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

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Photo credit: UNICEF

Madagascar

**Key highlights from a real-time
assessment based on qualitative data**

Preface

UNICEF's Eastern and Southern Africa Regional Office (UNICEF ESARO) 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 Madagascar country case study. Drawing on the qualitative data gathered during the course of interviews with key informants, 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, adapted for a country-level analysis.

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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. Many thanks to Ndriakita Solonionjanirina at the UNICEF Madagascar Country Office (CO) for his kind and efficient support in organising the interviews, as well as to the Madagascar UN staff, implementation partners, and frontline workers who participated in this study.

Executive summary

This is a case study of the UNICEF response to COVID-19 in Madagascar. This study forms part of a broader real time analysis (RTA) of UNICEF's COVID-19 response in eastern and southern Africa.



The RTA was 'light touch', with a tight timeline. Due to this, only a small sample of stakeholders were interviewed, and the broad sectoral focus precluded in-depth analysis. The research was undertaken between December 2020 and January 2021.

The study aimed at answering **four overarching questions**: (i) how has UNICEF Madagascar adapted to the COVID-19 pandemic and to evolving needs?; (ii) how can the implementation and quality of the Country Office's (CO's) COVID-19 response be characterised?; (iii) what are the emerging themes?; and (iv) what are the early lessons?

Themes emerging from the findings

Notable positives

Adaptation in the COVID-19 response:

- UNICEF took on a leadership role in the COVID-19 pandemic in Madagascar, leveraging its expertise and deep knowledge of the country and mounting a coordinated response that focused on protecting the most vulnerable populations.
- UNICEF led in key COVID-19 response working groups (risk communication and community engagement (RCCE), education, nutrition, child protection, and social protection/Cash Working Group (CWG)) but took on a leadership role in the health sector as well.
- UNICEF provided invaluable technical expertise, leadership capacity building, and equipping of tertiary care public hospitals for COVID-19 patient care.
- UNICEF trained physicians in critical care, anaesthesiology, and paediatrics, and developed standards and protocols for a hospital-based response to treatment of critically ill adult and child patients.

Implementation of the COVID-19 response:

- UNICEF emphasised maintaining the continuity of basic services but also sought to provide support to new areas of need (particularly for the urban and peri-urban poor).
- UNICEF played an important role in protecting the most vulnerable populations (including in cash transfers, the supply of subsidised water resources to the poorest households, protection of incarcerated minors, and for homeless children in urban centres).
- **Ability to assure quality in the COVID-19 response:** UNICEF delivered in a timely manner, and was mostly able to adhere to processes and verification systems.

Notable challenges

The challenges encountered in the Madagascar CO's response to COVID-19 included:

- Funding shortages; laborious coordination mechanisms; difficulty in international procurement, both in regard to availability of critical supplies and price hikes.
- Ensuring continuity of services in spite of strict national COVID-19 containment measures; learning losses for children due to school closures; reduced visibility into activities/supplies distribution/ at regional and district level; chronic under-funding in key social sectors in health, education, and water, sanitation, and hygiene (WASH).

The following populations were identified by respondents as being particularly vulnerable in the medium to long term as a result of the COVID-19 pandemic:

- The urban and peri-urban poor;
- Adolescent girls at risk of unwanted pregnancies;
- Children with moderate to severe malnutrition;
- Children at risk of violence in the home;
- Out-of-school children; and
- Incarcerated children in major cities.

Lessons learned/ suggested action points

Suggestions by respondents **to inform UNICEF Madagascar's programming in the medium to long term** included the following:

- Improve preparedness for an effective response to emergencies, strengthen related systems, and preposition supplies.
- Scale up successful COVID-19-related partnerships such as the Madagascar National Order of Physicians to develop collaboration in the field of gender-based violence (GBV) screening and treatment in urban centres.
- Improve vaccination coverage in urban settings and improve reporting of vaccination services from the private sector.
- Continue the engagement with urban and peri-urban children – a new population target group for UNICEF as a result of the pandemic.
- Maintain frequent dialogue and interaction with partners and continued flexibility in responding to the needs they express.

List of abbreviations

AAP	Accountability to Affected People
C4D	Communication for Development
CO	Country Office
CWG	Cash Working Group
EPP	Emergency Preparedness Platform
ESAR	Eastern and Southern Africa Region
ESARO	Eastern and Southern Africa Regional Office (of UNICEF)
GBV	Gender-Based Violence
IPC	Infection Prevention and Control
KAP	Knowledge, Attitudes, and Practices
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
OPM	Oxford Policy Management
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
RTA	Real-Time Assessment
SSOP	Simplified Standard Operating Procedures
WHO	World Health Organization

Table of Contents

1	Introduction	1
1.1	Background.....	1
1.2	Summary of the impact of COVID-19 in Madagascar	2
1.3	Case study scope, approach, and methods.....	3
2	Findings	5
	Adaptation	6
2.1	How the UNICEF Madagascar CO has adapted.....	6
	Implementation.....	8
2.2	Effectiveness of the UNICEF response to COVID-19 in Madagascar.....	8
2.2.1	Offsetting the negative effects of the pandemic on access to basic services.....	8
2.2.2	Reaching the most vulnerable segments of the population and ensuring equity	10
2.2.3	Meeting programming standards and ensure community engagement	10
2.3	Extent to which the UNICEF Madagascar CO utilised preparedness and contingency planning during the COVID-19 response.....	11
2.4	What is known about needs and how UNICEF determined these	11
	Quality.....	12
2.5	What we know about the quality of the UNICEF response to COVID-19	12
3	Emerging themes/ conclusions.....	13
	Positives in adaptation	13
	Positives in implementation.....	13
	Challenges in adaptation	14
	Challenges in implementation	14
	Medium- to long-term implications of the COVID-19 pandemic for vulnerable children and communities, and implications for UNICEF's strategy	14
4	Lessons learned/ suggested action points	15
 Annexes		
A.1	Countries in eastern and southern Africa with UNICEF COs.....	16
A.2	UNICEF response to COVID-19 in ESAR	17
A.3	Interviewees - Madagascar	19
A.4	RAG Rating: Madagascar	20
B.1	KII Guide for UNICEF Country Offices	23
B.2	KII Guide for UNICEF Partners	25
B.3	KII Guide for Frontline Workers	27
B.4	Standard introduction and consent (all interviews)	29

1 Introduction

1.1 Background



Global context: Nearly 12 months since the early cases of the COVID-19 virus were cited in the press in December 2020, the worldwide total of confirmed cases was almost 80 million, with over 1.75 million deaths.¹ The global ramifications of the spread of COVID-19 cannot be overstated. Almost all countries have been affected but several countries have been particularly hard hit, and have experienced catastrophic social and economic consequences.

The COVID-19 virus itself has been the cause of very high rates of mortality worldwide, particularly among adults with pre-existing health conditions. A modelling exercise reported in the Lancet² early in the pandemic showed estimates of the indirect effects of COVID-19 on child and maternal mortality across 118 middle- to low-income countries. In a

maximum impact scenario, it was estimated that there would be an additional 1,570,000 child deaths and 56,700 maternal deaths due to decreases in health service coverage and in deaths due to untreated malnutrition.



Stringent international and national infection prevention measures including bans on international travel, national lockdowns, and closures of businesses and public services have resulted in major disruptions in people's livelihoods, pushing many people, already on the brink, into poverty.

Particularly hard hit are children, especially those living in low-income settings. The severe global recession has had very serious negative effects on children worldwide, but in particular has

exacerbated already existing inequalities and vulnerability for children living in low-income settings. Disruptions in essential services delivery such as health, education, nutrition, child protection, and psycho-social support have rendered many more children vulnerable in ways that may affect them for years to come. The Executive Director of UNICEF has referred to children as the 'hidden victims of this pandemic'.³

¹ WHO Coronavirus Disease (COVID-19) Dashboard, available at <https://covid19.who.int/> (last accessed 28 December 2020).

² Robertson, T et al (2020) Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. Lancet 8:7 E901-E908.

³ Fore, H. Don't let children be the hidden victims of COVID-19 pandemic. UNICEF <https://www.unicef.org.uk/press-releases/dont-let-children-be-the-hidden-victims-of-covid-19-pandemic-unicef/>

1.2 Summary of the impact of COVID-19 in Madagascar

Regional context: Madagascar is one of the 21 countries with UNICEF offices overseen by UNICEF ESARO. The region's first case appeared in South Africa on 5 March 2020.⁴

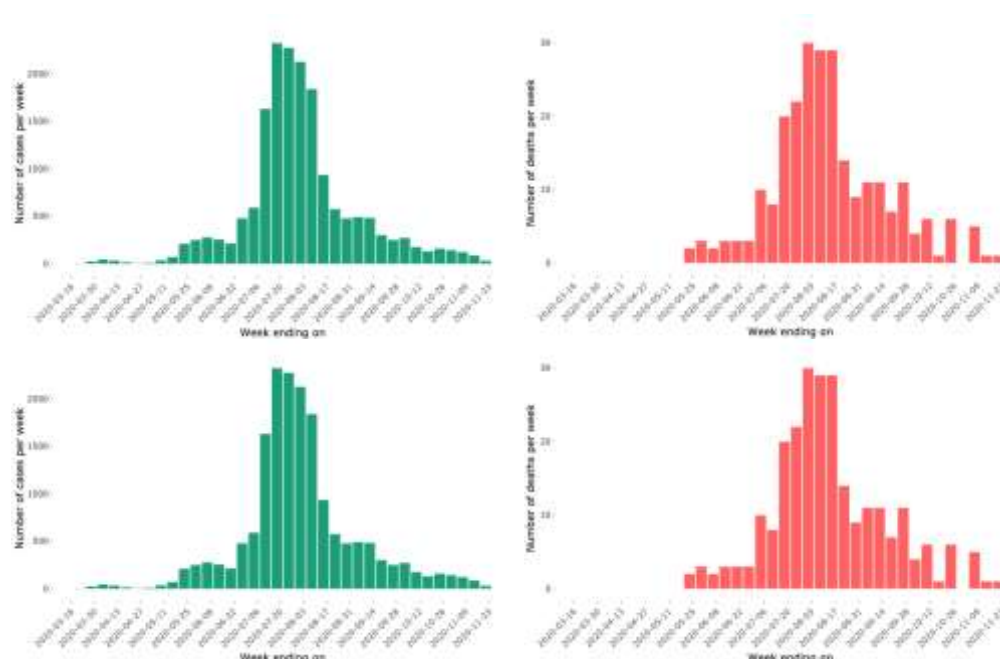
Madagascar, an island country in the Southern African region, has a population of 26.3 million, 77% of which live in poverty. Maternal and child health indicators are very low in Madagascar, signalling a fragile economy, an under-funded social welfare and social protection system, and numerous environmental challenges that impact upon the Malagasy people's livelihoods, health, and wellbeing. Many children in Madagascar suffer multi-dimensional poverty seen in high rates of malnutrition, disparities in educational achievement, poor health indicators, and weakness in child protection and early child development systems.

COVID-19 in Madagascar: The first case of COVID-19 was confirmed on 19 March 2020, having entered through the Antananarivo-Ivato airport via passengers from Europe and China. The President of the Republic declared a state of national health emergency the following day. By 26 March, there were 24 confirmed cases. From mid-May to early July 2020, the number of people testing positive increased tenfold, rising exponentially from 304 to 3,250. Initially, COVID-19 cases were confined in the first wave to urban and peri-urban areas in the coastal city of Tamatave and in the capital city of Antananarivo.



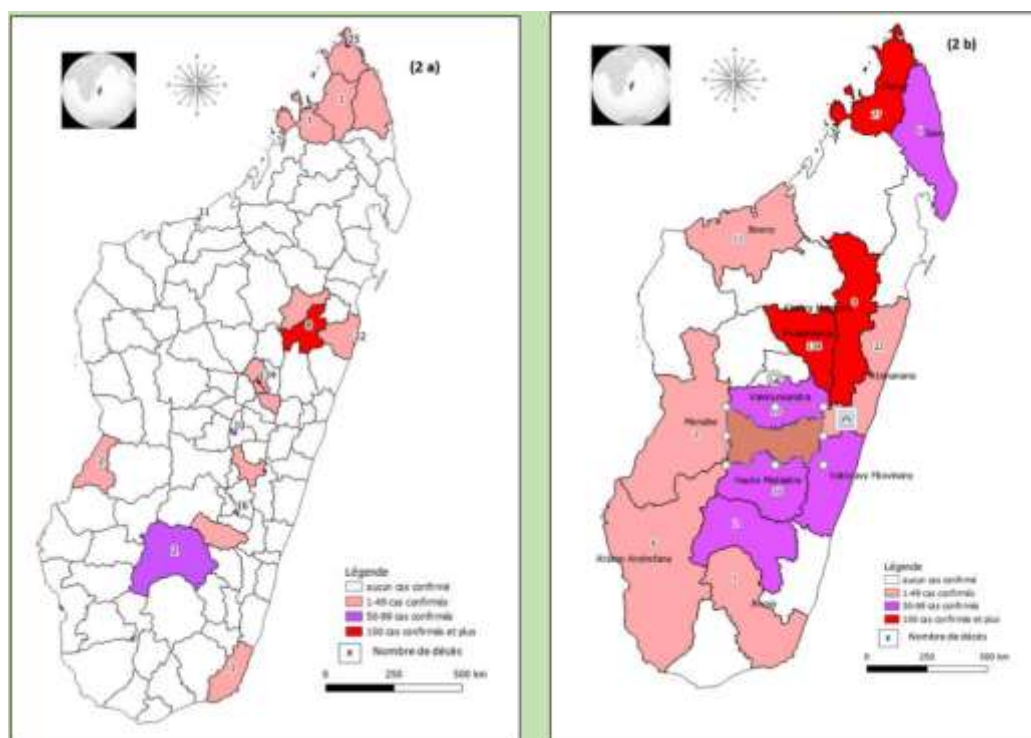
By November 2020, however, COVID-19 had spread to 14 regions in Madagascar, with a total 17 341 confirmed cases and 251 deaths.⁵

Figure 1 *Epidemiological histogram of COVID-19 cases and COVID-19-related deaths*



⁴ Wikipedia (2020) 'COVID-19 pandemic in Africa' https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Africa (last accessed 27 December 2020).

⁵ Johns Hopkins Coronavirus Resource Center <https://coronavirus.jhu.edu/region/Madagascar> (Accessed 12 January 2021)

Figure 2 *Regional spread of COVID-19 cases in Madagascar, March–November 2020*

1.3 Case study scope, approach, and methods

The aim of the RTA is to assess UNICEF COs' response to the COVID-19 pandemic in terms of adaptation, implementation, and quality of programming.

The case study was conducted primarily through key informant interviews (KIIs) but was supplemented by information from documents obtained from the regional and country level. Specifically, the KIIs seek to provide a better understanding of UNICEF's country-level implementation of the COVID-19 response, in six case study countries in the East and Southern Africa region, through one-on-one discussions with staff working on the ground. These key informants included UNICEF country-level staff in Operations and Programming; UNICEF's key government social sector line ministry counterparts; UN partner agencies; UNICEF's implementation partners; and frontline workers in the public sector and/or working with national civil society organisations. The case study interviews seek to better understand and draw lessons from country-level experiences in mounting a national response to the COVID-19 pandemic, and to use the findings to generate best practices and guidance for other UNICEF COs.

The KIIs for Madagascar focused on operational and programmatic adaptations, implementation, innovations, and new activities and approaches to reach the most vulnerable populations and accelerate results for children across Madagascar. These KIIs did not include all UNICEF programme areas (health, education, WASH, Communication for Development (C4D) (i.e. RCCE), nutrition, social protection, and child protection), and equally nor did they include all partners in the COVID-19 response in Madagascar.

The case study draws from 12 KIIs⁶ undertaken with UNICEF and its counterparts (three interviews with UNICEF country staff; four interviews with UN or governmental counterparts; and five interviews with UNICEF partners). These respondents were selected from a larger

⁶OPM had agreed with UNICEF in the inception stage that deep dive assessments will be limited to 10-14 key informant interviews.

sample (provided by UNICEF ESARO) of UNICEF CO staff, UNICEF key partners, and frontline workers collaborating on the ground. The selection from the larger sample was undertaken by CO focal points. As such, this case study is not an exhaustive review of UNICEF interventions in Madagascar, nor does it represent the views of all staff and partners.

UNICEF CO focal points aided in the scheduling of one-on-one Zoom calls between international M&E experts (members of the RTA Assessment team managed by OPM) and the 12 respondents in the selected sample. These interviews were conducted using a key informant guide to help focus the discussion. Although a guide was used, the KIIs were very informal in nature and lasted between 1 and 1.5 hours each. The interviews were recorded with explicit permission from the respondents and with a guarantee of confidentiality of responses. Interviews in Madagascar were conducted remotely during November 2020.

The RTA has **four overarching questions**, applied to this country case study as follows: (i) how has the UNICEF Madagascar CO and its partners adapted to the COVID-19 pandemic (ii) what are the main features of the CO's implementation and quality of its COVID-19 response?; (iii) what are the emerging themes?; and (iv) what are the early lessons?

Specific attribution of findings to individuals will not be included in this report in order to ensure confidentiality.

2 Findings

Inter-agency and government coordination in response to COVID-19 in Madagascar

According to KII respondents, UNICEF was able to bring to bear its substantial experience and in-depth knowledge of health, education, social protection, and child protection systems in Madagascar in responding to the COVID-19 pandemic. UNICEF's decentralised presence in the country, with a network of close collaborations with government and partner agencies at regional and district levels, and very strong logistical capacity, were important elements in its success in responding to the pandemic over the last year.



UNICEF was well placed to deftly coordinate with the highest levels of government (the Prime Minister's Office and the Office of the President), line ministries, and other UN agencies, placing it at the centre of the COVID-19 national response from early on in the pandemic. Already part of developed inter-agency working groups for the main programme areas in Madagascar, and with very good established relations with the government, UNICEF capitalised on its strong collaborations, legitimacy, and reputation to become a key player in the national COVID-19 crisis response.

As part of the joint task force under World Health Organization (WHO) leadership to respond to the coronavirus pandemic, UNICEF played a key coordination role in the early response and planning phase. UNICEF contributed to the elaboration of the National COVID-19 Response Plan (leading in the WASH, education, nutrition, and social policy clusters). UNICEF also participated substantially in the management of the health, WASH, social protection/CWG, and child protection clusters. UNICEF also acted as lead for RCCE with the inter-agency/ministry Communication Commission through the C4D sector. From the start of the crisis, senior staff of the UNICEF HQ in Antananarivo participated in strategic and technical meetings with the WHO, Ministry of Public Health, Ministry of Communications, Ministry of Water and Sanitation, and other key technical and financial partners. UNICEF's in-country logistics capacity (solidly in place because of its role in child immunisation at the national and regional levels) also facilitated its strong national role during the pandemic.

Adaptation

2.1 How the UNICEF Madagascar CO has adapted

The early guiding principle of the CO was to maintain (where possible) regular service delivery in health, nutrition, education, social protection and child protection; and to rapidly adapt activities (where needed) to respond to new vulnerabilities and new areas of need caused by the COVID-19 pandemic.

At the outset of the pandemic, the Madagascar CO sought flexibility within its existing country programme budget lines in order to quickly re-allocate regular programme funding for activities related to the COVID-19 response. UNICEF also approached its main external donors to seek similar flexibility for the re-programming of dedicated funds for activities related to COVID-19. UNICEF obtained this flexibility early on in its response, and also applied for external emergency funds from a variety of sources.

2.1.1 Strategic adaptation

Numerous respondents referred to the UNICEF Madagascar CO's flexibility and creativity in its response to the COVID crisis. For instance, UNICEF quickly shifted the geographic focus in WASH, nutrition and social protection from rural communities in the drought-prone areas of the south of Madagascar, to vulnerable communities in urban and peri-urban communities (who were deemed to be most at risk in terms of the spread of the COVID-19 virus). It also adapted several of its delivery models in order to respond to new areas of need as described below.

'UNICEF opened new horizons of work to respond and adapt to emerging needs' KII respondent

2.1.2 Adaptations in the health sector

According to KIIs, the UNICEF CO made a strategic choice to step into new roles in the health sector. UNICEF provided early leadership and a technical support role to the Ministry of Health in the development of treatment and case management protocols for severely ill adult and child patients with underlying health vulnerabilities. UNICEF also played a critical role in training and equipping anaesthesiologists, reanimation specialists, and paediatricians for the case management of critically ill COVID-19 patients and at-risk children in urban hospitals. UNICEF also partnered with local suppliers for the provision of oxygen for critical care of COVID-19 patients in 33 referral hospitals. Finally, it developed a partnership between public hospitals and the private-sector medical community within major urban centres for COVID-19 testing and case management, to help offload the overflow of patients presenting at government health facilities at the peak of the crisis.

2.1.3 Adaptations in WASH

UNICEF adapted its WASH activities from the drought-prone areas of Madagascar's 'Grand Sud'. Early in the crisis, UNICEF also shifted activities to the reinforcement of water and sanitation facilities in urban and peri-urban centres (the centre of the epidemic), with provision of clean water supplies and handwashing facilities. It undertook a massive installation of hands-free handwashing facilities in the main public gathering points in Tana and Tamatave, including community engagement in



COVID-19 awareness-raising campaign by ASOS, a UNICEF partner.

intensive WASH communications activities. UNICEF undertook these activities with local partners such as MEDAIR and ASOS. UNICEF also has supported the procurement and distribution of 10m³ water tanks, in addition to water trucking in urban and peri-urban areas of Antananarivo and the coastal city of Tamatave.

2.1.4 Adaptations in nutrition

Multi-cluster linkages were strengthened across health, WASH, and social protection to ensure the continuation of essential nutrition services with appropriate Infection Prevention and Control (IPC) measures. These included the procurement and distribution of personal protective equipment (PPE) and 404 no-contact handwashing devices for distribution in nutrition community sites. Programmatically, UNICEF suspended mass exhaustive screening of children and began messaging and promoting on protection of infant feeding practices. As part of UNICEF's adaptation of its service delivery model to focus on urban and peri-urban communities affected by COVID-19, it supported the treatment of children with severe acute malnutrition in 108 health centres across eight regions. Further, it supported the Ministry of Health in transporting vitamin A supplements to all 114 districts of Madagascar, along with communication material to increase the coverage of this essential child survival service.

2.1.5 Adaptations in education

UNICEF contributed to maintaining educational achievements by preparing self-directed learning workbooks for lower secondary schools; producing and distributing posters with information on the prevention of COVID-19; establishing the necessary agreements with regional governments to set up temporary storage facilities for the goods that need to eventually reach schools; and helping prepare schools for opening (through, for example, the disinfection of classrooms). UNICEF also contributed to the national effort by providing technical and financial support to adapt radio and TV broadcasts to the current context.

2.1.6 Adaptations in child protection

In partnership with *Grandir Dignement*, a local NGO partner based in Antananarivo, UNICEF undertook a proactive strategy to protect incarcerated minors from COVID-19, in prisons located in urban and peri-urban areas. According to KIIs, UNICEF showed flexibility in allowing the NGO partner to realign activities to provide specific support to incarcerated youth, such as testing, isolation of positive cases, separation of youth from general populations of adults, and food assistance.



Incarcerated youth receiving IPC Information and testing by Grandir Dignement

2.1.7 Adaptations in RCCE:

In response to COVID-19, UNICEF undertook a reorientation of the national RCCE plan, added to the COVID-19 messages bank, and adjusted and adapted information, education, and communication materials.

2.1.8 Local solutions

UNICEF responded to the crisis regarding the availability and supply of PPE and critical medical supplies by developing local solutions. The UNICEF CO's strong understanding of the capacity of the local market made it possible to select reputable local suppliers for the purchase of COVID-19 emergency supplies such as PPE, as well as helping it to develop arrangements with a local company to provide oxygen to referral hospitals.

Implementation

2.2 Effectiveness of the UNICEF response to COVID-19 in Madagascar

The effectiveness of UNICEF Madagascar's COVID-19 response is presented along four dimensions: offsetting the negative effects of the pandemic on access to basic services; reaching the most vulnerable and ensuring equity; meeting programming standards and protocols; and ensuring community engagement.

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 (ensuring coverage and scale-up)

Due to the national lockdown, restrictions on travel, curfews and closures of schools and businesses, the UNICEF Madagascar CO was highly concerned with ensuring continuity of basic services in the health, nutrition, child protection, and WASH sectors. The country experienced a reduction in use of key maternal and child health services at the start of the pandemic. This was less due to closures in health facilities, and more due to people's fear of visiting them.



UNICEF supported the government to develop national guidelines on essential service delivery; and mounted a rapid and robust response in the form of an RCCE strategy, with a focus on key messages related to infection control, handwashing, and social distancing. UNICEF provided WASH supplies, hands-free handwashing facilities, and PPE to frontline workers in almost all sectors (health, education, and child protection) to ensure continuity of services.

Health sector: In addition to assisting the government in maintaining the routine delivery of mother and child essential services (e.g. pre-natal care, institutional deliveries, curative services for sick children, and immunisation), UNICEF supplied health facilities with essential medicines, supplies, and vaccines. UNICEF capitalised on prepositioned medical supplies in its central warehouse, and in regional storage facilities, to continue the supply and distribution of commodities.

In partnership with GAVI, UNICEF provided PPE through the Ministry of Health to equip health workers to ensure the continuity of vaccination services in the four regions of Analamanga, Atsinanana, Alaotra Mangoro, and Analanjirofo

UNICEF also took a role in the provision of PPE to health staff to ensure that health staff were able to work safely, as well as training 'hygienists' in hospitals and health centres to ensure effective IPC measures. UNICEF also provided infection control supplies and WASH facilities in all health centres. It contributed substantially to intensive care preparedness through training and equipping key specialists, ensuring oxygen supplies, and boosting PPE stocks, and also contributed to expanding testing capacity through the purchase of reagents for COVID-19 testing.

Education sector: UNICEF has offered continuous support to the education system throughout the pandemic, by developing and distributing 636,000 self-learning guides to public schools to offset learning losses, disinfecting 90,000 classrooms, and distributing 28,000 handwashing devices. On the RCCE front, UNICEF distributed 120,000 school posters and 15,000 community posters with messages on sanitary practices to prevent contagion; and supported the Ministry of Education in the broadcasting of radio and TV-based educational programmes for schools.

RCCE: To date, UNICEF has covered the 22 regions to support media and mass communication and is specifically supporting the nine most affected regions in terms of communication and community engagement (Analamanga, Atsinanana, Haute Matsiatra, Boeny, Anosy, Analanjirofo, SAVA, Androy, and Ihorombe).



MEDAIR community health workers

WASH: UNICEF supported large-scale WASH programming support, consisting of subsidising the price of water to all vulnerable households in targeted cities. UNICEF paid the national water utility (JIRAMA) to cover the cost of 1.6 million cubic litres of water for three months. All water points have been equipped with handwashing devices and soap. Also, 200,000 of the most vulnerable people were provided with hygiene products for three months. Finally, 21,000 flyers and disinfectant gels were given to 12,500 taxis and public buses, in return for them supporting the communication campaign on handwashing and the wearing of masks

Nutrition: In urban and peri-urban clusters affected by COVID-19, UNICEF supported the government in the treatment of children with severe acute malnutrition (in 108 health centres across eight regions), as well as with the procurement and distribution of 14,920 face masks to be used during community screening. UNICEF also provided face masks, bars of soap, and no-contact handwashing devices for distribution in nutrition community sites. Multi-cluster linkages were strengthened with health, WASH and social protection to ensure the continuation of essential nutrition services with appropriate IPC measures. UNICEF also supported the Ministry of Health in transporting vitamin A supplements to all 114 districts of Madagascar, along with communication materials to increase the coverage of this essential child survival service. It is estimated that this service will enhance the protection of more than 4.3 million children (aged 6–59 months) against excess mortality due to common childhood diseases, with two high doses of vitamin A over a one-year period.⁷



Child protection: A new partnership was formed with the Ministry of Justice to prevent and respond to COVID-19 in prisons. UNICEF has facilitated the screening of quarantined minors and the provision of hygiene materials; and provides protective and preventive materials to the children's areas of prisons in COVID-19 high-prevalence regions. In addition, advocacy and technical support has aimed to reduce the incarceration of children during the epidemic (and in the future). UNICEF also ensured continuity in the monitoring of children

at risk of violence in home settings, through ramped-up programming. UNICEF drafted a technical note on the role of para-social workers in relation to COVID-19, which was shared electronically with all 22 regions of Madagascar. To date, 294 para-social workers have received this support and benefited from coaching.

⁷ UNICEF Madagascar Country Office Humanitarian Situation Report No. 3 Jan-Sept 2020. <https://protect-eu.mimecast.com/s/A-MRC7XRKizyjsxws8wj-k?domain=unicef.org>

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

Protection of the most vulnerable households and children in Madagascar

Poverty is one of the greatest risk factors for vulnerability in women and children and results in multiple and complex sets of deprivations. Children living in economically vulnerable households, children at risk of violence, out-of-school children, and children with underlying health conditions (such as malnutrition) are faced with a corresponding high risk in a pandemic such as COVID-19.



UNICEF launched its **Equity Campaign** to improve access to water for the poorest in the main cities hardest hit by the COVID-19 virus. The campaign *Avotr'Aina* ('Save life' in the Malagasy language) was undertaken to boost better access to safe water, scale up hygiene promotion, and implement IPC measures for public transport in the five cities Antananarivo, Toamasina, Moramanga, Majunga, and Tulear. To ensure fair access to water for urban communities, UNICEF undertook the **provision of subsidised water supplies** in partnership with the water and electrical utility company (JIRIMA) in urban and peri-urban communities in Antananarivo.

UNICEF took on a critically important role in advocating on behalf of the poorest of the poor in urban areas by tackling the problems of **water pricing**. UNICEF was crucial in negotiating a social price of water with the government and private water supply companies, and has applied pressure to these groups to provide equitable access to water resources through fair pricing.

To address financial barriers and livelihoods, UNICEF coordinated with the Ministry of Population, Social Protection and Promotion of Women, technical and financial partners, and the CWG to provide cash transfers to vulnerable households, to provide critical financial support to vulnerable families hardest hit by the economic consequences of COVID-19. UNICEF helped ensure cash transfers were provided to a total of 82,000 households. This was intended to compensate for the loss of revenues in the informal sector affected by lockdown and business closures.

UNICEF also provided support to *Grandir Dignement*, an organisation working with **incarcerated youth in urban areas** of Madagascar to facilitate the screening of incarcerated minors. Another collaboration was with the Municipality of Antananarivo to find placements for street children without parental care during lockdown in the capital.

2.2.3 Extent to which UNICEF has been able to meet programming standards and protocols and ensure community engagement

UNICEF Madagascar aligned itself closely with WHO-led recommendations on the COVID-19 response and adhered to UNICEF's global and regional guidance. The CO was intent on obtaining more information on communities' perceptions and understanding of the risks of COVID-19, so undertook several extensive Knowledge, Attitudes, and Practices (KAP) studies and monitored the reach of RCCE activities through rapid community surveys. In terms of Accountability to Affected People (AAP), respondents cited numerous feedback loops that allowed UNICEF to engage more meaningfully with communities.

UNICEF continued to provide technical and financial support in the implementation of COVID-19-related communication plans in six regions (Atsinanana, Haute Matsiatra, Boeny, Anosy, Analanjirofo, and Analamanga). In this context, 2,330 community agents were

engaged and mobilised, allowing UNICEF to reach more than 500,000 people through participative and interactive communication approaches. In addition, more than 4,000 people shared their questions, feedback, and complaints through community surveillance and feedback mechanisms.

2.3 Extent to which the UNICEF Madagascar CO utilised preparedness and contingency planning during the COVID-19 response, and how it revised COVID-19 response plans based on the evolving needs of the population

UNICEF utilised an emergency response plan, initiated in January and February 2020, which forecast different scenarios. This planning document quickly became an action plan that followed the predictions – from just a few cases, to concentrations of cases, to a situation with community-level transmission. In doing so, UNICEF drew on its experience and planning for other emergencies in Madagascar (plague, drought and cyclones).



2.4 What is known about needs in Madagascar and how UNICEF has determined and verified those needs

UNICEF had a good understanding of existing vulnerabilities for women and children in Madagascar because of its solid routine monitoring mechanisms such as the Multiple Indicator Cluster Survey (MICS) and Multiple Overlapping Deprivation Analysis. However, in order to monitor new emerging needs related to the COVID-19 crisis, UNICEF Madagascar prepared a rapid socio-demographic survey (with the National Institute of Statistics) using standard MICS questions adapted to COVID-19. UNICEF also undertook a KAP survey on COVID-19 and a number of C4D rapid assessments to regularly measure the perceptions, opinions, attitudes, knowledge, and practices of the population in the context of the pandemic.

Innovation: Mapping of vulnerable households and communal waterpoints in urban and peri-urban areas as part of UNICEF IPC and WASH efforts in main towns and cities

UNICEF initiated an analysis to assess and monitor the socio-economic impacts of COVID-19 on the wellbeing of children. This included a rapid desk review of existing data as well as simulations to estimate the impacts of COVID-19 on poverty and inequality, the mitigation potential of cash transfer programmes, and the costs and impacts of scaling up cash transfer programmes over time. UNICEF also conducted phone surveys, and built a system for monitoring of rumours and misinformation about COVID-19. Further, it developed a number of critical new tools for monitoring the extent of the COVID-19 crisis in the main urban centres, including the monitoring of oxygen use in tertiary-level hospitals (university and regional hospitals) throughout Madagascar. This enabled UNICEF to provide information to the Ministry of Health on the evolving situation of the pandemic.

Innovation: UNICEF provided the Ministry of Health with data on oxygen use by critically ill patients in district and regional hospitals as a way to monitor COVID-19 case outbreaks and hospitalisations

Quality

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



The quality of the UNICEF response to COVID-19 in Madagascar can be analysed through three lenses: the effects of the pandemic and related containment measures on quality; timeliness of the UNICEF response; and efforts made by the CO to ensure quality. Partners and frontline workers were unanimous about the overall timeliness of UNICEF COVID-19 response: **the response was very timely.**

To bridge the gap during national lockdowns and restrictions on travel, UNICEF relied on partnerships with national NGOs (MEDAIR, Action Contre La Faim, Population Services International) and civil society groups and associations. These were used to extend its reach for RCCE activities, WASH, and collaboration with health centres and schools during lockdowns.

UNICEF used digital technologies to keep staff in touch and utilised prepositioned stock. UNICEF also developed contracts with private trucking companies with special waivers for travel during lockdown, to ensure the continuity of essential medicines and vaccines.

UNICEF supported ASOS, who relied on public criers using megaphones to spread IPC and COVID-19 prevention messages in communities. Mobile teams were also used to expand RCCE messaging (see the two photos to the right and above).



UNICEF also worked with an NGO partner (Youth First) by providing support to strengthen awareness of the risks of online violence against children during COVID-19 and the confinement via social media.

3 Emerging themes/ conclusions

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

Positives in adaptation

- UNICEF Madagascar has developed new types of partnerships (with the Ministry of Justice, the Municipality of Antananarivo, and JIRAMA in Antananarivo). These aid the protection of some of the most vulnerable populations in Madagascar.
- Collaboration with the private-sector medical community in urban and peri-urban areas can lead to continuing collaboration on GBV detection and treatment, as well as a new network expanding vaccination delivery for children and vaccine reporting in urban centres.
- UNICEF's work on water subsidies in Antananarivo provided an opportunity to initiate a high-level dialogue with the authorities on the cost of water services, which should be equitable and affordable for the poorest households.

A public–private partnership between UNICEF and the **National Order of Medical Doctors** in Madagascar proved very effective as 146,288 consultations have been monitored in over 151 private health facilities, identifying 8,878 suspected COVID-19 cases, either directly treated or referred.



Positives in implementation

- Increased emergency coordination with the Prime Minister's Office, line ministries, and other UN agencies.
- UNICEF and partners were able to draw on experience and planning for other emergencies in Madagascar (plague, drought, and cyclones).
- Development of relationships with professional associations for adult and paediatric intensive care for critically ill COVID-19 patients, filling an important gap.
- Partnering with local suppliers for the provision of oxygen for critical care of COVID-19 patients in 33 referral hospitals.
- In urban and peri-urban clusters affected by COVID-19, UNICEF supported the treatment of children with severe acute malnutrition.
- UNICEF provided subsidised water resources to all vulnerable households by paying the national water utility, JIRAMA, to cover the cost of water during the pandemic.

Partnership with the Anaesthesia and Resuscitation Society of Madagascar
UNICEF contracted with the Anaesthesia and Resuscitation Society of Madagascar for the training of all resuscitation service providers from 34 university hospital centres selected for the management of cases of COVID-19 in the 22 regions of the country, prioritising the regions most affected by the COVID-19 pandemic

Challenges in adaptation

- Shifting programmatic focus from the rural drought-prone populations in the south to urban and peri-urban communities was challenging.
- Supply chain challenges were an issue, particularly in international procurement.
- Rapid increases in prices and shortages of supplies in international procurement.
- Weakness encountered in field-based monitoring, data verification systems, and quality of follow-up.

Challenges in implementation

- Strict lockdown measures, although important for reducing the spread of the virus, had very severe effects on the economy and livelihoods, plunging many families and households into poverty and requiring more inputs for successful implementation.
- Lockdowns affected UNICEF's ability to have good visibility over the distribution of supplies and cash.
- Maintaining an understanding of evolving population needs through data collection was challenging.
- Failings in international procurement were offset by the forging of new partnerships with local suppliers.

Medium- to long-term implications of the COVID-19 pandemic for vulnerable children and communities, and implications for UNICEF's strategy

- Decreased coverage of essential health services (nutrition, immunisation, postnatal care, sexual and reproductive health and family planning services, skilled birth attendance, newborn care).
- Increases in child morbidity due to diarrheal diseases, vaccine-preventable diseases, and malnutrition
- Increases in unwanted pregnancies among girls.
- Losses in learning for children due to school closures.
- Break-down in child protection activities/supervision.

4 Lessons learned/ suggested action points

The following is a combination of suggestions made by respondents and suggestions made by the consultant based on the case study analysis. UNICEF CO may consider the need to:

- Improve preparedness for an effective response to emergencies, strengthen related systems, and preposition supplies.
- Strengthen cross-sectoral emergency and contingency planning.
- Scale up successful COVID-19-related partnerships such as with the Madagascar National Order of Physicians to develop collaboration in the field of GBV screening and treatment in urban centres.
- Improve vaccination coverage in urban settings and improve reporting of vaccination services from the private sector.
- Continue the engagement with urban and peri-urban children – a new population target group for UNICEF as a result of the pandemic.
- Maintain frequent dialogue and interaction with partners and continued flexibility in responding to the needs they express.
- Bolster AAP mechanisms.
- Improve end-user monitoring.

ANNEX A: Regional context

A.1 Countries in eastern and southern Africa with UNICEF COs

The map below (Figure A1) shows the countries with UNICEF COs that fall under the purview of UNICEF ESARO.

Figure A1 Countries in ESAR with UNICEF offices



A.2 UNICEF response to COVID-19 in ESAR

Excerpted from OPM's Inception Report⁸

Soon after the pandemic was declared by the World Health Organization (WHO) the UNICEF country offices and regional office in ESAR began working with the governments and the development partners in the region to respond to the pandemic with the aim to reduce transmission and mitigate the impacts of COVID-19. The region received nearly US\$350 million, which is approximately 18% of UNICEF's global Humanitarian Action for Children (HAC) to respond to COVID-19.

UNICEF is responding to COVID-19 in the Eastern and Southern Africa Region (ESAR) mainly through two distinct but complementary pathways, namely, programmatic response and operational response. [As part of the programmatic response], UNICEF is...working to ensure the continuity of ongoing basic essential services⁹ in the region. Further details on these responses based on the information included in the ToRs of the RTA is outlined below.

Programmatic response

The programmatic response to COVID-19 in ESAR is aimed to minimise the impact of the pandemic on women and children by ensuring the continuity of basic essential services and adapting the services to incorporate safety measures and COVID-19 transmission prevention activities, more specifically:

- Ensuring access to essential health and nutrition services, including sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) and HIV;
- Supporting government to provide distance and home learning through eLearning platforms and take-home packages, and promoting and supporting the early and safe re-opening 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, refugee, internally displaced, migrant and returnee children, and girls who face increased risk to e.g. child marriage as a result of the pandemic;
- Providing support to caregivers on how to talk to children about COVID-19, managing their children's mental health and well-being and; supporting the continuity of learning whilst schools and centres are closed;
- Adapting and refining standard COVID-19 response measures to support children and families living in challenging settings such as refugee camps, informal settlements, rural areas and densely populated urban and peri-urban areas;
- Expanding sustainable social protection programmes (including cash top ups to existing beneficiaries and identifying new beneficiaries including the borderline poor), including gender-sensitive measures such as cash transfers to support girls' re-entry to school;
- Helping finance ministries access international funding opportunities to invest in health, WASH, social protection systems and social welfare services;

⁸ OPM, Inception Report for the Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa, 10 November 2020.

⁹ Basic essential services comprise health services (including sexual, reproductive, maternal, newborn, child and adolescent health); nutrition; social welfare, child protection and gender-based violence; access to and retention and performance in education and learning; WASH, including in schools (including menstrual hygiene management), health facilities, households and communities; social protection; HIV.

- 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 risk communication and community engagement (RCCE) for the COVID-19 response;
- Supporting coordination mechanism and evidence generation;
- Supporting the procurement and supply of essential commodities for treatment and prevention; and
- Identify and protect children and adolescents who may be more vulnerable to developing serious complications of COVID-19.

Operational response

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. This includes measures like:

- Protecting staff most at risk of complications, reducing overall exposure through teleworking and adopting measures to protect staff with critical functions;
- Simplifying internal procedures, adopting digital signatures and setting emergency protocols in place; and
- Declaring a global Level-3 (L3) emergency on 16th April 2020 and putting in place emergency procedures associated with L3 declaration.

Continuity of essential services

UNICEF support to continuity of essential services across programmatic areas includes supporting strategy, design and implementation (UNICEF, 2020) in regard to:

- **Health services:** In collaboration with the governments, WHO and other development partners, UNICEF is working on communication activities at health facilities, in the communities and at schools. UNICEF is also working on capacity development and development of guidelines on the continuity of essential health services including SRMNCAH and HIV.
- **Nutrition:** UNICEF is working on ensuring continuity of nutrition programmes including management of acute malnutrition, vitamin A supplementation and expansion of Family Mid-Upper Arm Circumference (MUAC) services.
- **Child protection and GBV:** UNICEF is protecting refugee, internally displaced, migrant and returnee children, including reaching children on the move with registration, vulnerability assessments, family tracing and reunification and basic counselling support services; advocating for releasing children from detention; providing life-saving sexual and gender-based violence services including prevention of child marriage; facilitating community-based mental health and psychosocial support for children, their parents and caregivers; and supporting social welfare services for example, by ensuring that children without parental or family care are provided with appropriate alternative care arrangements.
- **Access to education and learning services:** UNICEF is supporting distance/ home-based learning, and plans for safe re-opening and keeping schools open. This includes an emphasis on girls' access to distance learning and data collection on the negative consequences of school closure on girls (e.g. early pregnancy and child marriage).
- **WASH:** UNICEF is providing critical WASH supplies as well as training of the health facility and community health workers on IPC.

- **RCCE:** UNICEF's communication campaign reached 86% of the population with information on preventative measures and how to access services related to COVID-19 pandemic. UNICEF also support partners on rumour management tools and strategies to mitigate pandemic misinformation.
- **Supply:** As at 28 July, UNICEF delivered Personal Protective Equipment (PPE), oxygen sets and diagnostics worth of US\$ 21 million to all the countries in the region.
- **Social protection:** UNICEF is engaging with government and partners to promote the use of shock responsive / adaptive social protection intervention to reduce vulnerabilities, poverty and improve the linkages with essential services and over 13 million households received cash transfers.

There remains significant uncertainty on what will be the trajectory of the COVID-19 pandemic in ESAR due in part to incomplete understanding of its immunology, epidemiology, clinical management, both acute and longer-term outcomes, and effective strategies for influencing and sustaining preventative behaviours amongst the population. UNICEF country offices are supporting national governments in 21 ESAR countries across a number of programme areas that provide essential services to the population and particularly to children, women and other vulnerable groups. It is critical that these programmes continue to be delivered and adapted to maintain and extend where needed the reach (particularly to the vulnerable), and quality of these services. To this end, country offices have developed COVID-19 response plans which they are implementing. However, given the general lack of evidence-based good practices, together with the non-static nature of the pandemic, it is essential that these response plans are able to adapt to the changing transmission and impacts of the pandemic.

A.3 Interviewees - Madagascar

Interviewees by organisational category	
Front line workers	4
Malagasy government staff	3
NGO/INGO	1
UN Agency	-
UNICEF Partners	5
Malagasy government staff	3
Bilateral (foreign government) staff	-
NGO/INGO	1
UN Agency	1
UNICEF staff	3
TOTAL	12

Interviewees by sector	
Education	2
WASH	1
Health	3
Nutrition	1
C4D	2
Private sector engagement	1
Social protection	1
Other (coordination)	1
TOTAL	12

A.4 RAG Rating: Madagascar

Key: **Green:** Meets or surpasses expectation; **Amber:** partially meets expectation; **Red:** Below expectation

Programme adaptation		RAG rating
Approaches to meeting evolving environment/ operating context	To what extent does the country office have the ability to identify and serve the most vulnerable and hard to reach women and children through its programming? <i>[For example, use of gender analysis during needs assessment; use of indicators disaggregated by gender, age and disability, including age- and gender-disaggregated adolescent-specific indicators (10-14; 15-19; or 10-19); participation in for example inter-agency working group on gender; partnerships with civil society organizations representing persons with disabilities etc.]</i>	
Approach to promoting local solutions	To what extent is the country office developing action plans and local solutions in response to these?	
Support for evolving institutional gaps	Have adaptations been developed across all programmatic areas?	
Implementation		
Preparedness and contingency planning	To what extent did country office's existing preparedness and contingency planning processes contribute to the implementation of the COVID-19 emergency and mitigation response?	
Implementation as planned	To what extent do response (emergency and mitigation) plan activities and modalities contribute to the achievement of planned objectives?	
Coverage vs need	To what extent did the COVID-19 response (emergency and mitigation) activities target the coverage of vulnerable population?	
Equity vs gaps	To what extent was gender mainstreamed into institutional systems and processes during implementation? <i>[For example, gender-responsive human resourcing and policies; incorporation of gender sensitive and gender transformative approaches throughout the programme cycle; and accountability for results on gender].</i> This indicator above focuses on the 'feedback and complaints' pillar, while the indicator below focuses on the 'PSEA' pillar.	
	To what extent did the COVID -19 response (emergency and mitigation) consulted with the affected people, including the most vulnerable groups?	

	<p>To what extent has accountability to affected people (AAP) been undertaken as part of implementation including Prevention of Sexual Exploitation and Abuse by humanitarian personnel (PSEA)?</p> <p><i>[AAP is defined as: "An active commitment to use power responsibly by taking account of, giving account to, and being held to account by the people humanitarian organizations seek to assist" but it is a broad concept consisting of seven pillars: participation (Safe, appropriate, equitable and inclusive opportunities for girls, boys, women and men of all ages especially the most vulnerable and marginalized groups, to participate in decisions that affect them); information and communication (Safe, appropriate, equitable and inclusive access to life-saving information as well as information on people's rights and entitlements and how to exercise them); feedback and complaints; PSEA; strengthening local capacity; evidence-based advocacy and decision-making; and coordination and partnerships].</i></p>	
Participation	To what extent does the country office coordinate and collaborate with and complement existing work on COVID-19 response (emergency and mitigation)?	
Quality		
Focus on most essential interventions	Perception and evidence that most essential services in the country have been the focus of COVID-19 response activities	
	Evidence that selected essential services have been maintained as part of the COVID-19 response	
Quality of assistance delivered	Quality of assistance delivered	
Timeliness	To what extent has the country office been successful in making programming adaptations and delivering them in a timely manner?	
Robustness of verification system	Are there adequate oversight and accountability mechanisms in place, including effective monitoring, feedback loops and reporting systems including AAP and PSEA?	
Average RAG rating: Madagascar		

Annex B Data collection tools

B.1 KII Guide for UNICEF Country Offices

Adaptation

1. What have been the **most critical COVID-19-related operational adaptations** required by your country office? *[Note to interviewer: This question pertains to operational aspects such as remote working, putting Level 3 Simplified Standard Operating Procedures in place, etc.]*
2. What have been the **most critical COVID-19-related programming adaptations** required by your country office? *[Note: This question pertains to substantive programming aspects.]*
3. Based on your country office's responses to the online questionnaire, we know that you have made **increased use of local solutions** in responding to COVID-19 restrictions. Can you tell me what that has meant in terms of implementation successes and challenges, as well as in terms of quality of product or service?
4. To reach the most at-risk and most vulnerable groups of women and children in the COVID-19 context, to what extent is your country office able to **fill the gaps** (in geographic areas, for example) vacated or not reached by others?

Implementation

5. Can you describe your country office's efforts to **sustain basic essential services** despite COVID-19 crisis, *specifically* with regard to how successful you have been in (a) ensuring coverage and (b) scaling-up? *[Note to interviewer: Here, 'basic essential services', refers to health services (sexual, reproductive, maternal, newborn, child and adolescent health), nutrition, social welfare, child protection and gender-based violence, access to and retention and performance in education and learning, WASH, including in schools (including menstrual hygiene management), health facilities, households and communities, social protection, HIV.]*
6. Given the description you just provided, on a scale of 1 to 5 *[where 1=low and 5=high]*, could you please **rate** the extent to which your country office has been successful in **sustaining basic essential services**?
7. How have the most vulnerable and excluded groups of women and children been **identified** in the context of the COVID-19 pandemic?
8. If the **method of vulnerable and excluded group identification** represents a change to how vulnerable groups were identified pre-COVID-19, could you briefly describe the nature of that change?
9. To what extent is **data on the most vulnerable groups sufficiently disaggregated** to provide information on different categories of vulnerable groups?
10. Can you describe your country office's efforts **to assess and meet the needs** of the most at-risk and vulnerable groups of women and children in the COVID-19 context? *[Note to interviewer: Here we are aiming to understand if the country office has any needs assessment mechanism in place to understand evolving population needs in the COVID-19 context; and how the country office has gone about meeting those needs].*
11. To what extent has **ensuring gender equality** been taken into account during implementation of the COVID-19 response?
12. What **role have Accountability to Affected Populations (AAP)¹⁰ mechanisms**, including Prevention of Sexual Exploitation and Abuse by humanitarian personnel (PSEA), **played** in the overall response to COVID-19? *[Note to interviewer: If the interviewee doesn't say anything about whether outputs of AAP mechanisms have led to programme or management decisions, probe to ask whether this is the case. Also probe to find out how community engagement has been affected, especially in terms of monitoring and feedback loops.]*

¹⁰ Note to interviewer: AAP is described in UNICEF's ESARO's AAP guidelines 2020, see [here](#).

13. What **role have preparedness and contingency planning (at the national, sub-national, and country office levels) played** in the overall response to COVID-19? In your response, please also make reference to the extent to which your country office is making use of the Emergency Preparedness Platforms (EPPs)¹¹, any lessons learned, intentions to update the EPPs and the extent to which your country office had the 'right' partners in place for the COVID-19 response? *[Note to interviewer: Only ask if not adequately evoked in earlier responses but do probe on EPPs and 'right' partners if not specifically mentioned earlier.]*
14. To what extent has **guidance from UNICEF headquarters** informed your country office's COVID-19 response? *[open ended]* *[Note to interviewer: Here, we are aiming to get at how useful UNICEF HQ guidance has been, but we are avoiding use of the word 'useful' to avoid bias and allow the interviewee the maximum freedom to respond as they wish.]*

Quality of Response

15. In what ways has your country office and its partners **ensured** that implementation of the COVID-19 response is taking place **as intended and is of good quality**? One aspect of this is how your country office has ensured that it meets **programming standards and protocols** in the COVID-19 context, so please speak to that as well in your response. *[open ended]* *[Note to interviewer: Probes to include: how relevant, effective, efficient the support has been; how multi-sectoral the support has been; are girls and women targeted with specific gender-sensitive approaches which recognize their increased vulnerability and risks; are children/adolescents with disabilities and refugee, internally displaced, migrant and returnee children included]*
16. Given the description you just provided, on a scale of 1 to 5 *[where 1=low and 5=high]*, could you please **rate** the extent to which your country office has been successful in **meeting programming standards and protocols**? *[Note to interviewer: You may choose to introduce this question with the following: This last question in this section is linked to one I just asked about ensuring that you meet programming standards and protocols, so there may be some overlap but I'd like to ask it from another angle:]*
17. How are you monitoring the quality of your interventions and, in this process, are you using any new **remote monitoring methods**? *[Note: If the interviewee doesn't say anything about negative consequences to IP monitoring, probe whether this is the case].*

Lessons for Future Programming

18. Could you take a moment to recap the successes you perceive in your country office's COVID-19 response and talk about what you think accounts for those successes and how you think they can be built upon? *[Note to interviewer: Only ask if the successes have not adequately been mentioned in the interview up to this point.]*
19. What have been the **most critical challenges (bottlenecks and barriers) confronted** in the course of your country office's effort to support the COVID-19 response effectively? *[Note to interviewer: Only ask if the challenges haven't adequately been mentioned, probe: if L3 SSOPs have not yet been specifically mentioned: If your CO is putting Level 3 Simplified Standard Operating Procedures in place, are there any issues around lag times?]*
20. What, in your opinion, are **solutions** to address these challenges to ensure that UNICEF programming reaches the most vulnerable groups?
21. Which COVID-19-related adaptations would it be useful to **keep as a permanent part** of your country office's programming and operations?
22. Are there **new/emerging vulnerable groups** of women and children that your UNICEF country office and your in-country partners should consider focusing on as you further respond to COVID-19 in the medium and long term? *[Note to interviewer: If women and children with disabilities are not specifically mentioned in the response, please probe on considerations for that group. Also check if migrant children and other vulnerable sub-groups are of special concern in the country.]*
23. Lastly, I'd like to give you the opportunity to share any additional thoughts you might have that would contribute to the objectives of the real-time assessment; i.e., is there anything you'd like to add that UNICEF should consider as it reviews its response to date and as it plans ahead? *[This question is optional, only to be asked if time allows].*

¹¹ EPP is described in UNICEF's guidance note on Preparedness for Emergency Response (2016), see [here](#).

B.2 KII Guide for UNICEF Partners

Preliminaries

1. What is your programmatic area of work generally (setting aside the COVID-19-related activities for a moment)?
2. What is your geographic area of work generally (setting aside the COVID-19-related activities for a moment)?

Adaptation

3. What have been the **most critical elements of the response to COVID-19** in your work?
4. What has been the **focus of UNICEF support to/collaboration with your work** during the COVID-19 response?
5. How is that **different from UNICEF support/collaboration prior** to the pandemic?
6. What have been the **most critical changes** required to sustain **basic essential services** in the geographic area where you work to meet new and emerging COVID-19 needs, and how has UNICEF supported/collaborated on those changes? *[Note to interviewer: 'basic services' refer to health services (including sexual, reproductive, maternal, newborn, child and adolescent health), nutrition, social welfare, child protection and gender-based violence, access to and retention and performance in education and learning, WASH, including in schools (including menstrual hygiene management), health facilities, households and communities, social protection, HIV.]*

Implementation

7. Given the description you just provided, on a scale of 1 to 5 *[where 1=low and 5=high]*, could you please **rate** the extent to which your organization has been successful in **sustaining basic essential services**?
8. What role have **pre-existing preparedness and contingency planning (at the national, sub-national, and institutional levels)** had in your overall response to COVID-19? *[open ended]*
9. **Who have been the most vulnerable and excluded groups** of women and children most affected by COVID-19?
10. **How** have these vulnerable groups been **identified**?
11. Can you describe your entity's efforts **to assess and meet the needs** of the most at-risk and vulnerable groups of women and children in the COVID-19 context?
12. To what extent has UNICEF support/collaboration helped you reach your **intended beneficiaries, including the most vulnerable and excluded groups of women and children, in the response to COVID-19?** *[open-ended] [Note to interviewer: UNICEF support may include the following: supplies like PPE, communication messages, cash assistance, training, support for specific programmes e.g. primary health care, nutrition, education, child protection, gender programming, GBV prevention and response etc.]*
13. Given the description provided, on a scale of 1 to 5 *(where 1=low and 5=high)*, **to what extent have the most vulnerable and excluded groups of women and children received support**, in response to COVID-19?
14. How **critical** has **UNICEF's support/collaboration** been in meeting the needs of **the most vulnerable and excluded groups of women and children**, as part of the COVID-19 response?

Quality of Response

15. How **timely** has UNICEF's COVID-19 response been so far, based on its support to/collaboration with your work?

16. Give the description you just provided, on a scale 1 to 5 (*where 1=low and 5=high*), could you please rate the **timeliness of UNICEF's COVID-19 response**?
17. In what ways has UNICEF **ensured** that implementation of the COVID-19 response is taking place **as intended and is of good quality**? [*Probes: how relevant, effective, efficient the support has been*] [*open-ended*]; *are girls and women targeted with specific gender-sensitive approaches which recognize their increased vulnerability and risks; are children/adolescents with disabilities and refugee, internally displaced, migrant and returnee children included*]
18. Could you please rate, along the categories that I'll read to you, how **easy** is it for you and your colleagues **to contact UNICEF** to make suggestions/requests, to complain, or to provide feedback? Is it:
 - a. Very easy;
 - b. Easy;
 - c. Somewhat easy;
 - d. Not easy; or
 - e. Don't know/not sure?

Could you please elaborate on what informed your rating? [*open-ended*]

19. Is it your experience that when UNICEF asks for your opinions on a programme approach or operations that UNICEF **will change the programme approach or operations in line with your feedback**?

Lessons for Future Programming

20. As we near the end of our interview, could you take a moment to summarize what you think accounts for the **successes** (i.e., any successes you perceive) **of UNICEF's support to/collaboration with your work** in the context of the COVID-19 response, and how can these be built upon?
21. What accounts for any **gaps in the design and implementation of UNICEF's support to/collaboration with your work** in the context of COVID-19 response activities?
22. What, in your opinion, are the **major challenges** that will require **more attention** in the next few months and in the longer term as a result of COVID-19?
23. What in your opinion are the **solutions, local or otherwise**, to address these challenges and how could UNICEF support or enhance support to such local solution(s)?
24. Are there **new/emerging vulnerable groups** of women and children that UNICEF and other partners should consider focusing on as they further respond to COVID-19 in your area of operation?
25. Lastly, before we wrap up the interview, I'd like to give you the opportunity to share any additional thoughts you might have that would contribute to the objectives of the real-time assessment; i.e., is there anything you'd like to add that UNICEF should consider as it reviews its response to date and as it plans ahead? [*This question is optional, only to be asked if time allows*].

B.3 KII Guide for Frontline Workers

Preliminaries

1. What is your organization's programmatic area of work in general, setting aside for a moment the COVID-19-related activities?
2. What is your organization's geographic area of work, again without considering, for a moment, the COVID-19-related activities?

Adaptation

3. What has been the **focus of UNICEF support to your work** during the COVID-19 response?
4. How is that **different from UNICEF support prior** to the pandemic?
5. In the COVID-19 context, what have been the **most critical changes** required to ensure **basic essential services** in the area where you work? *[Note to interviewer: 'basic services' refer to health services (including sexual, reproductive, maternal, newborn, child and adolescent health), nutrition, social welfare, child protection and gender-based violence, access to and retention and performance in education and learning, WASH, including in schools (including menstrual hygiene management), health facilities, households and communities, social protection, HIV.]*

Implementation

6. What role has **pre-existing preparedness and contingency planning (at the national and sub-national levels and at your organization's level)** had in the overall response to COVID-19?
7. Who have been the **most vulnerable and excluded groups of women and children most affected** by COVID-19?
8. How have these vulnerable groups been **identified**?
9. Can you describe your organization's efforts **to assess and meet the needs** of the most at-risk and vulnerable groups of women and children in the COVID-19 context? *[Note to interviewer: Here we are aiming to understand if there is a needs assessment mechanism in place to understand evolving population needs in COVID-19 context and then of course how the respondent's organization has gone about meeting those needs.]*
10. To what extent has UNICEF support helped you reach your **intended beneficiaries, including the most vulnerable and excluded groups of women and children, in the response to COVID-19**? *[Note to interviewer: UNICEF support may include the following: supplies like PPE, communication messages, cash assistance, training, support for specific programmes e.g. primary health care, nutrition, education, child protection, gender programming, GBV prevention and response etc.]*
11. Given the description provided, on a scale of 1 to 5 (*where 1=low and 5=high*), to what extent has UNICEF's support helped you reach the most vulnerable and excluded groups of women and children, in your response to COVID-19?
12. How **critical** has **UNICEF and its partners' support** been in meeting the needs of **the most vulnerable and excluded groups of women and children**, as part of your work in the COVID-19 response? *[Note to interviewer: Only ask this question if it isn't clear on the basis of what's been shared in the course of the interview up to here and if time permits.]*

Quality of Response

13. How **timely** has UNICEF's COVID-19 response been so far?
14. Give the description you just provided, on a scale 1 to 5 (*where 1=low and 5=high*), could you please rate the **timeliness of UNICEF's COVID-19 response**?

15. In what ways has UNICEF and its partners **ensured** that implementation of their support in the COVID-19 response is taking place **as intended and is of good quality**? *[Probes: how relevant, effective, efficient the support has been]; are girls and women targeted with specific gender-sensitive approaches which recognize their increased vulnerability and risks; are children/adolescents with disabilities and refugee, internally displaced, migrant and returnee children included]*
16. Could you please rate, along the categories that I'll read to you, how **easy** is it for you and your colleagues **to contact UNICEF or UNICEF partners** to make suggestions/requests, to complain, or to provide feedback? Is it:
- Very easy;
 - Easy;
 - Somewhat easy;
 - Not easy; or
 - Don't know/not sure?

Could you please elaborate on what informed your rating?

17. When UNICEF or a UNICEF partner asks for your opinions on a programme approach or operations, is it your experience that UNICEF or its partner **will change the programme approach or operations in line with your feedback**?

Lessons for Future Programming

18. As we near the end of our interview, could you take a moment to summarize what you think accounts for the successes (i.e., any successes you perceive) of UNICEF's support to your organization's COVID-19 response and how can these be built upon?
19. What accounts for any gaps in the design and implementation of UNICEF's support to your organization's COVID-19 response activities?
20. What are the **challenges** that will require **more attention** in the next few months and in the longer term as a result of COVID-19?
21. What in your opinion are **solutions**, local or otherwise, to address these challenges and how could UNICEF support or enhance support to such local solution(s)?
22. Are there **new/emerging vulnerable groups** of women and children that UNICEF and other partners should consider focusing on as they further respond to COVID-19 in your area of operation?
23. Have **female frontline workers** received adequate support in light of potential increased burdens and responsibilities at home and in the community? *[open-ended]*
24. Lastly, before we wrap up the interview, I'd like to give you the opportunity to share any additional thoughts you might have that would contribute to the objectives of the real-time assessment; i.e., is there anything you'd like to add that UNICEF should consider as it reviews its response to date and as it plans ahead? *[This question is optional, only to be asked if time allows].*

B.4 Standard introduction and consent (all interviews)

The objective of this interview is:

- to understand how population needs are assessed and action plans developed to respond to these; how effectively the UNICEF CO has monitored changing needs and made adaptations; what are the barriers, challenges and successes?
- to understand how effective these processes were in contributing to the COVID-19 response; explore the link between existing preparedness process, COVID-19 response plan and implementation.
- to understand how plans were developed implemented; what adaptations were made; what were the successes and why? what were the barriers and why?
- to explore quality and effectiveness of partnerships in relation to COVID-19 response
- to understand the quality of the response.

Hello, [state name of interview participant]

Thank you for making yourself available for the interview today. My name is [state name], and I am a member of the Assessment Team engaged by UNICEF ESARO to undertake a real-time assessment of the support the country offices in the region have provided to the COVID-19 response.

Your feedback will inform this analysis, including aspects of adaptation, implementation, and quality that UNICEF should consider in the upcoming months at all levels.

Your input is valuable, but participation in this interview is entirely voluntary. Whether or not you participate will have no consequence on any aspect of your relationship with UNICEF. Please be aware that even if you initially agree to participate in this interview, you may stop participating at any time. You may also skip any specific question that you do not wish to answer.

Your responses will be kept confidential and anonymous. No one except the Assessment Team (OPM researchers and UNICEF evaluation staff) will have access to them.

The interview should take approximately 45 minutes.

With that introduction, unless you have any questions at this point, I'd like to request your explicit consent for participation in, and the recording of, this interview.

Do you agree to participate in this interview, given the stipulations I just laid out?

➔ If Yes, continue the interview.

➔ If No, end the interview (and search for an alternative respondent).

*[Note to interviewer: Before starting off, ask the interviewee to please, in their responses, to the extent possible, **distinguish between the emergency response** (containment and case management) activities and the activities associated with the **mitigation of unintended consequences** of containment measures. Keep this in mind throughout the interview so that you can probe whenever the distinction is not clear.]*