEF's global Humanitarian Action for Children (HAC) appeal, to respond to COVID-19.

The Evaluation Office proposed an RTA of UNICEF's ongoing response and response planning to COVID-19 at country level to take stock and inform a forward-looking reflection on implementation, with the intention that the RTA is adapted and undertaken by regional offices. The Evaluation Section of UNICEF ESARO subsequently commissioned OPM to carry out an RTA of UNICEF's COVID-19 response in the region. This is intended to support UNICEF in its locally appropriate (i.e. contextualised) adapted delivery of essential services, building on affected people's needs and concerns through the sharing of timely evidence to COs and throughout the region to subsequently support timely ongoing course correction through programme adaptations.

The RTA covers UNICEF's response to COVID-19 in ESAR from 11 March 2020. It is being undertaken from October 2020 to July 2021 in two distinct phases. The first phase has taken place from October 2020 to January 2021 and the second phase is planned for February to July 2021. The primary users of this RTA are intended to be the COs in ESAR, and it is expected that they will benefit from these real-time reflections on their activities in response to COVID-19. The regional office and headquarters will also use the findings of the RTA for planning and programmatic purposes.

1.2 Scope, approach, and methods

The RTA has four overarching assessment questions provided in the terms of reference (ToR). These relate to: whether the response is needs-based and adaptive; the response to COVID-19 in terms of implementation and quality; early lessons and their applicability to different settings; and what should be done differently. These overarching questions have been broken down into specific assessment questions, which were provided as part of the inception report. The RTA activities have been designed to generate evidence to answer these questions. Phase one evidence generation activities are divided into two components: a) light-touch regional analysis; and b) deep dives or case studies in Kenya, Madagascar, Namibia, Somalia, South Africa, and Uganda.

The light-touch regional analysis has involved:

- **Secondary data and document review**. This involved a review of 500+ documents provided by UNICEF ESARO Evaluation Section and others viewed on the UNICEF website/SharePoint related to all 21 countries, including: UNICEF HQ and ESARO programming guidance; country preparedness and response plans; regional- and country-level situation reports; data on funding and performance against targets; information on the COVID-19 situation in each country; and data related to service continuity and socioeconomic impacts, etc.
- **Primary data collection** using an online questionnaire administered to external partners and drawing on UNICEF's analysis of an online questionnaire administered

to COs via SurveyMonkey.[1] In total, responses were collected from 67 stakeholders: 21 COs completed the SurveyMonkey questionnaire and 46 partners from the 15 countries that were not selected for deep dives/case studies completed the partner questionnaire.[2] Stakeholders included government counterparts and NGO, UN agency, and private sector partners selected in consultation with UNICEF CO focal points. The regional analysis also draws on the findings of the RTA case studies, which collected the perspectives of an additional 40 stakeholders including CO staff and partners.

The data was analysed using a framework analysis technique. This involved:

1. creating an assessment matrix for each country that listed data sources across the horizontal axis and assessment questions across the vertical axis;
2. reviewing each document, and entering information in the relevant cell of the matrix—relevant information from UNICEF's analysis of the CO survey and the RTA case studies was also entered into the matrix;
3. reviewing the evidence from each source against each assessment question and rating the CO's performance using the following classifications: 'meets or surpasses expectations'/GREEN if evidence indicated that the CO performed well or exceedingly well in relation to a specific question; 'partially meets expectations'/YELLOW if evidence indicated that the CO performed somewhat well but did not meet the criteria for 'meets or surpasses expectations' in relation to a specific question; 'does not meet expectations'/RED if evidence indicated that the CO performed poorly in relation to a specific question or if evidence was not available where it was reasonable to expect that it should be available; 'not applicable' if the question was not considered relevant to the specific CO; and 'unable to verify' if it was not possible to judge the CO's performance in relation to the specific question due to lack of sufficient evidence.

   Numerical scores were automatically assigned to each question based on the classification received.[3] By calculating averages, classifications for each question were used to produce regional ratings for each question.[4] A regional rating for each of the three thematic areas—adaptation, implementation progress, and quality—was calculated by averaging the scores for each of the questions relevant to that thematic area.

1.2.1 Limitations

The methodology was subject to a number of limitations:

- The broad scope of the RTA (covering all 21 countries and all response areas) limited the level of depth that could be achieved and the extent to which each response area could be covered. Rather than an in-depth analysis, this report and the accompanying matrix aim to highlight key successes and gaps related to each assessment question for further exploration.

[1] The results of the CO questionnaire were analysed by Karen Hickson and the findings are presented in a separate report. UNICEF made the report and the primary data available to the RTA team and this report draws on the findings in that earlier report.
[2] In addition, DARA completed the partner survey on behalf of partners in Malawi who had already been interviewed as part of the Real Time Evaluation.
[3] Questions classified as GREEN received a score of 3; those classified as YELLOW received a score of 2; and questions that were classified as RED were scored 1. Questions that received a 'not applicable' or 'unable to verify' classification were not considered in the scoring.
[4] A GREEN classification was assigned to the region if the average score across all countries for a question was >=2.5, YELLOW if the average score across all countries for a question was 1.5–2.4, and RED if the average score across all countries for a question was <1.5.

- Core documentary information sources such as response plans and SitReps are heavily geared to describing which activities were implemented: it was challenging to ascertain the relative effectiveness of different implementation approaches. COs are also likely to be undertaking more activities than are documented.
- There was limited documentary information on preparedness and factors related to the quality theme, including on the timeliness of activities and implementation of planned M&E activities.
- Responses to the questions in the partner survey were limited in several cases.

1.3 Summary of impact of COVID-19

Globally, as at 3 February 2021, there have been more than 103 million confirmed COVID-19 cases and nearly 2.24 million deaths.[5] There have been more than 2.6 million confirmed cases and 63,940 deaths in Africa.[6] Of those, 2 million confirmed cases and nearly 55,000 deaths have occurred in ESAR, with the majority in South Africa – which has a total of 716,759 confirmed cases.[7] Countries across the region are now discussing the availability and roll-out of COVID-19 vaccines: WHO, Africa Centers for Disease Control, African Union, and other partners are engaging governments on issues such as resource requirements and distribution modalities.

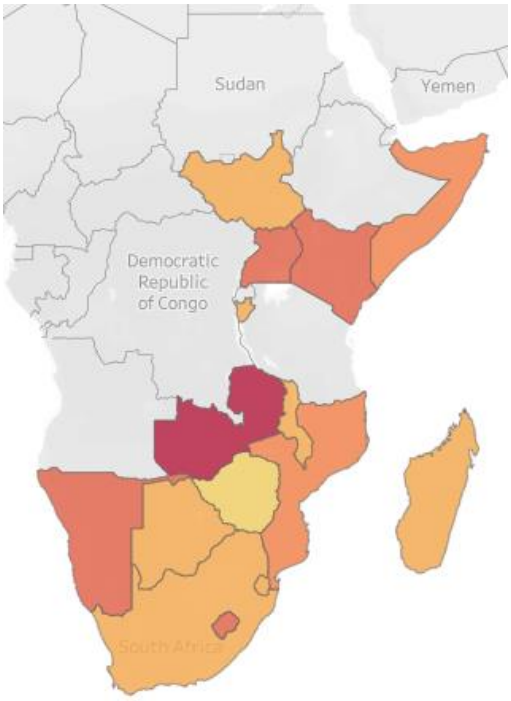
While according to modelling predictions the proportion of people with higher risks of developing complications and dying from COVID-19 is lower in Africa compared to Europe and the America due to the continent's relatively younger population, some African countries with a high HIV/AIDS prevalence are particularly vulnerable to serious health impacts.[8] The peak of the pandemic was delayed in Africa compared to other continents and, as a result of proactive preparedness and response, the continent has shown some resilience against COVID-19. However, there are many areas of concern that hinder the response to the pandemic, including weak governance, healthcare systems, economies, and conflicts.[9] There are also concerns that the economic impact of COVID-19 will be most severe in Sub-Saharan Africa.[10]

The evidence affirms that mortality and morbidity associated with COVID-19 are higher among the elderly and in people with underlying medical conditions.[11] However, the societal effects of the COVID-19 pandemic have a detrimental impact on a large number of women and children, especially in low and middle-income countries, and are likely to be underestimated.[12] This includes widespread disruption to essential health and nutrition services. Figure 1 shows that out of 18 reporting countries in ESAR, 14 described reduced

[5] WHO (2020) 'Coronavirus Disease (COVID-19) Dashboard'. Available at: https://covid19.who.int/
[6] Ibid.
[7] UNICEF (2020) 'Coronavirus disease (COVID-19) Pandemic Dashboard for Eastern and Southern Africa – Round 11', Nairobi: UNICEF.
[8] Clark, A. *et al*. (2020) 'Global, regional, and national estimates of the population at increased risk of severe COVID-19 due to underlying health conditions in 2020: a modelling study'. *Lancet Global Health,* 8(8), pp. e1003-e1017.
[9] Blanton, R. *et al*. (2020) 'African Resources and the Promise of Resilience against COVID-19'. *American Journal of Tropical Medicine and Hygiene,* 103(2), pp. 539–541.
[10] Buheji, M. *et al*. (2020) 'The Extent of COVID-19 Pandemic Socio-Economic Impact on Global Poverty. A Global Integrative Multidisciplinary Review'. *American Journal of Economics,* 10(4), pp. 213–224.
[11] Jordan, R., Adab, P., and Cheng, K. (2020) 'Covid-19: risk factors for severe disease and death'. *BMJ,* Volume 368, p. m1198.
[12] Simba, J. *et al*. (2020) 'Is the effect of COVID-19 on children underestimated in low- and middle- income countries?' *Acta Paediatrica,* Volume 109, pp. 1930–1931.

coverage of health services as at August 2020.[13] Nutrition services were also disrupted, with 75% of countries reporting a fall in treatment of child wasting. Services were disrupted for a variety of reasons, including reduction in demand due to fear and misinformation, inadequate PPE for frontline workers, and inaccessibility due to movement restrictions.[14]

Figure 1 ESAR countries reporting disruptions to health services and drops in coverage and service use



National efforts to control the spread of the virus have included school closures, which can lead to adverse effects for children beyond loss of education. These include nutritional problems, social isolation and related psychological harms, and child welfare concerns, especially for the most vulnerable.[15] Movement restrictions also hamper the ability of households to continue to earn an income, particularly poorer families working in the informal sector. This has detrimental effects on access to quality food and housing, increasing the risk of malnutrition and suboptimal living conditions.[16]

With the concerns of widespread and devastating short- and long-term impacts on physical health, mental health and wellbeing, development, and prospects, the Executive Director of UNICEF has referred to children as the 'hidden victims of this pandemic'.[17] Further, although women and children as a whole are a vulnerable group, there are multiple categories of vulnerable women and children who need particular support due to having unique risks (and intersectionality of risks) such that the COVID-19 pandemic disproportionally impacts them. Children in the most vulnerable and marginalised situations include (but are not limited to): the girl child, due to gender norms, with a focus on adolescent girls; the poorest children; children with disabilities; refugee, internally displaced, migrant and returnee children, and those living in marginalised communities and fragile environments (such as refugee camps and urban and informal settlements); children deprived of their liberty; children subject to grave violations due to conflict and non-state armed groups designated as terrorist; children in dysfunctional family settings; children in street situations; and children from marginalised groups. In addition, these children may be at increased or decreased risk depending on their age (i.e. young children aged 0–9 years; adolescents aged 10–14 years and 15–19 years; and youth aged 19–24 years).

1.4 Regional context in relation to the COVID-19 pandemic

As summarised in Figure 2, UNICEF's response in ESAR can be divided into two distinct but complementary efforts: its programmatic response and its operational response.[18]

[13] Ibid.
[14] UNICEF (2020) 'Tracking the situation of children during COVID-19: Dashboard'. https://data.unicef.org/resources/rapid-situation-tracking-covid-19-socioeconomic-impacts-data-viz/
[15] Viner, R. *et al*. (2020) 'School closure and management practices during coronavirus outbreaks including COVID-19: a rapid systematic review'. *The Lancet Child & Adolescent Health*, ISSN: 2352-4642, Vol: 4, Issue: 5, pp. 397–404.
[16] Simba, J. *et al*. (2020) 'Is the effect of COVID-19 on children underestimated in low- and middle- income countries?' *Acta Paediatrica,* Volume 109, pp. 1930–1931.
[17] Fore, H. (2020) 'UN launches global humanitarian response plan to COVID-19 pandemic'. Available at: www.unicef.org/press-releases/un-launches-global-humanitarian-response-plan-covid-19-pandemic.
[18] UNICEF (2020) 'Description of UNICEF Strategy for COVID-19 Response in ESA (Living document at 22 April 2020)'.

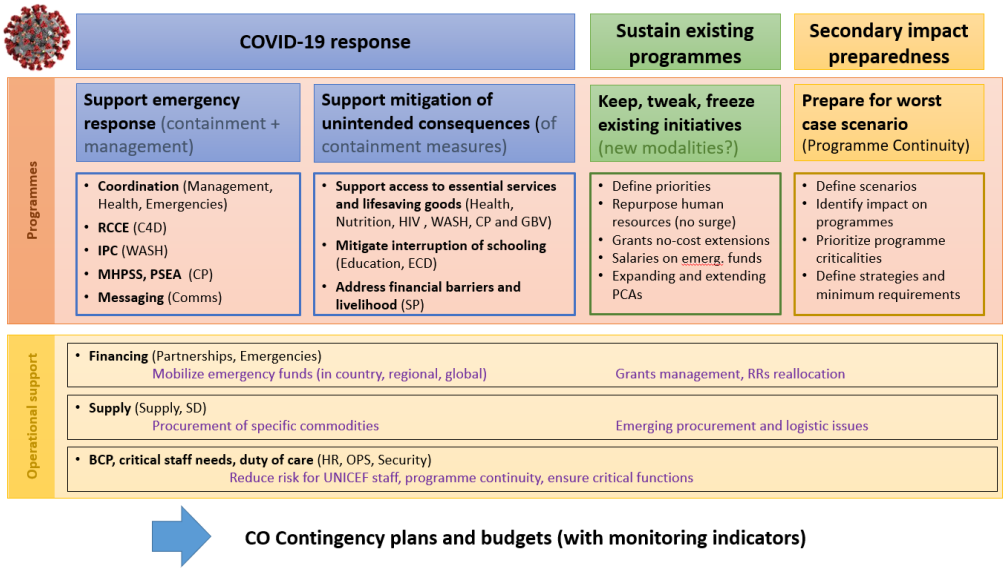
UNICEF's **operational response** to COVID-19 in the region is aimed to protect its staff and implementing partners from the harmful effects of COVID-19 and its response measures.

The **programmatic response** focuses on the following programmatic actions:

To minimise the impact of the COVID-19 response on children: Ensuring access to essential health and nutrition services; Supporting government to provide distance and home learning through eLearning platforms and take-home packages, and promoting and supporting the early and safe reopening of schools; Ensuring availability of water and other lifesaving commodities; Identifying and protecting children and adolescents in the most vulnerable households and circumstances, such as children with disabilities, children deprived of their liberty, children on the move, and girls who face increased risk of, for example, child marriage as a result of the pandemic; Providing support to caregivers on how to talk to children about COVID-19, and managing their children's and their own mental health; Adapting and refining standard COVID-19 response measures to support children and families living in challenging settings; and Expanding sustainable social protection programmes, especially cash transfers to all vulnerable families;

To support the response to COVID-19: Helping finance ministries access international funding opportunities to invest in health, water, sanitation, and hygiene (WASH), and social protection systems; Strengthening community platforms to facilitate community surveillance of COVID-19, early response to new clusters, referrals for testing, and education on appropriate health and WASH practices, while keeping health professionals safe; Supporting RCCE for the COVID-19 response; Supporting the procurement and supply of essential commodities for treatment and prevention; and Identifying and protecting children and adolescents who may be more vulnerable to complications.

Figure 2 ESAR Framework



2 Findings

ADAPTATION

2.1 How COs have adapted to the COVID-19 pandemic

UNICEF's strategy for the COVID-19 response makes clear that countries should prioritise and adapt the programmatic actions listed in Section 1.4 for greatest impact in the country context.[19] In line with this, the RTA has assessed whether adaptations have been developed across all programme areas, i.e. RCCE/Communication for Development (C4D), Infection Prevention and Control (IPC), Mental Health and Psychosocial Support (MHPSS)/Prevention of Sexual Exploitation and Abuse (PSEA), Health, Nutrition, WASH, Child Protection/GBV, Education, and Social Protection.

The classification framework in Annex 1 shows that the region has 'partially met expectations' in relation to the adaptation theme overall and the related question. This is because only Ethiopia and South Africa were judged to have developed adaptations across all programme areas, while the other COs developed adaptations in some areas. For example, following a socioeconomic needs assessment the Ethiopia CO adapted its targets and adopted social protection targeting mechanisms[20] and, in response to school closures, in coordination with the Ethiopian Red Cross supported distance learning[21] via television and radio and distributed solar powered radios and learning content, targeting children in refugee, internally displaced person (IDP), and host communities.[22]

Partners perceived that UNICEF had been flexible in supporting them to implement activities to meet new or different community needs. The exceptions were partners in Ethiopia and Comoros, who rated this question as average. One partner in Comoros recommended that, in order to enhance programming for children and their communities, the CO should improve the flexibility to use funds as soon as new needs are demonstrated. In all but two countries (Comoros and South Sudan), partners considered that UNICEF had been very supportive to considerations of new programmes, approaches, or initiatives related to the COVID-19 response made by the government since 11 March 2020. However, on average, only 40% of partners said that their organisation or government department was working differently or in a new sector to respond to COVID-19. Despite this, partners perceived UNICEF support to be very relevant to the government response and priorities.

According to the results of the CO questionnaire, the most significant way in which COs adapted their work was enhancing coordination with government counterparts.[23] This included supporting government partners to develop and implement national COVID-19 preparedness and response plans and leading national coordination structures, including developing national RCCE plans and coordination mechanisms. COs also described 'scaling up the use of digital platforms for remote programming and monitoring' and 'increasing the use of local solutions' as significant adaptations. These were also identified as part of the secondary data and document review as being some of the most frequent adaptations, along with reprogramming resources and hiring new staff or redeploying existing staff.

[19] UNICEF (2020) 'Description of UNICEF Strategy for COVID-19 Response in ESA (Living document at 22 April 2020)'.
[20] UNICEF (2020) 'Preliminary RTA of UNICEF's ongoing response to COVID-19 in the ESAR'.
[21] UNICEF Ethiopia (2020) 'Ethiopia Novel Coronavirus (COVID-19) Situation Report No. 11, 23–29 May 2020'.
[22] UNICEF Ethiopia (2020) 'Ethiopia Novel Coronavirus (COVID-19) Situation Report No. 17, 16–31 August 2020'.
[23] UNICEF (2020) 'Preliminary RTA of UNICEF's ongoing response to COVID-19 in the ESAR'.

Reprogramming resources. All COs channelled available resources toward the COVID-19 response. The Burundi, Comoros, Eritrea, Ethiopia, Kenya, and Zimbabwe COs applied to reprogramme GAVI funds, including for the purchase of PPE, essential drugs, testing devices, printing of learning modules, and C4D.[24] COs reprogrammed funds toward the child and social protection responses where there were relatively large funding gaps:[25] UNICEF Malawi reprogrammed a grant from the UN/European Union Spotlight Initiative in order to strengthen the provision of protection services through Community Victim Support Units in partnership with Save the Children, while the Zimbabwe CO increased its allocation to social protection to expand the number of households reached with emergency social cash transfers.[26] The Uganda CO noted that donors were flexible with regards to reprogramming resources[27] and this flexibility has been attributed to strong relationships and early engagement with donors.[28]

Hiring new staff and redeployment of existing staff. COs such as Rwanda responded to the demands of the COVID-19 pandemic by reassigning staff from the Ebola response. The Namibia, Tanzania, South Africa, Uganda, and Ethiopia COs also hired additional staff to support the response. The pandemic appears to have highlighted the need for (additional) capacity in RCCE/C4D within UNICEF and beyond: the South Africa office did not have any C4D staff and had to accelerate the recruitment of three C4D consultants,[29] UNICEF Uganda hired a C4D emergency consultant to support capacity building at the Ministry of Health,[30] and seven regional technical assistants were assigned to the Ethiopian Public Health Institute to build government capacity to deliver regional risk communication plans.[31]

Scaling up the use of digital platforms. COs have made use of online meeting platforms such as Skype for Business and Zoom including for cluster meetings, with the Madagascar CO providing internet connection to government partners to facilitate this.[32] The Somalia, Angola, Mozambique, Ethiopia, and Tanzania COs have undertaken online training of implementing partners, maternal and child health nurses, social workers, etc. The use of digital platforms was enabled by prior investment in electronic systems and some COs are considering their use beyond the pandemic, given their benefits in terms of time and cost savings.[33] In other contexts, poor connectivity and inadequate ICT infrastructure have acted as barriers to realising these benefits.[34]

Increasing the use of local solutions. There was evidence that 14 COs used local solutions in either the emergency response or the mitigation response, with two COs (Ethiopia and Kenya) using local solutions in both responses. The Ethiopia CO WASH and Education sections worked with a local metalwork supplier to develop a prototype hands-free handwashing stand[35] and initiated local procurement of ready-to-use therapeutic food for severely wasted children.[36] Other countries used local procurement, predominantly to ensure constant supply of products for the IPC response, although local procurement was not possible in some countries due to there being little to no local production.[37]

[24] UNICEF ESARO (2020) 'EPI Continuity Matrix – May'.
[25] UNICEF ESARO (2020) 'HAC 2021 Planning toolbox'.
[26] UNICEF Zimbabwe (2020) 'Revised COVID-19 Preparedness and Response Plan Budget'.
[27] UNICEF ESARO (2020) 'Humanitarian Performance Monitoring Jan – May 2020 Mid-year report'.
[28] UNICEF ESARO (2020) 'Session 1 Mini-RMT – Successes and challenges of C-19 response in ESAR'.
[29] UNICEF South Africa (2020) 'CORONAVIRUS 19 response plan 2, UNICEF South Africa August to December 2020'.
[30] UNICEF Uganda (2020) 'Uganda Country Office COVID-19 Situation Report No. 1'.
[31] UNICEF Ethiopia (2020) 'Ethiopia Novel Coronavirus (COVID-19) Situation Report No. 9, 9–15 May 2020'.
[32] Email communications between ESARO Evaluation Section and Madagascar CO.
[33] OPM (2021) 'RTA of UNICEF's Ongoing Response to COVID-19 in ESA Case study: Kenya'. OPM, Oxford.
[34] UNICEF ESARO (2020) 'Session 1 Mini-RMT – Successes and challenges of C-19 response in ESAR'.
[35] UNICEF Ethiopia (2020) 'Ethiopia COVID-19 Situation Report No. 8, 2–8 May 2020'.
[36] UNICEF Ethiopia (2020) 'Ethiopia COVID-19 Situation Report No. 3, 27 March–3 April 2020'.
[37] UNICEF ESARO (2020) 'Session 1 Mini-RMT – Successes and challenges of C-19 response in ESAR'.

IMPLEMENTATION

2.2 Effectiveness of the UNICEF regional response to COVID-19

Under effectiveness, we assessed the extent to which COs are: achieving planned objectives; coordinating and collaborating with existing work on COVID-19; maintaining the most essential services; successfully using existing preparedness and contingency planning processes; covering the most vulnerable; implementing gender programming and taking steps to mainstream gender; and undertaking AAP, including PSEA. Based on the evidence reviewed as part of this assessment, the region has only partially met expectations relating to the implementation of the response as higher performance in achieving objectives, coordination and collaboration, and maintaining essential services has been offset by more average performance in the other areas.

2.2.1 Extent to which UNICEF has been able to contribute to offsetting the negative effects of the pandemic on access to basic services

The region has met expectations in terms of maintaining most essential services as part of the response. For all but three COs (Eritrea, Eswatini, and South Sudan), there is evidence that there have been efforts to maintain most or all essential services as part of COVID-19 response activities. In the remaining countries, there have been efforts to maintain at least some of these services. Figure 3 shows the average performance against selected SitRep targets related to provision of essential services:[38] 12 COs are performing well, five COs show average performance, and one CO shows low performance according to the criteria used in UNICEF's own humanitarian performance monitoring.[39] In high-performing countries, success was attributed to the availability of funding, technical capacity, and strong partnerships, collaboration, and coordination. On the other hand, in lower performing countries limitations included insufficient or delayed funding, difficulties procuring commodities, movement restrictions, and unhelpful government attitudes and ways of working. On average, partners rated COs highly in regard to the extent to which supplies, communication materials, training, and cash assistance reached intended beneficiaries.

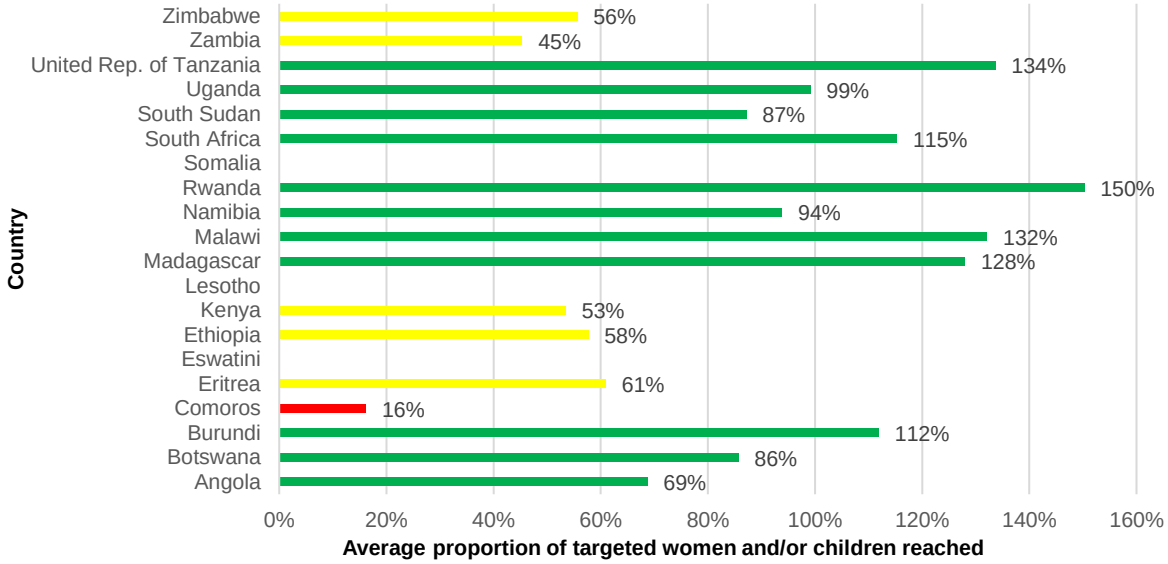


Figure 3 Provision of essential services

[38] Based on SitRep 11 data. Including essential health services, treatment of SAM, and alternative care. Mozambique has been removed due to scaling issues. Performance is >1000. Eswatini, Lesotho, and Somalia are omitted due to lack of available data.

[39] UNICEF ESARO (2020) 'ESA Regional Humanitarian Performance Monitoring Jan – May 2020, Mid-year report'. High >68%, Average 34–67%, Low <34%.

Analysis of the CO survey results found the RCCE interventions to be the highest rated for ensuring the continuity of essential services. Similarly, partners highlighted RCCE interventions as one of the main successes, recognising UNICEF's technical expertise in this area. COs supported the maintenance of coverage of basic services by undertaking qualitative and quantitative research to inform the response, engaging communities through government and civil society, training frontline workers on IPC, and generating demand through radio, television, and social media messages. These activities were hampered by movement restrictions and limitations on mass gatherings, but COs overcame some of these obstacles by using digital platforms for data collection, communication and training, and disseminating messages using mobile vans.

Partners also highlighted the education response as one of the main successes. UNICEF COs responded to school closures by supporting distance learning including through the production of educational radio and television broadcasts, distribution of workbooks[40] and learner kits,[41] and support to online educational platforms such as DBE with 2Enable in South Africa, including those designed to ensure continuity of education for girls.[42] COs also advocated for the reopening of schools and supported their safe reopening by providing, for example, technical support for the development of Standard Operating Procedures in Zimbabwe, training on safe school operations in Somalia,[43] and disinfection of classrooms in Madagascar.[44] However, as the Tanzania CO noted, it was difficult to track performance given that the number of children accessing distance learning is not captured by national education information monitoring systems.[45]

Protection against GBV and social protection received lower ratings in the CO survey in terms of mitigating the negative effects of the pandemic. COs also showed weaker performance against social protection-related indicators.[46] COs noted the need for continued advocacy to direct resources to child protection and social protection and the need to collect data to target protection activities.

COs maintained essential services by finding innovative ways to provide services in the context of movement restrictions. For example, in the field of nutrition, mother mid-upper arm circumference tapes are being distributed to families with children under five in South Sudan, Zimbabwe, Tanzania,[47] Ethiopia,[48] and Angola[49] to check their children's nutrition status, allowing screening for acute malnutrition in the context of movement restrictions. In the HIV/AIDS response, the Uganda CO is supporting multi-month dispensing of antiretroviral drugs to mitigate the impact of movement restrictions on the supply chain.[50] COs have also leveraged existing partnerships and entered into new partnerships in order to increase coverage of critical services. The social protection response has seen the Angola CO partner with private sector organisations such as Banco BAI in Angola, the National Bank of Angola, and three other banking service providers to implement and expand the country's first social cash transfer programme.

Efforts to maintain health, nutrition, HIV/AIDS, and WASH services have been hindered by disruptions to the supply chains for lifesaving commodities. UNICEF's efforts have been key

[40] UNICEF Madagascar (2020) 'COVID-19 Situation Report, Madagascar, 12 June 2020'.
[41] UNICEF Angola (2020) 'Angola COVID-19 Situation Report No. 4, 8–22 June 2020'.
[42] UNICEF ESARO (2020) 'Gender Equality in COVID-19 Response: Progress Update October 2020'.
[43] UNICEF ESARO (2020) 'ESA Regional Humanitarian Performance Monitoring Jan–May 2020, Mid-year report'.
[44] UNICEF Madagascar (2020) 'COVID-19 Situation Report, Madagascar, 12 June 2020'.
[45] UNICEF ESARO (2020) 'ESA Regional Humanitarian Performance Monitoring Jan–May 2020, Mid-year report'.
[46] Based on SitRep 12 data: average performance against 'Number of households receiving HUMANITARIAN CASH TRANSFERS…' = 33% and performance against 'Number of households benefitting from new or additional SOCIAL ASSISTANCE MEASURES…' = 49%.
[47] UNICEF ESARO (2020) 'ESA Regional Humanitarian Performance Monitoring Jan–May 2020, Mid-year report'.
[48] UNICEF Ethiopia (2020) 'Ethiopia Novel Coronavirus (COVID-19) Situation Report No. 17, 16–31 August 2020.
[49] UNICEF Angola (2020) 'COVID-19 Situation Report No. 6, September 2020'.
[50] UNICEF ESARO (2020) 'Gender Equality in COVID-19 Response: Progress Update October 2020'.

in mitigating this through tracking availability, procuring on behalf of the government, prepositioning supplies, and providing technical support to government to enhance all aspects of procurement. COs noted that there was good support from the Supply Division in this regard.[51]

2.2.2 Extent to which UNICEF has been successful in reaching the most vulnerable segments of the population and ensuring equity

Overall, the region only partially met expectations regarding the extent to which all populations identified as vulnerable by COs were targeted and covered by interventions. Only three COs met or exceeded expectations in relation to this indicator: Angola, Madagascar, and Mozambique. The Angola CO identified women (especially heads of households), elderly people, and people with disabilities as vulnerable and supported integrated WASH/Nutrition/COVID-19 activities where the priority beneficiaries were women heads of households, elderly people, and people with disabilities.[52] In the remaining countries, interventions appeared to target only some of the populations identified as vulnerable. On average, partners rated the extent to which the needs of vulnerable children were met through UNICEF-supported interventions as 3.5/5. It should be noted that the COs and partners often had different perceptions of who the most vulnerable populations were. For example, UNICEF partners working in Eswatini identified school-age children and adolescents as being the most vulnerable or excluded, while the CO targeted people with AIDS and people in high-density informal settings. The majority of COs identified lack of reliable data and lack of funding as constraints to reaching the most vulnerable.[53] Partners most commonly identified adolescents and children in rural settings as being the most in danger of being left behind.

The region appeared to only partially meet expectations with regards to gender equality, including gender inclusion in the planning and implementation of the COVID-19 response and examples of gender mainstreaming into institutional processes. All COs are implementing some form of gender equality or GBV-related programming. Of these, Comoros, Ethiopia, Madagascar, Malawi, Rwanda, South Sudan, Uganda, and Zimbabwe appear to be making efforts to mainstream gender and have therefore been classified as meeting expectations related to this indicator. Between them, these eight COs have made efforts to report on sex- and age-disaggregated data and implement gender-responsive human resourcing. COs are hampered from further mainstreaming gender by a lack of reliable data on gender inequalities and limited funding (including a lack of earmarked funding and the reprogramming of funding for addressing gender inequality toward the other response areas). COs also lack dedicated gender/GBV expertise: only two COs (Somalia and South Sudan) have a dedicated GBV specialist staff position and the gender specialist posts in Somalia and South Sudan are both vacant as at October 2020.[54]

2.2.3 UNICEF's ability to ensure/sustain community engagement/AAP mechanisms

For this round of the RTA, our assessment of AAP focused on the extent to which the response consulted with the affected people and adjusted plans and activities based on their concerns and questions. We found that the region partially meets expectations in this regard. Thirteen countries are collecting feedback on UNICEF's COVID-19 response activities using call centres, online platforms, phone surveys, U-report polls and dedicated community structures. For the three countries with the highest rating – Ethiopia, Kenya, and Uganda – it is clear that COs are adjusting plans and activities based on community feedback. For example, feedback and questions received via Ethiopia's regional hotlines have been used to

[51] UNICEF ESARO (2020) 'Session 1 Mini-RMT – Successes and challenges of C-19 response in ESAR'.
[52] UNICEF Angola (2020) 'Angola COVID-19 SitRep 27 July 18 August'
[53] UNICEF (2020) 'Preliminary RTA of UNICEF's ongoing response to COVID-19 in the ESAR'.
[54] UNICEF ESARO (2020) 'Gender Equality in COVID-19 Response: Progress Update October 2020'.

inform new RCCE campaigns and materials. For other countries, it is not clear how feedback is being used to inform the programme, or the collection of feedback appears to be *ad hoc* rather than systematic. Some challenges include difficulties in accessing data collected by national hotlines, the need for additional skills and tools to establish and scale up feedback collection mechanisms, and weak systems to analyse the data.[55] Eight COs appear to be involving members of the community in the delivery of their responses, including community agents, opinion leaders, and social media influencers. There is evidence of efforts to engage youth, including in collecting data, communicating messages on COVID-19 awareness and access to essential services, and even case management for GBV survivors.

Based on the available evidence, 14 out of 21 COs are undertaking activities related to PSEA, including integrating PSEA into social policy programmes, AAP mechanisms, and digital platforms such as U-report, expanding community engagement on PSEA, and continuing to assess implementing partners against PSEA indicators. The Namibia and Uganda COs, which performed well in relation to the SitRep indicator on access to safe and accessible channels to report SEA[56] (125% and 99% respectively), have integrated SEA reporting into existing helplines.[57] The Uganda CO partnered with Sauti 116 and the Namibia CO trained operators of national child helplines on PSEA and specific referral pathways. It has been suggested that actions to build on achievements in this area should include strengthening collaboration between PSEA, AAP, and child safeguarding, continuing to build capacity for investigation among partners, engaging with governments on PSEA, and including PSEA in violence against children and social service workforce strengthening in order to promote government ownership.

2.3 How UNICEF COs have utilised preparedness and contingency planning during the COVID-19 response and revised COVID-19 response plans based on the evolving needs of the population

The overall response was deemed to only partially meet expectations related to the extent to which preparedness and contingency planning processes contributed to the implementation of the response. Six COs (Burundi, Eritrea, Kenya, Somalia, South Sudan, and Uganda) were assessed as meeting expectations related to this indicator. These countries shared some of the following characteristics: past experience with mounting emergency responses, ability to leverage structures from Ebola preparedness such as plans and frameworks, existing partnerships with implementing partners, or mechanisms for swift activation of partnerships, and access to supplies from a variety of sources. For other countries, the available evidence was not sufficient to know whether the preparedness or contingency mechanisms mentioned contributed positively to the implementation of the response.

COs revised their response plans during the pandemic to capture changes in funding, programming, and targets. The pandemic has seen a new WASH programme established in South Africa,[58] MHPSS programming at community level in Eritrea, programming in new geographic areas in Malawi, geographic reprioritisation in Namibia, and targeting of vulnerable groups in high-density urban areas, refugee settlements, and IDP camps.[59] COs have also revised budgets to shift funding toward certain programmes. In this way, social protection programming was prioritised in Madagascar, Eritrea, Burundi,[60] and Zimbabwe.[61]

[55] UNICEF ESARO (2021) 'Strengthening AAP in ESAR: Orientation for Deputy Representatives'.
[56] Measuring progress against only one of the three outcomes of the UNICEF PSEA Results Monitoring Framework.
[57] UNICEF (2020) 'Global COVID-19 SitRep indicators'. Sitrep 12 data.
[58] OPM (2021) 'RTA of UNICEF's Ongoing Response to COVID-19 in ESA Case Study: South Africa'. OPM, Oxford.
[59] UNICEF (2020) 'Preliminary RTA of UNICEF's ongoing response to COVID-19 in the ESAR'.
[60] Ibid.
[61] UNICEF Zimbabwe (2020) 'COVID-19 Preparedness and Response Plan Budget'.

2.4 What is known about needs in each country and how UNICEF COs in the region have determined and verified these needs

COs used a variety of methods to identify needs including Knowledge, Attitudes, and Practice studies, Community Rapid Assessments, programme-specific monitoring using routine data or rapid assessments, monitoring of secondary impacts, and socioeconomic impact assessments to understand the situation of women or vulnerable groups. All COs were using at least one approach to determine needs in their country. The majority of countries collected data that allowed for identifying the most vulnerable, including U-report polls collecting data disaggregated by gender, age, location, and education level and/or data collected in partnership with organisations working with specific groups (e.g. the National Institute against HIV/AIDS in Angola). For the 11 COs receiving the highest classification, it was clear how the data collected had fed into the response. For example, the Mozambique CO conducted rapid assessments of COVID facilities and used this data to improve accessibility to WASH, advocate for support for continuity of centralised water supply networks, and develop a response plan with the WASH Cluster.[62] There is insufficient evidence to understand how COs have verified the needs identified through data collection exercises.

QUALITY

2.5 What we know about the quality of the UNICEF response to COVID-19

Under the theme of quality, the RTA has assessed the extent to which UNICEF COs have been able to deliver their responses in a timely manner and maintain adequate oversight and accountability mechanisms, including effective monitoring, feedback loops, and reporting systems. Despite the negative impacts of the crisis on UNICEF's ability to deliver quality, the region has met or surpassed expectations related to these quality-related indicators.

2.5.1 The effects of the crisis and related constraints on lockdown and movement upon UNICEF's ability to deliver quality

Movement restrictions have had a profoundly negative effect on the ability of persons to access or be reached by activities implemented as part of both the emergency and mitigation responses. This was especially challenging for services requiring in-person assessment and outreach activities such as child protection services or direct access to affected communities such as WASH response activities. For example, as a result of COVID-19-related restrictions, the Child Health Days campaign in Uganda was suspended and children could not be reached by Vitamin A supplementation and deworming.[63] Beyond this, constrained movement negatively affected the quality of services that were received by those who were able to overcome access barriers as a result of the inability to provide training to frontline workers and maintain continuous stocks of lifesaving commodities. As regards training, the Somalia CO was unable to administer critical training that benefitted from practical demonstrations, such as on IPC measures like wearing and removing PPE.[64] There was also limited opportunity to provide technical assistance in the form of supportive supervision.

Difficulties transporting supplies (including flight cancellations) led to an increased risk of stock-outs of vaccines, as was seen in Lesotho and Malawi.[65] Supply chain disruption was

[62] UNICEF ESARO (2020) 'ESA Regional Humanitarian Performance Monitoring Jan–May 2020, Mid-year report'.
[63] Ibid.
[64] Ibid.
[65] UNICEF ESARO (2020) 'EPI Continuity Matrix – May'.

reportedly less of an issue in countries like South Africa where there is a strong domestic market.[66] Movement restrictions led to some difficulties in monitoring, tracking, and reporting on programme progress and quality. The Somalia CO faced difficulties in monitoring nutrition services because partners and UNICEF staff could not make site visits.[67] The negative effects of movement restrictions were exacerbated where there was a lack of a field presence. Nonetheless, as described above in sections 2.1 and 2.2, COs made efforts to mitigate the negative effects of movement restrictions. For example, UNICEF Uganda planned to support district local governments to implement door-to-door Vitamin A supplementation in refugee-hosting districts.[68]

2.5.2 Timeliness of the UNICEF response to COVID-19

We consider that the overall response has been timely. We have classified 14 COs as having met or exceeded expectations in relation to this question, meaning that there is evidence of perceptions that most or all aspects of the response have been delivered in a timely manner. These 14 COs attributed the timeliness of the response to a number of factors including quick turnaround of funds, preparedness, existing coordination and communication structures from the Ebola response, swift formulation of response plans, early adaptation/adoption of new ways of working, pre-selection of humanitarian emergency partners, close collaboration with stakeholders, timely orientation of stakeholders, and support in acquisition and distribution of products. However, several of these countries still experienced delays in obtaining funding. COs[69] and partners singled out the RCCE response for being especially timely: partners working with the Eritrea CO noted that the RCCE plan was developed as early as the second week of March based on an earlier preparedness assessment.

In Angola, Ethiopia, Lesotho, Somalia, and Zimbabwe, we deemed that only some of the response had been delivered in a timely manner based on the available evidence. In Angola, partners perceived the timeliness of the response to be reasonably strong (4/5); however, insights from the analysis of the CO questionnaire show that timeliness was negatively affected by delays in programme document and ToR approvals. In addition, the nutrition response faced multiple delays, including late signing of programme cooperation agreements with implementing partners and late arrival of nutrition supplies by sea. Reduced timeliness of the Somalia response was attributed to a two-month delay in getting agreements signed by partners in addition to delays in supplies arriving and their distribution to implementing partners as a result of logistical constraints such as high costs and lengthy tax exemption processes, etc.

The above examples highlight that delays in mobilising partnerships and procuring supplies persist despite the introduction of Level 3 Simplified Standard Operating Procedures and simplified emergency procedures before this.[70] While some COs have made use of these streamlined procedures and reported more efficiently taking on new partners and procuring supplies as a result, other COs perceive the rules and procedures for engaging new partners and procuring commodities to be complicated and cumbersome.[71] The CO survey reveals that there may be delays in putting these procedures into place or understanding how to adapt them, and there is a call for wider use of contingency planning where supplies are concerned.[72] For two COs, there was a perception that the response has been delivered in an untimely manner. Partners who worked closely with the Comoros CO rated timeliness as low (2), reasoning that there had been a lack of financial support. Interviews conducted with

[66] OPM (2021) 'RTA of UNICEF's Ongoing Response to COVID-19 in ESA Case Study: South Africa'. OPM, Oxford.
[67] UNICEF ESARO (2020) 'ESA Regional Humanitarian Performance Monitoring Jan–May 2020, Mid-year report'.
[68] Ibid.
[69] UNICEF (2020) 'Preliminary RTA of UNICEF's ongoing response to COVID-19 in the ESAR'.
[70] UNICEF (2020) 'UNICEF Emergency Procedures for Coronavirus (COVID-19) response'
[71] UNICEF ESARO (2020) 'Session 1 Mini-RMT – Successes and challenges of C-19 response in ESAR'.
[72] UNICEF (2020) 'Preliminary RTA of UNICEF's ongoing response to COVID-19 in the ESAR'.

stakeholders in South Africa as part of the deep-dive case study revealed that UNICEF was late to contribute and there were delays in funding disbursements.

2.5.3 How UNICEF has ensured the quality of the response, and the processes and verification systems used to ensure quality

Across the region, UNICEF has met or exceeded expectations in relation to the robustness and comprehensiveness of monitoring and reporting systems. For 17 COs, there was evidence that monitoring and reporting systems have been effectively adjusted to the COVID-19 context and adequately implemented. More than 75% of COs felt that standard UNICEF or implementing partner monitoring and verification of implementation had taken place[73] and, on average, partners rated COs 3.9/5 with regards to the extent to which UNICEF-supported activities have been monitored.

Despite movement restrictions, COs have continued to use traditional monitoring mechanisms. The South Africa CO has found that supervision visits remain a valuable mechanism and were able to identify cases of staff shortages, inadequate training of staff in IPC, and stock-outs of key commodities during visits to quarantine sites in Gauteng and health facilities in Free State.[74] Joint supervision has taken place in Burundi and joint visits between the CO and the government took place to monitor enrolments in Mozambique's cash-based assistance programme.[75] COs including Ethiopia, Kenya, South Africa, and Zambia are conducting monitoring through external partners or third-party monitoring. COs have also continued to conduct and plan formal reviews and evaluations. UNICEF Namibia expanded the scope of an evaluation of the UNICEF WASH programme to include the current WASH COVID-19 response.[76] An external real-time evaluation of UNICEF's response to the COVID-19 crisis is ongoing in Malawi and planned in Zambia.[77]

As in other parts of the response, COs are using digital solutions to ensure the continuity of monitoring activities. COs such as Uganda, Somalia, and South Africa are holding virtual progress meetings with partners and frontline workers.[78] The Madagascar CO developed real-time monitoring using KoBo software to monitor WASH C4D activities in Toamasina and Antananarivo.[79] COs such as Ethiopia and Zimbabwe also collect user feedback, including using the U-report platform.[80] UNICEF Ethiopia has begun to roll out an end-user monitoring tool that will monitor the impact of interventions across various nutrition response indicators.[81] Key informants in Uganda noted that remote monitoring was not perceived to have had a negative impact on quality.[82] Several COs successfully used hybrid approaches combining visits by UNICEF staff with third-party monitoring, enabling triangulation. In this way, the Somalia and South Sudan COs appear to be combining staff visits with third-party monitoring or remote monitoring in less accessible areas.[83] UNICEF staff visits are facilitated by the presence of a field team at the decentralised level.

[73] UNICEF (2020) 'Preliminary RTA of UNICEF's ongoing response to COVID-19 in the ESAR'.
[74] UNICEF South Africa (2020) 'COVID-19 SitRep, 30 April 2020'.
[75] UNICEF Mozambique (2020) 'COVID-19 Situation Report No. 7, 22 July 2020'.
[76] UNICEF Namibia (2020) 'COVID-19 2020 response plan (27 August 2020 version)'.
[77] Communications with UNICEF ESARO Evaluation Section, UNICEF Zambia (2020) 'COVID-19 Preparedness and response plan: March to December 2020'.
[78] OPM (2021) 'RTA of UNICEF's Ongoing Response to COVID-19 in ESA Case Study: South Africa'. OPM, Oxford. OPM (2021) 'RTA of UNICEF's Ongoing Response to COVID-19 in ESA Case study: Somalia'. OPM, Oxford.
[79] UNICEF Madagascar (2020) 'COVID-19 Situation Report, 31 May 2020'.
[80] ESAR Chiefs of Health Meeting on COVID-19 of 21 May 2020.
[81] UNICEF Ethiopia (2020) 'Novel Coronavirus (COVID-19) Situation Report No. 17, 16–31 August 2020'.
[82] OPM (2021) 'RTA of UNICEF's Ongoing Response to COVID-19 in ESA Case Study: Uganda'. OPM, Oxford.
[83] UNICEF (2020) 'Preliminary RTA of UNICEF's ongoing response to COVID-19 in the ESAR'. OPM (2021) 'RTA of UNICEF's Ongoing Response to COVID-19 in ESA Case Study: Somalia'. OPM, Oxford.

3 Emerging themes/Conclusions

3.1 Emerging positives from the COVID-19 response

The following key **positive** conclusions can be drawn from UNICEF's performance in the COVID-19 response:

- **Partnerships:** strong partnerships with government, civil society, UN agencies, donors, and the private sector have been instrumental in reaching targeted populations in order to mitigate the secondary impacts of the response.
- **Access to funding:** continued access to funding, including through successful applications for reprogramming funds, has contributed to the timeliness of the response and enabled the implementation of child protection and social protection programmes; this has been made possible due to strong relationships and early engagement with donors.
- **Innovative solutions:** use of digital and mobile phone platforms for communication, training, and service delivery, and local procurement have been successful and demonstrated efficiency benefits.
- **Supplies:** support from the Supplies Division and use of local procurement have been key to mitigating shortages in PPE and lifesaving commodities.
- **RCCE:** is considered to be one of the most successful and timely aspects of the response and has helped in generating demand for essential services.

3.2 Challenges encountered in the implementation of the COVID-19 response

The following **challenges** have been identified in relation to UNICEF's performance in the COVID-19 response:

- **Lack of preparedness** in countries without previous experience mounting an emergency response.
- **Movement restrictions** affecting essential services delivery, programme monitoring, and procurement.
- **Access to supplies:** especially for PPE due to high global demand and low/non-existent local production, which was exacerbated by movement restrictions, customs delays, insecurity, etc.
- **Access to funding:** delayed funding was one of the main hinderances to a timely response.
- **Lack of reliable data** on some aspects of programme performance (e.g. access to distance learning), gender inequality, and vulnerable populations was exacerbated by travel restrictions and poor-quality routine data from government.

4 Lessons/Suggested action points

The major **lessons** that can be drawn from this light-touch analysis are:

1. **Use the COVID-19 response to strengthen preparedness and emergency response**, especially in COs with limited experience of responding to emergencies.

2. **Continue to advocate for additional funding** that can be used flexibly and improve the speed of disbursements to prevent programming delays.

3. **Strengthen and expand partnerships** with UN agencies, government, technical agencies, civil society, donors, and suppliers, including developing long-standing partnerships, simplifying the procedures to make new partnerships in an emergency, and ensuring that COs are supported to use and adapt simplified procedures.

4. **Continue testing and use of innovative approaches**, including use of digital platforms, local procurement of supplies, and new modes of service delivery; invest in electronic systems and advocate for improved connectivity and ICT infrastructure.

5. **Improve availability of data**, including disaggregated data and data on vulnerable populations, and ensure data is used to adapt programming to country needs.

6. **Improve access to supplies**, including making it easier for COs to leverage local suppliers and greater use of contingency planning.

7. Increase **prioritisation of child protection, social protection, and RCCE** by continuing to advocate for additional resources and ensuring COs have adequate numbers of staff with the relevant expertise.

8. **Improve gender programming**, including accountability for results on gender, reporting of sex-disaggregated data, availability of gender experts, and funding.

9. Improve **AAP**, by building on existing feedback platforms and ensuring the availability of necessary skills and systems to collect and analyse data; ensure all COs are implementing activities to address the **risk of SEA**.

10. **Improve coverage of vulnerable groups**, ensuring that activities are targeted at all groups that have been identified as vulnerable and that COs and partners have a shared understanding of who the vulnerable groups are.