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

Case Study:

UGANDA

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

Photo credit: UNICEF

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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 Uganda country case study, drawing on the qualitative data gathered during the course of interviews with key informants. In line with the 'light-touch' nature of the overall RTA and respecting the maximum length of 3,600-4,000 words[1], 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.

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

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.

Furthermore, for the specific purposes of this case study:

- The invaluable support of UNICEF Uganda colleagues cannot go unmentioned. Without the energetic engagement of Lotte van't End, Viorica Berdaga, Chimwemwe Msukwa, Mandi Chikombero, Wilberforce Kimezere, Shivanarain Singh, Lisa Zimmerman, and other members of the team, data collection for the case study would have been impossible to complete within the tight timeline. Their teamwork and participative attitude were remarkable and allowed for the delivery of a complete data set. We also thank Proscovia Nakibuuka, Douglas Lubowa Sebba, and Lotte van't End for making available the images that bring visual life to this report.

- Most crucially, we thank the key informants for the attention and care they gave to responding to the interview questions and for sharing their perspectives and insights with such generosity and enthusiasm. We were moved by the dedication they demonstrated to their work, which seeks to make a meaningful, positive difference in the lives of Ugandan residents, notably those who are most vulnerable and most excluded. That such important work is being carried out by individuals with a sincere passion for what they do is heart-warming.

[1] Calculated on the basis of the eight-page maximum, assuming standard 11-point, single-spaced Arial font.

Executive summary

Introduction

This case study of the UNICEF response to COVID-19 in Uganda, where almost 31,400 COVID-19 cases and 238 deaths have been recorded as at 20 December 2020,[2] forms part of a broader RTA of UNICEF's COVID-19 response in eastern and southern Africa (ESA).

The 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 it was not possible to include beneficiaries. The broad sectoral focus also precluded in-depth analysis. The research was undertaken between late November to mid-December 2020.

Qualitative data collection, in the form of 16 key informant interviews (KIIs), was undertaken alongside a limited review of documentation and a survey of wider UNICEF Country office staff. The study aimed at answering **four overarching questions**: (i) how has UNICEF Uganda 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 from UNICEF Uganda's response to COVID-19 include the following:

- **Adaptation in the COVID-19 response:** UNICEF ensured business continuity while undertaking a significant operational adaptation. It also responded to evolving needs with new or adapted agreements; and successfully partnering with local suppliers on innovative solutions. There was also successful scaling up of the use of digital platforms for remote programming and remote monitoring; and enhanced partnerships with government. UNIFEF also adopted new ways to assess and meet population needs; filled gaps by identifying and extending programming to excluded populations; and adopted new modalities of service delivery.

- **Implementation of the COVID-19 response:** The CO contributed significantly to offsetting the negative effects of the pandemic on access to basic services. UNICEF reached many of the most vulnerable segments of the population and helped ensure equity. It also met programming standards and protocols; was largely able to maintain community engagement; and capitalised on pre-existing preparedness and contingency planning and trust.

- **Ability to assure quality in the COVID-19 response:** There was timely programme delivery; and adherence to the processes and verification systems used to ensure quality.

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

- **In terms of adaptation,** key challenges were a lack of funding; difficulties in reassigning UNICEF staff to certain roles and to accessing certain supplies, and related price fluctuations. There was also a focus on meeting national priorities rather than predefined interventions; and challenges in keeping up with the evolution of the COVID-19 situation.

- **In terms of implementation:** there were challenges in overcoming COVID-19 containment measures; slow government systems and the return of slow UNICEF

[2] See the Government of Uganda's COVID-19 Response Info Hub's section on stats, available at https://covid19.gou.go.ug/statistics.html (last accessed 22 December 2020).

systems. There was also chronic underfunding of key sectors (notably in basic education) which created weaknesses that carried over into the COVID-19 context; and an overly complex COVID-19 Supply Chain System.[3]

- **In terms of quality.** There was perceived excessive guidance from UNICEF-global, with inadequate real-time, practical solutions.

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

- The poor, especially the urban poor;
- Adolescents who have been out of school for an extended period and some of whom will drop out; and
- The 'girl-child as mother', given the increase in the teenage pregnancy rate during lockdown.

Lessons learned/ suggested action points

Based on their perspectives on emerging challenges, and considering the broader objective of the RTA, respondents participating in this case study offered the following suggestions to inform UNICEF Uganda's programming in the medium to long term:

- Strengthen the government's coordination function through technical assistance.
- Expand access to digital innovations, including to digital means of learning.
- Mainstream successful COVID-19-related innovations.
- Continue risk communication to raise people's understanding of the risk and mitigate community-wide spread.
- Engagement addressing access issues once a COVID-19 vaccine is developed.
- Support the go-back-to-school campaign when all classes reopen.
- Support the COVID-19 response within the school setting, including to observe the Ministry of Health's standard operating procedures (SOPs), to address teachers' and learners' psychosocial needs, and the development of learning materials for continuity of learning for children with special needs.
- Ensure programming for the increased number of school dropouts.

In addition, the following action points proposed by the RTA team might be considered:

1. Keep hiring staff passionate about their work – but care should be taken to avoid excessive pressure and overburdening.
2. UNICEF would serve itself well by taking a close look at work modalities, including continued use of digital systems, preserving paper-free aspects, and migrating fully to electronic procedures.
3. Simplify bureaucratic procedures to enable timely responses even in non-emergency situations.
4. Improve preparedness for an effective response, strengthening related systems and prepositioning supplies to the extent possible.
5. Consider innovations to render fundraising-related efforts more effective, while working in a way that effectively capacitates developing countries to function without external assistance, thus reducing the need for fundraising.
6. The Country Programme Action Plan's (CPAP's) reorientation from a 'project approach' to a well-coordinated, government-led 'systems-approach' was on the right path – this should be maintained.
7. Position UNICEF in national and subnational coordination mechanisms, both in terms of active participation and to inject capacity.

[3] See: WHO (2020) 'COVID-19 Supply Chain System', available at www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-operations (last accessed 27 December 2020).

8. Maintain more frequent dialogue with partners and continued flexibility in responding to the needs expressed, including deliberately considering populations that may have been previously missed or ignored in the CO's programme.
9. UNICEF Uganda has the goodwill and trust of its partners and frontline workers, which should be leveraged to provide support based on local priorities rather than predefined interventions.
10. Leverage UNICEF's comparative advantages to deliver in areas where it does so best.
11. Integrate the COVID-19 response into ongoing programmatic interventions.

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List of abbreviations

AAP	Accountability to Affected People
CO	Country Office
CPAP	Country Programme Action Plan
EPP	Emergency Preparedness Platform
ESA	Eastern and Southern Africa
ESAR	Eastern and Southern Africa Region
ESARO	Eastern and Southern Africa Regional Office (of UNICEF)
GBV	Gender-based Violence
KII	Key Informant Interview
M&E	Monitoring and Evaluation
OPM	Oxford Policy Management
PPE	Personal Protective Equipment
PSEA	Prevention of Sexual Exploitation and Abuse
RCCE	Risk Communication and Community Engagement
RTA	Real-Time Assessment
SIDA	Swedish International Development Cooperation Agency
SOPs	Standard Operating Procedures
SSOPs	Simplified Standard Operating Procedures
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

1 Introduction

1.1 Background

Global context: Following evidence of rapid and widespread transmission of COVID-19, the World Health Organization (WHO) declared the disease a global pandemic on 11 March 2020. COVID-19 is 'an unprecedented global crisis, causing high mortality, morbidity, social disruption, and economic [hardship]'.[4] As at 28 Dec 2020, the worldwide total of confirmed cases was almost 80 million, with over 1.75 million deaths.[5]

Purpose: This case study of the UNICEF response to COVID-19 in Uganda forms part of a broader RTA of UNICEF's COVID-19 response in ESA. The aim of the RTA is to inform a forward-looking reflection on UNICEF COs' responses to COVID-19 and thus support timely course correction for the medium and long term.

Audience: The primary intended users of the RTA are the COs in the region as well as UNICEF's regional and global offices, which might consider the findings as they plan ahead.

Timeline: The RTA is being undertaken in two phases from October 2020 to July 2021.

1.2 Case study scope, approach, and methods

Scope: The RTA has four overarching questions, applied to this country case study as follows: (i) how has UNICEF Uganda adapted to the COVID-19 pandemic and to evolving needs?; (ii) how can the implementation and quality of the CO's COVID-19 response be characterised?; (iii) what are the emerging themes?; and (iv) what are the early lessons?

Approach: The approach is qualitative, which is pertinent given the broad and contextual nature of the questions and the goal of obtaining illustrative and explanatory responses.[6]

Methods: Data collection involved remote KIIs mainly conducted in November 2020 with 16 purposively selected respondents, including from among UNICEF CO management (five respondents), UNICEF partners (seven), and frontline workers (four). Annex A.4 provides a breakdown of the respondents. The primary qualitative data was supplemented with a review of secondary documents (where these were available) provided by the ESARO evaluation team; and a survey of wider UNICEF Country Office staff.

Limitations: The assessment was designed as a 'light touch' real-time analysis, with a tight timeline and relatively small budget. Due to this, only a small sample of stakeholders were interviewed,[7] and it was not possible to include beneficiaries. The broad sectoral focus also precluded in-depth analysis. As the research was conducted at the end of the year, some key informants were unavailable (due to the Christmas period).

[4] OPM (2020) 'Inception Report for the Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa', OPM, Oxford.
[5] WHO (2020) 'Coronavirus Disease (COVID-19) Dashboard', available at https://covid19.who.int/ (last accessed 28 December 2020).
[6] The primary qualitative data is supplemented to a limited extent by document review.
[7] As agreed with UNICEF during the inception phase, the deep dive assessments involved key informant interviews with 10-14 stakeholders in each of the deep dive countries. A purposive sampling approach was used to identify key informants across key sectors involved in COVID-19 response. This sample was drawn from a list of potential key informants provided by the UNICEF CO focal point, with a focus towards covering respondents from a diverse range of organization types (UNICEF CO, NGOs, government, and UN agencies) and prioritizing sectors/areas which have been key focus of COVID-19 response. Due to time and resource constraints, the assessment did not cover all sectors or programme areas that were part of COVID-19 response.

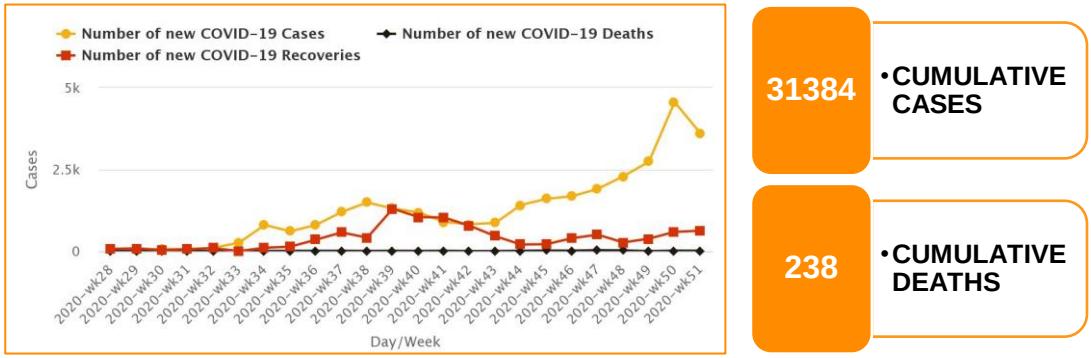
1.3 Regional context in relation to the COVID-19 epidemic

Regional context: Uganda is one of the 21 countries with UNICEF offices overseen by UNICEF ESARO (see Figure 1 in Annex A). Although countries in the region are among the most vulnerable in the world in terms of socioeconomic development and institutional strength, the delay of the pandemic's onset and proactive containment measures appear to have enhanced the region's ability to contain the disease.[8] The region's first case appeared in South Africa on 5 March 2020.[9]

1.4 Summary of the impact of COVID-19 in Uganda

In Uganda, almost 31,400 COVID-19 cases have been confirmed, with 238 deaths recorded as at 20 December 2020.[10] The chart below illustrates the weekly trend of new cases.

Figure 1: Epidemiological profile of COVID-19 in Uganda, as at 20 December 2020



(**Source**: Government of Uganda COVID-19 Response Info Hub)

Once COVID-19 was seen to be spreading, the Government of Uganda acted swiftly to prevent and slow the spread of the disease, with the first containment measures being implemented ahead of WHO's declaration of a pandemic.

Figure 2: Chronology of Government of Uganda's COVID-19 containment measures

(**Source**: UNICEF Uganda, Proposal to the Swedish International Development Cooperation Agency, 22 June 2020)

The government also established a coordination structure to respond to the crisis, and UNICEF Uganda was among the key actors in the structure (see Annex A.3). In addition, UNICEF Uganda, like other UNICEF COs in the region and around the globe, responded by

[8] Though it should be noted that those measures had unintended consequences in other respects.
[9] Wikipedia (2020) 'COVID-19 pandemic in Africa', available at https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Africa (last accessed 27 December 2020).
[10] See the Government of Uganda's COVID-19 Response Info Hub's section on stats, available at https://covid19.gou.go.ug/statistics.html (last accessed 22 December 2020).

adapting its operations and programming to support the country's COVID-19 response. On the basis of our 16 KIIs, this report highlights how this was done and outlines emerging themes as well as lessons that can be drawn.

2 Findings

Prior to COVID-19: UNICEF Uganda was mandated to implement interventions related to the 2016–2020 CPAP,[11] as agreed with the Government of Uganda. The CPAP represented a 'shift from a "project approach" to a **government-led and well-coordinated "systems-approach"** with a view to build sustainable and scalable programmes to increase the quality and coverage of basic services for children'. It sought to strengthen the linkages with results-based programming and between humanitarian and development programming.[12] CPAP programme areas included:

- Child survival and development;
- Basic education and adolescent development; and
- Child protection.

These were 'supported through evidence-based policy analysis and advocacy, communication and partnerships and improved accountability for results.'[13]

Emergence of COVID-19: The first COVID-19 case in Uganda was confirmed on 21 March 2020,[14] although by then containment measures had already been put in place by the government (see sub-section 1.4).

A necessary shift: There was no option except to adapt. This raises certain questions:

- How did UNICEF Uganda **adapt** its programming and operations in the context of COVID-19 and related containment measures?
- What did this mean for the **implementation** of CPAP interventions?
- What were the implications of this adaptation on the **quality** standards that are so important to UNICEF?

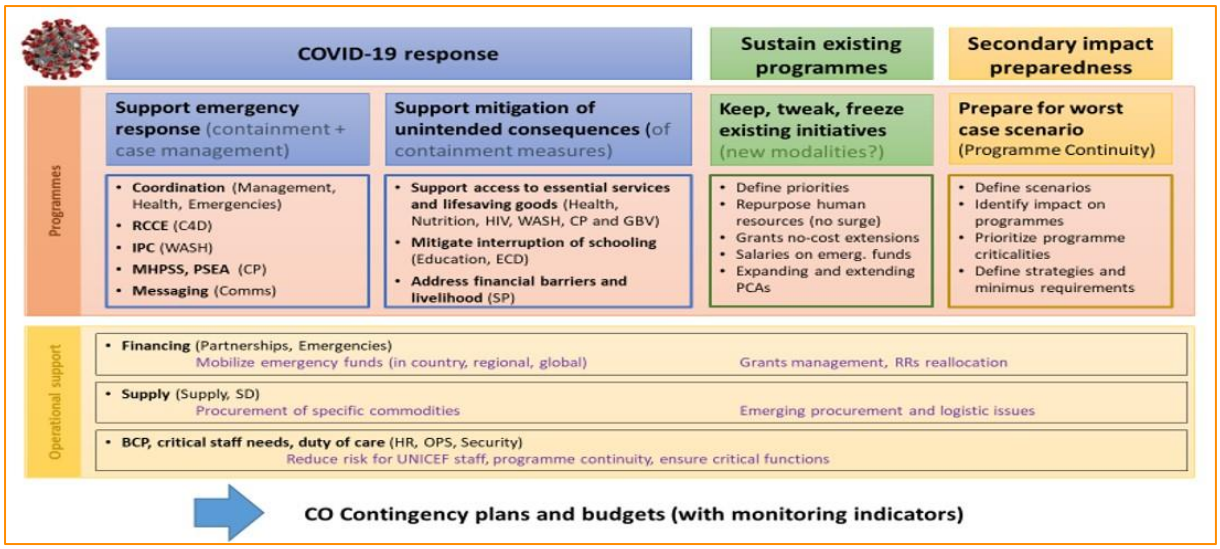
ADAPTATION

2.1 How the UNICEF Uganda CO has adapted

With the onset of the COVID-19 epidemic, the UNICEF Uganda CO was perceived to have adapted both operationally and programmatically to respond to both the disease (and to respect containment measures) and to address the unintended consequences of public health and safety measures on the most vulnerable and excluded populations. This aligns with the UNICEF framework for the COVID-19 response (Figure 3).

[11] UNICEF Uganda (2016) 'Country Programme Action Plan 2016–2020', available at www.unicef.org/uganda/media/5566/file/GoU%20UNICEF%20Country%20Programme%20Action%20Plan%20(CPAP)%202016%202020.pdf (last accessed 26 December 2020).
[12] Ibid, pp. 42–43.
[13] Ibid, p. 57.
[14] UNICEF Uganda (2020) 'COVID-19 Situation Report No. 1, Reporting Period: 1 to 15 May 2020'.

Figure 3: Framework for UNICEF's COVID-19 response



(**Source**: UNICEF ESARO)

'The in-house rearrangement was massive'

The KIIs revealed that the most critical **operational adaptations** were the adoption of remote and digital working modalities and increased use of local solutions. The operational adaptations converged with the **programmatic adaptations,** which respondents confirmed were made across all programme areas. The convergence was to such an extent that respondents often had difficulty distinguishing between them in their responses. They included:

- Adopting new ways to assess and meet population needs;
- Entering into new or adapted agreements, approaches and focus areas to respond to evolving population needs, fill gaps, and reach excluded populations;
- Partnering with local suppliers on innovative solutions;
- Scaling up the use of digital platforms for remote programming and remote monitoring;
- Enhancing partnership with government and participating in national and subnational coordination structures; and
- Adopting new modalities of service delivery.

According to the KIIs, these adaptations were largely effective.

IMPLEMENTATION

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

The effectiveness of UNICEF Uganda's COVID-19 response is presented along four dimensions: (a) offsetting the negative effects of the pandemic on access to basic services; (b) reaching the most vulnerable and ensuring equity; (c) meeting programming standards and protocols; and (d) 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)

'Immediately at the start of the lockdown, there was a significant drop in [measures of accessing] essential health services'

Uganda has experience of protracted crises, and UNICEF Uganda's programming in such circumstances had been **based on the principle of continuity of essential services**. The KIIs suggested that this continued to be the case in the COVID-19 context. The dilemma was how to ensure coverage and scale-up without compromising the health of both providers and beneficiaries.

Key informants provided several examples of how this was approached in each CPAP programme area:

- **Child survival and development**: the CO supported the government to develop national guidelines on essential service delivery. This included advocating for the establishment of a dedicated pillar (within the national response management structure) on essential health services continuity; and using routine data for monthly monitoring of service coverage and utilisation, as well as monitoring of the media.
- **Basic education and adolescent development**: UNICEF Uganda advocated for the continuity of learning during lockdown, installed Water, Sanitation, and Hygiene (WASH) supplies at schools in preparation for their reopening, and supported youth-targeted messaging about the virus and related issues.
- **Child protection**: UNICEF Uganda successfully advocated for social workers to be classified as essential workers, thus enabling the continued delivery of related services. The CO also supported the helpline used for reporting situations that necessitated child protection.

To ensure that necessary inputs[15] were in place for the provision of these essential services, respondents perceived that **the CO capitalised on its comparative advantage in global supply**, to access certain categories of supplies when others were not able to do so, or were not able to do so rapidly. The CO also made increased use of **local solutions.** For example, it entered into agreements with local mask producers, and engaged local service providers to adapt WASH facilities to be hands-free.

Figure 4: A handwashing facility adapted locally for hands-free usage

(**Photo credit**: © UNICEF/UN0357071/Kabuye)

The CO also broadened its use of local media organisations and local consultants to fulfil programme delivery needs.

[15] Such as personal protective equipment (PPE), sanitisers, and access to water.

'I turned to [UNICEF]: the most reliable of my partners'

Related to the idea of local solutions, key informants explained that UNICEF Uganda maintained CPAP's **systems-strengthening** approach. This was applied at both national and subnational level, notably in setting up core capacities that focused on building the country's resilience. Feedback from UNICEF Uganda partners and those on the frontline underscored the enormous value they place on their partnership with the UNICEF CO.

Overall, respondents rated the ability to maintain basic essential services between 3 and 4 on a scale of 1 to 5 (where 5 is high).

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

The UNICEF programme in Uganda is designed to reach the most vulnerable segments of the population. For example, funds are earmarked for priority regions and groups, and work done through national and district structures. In the COVID-19 context, the same principle was applied as resources were mobilised and related planning and implementation took place.[16] In fact, many of the adaptations outlined in Section 2.1 were aimed at reaching the most vulnerable segments of the population.

Figure 5: A nurse treats a premature baby admitted in a neonatal intensive care unit

UNICEF, with financial assistance from the Swedish International Development Cooperation Agency (SIDA), equipped neonatal intensive care units in referral hospitals in West Nile to support the care of prematurely born and sick babies. The support extended to training health workers that work in the intensive care units.

(**Photo credit**: © UNICEF/UNI313178/Abdul)

Despite the CO's efforts, key informants felt that some **gaps were not fully overcome**, and most notably those created by the digital divide (i.e. the gulf between those who have ready access to computers and the internet, and those who do not).

Overall, UNICEF Uganda's partners and frontline workers gave an **average rating of between 3.5 and 4.5** (on a scale of 1 to 5, where 5 is high) when asked about the **extent to which UNICEF support helped them reach the most vulnerable and excluded** subgroups of women and children.

[16] Respondents identified the following sub-groups of women and children as the most vulnerable and most excluded in the COVID-19 era: pregnant women; children due to be immunised; school-going children; adolescents; those with chronic health conditions, including psychosocial conditions; refugees; those living in hard-to-reach-areas; the urban poor, particularly those depending on daily economic activities such as selling goods and services at the market; women and the girl-child subject to gender-based violence (GBV).

2.2.3 How UNICEF has been able to meet programming standards and protocols?

Key informants from the CO **rated their overall ability to meet programming standards and protocols as 3.75 on average** (on a scale of 1 to 5 where 1 is low and 5 is high). This relatively high rating was based on the perception that standards had been adhered to. For example, mandatory Prevention of Sexual Exploitation and Abuse (PSEA) by humanitarian personnel training was maintained, and reporting strengthened.

This assessment was **confirmed by partners and frontline workers**. They indicated that continuous feedback, reporting, supervision and other monitoring and tracking activities were ways in which UNICEF Uganda ensured that programming was taking place as intended and was of good quality.

The key informants indicated that **guidance from UNICEF ESARO was helpful** in informing COVID-19-era programming. However, there may have been an **excess of guidance from UNICEF global**, thus creating an information overload.

2.2.4 UNICEF's ability to ensure and sustain community engagement/ Accountability to Affected People (AAP) mechanisms

UNICEF Uganda was perceived as **successful in ensuring community engagement**. The mechanisms for this, referenced by key informants, included: knowledge, attitude and practice (KAP) studies; phone surveys; monitoring the reach of risk communication and community engagement (RCCE); U-Report polls; a hotline for reporting GBV and other issues requiring social/child protection; social listening; strengthening social media platforms; making use of cultural and religious channels; and conducting PSEA assessments. Respondents spoke of evidence that communication messages are reaching the intended audiences, although questions remain about whether communities are adopting the practices that the messaging advocates. In terms of AAP, the key informants indicated that these mechanisms were strengthened in the COVID-19 context.

2.3 How has the UNICEF Uganda CO utilised preparedness and contingency planning during the COVID-19 response, and how has it revised COVID-19 response plans based on the evolving needs of the population?

With little exception, frontline workers and UNICEF Uganda's partners expressed the sentiment that **Uganda's experience with other crises such as Ebola provided the country with some element of preparedness**. Through its participation in the national response management structure, the CO benefited from such pre-existing readiness plans as well. Internally, however, UNICEF's **Emergency Preparedness Platforms (EPPs) do not seem to have played a central role** and were not linked to the CO's rolling workplan.

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

According to key informants, COVID-19 containment measures allowed for a systemic assessment of population needs in Uganda. Meanwhile, **programme-specific needs assessments, collaboration with sector partners, and data flowing from service points** (e.g. health centres and hotlines) enabled the CO to further understand and verify those needs and thus inform its response. In addition, UNICEF interventions were perceived as helping to strengthen the health information system. However, the **lack of sufficiently disaggregated data** in the educational system posed a challenge.

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 Uganda can be analysed through three lenses: the effects of the crisis and related containment measures on quality; timeliness of the UNICEF response; and efforts made by the CO to ensure quality.

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

The KIIs suggested that **the CO was able to overcome the potential negative consequences** of an overburdened international supply chain in the COVID-19 context. For example, while awaiting hands-free WASH facilities that were in high demand on the international market, UNICEF Uganda engaged with local suppliers to adapt existing facilities. The CSO also made increased use of other local solutions to overcome global supply bottlenecks.

Furthermore, the CO's efforts to determine and verify population needs and adapt programming and service delivery modalities **helped ensure the relevance and effectiveness of its actions**. Adaptations covered multiple programmatic areas and targeted girls and women with specific gender-sensitive approaches.[17] These recognised their increased vulnerability and risks, as well as deliberately targeting other vulnerable and excluded subgroups that may have been previously missed by the CO (such as refugees).

Figure 6: An expectant mother benefitting from UNICEF-supported transport to care

Through the UNICEF-supported transport voucher system, pregnant women and sick children could access health facilities in a timely manner. This supported the uptake of health services for women and children during and after the lockdown.

(**Photo credit**: © UNICEF/UNI358262/Emorut)

However, **the efficiency of the response was negatively impacted** in some respects, given that global supply bottlenecks caused price fluctuations that increased costs.

2.5.2 Timeliness of the UNICEF response to COVID-19

Partners and frontline workers were unanimous about the overall timeliness of UNICEF Uganda's COVID-19 response: Overall, the **response was seen as extremely timely**, with the exception of certain procurements. This was likely thanks to simplified standard operating procedures (SSOPs).

On the flip side, as reflected in the quote to the right, this timeliness reveals a deficiency in the timeliness of regular UNICEF Uganda programme delivery. The KIIs suggested that **the perceived 'usual slowness' is creeping back into the CO's delivery mechanisms,** as the initial emergency phase of the crisis fades.

'UNICEF support is never timely. But for this, it was very timely'

[17] See also: UNICEF Uganda (n.d.) 'Uganda Country Office inputs to Gender Stocktaking exercise'.

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

Based on the KIIs, UNICEF Uganda ensured the quality of the response. This was achieved by insisting that quality standards be met; adhering to programming standards and protocols; ensuring that in-person programme visits took place; and (when these were not possible) adopting remote monitoring mechanisms to ensure adequate oversight.

'[UNICEF Uganda] made [it] very clear…that…the quality would have to be confirmed and assured before they can commit resources, because there's nothing worse in a resource-constrained environment than to commit your hard-earned resources to products that don't offer much in terms of protection'

Remote monitoring was not perceived to have had a negative impact on quality, despite some concern about the risk that it represented.

3 Emerging themes/ conclusions

3.1 Emerging positives from UNICEF Uganda's performance in the COVID-19 response

POSITIVES IN ADAPTATION

- It is possible to ensure business continuity even while undertaking a significant operational adaptation.
- The CO responded well to evolving needs with new/adapted agreements.

Figure 7: Cover of UNICEF proposal to SIDA for COVID-19-specific interventions

UNICEF Uganda entered into a new programme agreement with SIDA, which had the following desired outcomes:

Outcome 1: Improved health sector capacity to prepare for and respond to the COVID-19 epidemic

Outcome 2: Sustained health sector capacity to deliver essential health services for pregnant and lactating women, newborns and young children, and adolescents

(**Source**: UNICEF Uganda, Proposal to the Swedish International Development Cooperation Agency, 22 June 2020)

- Partnering with local suppliers on innovative solutions is possible and works well.
- Scaling up the use of digital platforms for remote programming and remote monitoring was successful.
- UNICEF Uganda's enhanced partnership with government and active participation in national and subnational coordination structures was highly acclaimed.
- The CO was successful in adopting new ways to assess and meet population needs, including advocating for social workers to be classified as essential workers.

UNICEF supported Uganda not only by providing aid but 'also really getting their hands dirty and doing the hard work'

- The CO played a critical role in filling gaps by identifying and extending programming to excluded populations.
- UNICEF Uganda adopted new modalities of service delivery, ensuring that the needs of the most vulnerable and excluded were met.

POSITIVES IN IMPLEMENTATION

- UNICEF Uganda contributed significantly to offsetting the negative effects of the pandemic on access to basic services.

Figure 8: Teaching children during lockdown to ensure continued learning

Following the closure of schools in March due to the COVID-19 pandemic, the government with support from partners like UNICEF produced learning materials and distributed them to homes for pupils to continue learning from home.

(Photo credit: © UNICEF/UN0353020/Adriko)

- The CO has been successful in reaching many of the most vulnerable segments of the population and helping ensure equity.
- Even in the COVID-19 context, UNICEF Uganda met programming standards and protocols.
- UNICEF Uganda was largely able to maintain community engagement/AAP.
- UNICEF Uganda capitalised on pre-existing preparedness and contingency planning and trust, working through existing national structures and using EPPs.

POSITIVES IN QUALITY ASSURANCE

Despite the challenges posed by COVID-19, UNICEF Uganda was able to:

- deliver on time; and
- insist on adherence to processes and verification systems used to ensure quality.

'When we went down to do supportive supervision to see how the teams are doing the work, we had [UNICEF] people going down with us to see what was going on'

Global advocacy by and guidance from UNICEF global (especially from UNICEF regional) was perceived to be of great value.

3.2 Challenges encountered in UNICEF Uganda's implementation of the COVID-19 response

The challenges encountered in the Uganda CO's response to COVID-19 can be summarised along the same three dimensions (adaptation, implementation, and quality) as follows:

CHALLENGES IN ADAPTATION

- Lack of funding was cited as the single largest challenge.
- Internally, it was difficult to reassign UNICEF staff to certain roles and the overall increased pressure on staff, both work related and personal, should be acknowledged.
- There were difficulties in accessing certain supplies, and price fluctuations further challenged procurement.
- A couple of partners/frontline workers felt UNICEF came in with a 'fixed bag of activities', making adaptation to meet national priorities difficult.
- The COVID-19 situation and related needs evolved faster than the pace of UNICEF's systems allowed it to respond, though the CO's response was considered timely in the initial emergency phase.

CHALLENGES IN IMPLEMENTATION

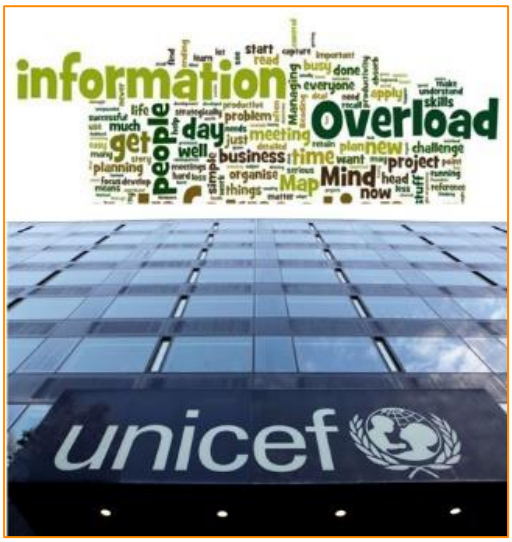
- COVID-19 containment measures posed a challenge to programme delivery, both operationally and programmatically.
- Slow government systems and the return of slow UNICEF systems hampered implementation.
- Chronic government underfunding of key sectors, notably in basic education, created weaknesses that carried over into the COVID-19 context.

'At the beginning, nearly everything UNICEF touched was really in timely fashion; right now there are some aspects that have become slow… they're back in the grind of bureaucracy'

- The COVID-19 Supply Chain System,[18] though acknowledged as being a good concept, was found to be overly ambitious and excessively complex, casting doubt on whether it can be successful at achieving its intended objectives.

CHALLENGES IN ASSURING QUALITY

- While guidance from UNICEF global was helpful, it may have been too much, leaving staff feeling 'a bit overwhelmed' and 'fatigued'.
- Furthermore, the KII data indicate guidance on real-time solutions that was more practical in nature would have been helpful, for example on how to assure the quality of PPE in light of the overburdened global supply chain.



[18] See: WHO (2020) 'COVID-19 Supply Chain System', available at www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-operations (last accessed 27 December 2020).

3.3 Medium- to long-term implications for vulnerable children and their communities in Uganda, and implications for UNICEF's strategy and action in the medium to long term

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

- The poor, whose numbers are likely to grow, with the urban poor needing particular attention.
- Adolescents who have been out of school for an extended period and some of whom will never return.
- Very young mothers, given the increase in the teenage pregnancy rate during lockdown.

'They are going to be [relegated] to a life of poverty'

UNICEF Uganda might take the abovementioned predicted trends into account as it develops its medium- and long-term strategies.

3.4 (Re)focusing UNICEF's programming to reach vulnerable children in the medium to long term

Based on their perspectives on emerging challenges, and considering the broader objective of the RTA, respondents participating in this case study offered the following suggestions to inform UNICEF Uganda's programming in the medium to long term:

- The government's coordination function needs further strengthening so that limited resources are better utilised.
- There is a continuous need for digital innovation, expanding access to digital means of learning.
- Mainstream the effective COVID-19-related innovations.
- Risk communication is key going forward, in order to raise people's understanding of the risk and mitigate community-wide spread.
- Engagement to address access issues once a COVID-19 vaccine is developed.

'I think UNICEF could be our main partner to mainstream and scale up the platforms and processes we've set up'

Many of the suggestions from respondents related to the educational system, notably that UNICEF Uganda should:

- support the COVID-19 response within the school setting, including supporting schools to observe the Ministry of Health's SOPs;
- support teachers' and learners' psychosocial needs and, specifically, support a comprehensive school-based mental health programme;
- support the go-back-to-school campaign when all classes reopen;
- support the development of learning materials for continuity of learning for children with special needs; and
- ensure programming for the increased number of school dropouts.

4 Lessons learned/ suggested action points

The major lessons and suggestions for programming are provided in Section 3 of this report. Rather than repeating them here, this space will be used to highlight action points that are particularly important or that have not yet been articulated and that may be useful for consideration in UNICEF's programming (in Uganda and beyond).

OPERATIONS

1. Keep hiring staff passionate about their work, but care should be taken to avoid excessive pressure and overburdening.
2. UNICEF would serve itself well by taking a close look at work modalities, including continued use of digital systems, preserving paper-free aspects, and migrating fully to electronic procedures.
3. Simplify bureaucratic procedures to enable timely responses even in non-emergency situations.
4. Improve preparedness for an effective response, strengthening related systems and prepositioning supplies to the extent possible.
5. Consider innovations to render fundraising-related efforts more effective, while working in a way that effectively capacitates developing countries to function without external assistance, thus reducing the need for fundraising.

PROGRAMMING

6. Related to points 4 and 5 above, the CPAP's reorientation from a 'project approach' to a well-coordinated, government-led 'systems-approach' was on the right path – this should be maintained.
7. Position UNICEF in national and subnational coordination mechanisms, both in terms of active participation and to inject capacity.
8. Maintain more frequent dialogue with partners and continued flexibility in responding to the needs expressed, including deliberately considering populations that may have been previously missed or ignored in the CO's programme.
9. UNICEF Uganda has the goodwill and trust of its partners and frontline workers; this should be leveraged to provide support based on local priorities rather than predefined interventions.
10. Leverage UNICEF's comparative advantages to deliver in areas where it does so best.
11. Integrate the COVID-19 response in ongoing sectoral investments.

Annex A Regional context

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

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

Figure 1 Countries in ESAR with UNICEF offices

A.2 UNICEF response to COVID-19 in ESAR

Excerpted from OPM's Inception Report[19]

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 services[20] 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;

[19] 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.
[20] 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:

- **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 Gender-based Violence (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 (MHPSS) 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).

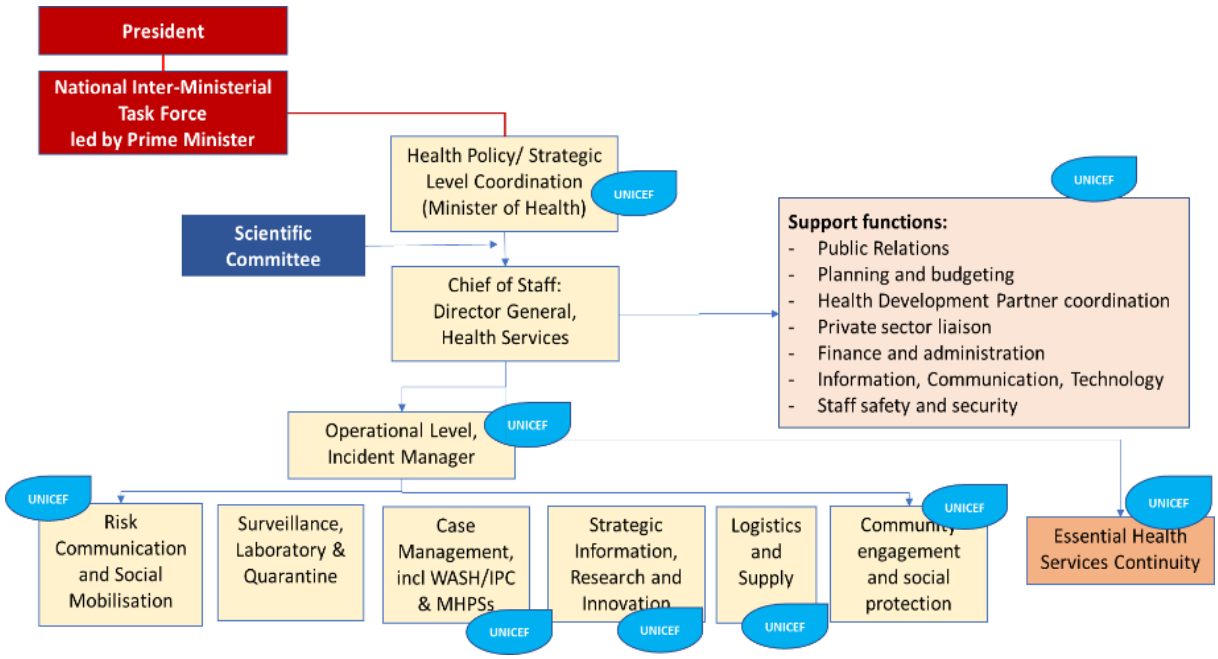
- **Water, Sanitation and Hygiene (WASH):** UNICEF is providing critical WASH supplies as well as training of the health facility and community health workers on Infection Prevention and Control (IPC).
- **Risk Communication and Community Engagement (RCCE):** UNICEF's communication campaign reached 86% of the population with information on preventative measures and on 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 of 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 UNICEF Uganda's presence in the national COVID-19 management structure

As is evident in the below figure, UNICEF Uganda featured in almost every part of the country's national COVID-19 response management structure.

Figure 9 UNICEF Uganda in the national COVID-19 management structure



(Source: UNICEF Uganda)

A.4 Interviewees – Uganda

Interviewees by organisational category	
Front line workers	**4**
Ugandan government staff	3
NGO/INGO	1
UN Agency	-
UNICEF Partners	**7**
Ugandan government staff	5
Bilateral (foreign government) staff	1
NGO/INGO	-
UN Agency	1
UNICEF staff	**5**
TOTAL	**16**

Interviewees by sector	
Education	2
Health and nutrition	3
Health Promotion/RCCE/WASH	5
Child Protection/Social Policy/ Social Development/Community Development	2
Other (Humanitarian)	1
Other (management, operations, supply)	3
TOTAL	**16**

A.5 RAG rating: Uganda

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? 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 e.g. inter-agency working group on gender; partnerships with civil society organizations representing persons with disabilities etc.	
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 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? Such as gender-responsive human resourcing and policies, incorporation of gender sensitive and gender transformative approaches throughout the programme cycle, and accountability for results on gender. 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?	

	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)? 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.	
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 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: Uganda		

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 to interviewer: 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, please 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)**[21] **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.]*

[21] *[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)[22], 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 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 so far.]*

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: If the challenges have not been specifically mentioned, probe: If your CO is putting L3 SSOPs 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, such as 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].*

[22] *[Note to interviewer: "The UNICEF Emergency Preparedness Platform (EPP) is described in UNICEF's guidance note on Preparedness for Emergency Response (December 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:
    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?

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.]*