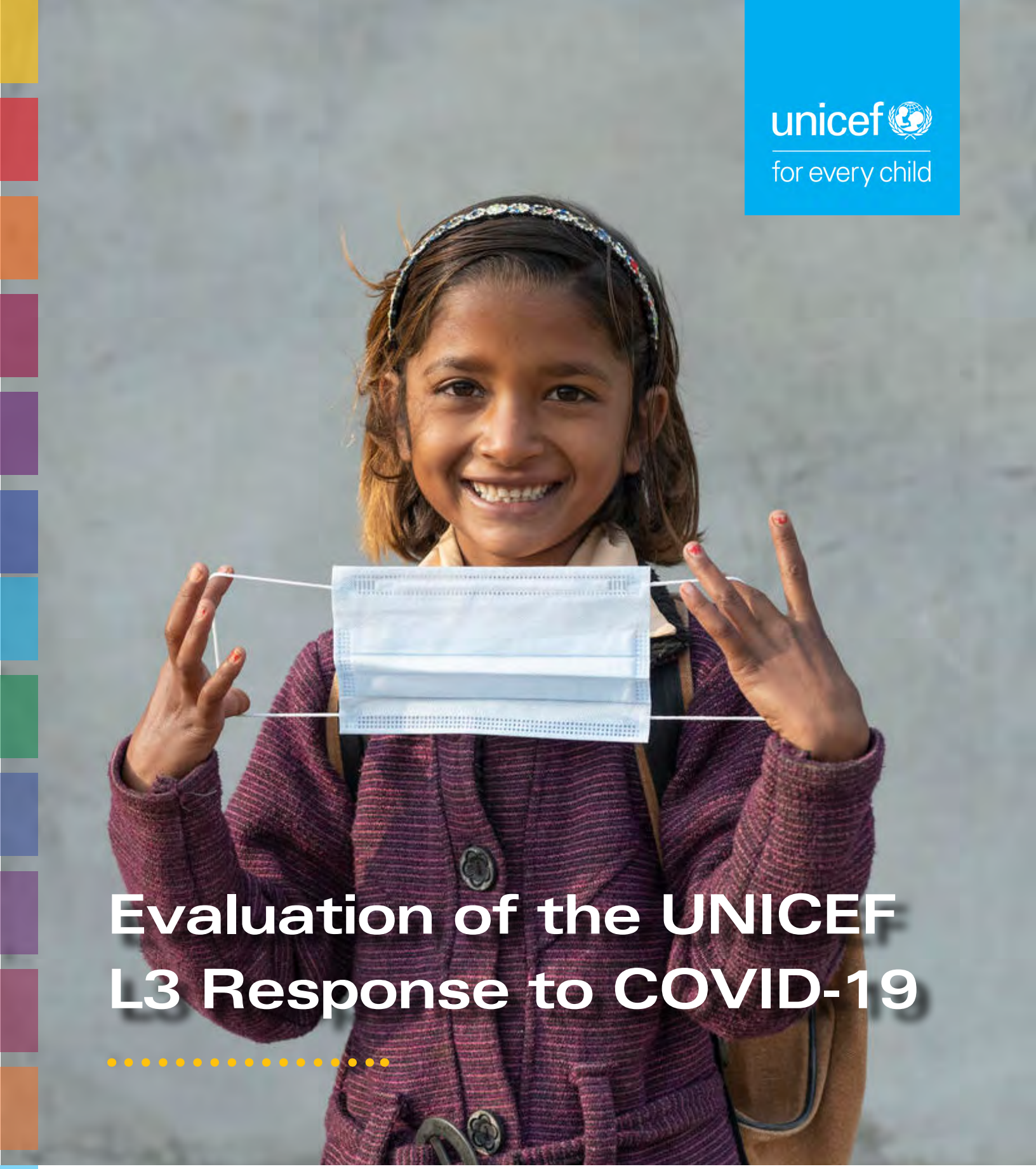

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Evaluation of the UNICEF L3 Response to COVID-19

EVALUATION REPORT

November 2022

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United Nations Children's Fund
Three United Nations Plaza
New York, New York 10017

November 2022

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PREFACE

The COVID-19 pandemic has impacted children in unprecedented ways, especially through its socio-economic effects, driven by stay-at-home policies, the disruption of education and basic services, and the general acceleration of serious child protection risks that all this entailed. As countries and UNICEF offices were adjusting to an emergency of unseen scale and complexity, the UNICEF Evaluation function rolled out a series of evaluative exercises to help address the evidence generation needs that the COVID-19 pandemic was triggering as it unfolded.

Almost two years into the pandemic, the UNICEF Evaluation Office commissioned the evaluation of the UNICEF response to COVID-19. An organizational requirement, as outlined in the UNICEF Evaluation Policy, the evaluation also represented a unique opportunity to evaluate the first Level 3 (L3) emergency that featured a global (as opposed to the more typical country-level) scale. The evaluation was intentionally designed as a relatively light exercise in terms of primary data collection, with a view to avoid over-burdening staff already significantly challenged by the response to the pandemic, while harnessing and synthesizing the wealth of evidence that had been generated over the first 18 months of the emergency.

I am pleased to present this evaluation report which sheds light on how the first global L3 activation was made operational by UNICEF, the results it achieved, alongside the challenges and opportunities that UNICEF faced, while offering inputs on how to inform the direction of future public health emergencies.

The evaluation suggests that the UNICEF response to COVID-19 is overall a positive story. Despite facing an unparalleled 'stress test', UNICEF was generally well positioned to face the challenges that the circumstances presented. UNICEF's mature, decentralized structure, the prior investments made in remote working systems, as well as the ability to learn from past experience, are some of the key enablers of the response. Further, UNICEF's adaptive capacity allowed it to deliver at-scale programmatic results in some sectors, as well as in the provision of PPE and cold chain infrastructure, while allowing UNICEF to be a key player in the global response to COVID-19. The evaluation also identifies factors that have been obstacles to UNICEF's response, and these include, among others: variable preparedness at country level; uncertainty regarding UNICEF's role within a global health emergency in the early months of the pandemic; uneven attention accorded to gender, equity and AAP, and some strained international partnerships.

The evaluation was conducted by a specialized team of independent consultants. I would like to thank the team leader, Dr Julia Betts, for her leadership, expertise and professionalism, and the rest of the team for their committed efforts throughout the evaluation, including Elizabeth Harrop, Hisham Khogali, Nicolas Ayensa and Daniela Hernandez Salazar.

A special thanks is also due to colleagues who contributed valuable time to the data collection process and through the various iterations of the evaluation report. This includes Carlos Navarro Colorado, Jerome Pfaffman, Sarah Karmin, Imran Mirza and Sophie Battas (PG); Manuel Fontaine, Segolene Adams, Tsedeye Girma, Anthea Moore, Deirdre Kiernan and Humberto Jaime (EMOPS), and Nisar Syed (GCCS); Etleva Kadilli, Suvi Rautio, Peter Leth, Anna Cristina Matos, Ann Ottosen, Elena Trajovska and Adebayo Adekola (SD); Megan Gilgan, Alison Jenkins and Olga Basurmanova (PPD); and Genevieve Boutin, Cecilia Sanchez-Bodas, Linda Jones and Shoubo Jalal (PG). The evaluation also significantly benefited from the valuable inputs of other colleagues from UNICEF regional and country offices. I would like to express my gratitude to the Representatives and the staff in the case study countries for participating in the evaluation, especially to the following who facilitated the process at the country level: Shereen Obaid (SoP), Carlos Roja (Peru Country Office), Viratsamay Visonnavong (Lao PDR Country Office), Anna Stativkina (Kazakhstan Country Office), Luis Gorjon Fernandez and Shamshad Begum (Pakistan Country Office), Samuel Debrah Osei Amakye (Ghana Country Office), and Cassandre Bechoua (Burundi Country Office). I would also like to recognize the inputs of colleagues from partner UN agencies and (I)NGOs, at HQ and field levels, who have contributed to the evidence base of this evaluation. All are gratefully acknowledged.

I would finally like to thank my colleagues in the Evaluation Office who have managed this evaluation, Jane Mwangi and Carlotta Tincati, alongside Celeste Lebowitz and Geeta Dey who provided critical administrative support throughout the evaluation process, and ProseWorks for managing the editing of this report.

Robert McCouch
Director, Evaluation Office

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ACRONYMS

AAP	Accountability to Affected Populations
ACT-A	Access to COVID-19 Tools Accelerator
AMC	Advance Market Commitment
CCCs	Core Commitments for Children in Humanitarian Action
C4D	Communication for Development
CEAP	Corporate Emergency Activation Procedure
CO	UNICEF Country Office
COVAX	COVID-19 Vaccines Global Access
CoVDP	COVID-19 Vaccine Delivery Partnership
CSO	Civil Society Organization
DAPM	Data, Analytics, Planning and Monitoring
DGCA	Division of Global Communication and Advocacy
DHR	Division of Human Resources
ECD	Early Childhood Development
EMOPS	Office of Emergency Programmes
GBV	Gender-Based Violence
GHRP	Global Humanitarian Response Plan
HAC	Humanitarian Appeal for Children
HQ	UNICEF Headquarters
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
IPC	Infection prevention and control
KAP	Knowledge, Attitudes and Practices
LIC	Low-Income Country
LMIC	Low- and Middle-Income Country
MPTF	Multi-Partner Trust Fund for COVID-19 Response and Recovery
PG	Programme Group
PFP	Private Fundraising and Partnerships
PHE	Public Health Emergency

PPD	Public Partnerships Division
PPE	Personal Protective Equipment
PSEA	Prevention of sexual exploitation and abuse
RO	UNICEF Regional Office
RCCE	Risk Communication and Community Engagement
SBC	Social and Behaviour Change
SD	Supply Division
SDG	Sustainable Development Goal
SSOPs	Simplified Standard Operating Procedures
TOR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WFP	World Food Programme

Executive Summary

INTRODUCTION AND BACKGROUND

This report comprises an independent evaluation of UNICEF's global response to the COVID-19 pandemic. The study's objectives were:

a) To examine the appropriateness, effectiveness and efficiency of UNICEF's work in response to the COVID-19 pandemic; and

b) To examine the coherence and effectiveness of UNICEF's collaboration and coordination efforts with partners in responding to COVID-19.

The evaluation addressed UNICEF's pandemic response from January 2020 to March 2022. It is mindful that, while lockdowns have ceased in many parts of the world, the disease itself is far from over.

The evaluation was conducted under the conditions of COVID-19, including UNICEF still under an L3 emergency declaration during 2022; travel and movement restrictions ongoing; and

a strong directive to avoid burdening overstretched country offices. It prioritized the use of existing data and information, analysing 89 independent evaluations alongside UNICEF corporate documentation and data. Interviews were conducted with 111 stakeholders, comprising both UNICEF staff and management, and external partners and stakeholders. A desk review was undertaken of 21 UNICEF country offices, and a more in-depth study of seven more. A consultation meeting was held with UNICEF staff and management in June 2022 and validation meetings were held with a series of UNICEF divisions in October 2022.

EVALUATION CONTEXT

What were UNICEF's organizational arrangements for the response?

UNICEF's early response to the pandemic was supported by the co-location of a staff member from its Public Health Emergencies team within the World Health Organization (WHO) office in Geneva. Attendance at meetings in the first few days of 2020 raised the concern of a cluster of undiagnosed disease in Wuhan, China; the issue was subsequently elevated within UNICEF headquarters.

Strategic frameworks: UNICEF launched its first COVID-19 global Humanitarian Action for Children (HAC) appeal on 17 February 2020, and initial Emergency Procedures in March 2020. The organization's first ever global Level 3 (L3) Scale-Up Corporate Emergency Activation Procedure (CEAP) was launched on 16 April 2020 for an initial period of six months. It was subsequently extended until 15 January 2021 and then deactivated on 12 July 2022.

At country level, draft COVID-19 Response Plans were prepared by more than 90 UNICEF country offices, and were completed by mid-March 2020, applying the indicators and priorities of


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the global HAC. In 2021, the global COVID-19 HAC appeal was discontinued and the COVID-19 response was integrated into seven regional appeals (for non-HAC countries) and standalone appeals. A global COVID-19 Chapeau HAC for 2021 consolidated the regional HACs and defined the integration of the COVID-19 response in the 2021 appeals.

Management structures: A corporate Coronavirus Secretariat was established in January 2020, divided into an Operational Response and a Strategic and Technical branch, with nine working groups. The Office of Emergency Programmes (EMOPS) Director was designated Global Emergency Coordinator for the response.

Under Level 3 procedures, Regional Representatives took oversight and accountability for UNICEF's regional- and country-level responses. Country Representatives were authorized to make the necessary adjustments to their country programmes and regular resource allocations in consultation with governments.

What was UNICEF's role in the global pandemic response?

UNICEF played a key role in global United Nations (UN) frameworks including the UN's Global Humanitarian Response Plan (GHRP), the World Health Organization's Strategic Preparedness and Response Plan (SPRP) and the UN's Socio-Economic Response Framework.

Although UNICEF was not initially engaged by partners in the governing body of the Access to COVID-19 Tools Accelerator (ACT-A), in 2021 it became co-lead of the vaccine pillar and health system and response connectors, which sought to support UNICEF's role in the global collaboration for the development,

production and equitable access to COVID-19 testing, treatment and vaccines ('COVAX'). It also co-led with WHO the Country Readiness and Delivery workstream. In late 2021, UNICEF partnered with WHO and Gavi, the Vaccine Alliance to launch the COVID-19 Vaccine Delivery Partnership (CoVDP).

How well funded was UNICEF's response?

The response was extremely well-funded, with US$1.6 billion raised by late 2020 under the Global COVID-19 HAC, 84 per cent of the funds requested. However, funding was not evenly spread across regions, with Europe and Central Asia, Latin America and the Caribbean, West and Central Africa and South Asia all receiving lower volumes than requested.

HAC-ACT-A appeal: UNICEF's ACT-A appeals were also well-funded, with 80 per cent of the 2021 appeal raised (US$776 million against US$969 million requested) and 66 per cent of the 2022 appeal (US$837 million against US$1.27 billion requested). The separate ACT-A Supplies Financing Facility (SFF), established to receive funds dedicated to support low- and middle-income countries to access, purchase and receive COVID-19 supplies via UNICEF Procurement Services, had received US$1.12 billion by March 2022.

FINDINGS

How well prepared was UNICEF for the global pandemic, and how well did its management systems/structures, resources and procedures support the response?

The evaluation finds that UNICEF was corporately well-positioned to respond to the needs created by the COVID-19 pandemic. Its advantages included (i) considerable emergency response experience, (ii) mature decentralization structures,

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and (iii) a Public Health Emergencies team member embedded within the World Health Organization (WHO).

At country level, however, its preparedness planning was variable. Where high-quality and relevant preparedness plans were in place – notably in country offices with a strong emergency background and team – these supported swift adaptation and rapid response to COVID-19. Where offices had limited preparedness plans, or where plans were more geared to natural disasters or political upheavals/conflict than to a disease outbreak, adaptive capacity was notably constrained.

UNICEF successfully grasped the opportunities presented by its early insight into the COVID-19 outbreak, and commenced internal discussion and preparation in early January 2020. However, its early-stage response was marked by corporate-level uncertainty regarding UNICEF's precise role within a global health emergency, and a lack of clarity concerning UNICEF's programmatic needs. Procedural flexibilities introduced at an early stage supported country-level responses, and a more cohesive organizational discourse emerged later in 2020.

In 2021, parallel management structures were established for the ACT-A response, including the COVAX facility. This had the effect of focusing the UNICEF COVID-19 response, at least in the eyes of external stakeholders, around vaccination efforts, meaning that UNICEF's strategic and programmatic response was not externally perceived as the 'whole of UNICEF'.

UNICEF was well-positioned for remote working, with some departments and units having mechanisms and systems already in place. Special human resources measures were introduced to ensure business continuity, alongside measures to support

staff mental health and wellbeing. Arising from UNICEF's dual mandate, a tension arose in attitudes to remote working, with many of those from an emergency background feeling that UNICEF's flexible approach disadvantaged the organization in the eyes of external stakeholders, while others appreciated the 'people first' model adopted.

How well did UNICEF respond to population needs, especially those of the most vulnerable?

UNICEF invested considerably in analysing needs during the pandemic. The broad range of evidence generated both contributed to the global evidence base and supported countries' knowledge of their population needs. Disaggregation by population group was, however, inconsistent, and a gap emerged between the availability of analysis and tangible programmatic adjustment to address the identified needs. Targeting was not consistently aligned with corporately articulated vulnerable groups.

An extensive volume of guidance was issued by Headquarters and regional offices on programmatic adaptation. Country offices appreciated its availability, though found its volume overwhelming. Adaptive capacity was strong, with extensive programmatic adaptation on the ground. Risk Communication and Community Engagement (RCCE), Social Protection, and Mental Health and Psychosocial Support (MHPSS) programming expanded considerably to meet needs, while educational provision supported remote delivery while schools remained closed. Health, water and sanitation and nutrition programming delivered both operational and policy-level support. The timeliness of programmatic action was mixed, with most country programmes experiencing delays, largely due to national lockdowns, travel and supply chain constraints.

Gender and equity concerns were corporately prioritized in strategic documents, but received only patchy and uneven programmatic attention on the ground. Accountability to Affected Populations (AAP) strategies and approaches were both unprioritized and inconsistent. The uncertain corporate positioning in the early phase of the pandemic response impeded clear and comprehensive advocacy positions, but as clarity emerged, momentum increased, and UNICEF's eventual advocacy successes included vaccine provision, schools re-opening, and the release of children in detention under pandemic conditions.

The supply chain played a major role in the response, particularly around the provision of personal protective equipment (PPE) and other items, as well as cold chain infrastructure strengthening. Many adaptations were made, but external difficulties alongside the challenges of a centralized approach created delays on the ground. UNICEF incurred some reputational risks due to a lack of promised delivery.

UNICEF also adapted its monitoring and evaluation systems to pandemic conditions, with remote approaches supporting real-time monitoring, and a wide range of studies and assessments conducted, including a Real-Time Assessment rolled out across seven regions. The comprehensive approach to learning validates the organizational aim of a 'learning culture' during the pandemic period.

How well did UNICEF engage in partnership in the global response to COVID-19?

UNICEF played a critical role in the global response to COVID-19, playing key strategic and operational roles in the GHRP, the UN Socio-Economic Response Framework and ACT-A including COVAX. Its contributions in areas such as social protection,

health campaigns, education, and water, sanitation and hygiene (WASH) were highly valued, with partners praising its proactive and supportive approach. UNICEF's well-established relationships with WHO through its Public Health Emergencies function provided a valuable and timely flow of information, facilitated through established working practices by the time the pandemic began.

At country level, relationships were mostly positive, and UNICEF played a central role in vaccine delivery and helping to build national capacity for preparedness. UNICEF's multi-sectoral nature provided a strong comparative advantage, offering established entry points across a range of government departments, and rendering it a critical partner for many national authorities across sectors. Expanded cooperation with implementing partners also supported the effectiveness and timeliness of national responses.

However, at a global level, external partners perceived UNICEF's COVID-19 response in 2022 to be largely focused on vaccine delivery, with the organization considered to be 'quiet' on other areas of the global response. Some relationships in the area of vaccine delivery came under strain, with territorial concerns and mindset differences impeding partnership. Tensions here continue to be unresolved, and further work is required to transcend boundaries, overcome territorial concerns, and place the greater good to the fore of international action.

What did the response achieve for populations in need during COVID-19?

UNICEF delivered significant and at-scale results during 2020 and 2021 in response to the needs created by COVID-19. In 2020, it scaled up extensively to deliver significant results in

education, MHPSS, RCCE, cash assistance and treatment of malnutrition particularly. UNICEF also met or mostly met its HAC strategic priority targets in three of four areas in 2020, with data unavailable in one area relating to the ACT-A partnership.

The year 2021 also saw significant results. Notable gains include increases in live births delivered in UNICEF-supported health facilities; children supported to prevent stunting and other forms of malnutrition; people reached with disability-inclusive programming and provided with skills development programmes; and people gaining or regaining access to water services for drinking and hygiene.

Vaccine delivery expanded greatly in 2021, with nearly 1 billion doses delivered to countries requiring support. UNICEF also made significant contributions under the GHRP in health and other areas. Evaluations identified some areas of programmatic strength, including RCCE, social protection, MHPSS, evidence and data and health systems strengthening, alongside some which could be enhanced for results achievement, including gender and disability, ensuring a multi-sectoral approach, and working on digital inclusion.

CONCLUSIONS

The evaluation concludes that UNICEF was comparatively well-positioned to meet the demands of COVID-19, though the road from preparedness to corporate response was neither straightforward nor easily achieved. Despite early corporate attention, it took time for the organizational narrative to reflect the pandemic's full spectrum of programmatic dimensions – and therefore, to reflect an appropriately rounded response. However, as the breadth of needs created by the pandemic became clear, the organization's mature and comprehensive emergency response systems gathered momentum to respond.

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UNICEF successfully scaled up its response to meet demands on the ground. A significant proportion of global vaccine delivery can be attributed to UNICEF's actions, and the agency's role in providing RCCE and social protection services has shielded many from both disease transmission and social and economic disaster. Its advocacy work has supported the re-opening of schools and with it, enabled millions of children to continue their education in comparative safety. An area of challenge has been the supply chain which faced acute global difficulties. Although many adaptations were made, it struggled to meet demands on the ground.

COVID-19 has also shone a light on the internal tensions of a double-mandated organization. Country offices with long emergency experience and with relevant preparedness plans in place adapted swiftly to the demands of COVID-19, while some more traditionally development-focused offices struggled. A disjunction has also emerged related to human resourcing approaches, with staff from a more development-focused background valuing the human-centred approach adopted by UNICEF to its staff, while some of those from emergency backgrounds, more accustomed to the 'stay and deliver' ethos of humanitarian assistance, were concerned for effectiveness and reputational risk. In a world where boundaries are becoming increasingly blurred, emergency capacity across the full UNICEF 'house' is increasingly essential.

While at country level, pre-existing relationships with government, implementing partners and the private sector have played a major role in supporting the response, at international level, some partnerships have experienced strain. The sense of territorialism which has crept into the issue of vaccines delivery and the sense from external partners that UNICEF's corporate response to COVID-19 has become concentrated largely on vaccination require course correction.

RECOMMENDATIONS

The evaluation makes eight recommendations for UNICEF to consider. These recognize the strength and maturity of UNICEF's response to the COVID-19 pandemic and propose measures for future qualitative enhancement. See section 4 for a full list of recommendations.

1 In line with recommendations from the 2020 Humanitarian Review, develop a clear corporate narrative for UNICEF's role in public health emergencies

The early phase of the response experienced a period of internal debate while the role of UNICEF was clarified, with diverse opinions on all sides. A clearer corporate understanding of UNICEF's role within public health emergencies which recognize the wider effects of such crises, as per the Core Commitments for Children (CCCs) and the findings of the Humanitarian Review, will support preparedness and generate a stronger sense of 'one organization' under conditions of acute pressure.

2 Refresh the corporate narrative on the priority of COVID-19

External perceptions from UN partners particularly are that UNICEF's response to COVID-19 has become focused on vaccination, and that the wider dimensions of the response risk losing momentum. It will be important to ensure that the corporate narrative reflects the significance of COVID-19 in the programmatic work still to be undertaken on the ground.

3 Consider undertaking a functional review of UNICEF's public health emergency capacity across the organization

Currently, UNICEF, like many international agencies, is battling both humanitarian and development crises on multiple fronts. Many crises are now protracted, with the boundaries between 'development' and 'humanitarian' action increasingly unclear. Public health emergencies span these boundaries.

The 2020 Humanitarian Review recommended increased technical capacity at all levels for public health emergencies. For any future pandemic, it is clear that both development and humanitarian action will be needed. UNICEF staff corporately, therefore, need to possess emergency response skills and be able to respond to public health emergencies at different levels.

4 **Build preparedness for public health emergency response across UNICEF**

The pandemic has highlighted the varying degrees of preparedness for public health crises across UNICEF's country offices. It is critical that staff in all country offices are trained in emergency preparedness and that all have appropriate emergency preparedness plans in place.

5 **Revisit the global ethos of partnership in vaccines particularly**

COVID-19 has highlighted both the strengths and weaknesses of UNICEF's international partnerships in the pandemic response. In the specific area of vaccine provision, reconsidering the ethos of partnership will help to rebuild relationships and maximize outcomes for those who still badly need UNICEF's support.

6 **Also in line with findings from the Humanitarian Review, reassess supply chain and procurement requirements and procedures for public health emergencies**

UNICEF's Supply Chain function has undergone considerable reflection and lesson-learning since the COVID-19 response. As the Humanitarian Review notes, however, improvement can still be undertaken, and most specifically on local procurement, where UNICEF has room to enhance scope for country offices to undertake their own procurement, particularly under emergency conditions.

7 Intensify the focus on equity and gender in emergency response

The response to the emergency conditions of COVID-19 has shown an unsystematic approach to gender and equity at best. A clearer articulation of why equity and gender matters in public health emergency response, and how it should be considered at all levels, will support equitable outcomes.

8 Define and establish the corporate-level knowledge management and learning system for public health emergencies

The pandemic response has shown up several fault lines in UNICEF's knowledge management, guidance and learning systems for emergencies – ranging from the volume to the quality of learning products and guidance produced.

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1
INTRODUCTION

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More than two years from its onset, the COVID-19 pandemic continues to have a lasting impact across the world. Over 500 million confirmed cases and 6.3 million deaths were reported as of June 2022.[1] New variants continue to create waves with alarming rapidity.

COVID-19 posed an existential challenge to the international community. Humanitarian and development agencies, and particularly those working in front-line situations, found themselves grappling with global lockdowns, suspended supply chains and restricted access to populations in need. Agencies were plunged into emergency conditions, with corporate headquarters affected concurrently to local field offices.

As the potentially drastic effect on the world's children became clear, the United Nations Children's Fund (UNICEF) found itself requiring rapid pivots to meet rapidly changing needs. For a large-scale organization, with presence in 190 countries, the challenge was unprecedented. It posed the most significant stress test the organization had ever known.

1.1 Evaluation features

In January 2022, the UNICEF Evaluation Office commissioned an independent evaluation to assess the organization's pandemic response. The study's primary objective was to assess, from a global perspective, how well UNICEF responded to COVID-19 and the extent to which it realized its intended role in the global pandemic response (learning and accountability). Its specific objectives were:

> **(i)** To examine the appropriateness, effectiveness and efficiency of UNICEF's work in response to the COVID-19 pandemic; and
>
> **(ii)** To examine the coherence and effectiveness of UNICEF's collaboration and coordination efforts with partners (including other UN agencies, governments and civil society organizations (CSOs)) in responding to COVID-19.[2]

This report presents the results of the evaluation. It addresses UNICEF's pandemic response from January 2020 to March 2022, mindful that, while lockdowns have ceased in many parts of the world, neither they, nor the disease itself, are 'over'.

1 WHO COVID-19 Dashboard, https://covid19.who.int
2 UNICEF, *Evaluation Terms of Reference*, 2021.

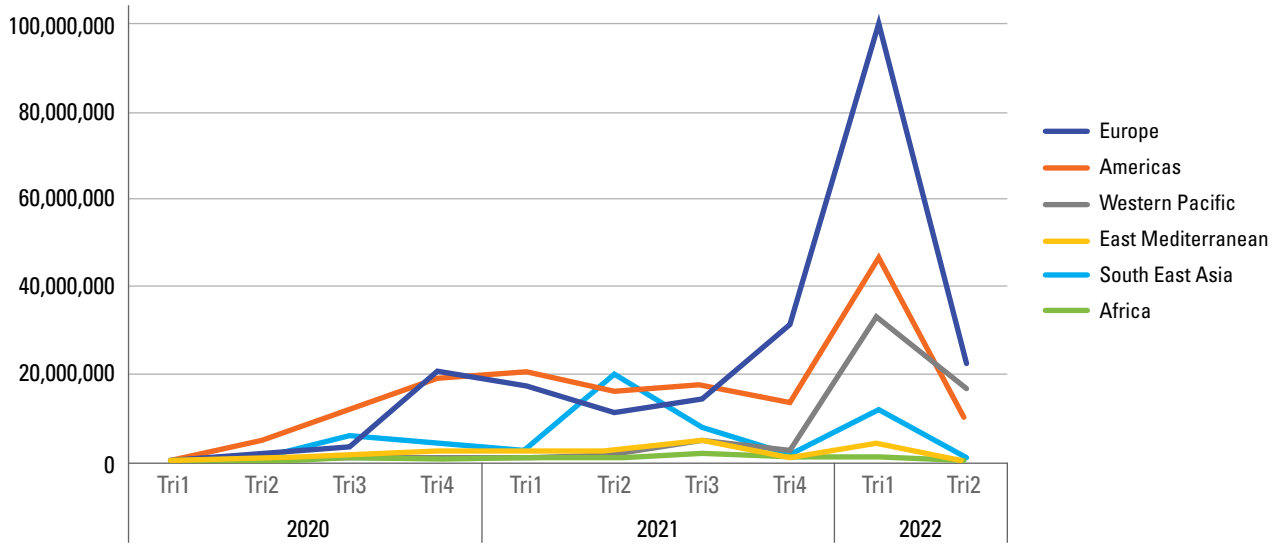
1.2 Evaluation context

COVID-19 presented an extraordinary challenge for the international community. Key among its features was its uncertainty – with the pathology of the disease unknown in the early stages – and the fact that global responses to it, in the form of national lockdowns and the closure of global supply chains, posed a concurrent challenge to the disease itself.

Figure 1 below shows the number of COVID-19 cases by region from January 2020 to June 2022. It illustrates the differential unfolding of the pandemic across the world, with waves occurring in different regions at different points in time. An exponential growth in cases occurred in January-March 2022 as a result of the latest COVID-19 variant (Omicron and sub-variants).

FIGURE 1

Number of COVID-19 cases per region (January 2020-June 2022)



Source: WHO COVID-19 Dashboard, https://covid19.who.int

COVID-19 resulted in multi-dimensional needs, with both the virus and the restrictions imposed by governments to control it resulting in major social and economic effects. Poverty increased dramatically, with World Bank estimates suggesting 97 million more people faced extreme poverty in 2021 as a result of COVID-19.[3]

The pandemic exposed and grew existing inequalities, even in wealthy countries.[4] The most vulnerable people suffered badly from national lockdowns, including those dependent on informal economies, women and girls, those living with disabilities, refugees, and the displaced, as well as those that suffer from stigma.[5]

The pandemic had unprecedented impacts on children: During 2020 alone, 1 in 7 children lived under stay-at-home policies for the majority of the year[6] and the number of children living in multi-dimensional poverty increased by 15 per cent, up to 1.2 billion globally.[7] Effects included:

a **Disruption of basic services to children,** whether due to the virus itself or government restrictions to control it. Global coverage of nutrition services to children, adolescents and women, for example, declined by nearly 40 per cent.[8]

b **A vastly increased number of children needing humanitarian assistance.** Prior to the pandemic, conflict, poverty, malnutrition and climate change were already driving unprecedented growth in the number of children in need of humanitarian assistance. COVID-19 intensified this situation.[9]

c **The largest suspension of face-to-face education in history,** which affected up to 94 per cent of students across the world, or nearly 1.6 billion learners in over 190 countries. The introduction of remote learning modalities induced a digital divide that exacerbated inequalities, with one-third of students

3 https://blogs.worldbank.org/opendata/updated-estimates-impact-covid-19-global-poverty-turning-corner-pandemic-2021. Extreme poverty is measured as the number of people living on less than $1.90 per day.
4 Editorial: 'COVID-19 – break the cycle of inequality', *The Lancet Public Health*, vol. 6, no. 2, E82, 1 February 2021.
5 https://feature.undp.org/coronavirus-vs-inequality
6 UNICEF, *UNICEF Annual Report 2020*, 2021.
7 UNICEF, *UNICEF GLOBAL COVID-19 Final Report, February–December 2020*, 2021.
8 UNICEF, *UNICEF Annual Report 2020*, 2021.
9 UNICEF, *UNICEF Humanitarian Action for Children*, 2021.

unable to access remote learning.[10] Children with disabilities were particularly affected.

d **The greatest disruption to immunization services ever known,** with 30 million children missing routine immunization in 2020 and diseases such as polio on the rise as a consequence.[11] In 2021, 25 million remained un- (or under-) vaccinated.[12]

e **Increased child protection risks** in a challenging combination of confinement measures on the one hand, and disrupted violence prevention and response services on the other. Violence, child labour, child marriage and pregnancies, and negative effects on mental health all increased during 2020 and 2021.[13]

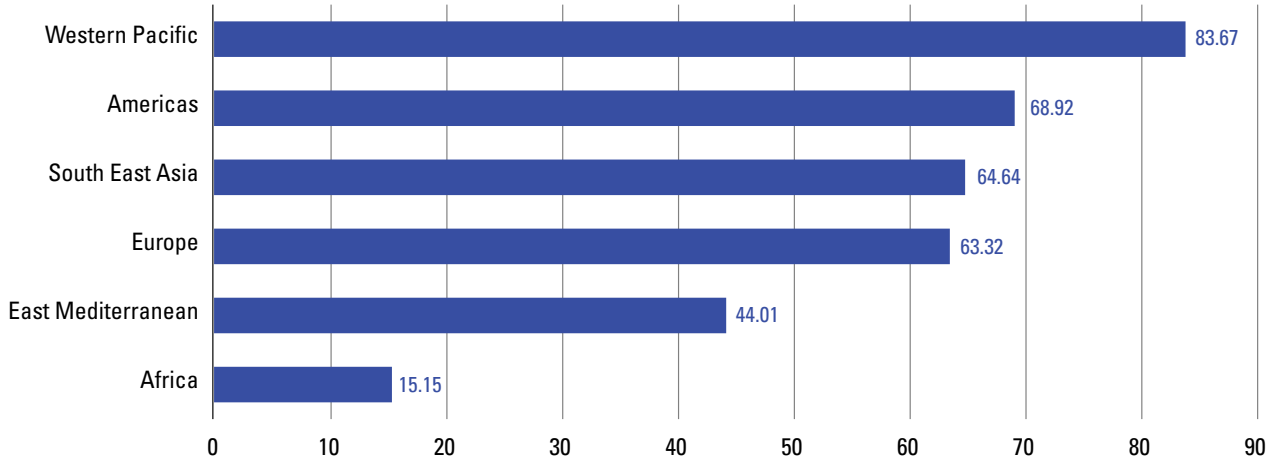
f **Intensification of gender inequalities,** with increased incidence of adolescent pregnancy and gender-based violence.[14] Women who are poor and marginalized face an even higher risk of COVID-19 transmission and fatalities, loss of livelihood, increased violence and huge increases in unpaid care work and their domestic work burden.[15]

Inequality in COVID-19 vaccination coverage: Figure 2 shows the stark differences in vaccine coverage by region. In 2022, Africa has the lowest COVID-19 vaccine coverage by far, despite regular international calls for equitable access to testing, treatment and vaccination.[16]

10 https://www.unicef.org/press-releases/covid-19-least-third-worlds-schoolchildren-unable-access-remote-learning-during
11 Causey, Kate, et al, 'Estimating global and regional disruptions to routine childhood vaccine coverage during the COVID-19 pandemic in 2020: a model ling study'. *The Lancet*, vol. 398, no. 10299, 14 July 2021.
12 https://www.unicef.org/press-releases/WUENIC2022release, 14 July 2022.
13 The Alliance for Child Protection in Humanitarian Action, *Protection of Children during the Coronavirus Pandemic*, Technical Note, version 1, 2021.
14 World Vision, *COVID-19 Aftershocks*, 2020. Access Denied, 21 August 2020. https://www.wvi.org/publications/report/coronavirus-health-crisis/covid-19-aftershocks-access-denied
15 UN Women, *COVID-19 and its economic toll on women: The story behind the numbers*, 16 September 2020. https://www.unwomen.org/en/news/stories/2020/9/feature-covid-19-economic-impacts-on-women
16 https://www.who.int/campaigns/vaccine-equity

FIGURE 2

Number of persons fully vaccinated per 100 population – June 2022



Source: WHO COVID-19 Dashboard, https://covid19.who.int

1.3 UNICEF's organizational response

On 2 January 2020, UNICEF's newly appointed Senior Adviser to its established Public Health Emergencies (PHE) team attended his first meeting of the first day in his new role. The PHE unit sits within UNICEF's Programmes Group and (in times of health crisis) its Emergency Operations Division (EMOPS). The PHE team's role is to monitor and report to UNICEF, as well as prepare and respond to public health threats emerging, as identified by WHO. Its Geneva-based Senior Adviser role is co-located within the World Health Organization (WHO) office.

That initial meeting raised a public health signal reporting a cluster of undiagnosed disease in Wuhan, China, and noted by WHO as an issue of concern. The initial pathology and anticipated spread of the disease were still unknown. However, the PHE team

decided, based on the information provided in the meeting, to elevate the signal within UNICEF headquarters, so that an appropriate response – at this point, assumed to be located within the Asia region – could be mounted.

This action catalysed a series of corporate responses:

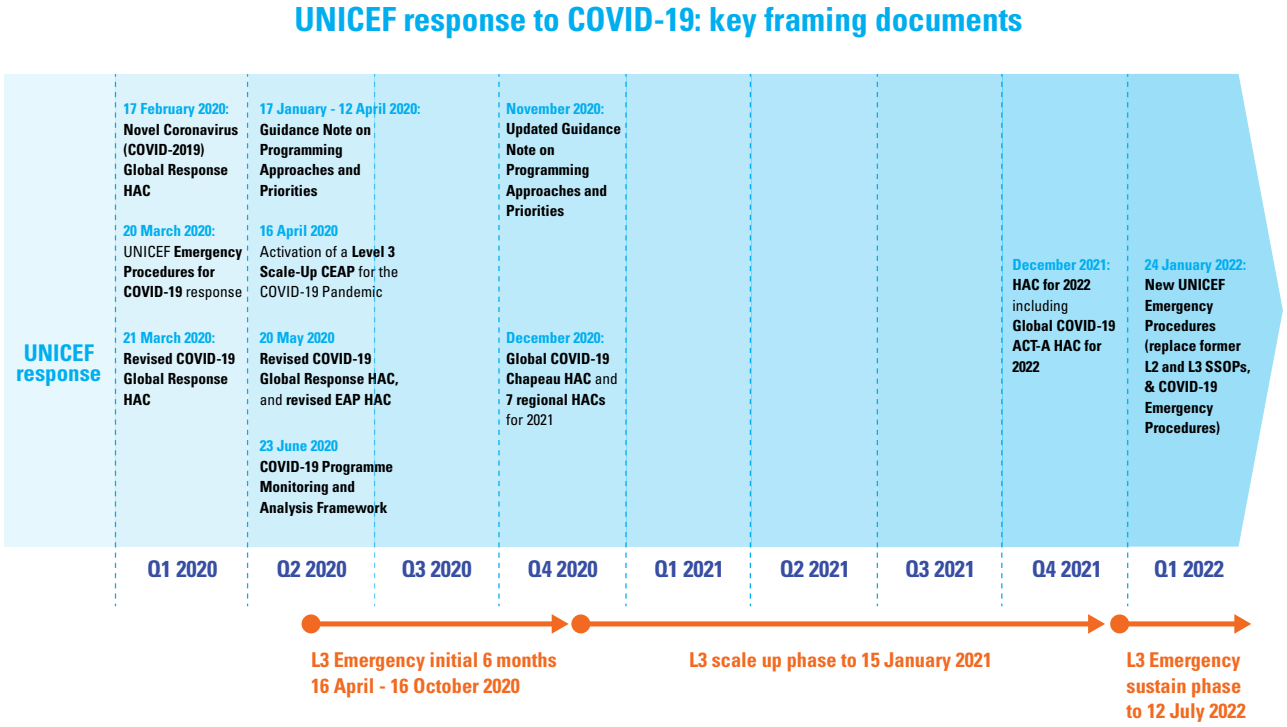
- From early January 2020, the PHE and EMOPS teams liaised with UNICEF's East Asia and Pacific Regional and China Country Offices to gain information on the virus spread/provide technical support to their response.[17]
- The first senior-level corporate meeting regarding COVID-19 in early January 2020.
- As cases rose, and concern grew, the corporate emergency machinery moved into action. In mid-January, prior to WHO declaring COVID-19 a Public Health Emergency of International Concern (30 January 2020), UNICEF declared an internal emergency.[18]

Strategic frameworks: UNICEF launched its first COVID-19 global Humanitarian Action for Children (HAC) appeal on 17 February 2020 (see Box 1 below), informed by the 2018 Core Commitments to Children in Public Health Emergencies.[19] Initial Emergency Procedures for the COVID-19 response were actioned for an initial three-month period from 20 March 2020. On 16 April 2020, the UNICEF Executive Director approved the activation of a Level 3 (L3) Scale-Up Corporate Emergency Activation Procedure (CEAP)[20] for the pandemic, which formalized the 'de facto' Level 3 ('L3') approach implemented since early February 2020. This was the first ever global L3 declared by the agency. The L3 was established for an initial period of six months to 16 October 2020 and was subsequently extended until 15 January 2021.[21] It was deactivated on 12 July 2022.[22]

17 Interviews with 68 UNICEF staff and management, April 2022.
18 Interviews with 68 UNICEF staff and management, April 2022.
19 https://www.corecommitments.unicef.org/ccc-2-5-1
20 See *UNICEF Procedure on Corporate Emergency Activation for Level 3 Emergencies*, Document Number: EMOPS/PROCEDURE/2019/001, Effective Date: 1 June 2019, https://aa9276f9-f487-45a2-a3e7-8f4a61a0745d.usrfiles.com/ugd/aa9276_303cc96bd1454d72acbcce55cc68b9bf.pdf
21 UNICEF Current Level-3 Emergencies.https://www.corecommitments.unicef.org/level-3-and-level-2-emergencies accessed 20 January 2022.
22 UNICEF, 'Executive Director Communication', Internal document, 25 January 2022.

FIGURE 3

UNICEF strategic frameworks for the pandemic response



Source: Evaluation team, based on analysis of UNICEF documentation

At country level, draft COVID-19 Response Plans were prepared by more than 90 UNICEF country offices, even those as yet unaffected by COVID-19. All were completed by mid-March 2020, using a common template, applying the indicators and priorities of the global HAC.

The main strategic and fundraising tools for the response were the global HAC in 2020, and regional HACs and country office HAC appeals in 2021 and 2022. Box 1 below provides their sequencing and priorities:

BOX 1
COVID-19 and HACs

2020: The first global COVID-19 HAC (17 February 2020) outlined the Key Areas of the Response as:

- Risk Communication and Community Engagement (RCCE);
- Infection prevention and control (including health and WASH);
- Child Protection (including psychosocial support);
- Education.[23]

Revisions took place in March, April and July 2020, with the July HAC outlining two strategic priority areas:

- Public health response to reduce disease transmission and mortality; and
- Continuity of health, HIV, nutrition, education, WASH, child protection, gender-based violence, social protection and other social services; assessing and responding to the immediate socio-economic impacts of the COVID-19 response.[24]

2021: The COVID-19 response was integrated into regional appeals and standalone appeals.[25]

Seven regional COVID-19-specific HACs[26] focused on: supporting the reduction of virus transmission and mortality; sustaining the continuity/restoration of essential social services; addressing/mitigating the socio-economic impacts of the pandemic; and providing access to vaccines, diagnostics and therapeutics.[27]

23 UNICEF, Novel Coronavirus (COVID-2019) Global Response Humanitarian Action for Children appeal (HAC), 17 February 2020.
24 UNICEF, Revised Coronavirus (COVID-19) Global Response HAC, July 2020.
25 The COVID-19 response was integrated in regional appeals for non-HAC countries and into standalone HAC appeals for: i) countries with an active humanitarian response prior to COVID-19; and ii) countries with a deteriorating COVID-19 situation and significant needs requiring a large-scale humanitarian response but without a standalone appeal before COVID-19.
26 UNICEF's East Asia and Pacific Regional Office (EAPRO) revised its 2020 HAC to incorporate COVID-19; remaining regions addressed COVID-19 in 2021 HACs and through the global response.
27 UNICEF, *Evaluation Terms of Reference*, 2021.

A global COVID-19 Chapeau HAC for 2021 defined the integration of the response into the 2021 HAC appeals and consolidated the seven regional HACs.[28] Priorities were:[29]

- Coordination with WHO, humanitarian country teams, United Nations Country Teams (UNCTs) and civil society partners;
- Prioritization of the most vulnerable children and adolescents;
- Redesign, reallocation and reimagining of regular programmes based on high-quality evaluative evidence, including real-time data;
- Strengthening systems and building technical capacities across all sectors and expanding field presence for decentralized operations;
- Conflict-sensitive interventions, that foster inclusion, trust and social cohesion;
- Support to roll out COVID-19 tests, treatments and vaccines through ACT-A/COVAX was directed through the 2021 ACT-A HAC.

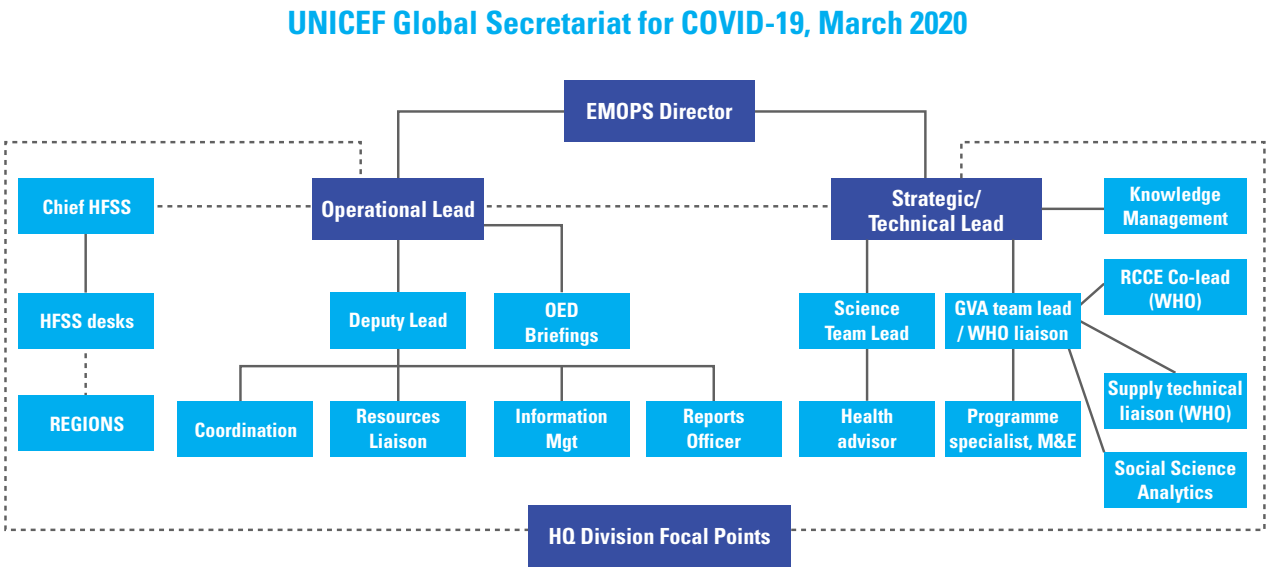
2022: For 2022, COVID-19 concerns and priorities beyond ACT-A were directed to be integrated in regional HACs and country-level HACs. All 2022 HACs contain proposed programmatic strategies and a budget to address COVID-19.[30]

As part of its contribution to the global response (see section 2.3 below), UNICEF also issued in 2021 and 2022 the Access to COVID-19 Tools Accelerator (ACT-A) appeals (US$659m in 2021, revised to US$969m; and US$933m in 2022, revised to US$1.3 billion).[31] This sought to support its role in the global collaboration for the development, production and equitable access to COVID-19 testing, treatment and vaccines ('COVAX'), which sought to deliver 2 billion vaccine doses in 2021.

28 Novel Coronavirus (COVID-2019) Global Response Humanitarian Action for Children appeal (HAC), 17 February 2020 and UNICEF, Global COVID-19 Chapeau HAC for 2021, December 2020.
29 UNICEF, Global COVID-19 Chapeau HAC for 2021, December 2020 and Evaluation ToR.
30 Analysis of seven regional HACs for 2022.
31 UNICEF, *Humanitarian Action for Children ACT-A 2022*, December 2021.

Management structures: A corporate Coronavirus Secretariat was established in January 2020 to support and coordinate UNICEF's global response to the pandemic,[32] divided into an Operational Response and a Strategic and Technical branch. Nine working groups were established, with the majority beginning work in February 2020 (see Table 1). On 28 March 2020, UNICEF designated the Emergency Operations (EMOPS) Director as Global Emergency Coordinator (GEC) for the response. The New York and Geneva-based COVID-19 'Cell', comprised of EMOPS/PHE team members embedded within WHO, provided insight and liaison on the developing global context. This also helped to direct the working groups and provide technical and strategic guidance.

FIGURE 4
UNICEF COVID-19 management structure



Source: Evaluation team, adapted from UNICEF documentation

32 UNICEF HQ, Coronavirus disease COVID-19 Secretariat, 'Terms of Reference', 28 March 2020.

TABLE 1

UNICEF COVID-19 Secretariat Working Groups

COVID SECRETARIAT WORKING GROUP	AREA OF WORK
Supply	Assess the impact that the crisis is having on essential and strategic supplies for programme implementation.
Funding	Leading engagement with donors to secure flexible and timely funding.
Human Resources	Providing guidance to support UNICEF offices and staff impacted by COVID-19 outbreaks.
Advocacy	Articulating UNICEF's narrative on the COVID response and adjustments made to continue delivering critical humanitarian action.
Digital Platform Coordination	Aiming to strengthen coordination between UNICEF's platform custodians/holders and digital capabilities.
Planning and Monitoring	Setting up a monitoring indicator system and online platforms and collecting data.
Programme Strategy and Guidance	Articulating strategy and application to specific contexts. Coordinating production of guidance by Programme Division.
Situation Awareness, Social Impacts	Developing and implementing a system to collect and analyse situation awareness information on social impacts.
Social Science Research	Developing guidance and strategy to implement country-level social science research plans to inform public health response.

Source: UNICEF Internal Document – COVID-19 Secretariat PowerPoint presentation 28 March 2020

Decentralized functions: Under Level 3 procedures, Regional Representatives took oversight and accountability for UNICEF's regional and country level responses. Country Representatives were authorized to make the necessary adjustments to their country programmes and regular resources (RR) allocations in consultation with governments, as required under COVID-19 conditions.[33]

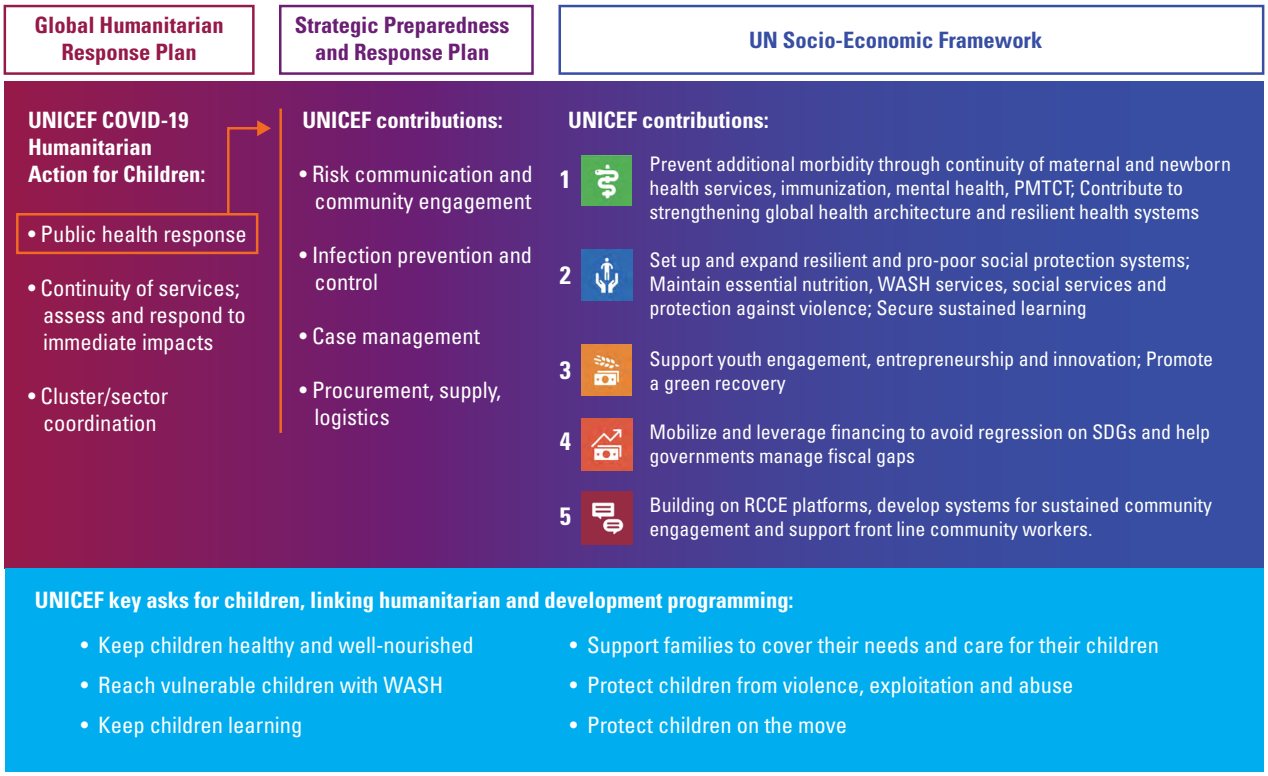
1.4 UNICEF's role in the global pandemic response

As well as shaping its own internal response to the pandemic, UNICEF had to align and coordinate with system-wide response plans underway. The three key global strategic frameworks for the response were: the WHO's Strategic Preparedness and Response Plan (SPRP) of 3 February 2020;[34] the UN Office for the Coordination of Humanitarian Affairs (OCHA) coordinated Global Humanitarian Response Plan (GHRP) of 25 March 2020;[35] and the United Nations' Socio-Economic Response and Recovery Framework of April 2020.[36] Figure 5 maps the UNICEF contributions to these wider frameworks:

33 UNICEF Executive Director email broadcast, 16 April 2020.
34 https://www.who.int/publications/i/item/strategic-preparedness-and-response-plan-for-the-new-coronavirus
35 UN OCHA, Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April–December 2020, 25 March 2020.
36 United Nations, *UN framework for the immediate socio-economic response to COVID-19*, April 2020.

FIGURE 5

UNICEF's role within the wider international response



Source: UNICEF Response to the COVID-19 Pandemic, Background Paper for the Executive Board, June 2020

WHO SPRP: The WHO's SPRP had three main pillars: (i) Suppress transmission, (ii) Protect the vulnerable and (iii) Save lives.[37] UNICEF defined its contributions to the SPRP as supporting risk communication and community engagement – a key lesson learned from the Ebola response of 2014–2016[38] – infection prevention and control; case management; and procurement, supply and logistics for vaccines.[39]

GHRP: The first UN OCHA-coordinated GHRP for COVID-19 set out two humanitarian priorities: (i) Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality, and (ii) Decrease the deterioration of human assets and rights, social cohesion and livelihoods. Updates subsequently followed in May and July 2020.[40] UNICEF's intended contribution to the GHRP were (i) Strengthen RCCE activities and provide supplies to communities, educational and health facilities and (ii) Ensure children and women have continued access to essential healthcare, education, child protection and gender-based violence (GBV) services, and collect data and analyse the outbreak's impact on children, pregnant women and communities.[41] By the third revision of the GHRP (July 2020), UNICEF was also named as leading the interagency coordination on GBV risk mitigation.[42]

UN Socio-Economic Response: For the UN's framework for the immediate socio-economic response to COVID-19,[43] UNICEF provided contributions in four main areas: (i) preventing additional morbidity through provision of key health services, (ii) supporting social protection and other key areas of service provision, (iii) supporting youth engagement and finance mobilization, and (iv) supporting frontline workers and ongoing community engagement.

37 https://apps.who.int/gb/COVID-19/pdf_files/2021/18_02/SPRP2021.pdf
38 UNICEF, *Evaluation of UNICEF's response to the Ebola outbreak in West Africa 2014–2015*, 2017.
39 UNICEF, 'UNICEF Response to the COVID-19 Pandemic', Background Paper for the Executive Board, June 2020.
40 UN OCHA, Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April–December 2020, GHRP May Update, 7 May 2020; UN OCHA, Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April–December 2020, GHRP July Update, 16 July 2020.
41 UN OCHA, Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April–December 2020, 25 March 2020.
42 UN OCHA, Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April–December 2020, GHRP July Update, 16 July 2020.
43 United Nations, *UN framework for the immediate socio-economic response to COVID-19*, April 2020.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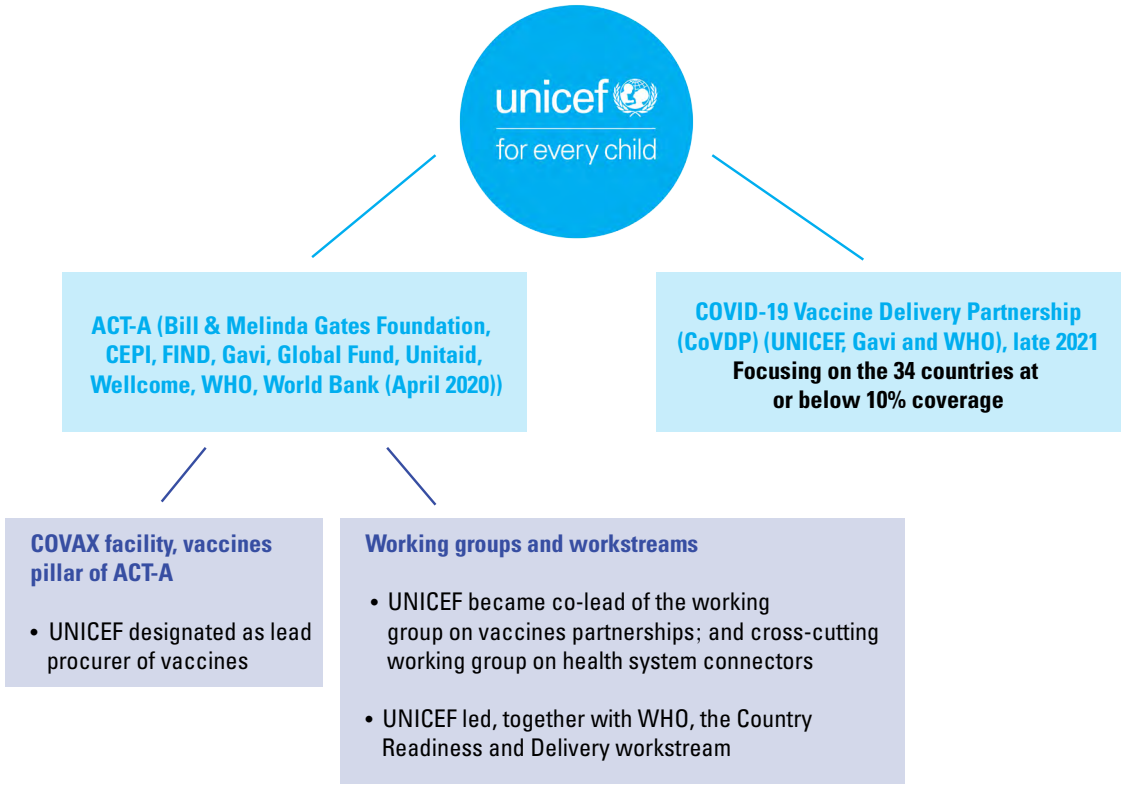
International vaccination structures: In 2021, UNICEF also engaged in the ACT-A facility, launched in April 2020 and bringing together initial partners of the Bill and Melinda Gates Foundation, the Coalition for Epidemic Preparedness Innovations (CEPI), Foundation for Innovative New Diagnostics (FIND, the global alliance for diagnostics), Gavi, the Vaccine Alliance, The Global Fund, Unitaid, Wellcome Trust, WHO and the World Bank to ensure global equitable access to vaccines, therapeutics and diagnostics.[44] Although UNICEF was not initially engaged by partners in the governing body of ACT-A, it became co-lead of the vaccine pillar and health system and response connectors, having been designated in September 2020 lead vaccine procurer through the COVAX facility (the vaccines pillar of the ACT-A).[45] With WHO, it led the Country Readiness and Delivery workstream, which provided support to countries as they prepared to receive and administer vaccines.[46]

In late 2021, UNICEF partnered with WHO and Gavi, the Vaccine Alliance to launch the COVID-19 Vaccine Delivery Partnership (CoVDP), focusing on the 34 countries at or below 10 per cent coverage in January 2022, and offering coordination of operational funding, technical assistance and political engagement to scale up vaccination and monitor progress.[47]

44 https://www.who.int/initiatives/act-accelerator; https://www.act-a.org
45 UNICEF, *Humanitarian Action for Children Overview 2022*, 2022.
46 https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines/covid-19-vaccine-delivery-partnership. UNICEF also co-led with WHO workstreams on Communication, Advocacy & Training, Data & Monitoring, Coordination, Implementation & Guidance, Vaccine Introduction, Demand, Supply & Logistics, Delivery Costing, and Innovation to Scale.
47 https://www.who.int/initiatives/act-accelerator/covax

FIGURE 6

UNICEF and its role in international vaccination structures



Source: Evaluation team

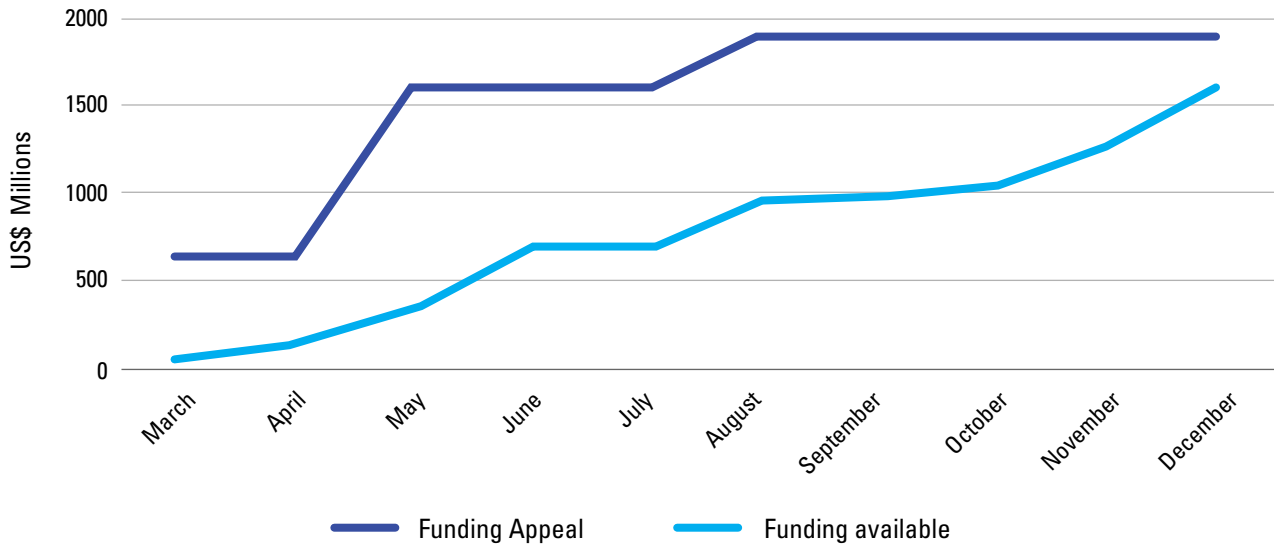
1.5 Funding the response

COVID-19 HAC appeals and funding receipt: By late 2020, UNICEF's funding appeal under the Global COVID-19 HAC had reached $1.93 billion.[48] Figure 7 shows the expanding requests and resources raised:

Overall, in 2020, the response was extremely well-funded. UNICEF raised 84 per cent of the funds it appealed for under the global COVID-19 HAC, receiving US$1.6 billion against the requested US$1.93 billion.[50] The amount was not evenly spread across regions, however, with Eastern and

FIGURE 7

Funding appeals and funding available for 2020 COVID-19 response (UNICEF Global COVID-19 HAC)[49]



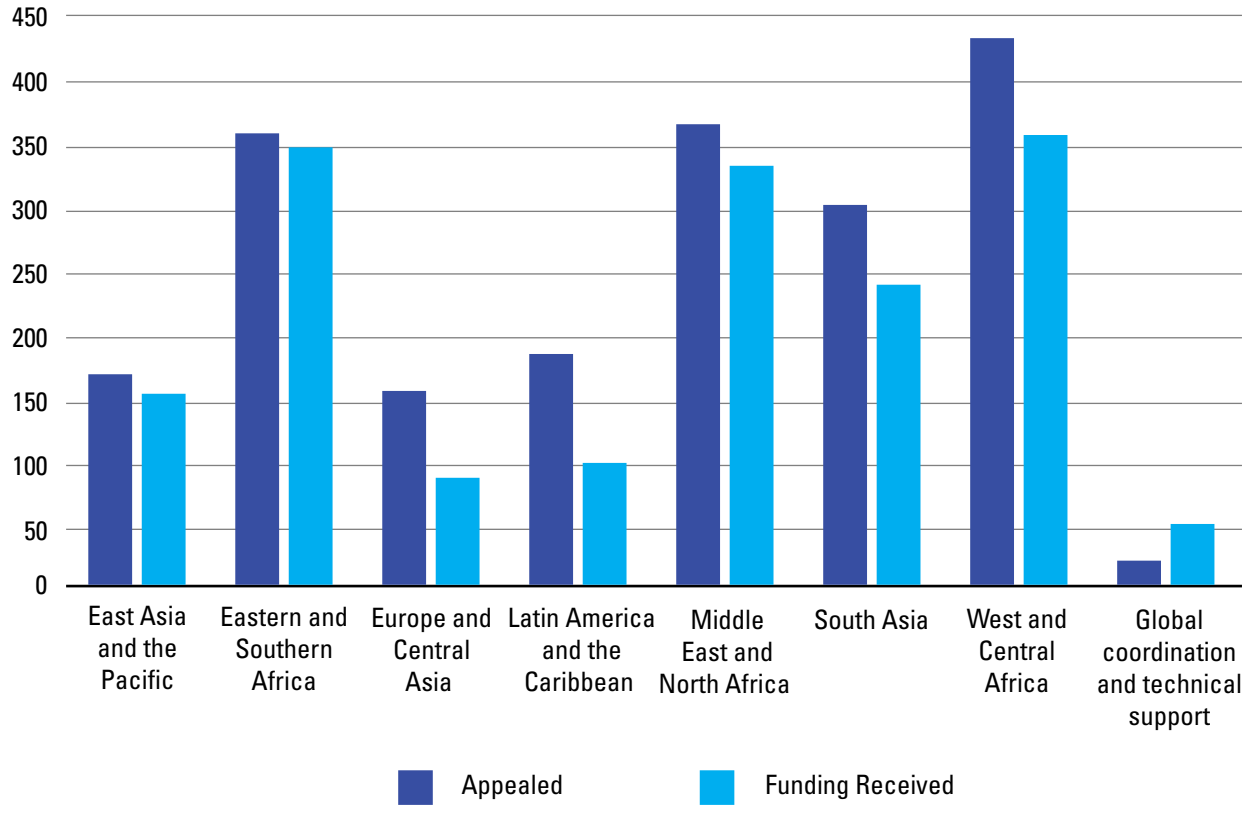
Source: UNICEF Global COVID-19 Situation reports (March-December 2020)

48 UNICEF, *UNICEF Global COVID-19 Situation Report No. 9, Feb–July 2020*, 2020.
49 Funding available includes funds received in the current year and repurposed funds with agreement from donors.
50 The volume appeal was progressively revised until July 2020. The figures are extracted from *UNICEF GLOBAL COVID-19 Final Report*, March 2021.

Southern Africa receiving almost all requested funding and Europe and Central Asia and Latin America and the Caribbean receiving 55 per cent and 52 per cent, respectively (see Figure 8).

FIGURE 8

Funding status by region, UNICEF COVID-19 HAC 2020 (US$ millions)



Source: UNICEF, UNICEF's 2020 Covid-19 Response Final Report (February–December 2020), 2021

Concurrent HACs: However, the COVID-19 HAC was not the only source of funding for the COVID-19 response (see Box 1). UNICEF's standard humanitarian appeals for children also addressed COVID-19 needs in 2020 and 2021. The 2020 HAC was updated over the course of the year, reaching US$6.3 billion by December;[51] it was funded at 34 per cent, with US$2.16 billion raised.[52] In 2021, the HAC was funded at 31 per cent (US$2.2 billion)[53] against US$7.15 billion requested.[54]

HAC-ACT-A appeal: Separate appeals were also made in 2021 and 2022 for UNICEF's engagement in the ACT-A. Table 2 provides the amounts requested and raised:

UNICEF also launched the ACT-A Supplies Financing Facility (SFF) to receive funds dedicated to support low- and middle-income countries to access, purchase, and receive the delivery of COVID-19 supplies via UNICEF Procurement Services. As of March 2022, that facility had received US$1.12 billion in funds.[58]

TABLE 2

ACT-A funding appeal and availability (2020-June 2022)

APPEAL	APPEAL VOLUME (US$ MILLIONS)	VOLUME AVAILABLE (US$ MILLIONS)	PER CENT FUNDED
HAC ACT-A 2021	969[55]	776[56]	80%
HAC ACT-A 2022[57] (Revised)	1,27	837	66%

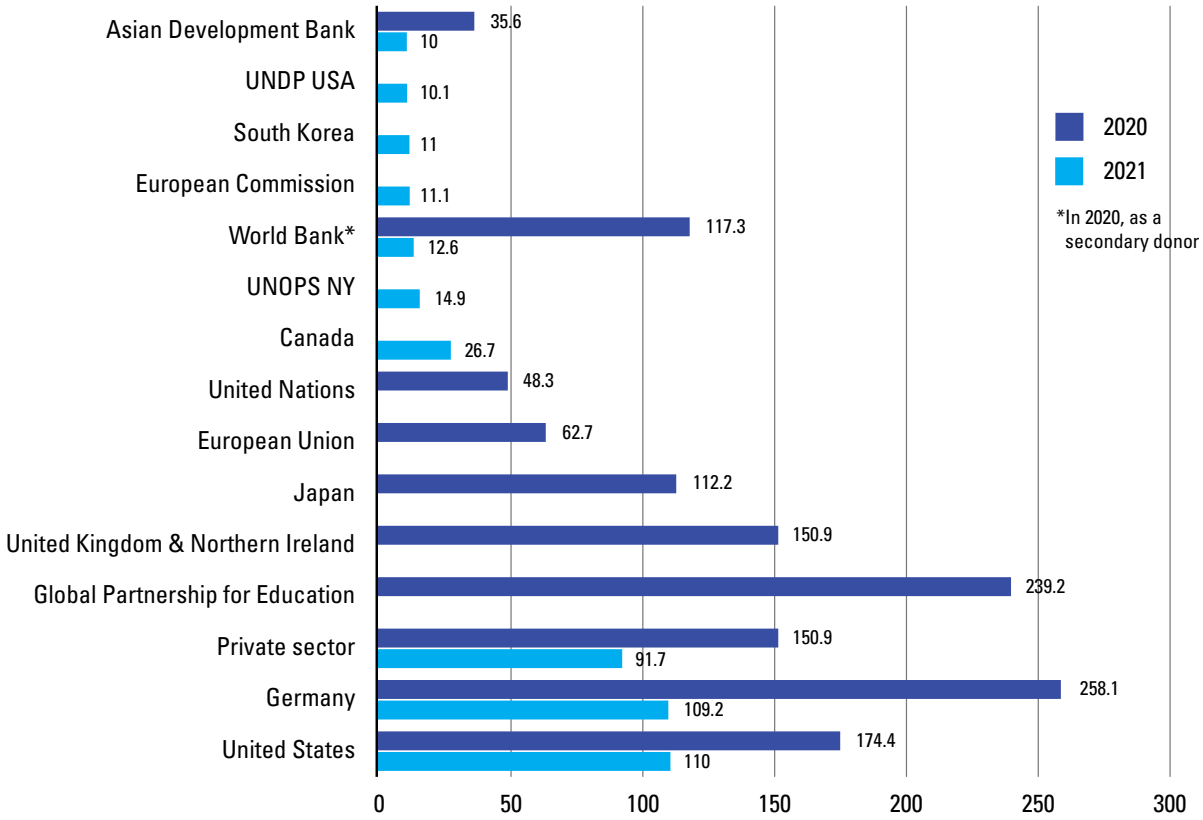
Source: UNICEF Internal Document – COVID-19 Secretariat PowerPoint presentation 28 March 2020

51 UNICEF, *UNICEF Humanitarian Action for Children Overview 2021*, 2020.
52 UNICEF, *Annual report on UNICEF humanitarian action*, p. 14, 2021.
53 As of 11 November 2021, as per *UNICEF Humanitarian Action for Children 2022, Overview*, 2021.
54 The initial US$6.4 billion appeal was raised to US$16 billion in November 2021. UNICEF, *UNICEF Humanitarian Action for Children 2022, Overview*, 2021.
55 By September 2021, UNICEF revised its ACT-A Humanitarian Action for Children (HAC) fundraising targets upwards from US$659 million to US$969 million (*ACT-A Humanitarian Situation Report No. 3*).
56 https://unicef.sharepoint.com/sites/GLB-DRP/Thematic_Narrative_Reports/SM219910_T49906_EFF_20220331140904.pdf
57 UNICEF, Humanitarian Action for Children Appeal, June 2022.
58 UNICEF, *Quarterly Report (January-March 2022) Access to COVID-19 Tools Accelerator Supplies Financing Facility (ACT-A SFF)*, 2022.

Funding by donor and type: In 2020, 10 main donors made up 77 per cent of all funding received by UNICEF for the COVID-19 response. Governments were the largest contributors, though private-sector funding contributions were the fifth and third largest contributions in 2020 and 2021, respectively, and the highest of all donors to ACT-A in 2021 (see Figure 9).

FIGURE 9

Contributions to the COVID-19 response in 2020 (COVID-19 Appeal) and 2021[59]



Source: Evaluation team analysis of UNICEF funding data; Coronavirus disease (COVID-19) response: Donors and partners/UNICEF

59 Contributions towards the 2020 COVID-19 Appeal ($1.62 billion) and contributions towards the COVID-19 response in 2021 ($471.6 million).

The bulk of resources were earmarked or 'soft earmarked', though a significant proportion (32 per cent) of private-sector donations in 2020 were flexible (see Table 3):[60]


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TABLE 3

Earmarked and flexible funding for the global COVID-19 response, 2020 (US$ million)

TYPE OF FUNDING	PUBLIC SECTOR	PRIVATE SECTOR
Earmarked	1.03bn	67.6m
Softly earmarked	48.3m	10.8m
Flexible	35.4m	37m
Proportion of flexible funding	3.2%	32%

Source: UNICEF, Humanitarian Action for Children 2021, Overview, 2020

Utilization of funding: Of total funds raised under the 2020 COVID-19 HAC, UNICEF had utilized[61] US$1.29 billion (or 83 per cent) by 31 December 2020. Of this:

- US$531.4 million was used for supplies (including personal protective equipment (PPE), diagnostics and oxygen).
- Close to US$537.8 million was transferred and committed to implementing partners to conduct programmatic activity.[62]

60 UNICEF, *Global COVID-19 Situation Report,* Final Report, February–December 2020, 2021.

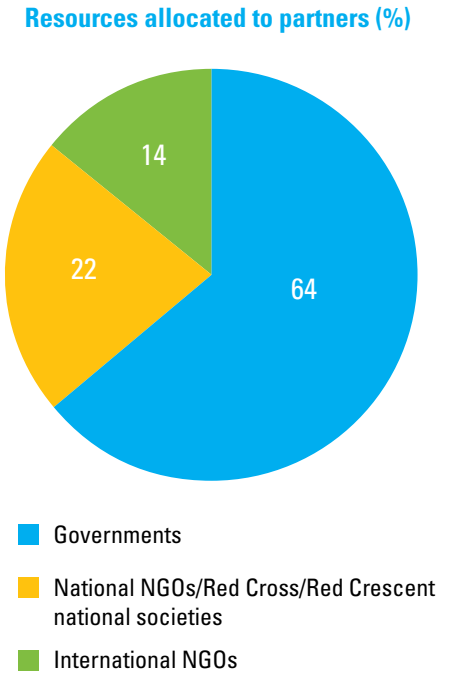
61 Utilized funds are funds that have been allocated but not necessarily spent yet.

62 This utilized amount includes funds received against the COVID-19 HAC Appeal as well as other sources of funding such as regular resources to support the response. Information extracted from: UNICEF, UNICEF's 2020 Covid-19 Response (February–December 2020), Final Report, 2021. Slight differences are observed between data publicly reported and internal data. As per Utilization 2020 Cube, the amount utilized and tagged 'COVID-19' rounded as US$1.24 billion (US$1,238,648,916) and included programme supplies (US$500.04 million) and cash assistance (US$533.31 million).

Of the funds UNICEF transferred to implementing partners, the bulk in 2020 was transferred to partner governments (see Figure 10):

FIGURE 10

Funds transferred to implementing partners (2020)



Source: Evaluation team, generated from UNICEF internal data

1.6 How the evaluation was conducted

The evaluation's full methodology is described in Annex 2. It was conducted under the conditions of COVID-19, including UNICEF still under an L3 emergency declaration during 2022, travel and movement restrictions ongoing, and a strong directive to avoid burdening overstretched country offices. A traditional cross-national evaluation design involving a series of field visits was therefore unfeasible.

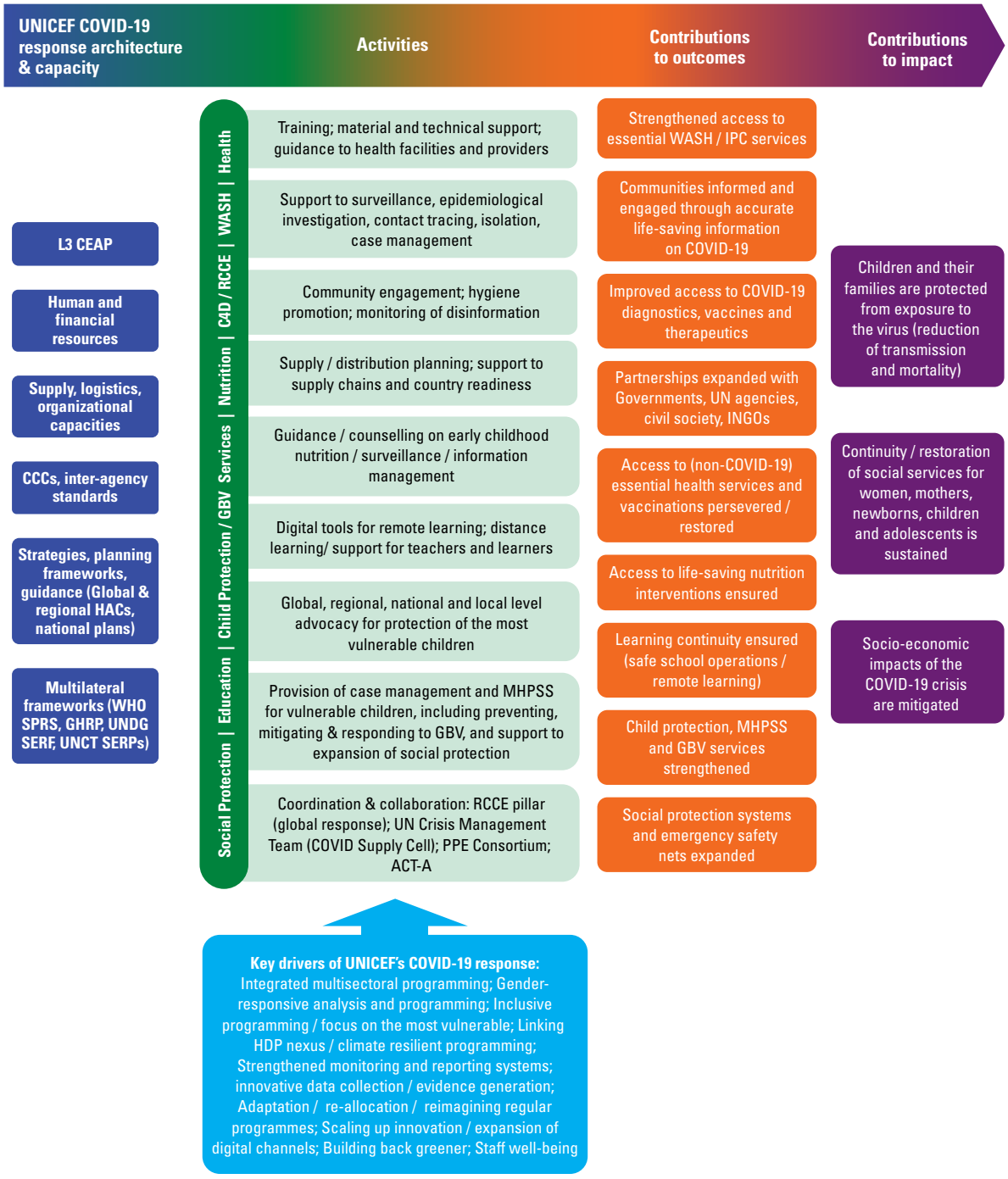
Accordingly, the evaluation design prioritized the use of existing data and information, and particularly UNICEF's extensive availability of centralized and decentralized evaluations.[63] Eighty-nine evaluations were analysed, using a systematic approach to data extraction, alongside UNICEF corporate documentation and data (for example, on financing and results), and the wider evaluative and other literature on COVID-19.

The evaluation applied a theoretical framework (see Figure 11) based on UNICEF's intentions for the response, as set out in its COVID-19 HAC and other corporate information, including an analytical framework developed internally.

63 The term 'evaluation', as used here, encompasses reviews and other assessments, such as the extensive Real-Time Assessment of UNICEF's response to COVID-19, which reported in June 2021. The term 'evaluation' is used for brevity.

FIGURE 11

Theoretical framework for the evaluation



Interviews were conducted with 111 stakeholders, comprising both UNICEF staff and management, and external partners and stakeholders (see Annex 4 for list of interviewees). A desk review was undertaken of 21 UNICEF country offices, and a more in-depth study of seven more (see Annex 2 for list of offices studied). A consultation meeting was held with UNICEF staff and management in June 2022 and validation meetings with a series of UNICEF divisions in October 2022.

Limitations: Even with a flexible design, the exercise encountered several limitations:

- Travel restrictions combined with the 'avoiding burdens' imperative meant that the evaluation team could not travel to observe the COVID-19 response in situ. Findings, therefore, relied on secondary data, complemented with country office, regional office and Headquarters as well as external stakeholder interviews.
- The 'avoiding burdens' imperative also meant that a limited number of staff per country office could be interviewed and fewer national stakeholders than optimal. The scope to enquire into individual country-level work was therefore limited.
- In-depth analysis of individual programme areas is not the focus of the evaluation, which adopts a global and corporate-level lens.

Despite these limitations, the evaluation's evidence base offers a realistic and, it is hoped, useful, reflection on UNICEF's organizational experience during the COVID-19 pandemic.

2
FINDINGS

2.1 How well prepared was UNICEF for the global pandemic, and how well did its management systems/structures, resources and procedures support the response?

SUMMARY

UNICEF was corporately well-positioned for the COVID-19 pandemic, with considerable emergency response experience, mature decentralization structures, a Public Health Emergencies (PHE) team member embedded within WHO and established systems for remote working. At country level, its preparedness planning was variable, however. Where high-quality and relevant plans were in place – notably in country offices with an emergency background – these supported rapid response to COVID-19. Where offices had limited preparedness plans, or where plans were geared to natural disasters or political upheavals/conflict rather than a disease outbreak, adaptive capacity was constrained.

UNICEF grasped the opportunities presented by its early insight into the COVID-19 outbreak, and corporate discussion and preparation began in January 2020. The early-stage response was marked by uncertain corporate positioning within a health emergency, and lack of clarity on UNICEF's programmatic role. A more cohesive organizational discourse emerged later in 2020, while procedural flexibility introduced supported the response at country level.

Into 2021, parallel management structures were established for the ACT-A response, including the COVAX facility. This had the effect of focusing the UNICEF COVID-19 response, at least in the eyes of external stakeholders, around vaccination efforts.

UNICEF was well-positioned for remote working, with some departments and units having mechanisms and systems already in place. Special HR measures were introduced to ensure business continuity, alongside measures to support staff mental health and wellbeing. Arising from UNICEF's dual mandate, a tension arose between attitudes to remote working, with those from an emergency background feeling that UNICEF's flexible approach disadvantaged the organization in the eyes of external stakeholders, while others appreciated the 'people first' model adopted.

2.1.i How well-prepared was UNICEF to respond to the COVID-19 pandemic?

UNICEF entered the COVID-19 pandemic as an experienced leader in emergency response. Evaluations of its engagement in the Ebola response and other complex emergencies praised its courage and tenacity of engagement (though noted more scope for reaching those in greatest need of assistance and who are least accessible).[64]

Corporately, some of UNICEF's pre-existing organizational arrangements also positioned it well for the global pandemic response. These included:

- **Mature decentralization:** UNICEF's organizational arrangements are operationally mature, with regional offices providing guidance to and accountability for the work of country offices, including under emergency conditions.[65] Roles and responsibilities are well-defined and practised – meaning that, when the COVID-19 emergency hit, the organizational machinery was at least established for, if not accustomed to, response at a global scale.

- **PHE team embedded within WHO:** The co-location of a UNICEF PHE staff member within WHO, and the New York-based team's close cooperating relationships with WHO, arose from learning from the West Africa Ebola crisis response 2014–2015.[66] This facility provided immediate access to global public health information – including confidential data – on a daily basis, as well as providing established working relationships and operating modalities, including for joint strategizing.

- **Reforming organizational culture:** In 2018–2019, UNICEF's review of its internal culture found pride in, and commitment to, UNICEF's mission but also a worrying 'results-at-all-costs' culture; an authoritative rather than empowering management culture; a non-person-centred human resources system; and organizational divides between types and seniority of staff.[67]

64 UNICEF, *Evaluation of UNICEF's response to the Ebola outbreak in West Africa 2014–2015, 2016; UNICEF, Evaluation of the Coverage and Quality of the UNICEF Humanitarian Response in Complex Humanitarian Emergencies*, 2019.
65 MOPAN, *Assessment of UNICEF*, 2021.
66 Interviews and written input from HQ staff.
67 UNICEF, *UNICEF's Journey of Organizational Transformation*, 2019.

UNICEF made a number of commitments to reforms, aimed at strengthening the implementation of core values of care, respect, integrity, trust and accountability.[68] These reforms were ongoing – and were to come to the fore – during the pandemic response.

- **Remote/flexible working:** Unlike some sister agencies,[69] UNICEF had already embarked on an early culture of remote working, with some teams (such as the Supply and Innovation Divisions) already working remotely. Many staff were equipped with laptops for working from home, and a culture of flexibility was already established within many divisions and units.

Two specific factors, however, compounded the challenges of the response:

- **UNICEF scale and size:** UNICEF is a very large organization, with almost 15,000 staff working in over 190 countries.[70] The pandemic unfolded differentially across regions, meaning that centralized decision-making from Headquarters – itself under emergency conditions in New York – was challenging. "No one size fits all."[71]

- **Diverse operational footprint:** While some UNICEF country offices are small and focused on providing technical assistance to governments, others comprise hundreds of staff working on complex emergency situations. This variability, alongside the diverse national responses adopted, affected the responses in different contexts.

Corporate systems in place for preparedness and of value where appropriate: The two main corporate requirements in place to support emergency preparedness are Business Continuity plans[72] in all country and regional offices, and disaster/emergency preparedness plans prepared for countries with high crisis propensity. However, the quality and utility of these plans were thrown into sharp relief by the pandemic.

68 Including improving internal accountability and response mechanisms in the event of wrongdoing; reforming its human resources system to make it more 'people-centric'. See ibid.

69 See, for example, World Food Programme (WFP), *Evaluation of WFP Response to COVID-19, 2021;* UNHCR, *Synthesis of Evaluative Evidence: UNHCR Response to COVID-19*, 2022 (forthcoming).

70 https://www.unicef.org/media/65626/file#:~:text=Today%2C%20more%20than%2015%2C000%20UNICEF,There%20is%20no%20separation

71 Interview with UNICEF country office staff member, March 2022.

72 See *UNICEF Procedure on Business Continuity Management* (BCM), PROCEDURE/DFAM/2022/001, 2 March 2022.

Where relevant and high-quality plans were in place – notably in country offices with recent exposure to emergency conditions – they proved their worth during the pandemic. Box 2 contains examples.

BOX 2
Preparedness examples

- In Albania, Montenegro, North Macedonia, Tajikistan, and Uzbekistan, preparatory work on emergency social protection relating to previous disasters (earthquakes, floods) was an important factor for the adaptability of the response during the pandemic.[73]

- In Ethiopia, risk analysis and the Emergency Preparedness Platform helped to ensure appropriate risk mapping. Staff noted that the country office 'was not starting from scratch' in designing its pandemic response.[74]

- In Madagascar, UNICEF drew on its experience and planning for other emergencies such as plague, drought and cyclone, to develop its COVID-19 emergency response plan.[75]

73 UNICEF, *Evaluation of UNICEF's Social Protection Response to COVID-19*, 2020.
74 Formative Evaluation of UNICEF work to link Humanitarian and Development Programming.
75 Oxford Policy Management, *Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa, Madagascar, January 2021*, 2021.

Many country offices with prior emergency experience also had existing infrastructure which supported pandemic preparedness, including pre-positioned contingency stocks, well-developed supply chains including for cash transfers, and extensive immunization programmes. Offices were able to build on this infrastructure and partnerships to facilitate scale-up (see Box 3).[76]

In some countries, UNICEF's experience in preparedness enabled it to take a lead role within the UN system in developing business continuity plans – as, for example, in Burundi, Pakistan, Kazakhstan, Iraq, Yemen and Afghanistan.

BOX 3

Preparedness infrastructure and experience

- In Somalia, Yemen, Afghanistan and Pakistan, the scale of pre-positioning of supplies, and the robust supply chains developed for emergency conditions, helped to facilitate the transition to emergency response.
- In Malawi, UNICEF's cash response to COVID-19 benefited from an established shock-responsive social protection mechanism which was prepared for scale-up under emergency conditions.
- In Rwanda, UNICEF's existing supply and cold chain strength provided infrastructural preparedness for vaccine deployment under the COVID-19 response.

76 UNICEF, *Real-Time Assessment of the UNICEF Response to COVID-19*, Global Synthesis Report, June 2021.

Inconsistent utility of preparedness plans: However, immediately useful preparedness plans were the exception rather than the rule. Evaluations[77] found considerable room for improvement in UNICEF's COVID-19 preparedness. Frequently, this stemmed from country offices having little recent emergency experience, and/or making assumptions that surge or other external capacities would be available to support the response in their context.[78] A recurring theme was the tendency of preparedness plans towards natural disasters or political upheavals/conflict rather than the potential of a disease outbreak, as well as insufficient contingency planning or infrastructure.[79] This constrained adaptive capacity on the ground.[80]

Swift country-level planning established: Nonetheless, relatively early into 2020, more than 90 UNICEF country offices had developed COVID-19 Response Plans, as noted on page 26. These plans – which in many countries effectively superseded prior preparedness planning – in effect became the country-level 'backbone' of the response. They were reviewed by EMOPS officers and others at regional level, and subsequently evolved and were utilized in different ways by programme countries, depending on national priorities and needs. No evaluative evidence exists as to their effectiveness, but interviews at country level spoke to their utility.[81]

77 In 18 out of 28 evaluations reporting on preparedness, alongside 7 out of 16 desk studies (all except DRC, Niger, Afghanistan, Iraq, Yemen, Cambodia, Somalia, Tanzania, Zimbabwe) and three case studies (all except State of Palestine, Ghana, Peru, Pakistan).

78 Oxford Policy Management, *Real-Time Assessment (RTA) of UNICEF's Response to COVID-19*, Global Synthesis Report, triangulated with evaluations and interviews with 68 UNICEF staff at HQ, country and regional level, 2021.

79 Ibid.

80 Reported in 18 evaluations.

81 Interviews with six country offices.

2.1.ii How well did UNICEF's management systems/ structures, resources and procedures support a flexible and timely response to COVID-19?

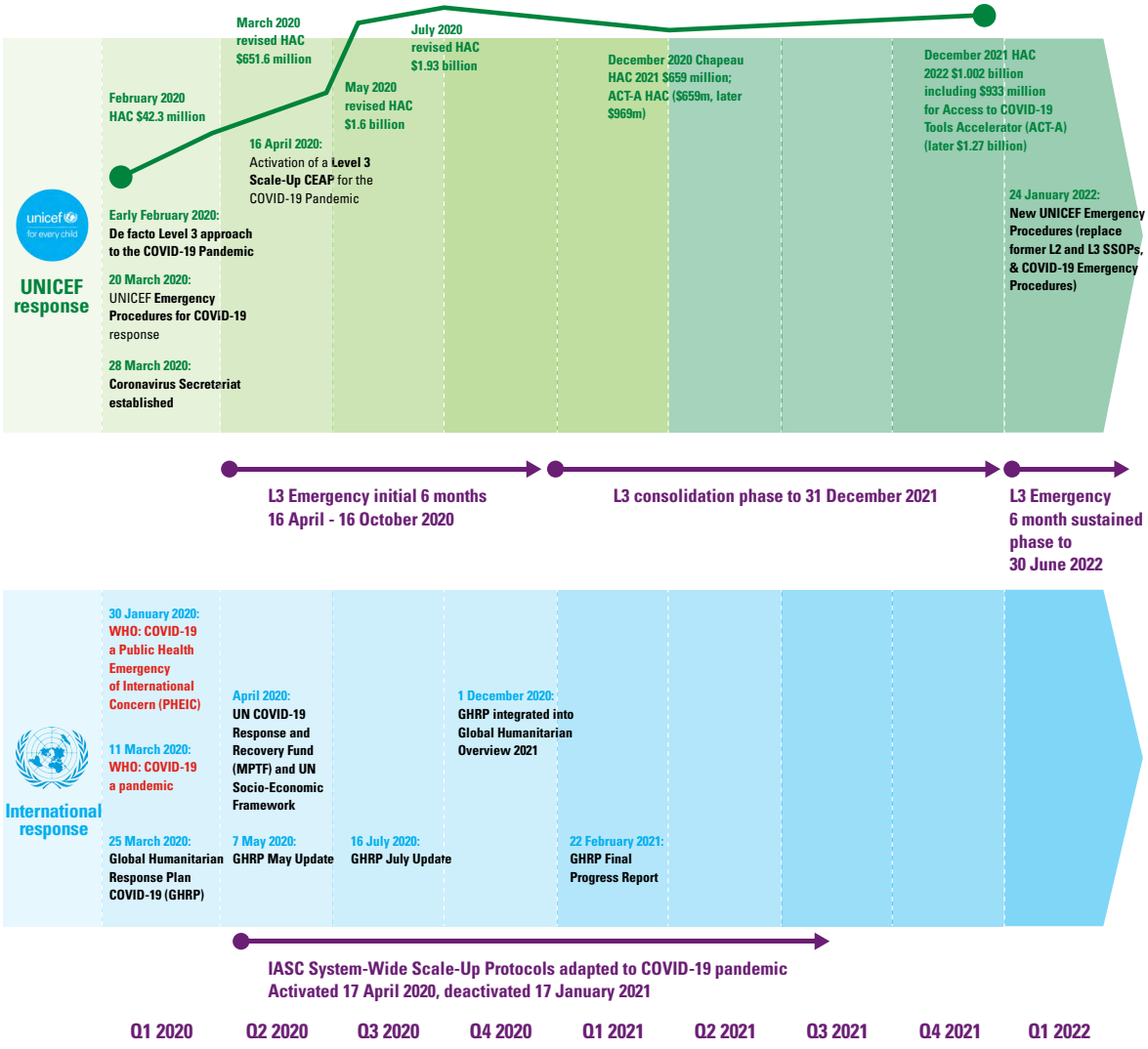
Swift corporate grasping of the importance of COVID-19 and emergency machinery: UNICEF's formal declaration of a Level 3 emergency on 16 April 2020 was later than that of some other UN agencies,[82] and over a month after the WHO global pandemic declaration of COVID-19 (11 March 2020). Critically, however, the emergency machinery was already in full flow.

The early decision by the PHE team to 'escalate' China's notification to WHO of an unknown virus in circulation at the end of December 2019 had catalysed the series of corporate actions listed in the Strategic Frameworks paragraph on page 24. Sectoral teams, such as the Education in Emergencies team, began in early January 2020 to work on emergency procedures, for example, for schools. By the time WHO had labelled COVID-19 a global pandemic, on 11 March 2020, therefore, UNICEF's strategic frameworks and management structure for the pandemic were already in place.

82 International Organization for Migration (IOM) produced its 'Global Strategic Preparedness and Response Plan: Coronavirus Disease' on 20 February 2022; WFP declared its Level 3 response on 27 March; UNHCR declared a Level 2 emergency on 25 March 2020.

Figure 12 reflects the timeliness of UNICEF's corporate emergency response structures in relation to international movements:

FIGURE 12
Timeliness of UNICEF emergency structures



Source: Evaluation team, based on analysis of UNICEF documentation

A strongly health-centred early corporate response and narrative: The designation of UNICEF's EMOPS and PHE team as the global emergency coordination function was logical, based on information available at the time. In March 2020, COVID-19 was internationally framed as a global public health emergency;[83] the far-reaching effects of national responses to it – highly diverse across countries – had not yet come to the fore.

The early corporate narrative within UNICEF therefore – as for most international agencies – placed health at the centre. The EMOPS/PHE-led emergency coordination structures were replicated across UNICEF's decentralized architecture, and the corporate narrative – reflected in the COVID-19 HAC of February 2020 and early corporate statements[84] – reflected this stance.

Clarifying UNICEF's role: During this stage, UNICEF staff and management described a period of intensive internal debate. For an agency whose mandated population is the world's children, what would be UNICEF's role and international contribution in a health emergency, whose direct clinical effects appeared to target primarily vulnerable adults? Interviewees described a wide range of opinions competing for internal space, with some holding that UNICEF should focus on its mandated population of children only and stay relatively removed from the WHO-led international response to COVID-19. Others urged a large-scale and immediate programmatic response.[85] A sense of 'competition' was described between these views.

Unclear role of some Programmes units in the response: The role of some units within UNICEF's Programmes Division was also unclear in the early months of the emergency response. Programme Group houses UNICEF's main thematic responses to development and humanitarian needs, whether in education, water and sanitation, social protection, child poverty or health. Some areas, such as education, readily found corporate space for their engagement, with early institutional recognition of the effects of school closures on children and their caregivers.[86] Others, however, found a less open corporate audience, and described

83 World Health Organization, WHO Director-General's opening remarks at the media briefing on COVID-19, 11 March 2020. https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19—11-march-2020

84 UNICEF, *Emergency Procedures for Coronavirus (COVID-19) response.* Effective Date: 20 March to 19 June 2020, 2020.

85 Interviews with 68 UNICEF staff and management, April–June 2022.

86 Ibid.

having to strongly advocate, lobby and challenge for recognition of the wider effects of COVID-19 within the corporate narrative of the pandemic as a fundamentally health emergency.

Confused coordination from the country office vantage point: Country and regional offices interviewed reported that, during this early phase, they were not consistently clear on HQ response structures. They experienced a lack of cohesion from the HQ response, with different information sources arriving at different times, and unclear reporting structures – a concern also experienced by some HQ units.[87] Moreover, the designation of health/emergency advisers as response leads at times caused challenges, with health staff, in particular, not always equipped to coordinate a large-scale emergency response.[88] As national shutdowns gained pace, country offices observed that the 'health-centred' narrative of the response lost relevance, particularly by mid-2020.[89]

A more cohesive narrative in mid-2020: However, as governments across the world closed borders, schools shut down, and humanitarian access closed in, the initially named 'secondary effects'[90] of the pandemic on children – a term unreflective of the primacy of multi-sectoral needs emerging – became increasingly clear. UNICEF's role in the pandemic response became more explicit, and, reflective of the substantive shift, the so-called 'secondary effects' were re-labelled its 'indirect effects' and subsequently 'socio-economic effects'.[91] The shift is reflective of the wider challenge of moving from a humanitarian response to a more systemic approach as socio-economic concerns emerge, while humanitarian and development systems are themselves disconnected.

Parallel structures for ACT-A and COVAX: In 2021, a management structure was established within UNICEF HQ to support engagement with the global ACT-A mechanism. This was outside the COVID-19

87 Ibid.
88 Ibid.
89 Ibid.
90 UNICEF, Novel Coronavirus (COVID-2019) Global Response Humanitarian Action for Children Appeal (HAC), 17 February 2020.
91 https://data.unicef.org/covid-19-and-children/, 10 September 2020.

Secretariat, and communication between the two functions was unclear at best. The issue was confounded by UNICEF's engagement with ACT-A occurring across the organization's HQ locations, namely in New York, Copenhagen and Geneva. External stakeholders spoke of confusion regarding roles and responsibilities and a lack of clarity on whom to approach in terms of the pandemic response. Internal stakeholders could not articulate the rationale for this decision, which – given that COVID-19 concerns within 2022 HACs were mainstreamed – had the effect of focusing the UNICEF COVID-19 response,[92] at least in the eyes of external stakeholders, around vaccination efforts alone.[93]

Streamlined resource allocation procedures but a lack of clarity at regional level: Adapted resource mobilization and management is a core element of UNICEF's emergency procedures and was activated by the deployment of Emergency Procedures on 20 March 2020, in advance of the Level 3 declaration.[94] While awaiting COVID-19 HAC financing in early 2020, UNICEF deployed its Emergency Programme Fund, with US$41.7 million in loans provided to regions for immediate response and scale-up. An additional US$4.5 million was allocated for Global Coordination and technical support.[95] An allocations committee, led by EMOPS and including the Humanitarian Financing and Partnerships team, determined criteria for devolving allocations to regional offices and thereafter from regional to country offices. Streamlined processes were brought in to reduce decision-making time, and 'tags' were introduced in UNICEF's internal financing system to track allocations to COVID-19.[96]

While country offices appreciated the timely transfer of resources through regional offices, it was not always clear to them how allocations were being prioritized. Different regional offices applied different

92 Interviews with 42 external stakeholders.
93 Interviews with 42 external stakeholders.
94 UNICEF, 'Emergency Procedures to respond to the COVID-19 pandemic', 20 March 2020.
95 UNICEF, *UNICEF Annual Report 2020*, 2021.
96 For example, the Deputy Head of the Public Partnerships Division moved to UNICEFs Humanitarian Financing and Partnerships team to help streamline decision-making. In 2020, a flag for COVID-19 was introduced in VISION SAP with new Other Regular Resource grants being tagged under 'HAC-CORONAVIRUS' Fundraising Purpose. Additionally, previously existing grant amendments were included under the 'Partial tag' indicator in VISION, for donors providing top-up funding or reprogramming to already existing grants for COVID-19 support. The Partial tag provided partial help but could not be applied to multi-year contributions, for example. The two solutions that were developed for COVID-19 therefore did not provide fully accurate reporting results.

criteria: some, for example, used COVID-19 caseloads and mortality data – but not all countries had comprehensive data available or were able to report these accurately. Other regions, such as South Asia, used income status. The differential application of the criteria across regions raised questions about equitable allocations within UNICEF.[97]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Procedural adaptations facilitated timeliness: Other emergency procedures implemented included the option to reprogramme resources at country level, to reprofile budgets with NGO partners, and to expedite partnership agreements at country level.[98] These changes facilitated programmatic adjustment – particularly important to enable business continuity at country level, and with rapidly closing supply chains. The increased procedural flexibility available was extensively utilized by country offices to meet needs. For example, considerable repurposing took place towards Risk Communication and Community Engagement (RCCE), as its centrality in the pandemic response became clear (see section 2.2.ii).[99] The flexibilities introduced were widely praised by staff for supporting UNICEF's agility during highly uncertain conditions.[100] In 2021 and 2022, the ACT-A HAC also made flexible funding available to support the rollout of COVID-19 tools, including PPE and RCCE.

97 Interviews with 68 HQ and country office staff.
98 UNICEF, *UNICEF Procedures on Corporate Emergency Activation for Level 3 Emergencies*, Document Number: EMOPS/PROCEDURE/2019/001, Effective Date: 1 June 2019.
99 UNICEF, *Real-Time Assessment of the UNICEF Response to COVID-19*, Global Synthesis Report, June 2021.
100 Noted in at least 27 out of 89 evaluations.

2.1.iii How well did UNICEF adapt to remote working?

UNICEF was advanced in its preparations for remote working: Although not universal across the organization, UNICEF had already implemented a range of mechanisms which were to prove both prescient and supportive when the pandemic struck. Many teams, such as Supply and Innovation Divisions,[101] were already practising flexible working approaches, and business continuity planning meant that UNICEF teams were prepared for remote methods, with technology already in place. Some senior management, including the Executive Director at the time, worked remotely from very early in the pandemic, and thereafter throughout.

Special measures implemented: UNICEF recognized the primacy of Human Resources in delivering the response, and the HR function was centrally engaged in the COVID-19 Secretariat. A set of Human Resources special measures were mobilized in the period March–April 2020.[102] These oriented around three main priorities: (i) compliance with evolving UN rules and regulations; (ii) supporting business continuity – such as a rapid adaptation to remote and virtual working modalities; and (iii) prioritization of individual staff wellbeing.[103] They included:

- Enhanced flexibility for country offices to respond to human resource needs, such as making workforce management decisions and clarifying benefits and entitlements for remote working.
- Launching internal deployment mechanisms such as surge support, staff loans and stretch assignments.
- Adjusted recruitment modalities to facilitate swift entry to the organization.
- Enhanced flexibility in leave, whether sick leave or special leave entitlements.

101 UNICEF, *Lessons Learned from UNICEF's Supply Division.* Supply Division's Response to COVID-19. Response Tier 1: Protecting SD Staff and maintaining regular supply operations. Lessons Learned Report Series, Undated.

102 UNICEF Headquarters, *Review of UNICEF's COVID-19 HR Special Measures: Humans who helped humans, March 2021*, Executive Summary, Draft 19 April 2022.

103 Ibid.

The rapid shift to remote working in March and April 2020 saw an approximately 2,330 per cent increase in recorded teleworking within Duty Stations.[104] However, only 50 per cent of surge requests were fulfilled during 2020, and an external recruitment freeze[105] and diversity targets constrained the pool of available talent to UNICEF, at a time when demands and competition were high.[106]

Supporting mental health and wellbeing: UNICEF extended staff access to wellbeing and psychosocial support during 2020 and 2021, with provision of staff counselling and Peer Support Volunteers (PSVs).[107] A staff survey conducted in June 2020 found that 84 per cent of staff were aware of wellbeing services, and that 88 per cent of staff had a positive response to the statement, "My manager demonstrates empathy and understanding under the unique experience of COVID-19."[108]

Country-level role in UN staff health and safety: UNICEF also frequently played a lead role in UN coordination for staff health and safety from COVID-19 at country level. Examples include:

- In Peru, UNICEF hosted and organized the UN vaccination process, delivered to 1,100 staff members and dependents.[109]
- In Zimbabwe, as chair of the Operations Management Team, UNICEF led the development of standard UN operating procedures to keep staff safe from COVID-19.[110]

104 Ibid.
105 UNICEF External Recruitment Freeze Guidance was launched on 29 May 2020. External Recruitment Freeze Frequently Asked Questions (FAQs), as of 12 June 2020.
106 UNICEF Headquarters, *Review of UNICEF's COVID-19 HR Special Measures: Humans who helped humans, March 2021*, Executive Summary, Draft 19 April 2022.
107 Ibid.
108 UNICEF, *Global Staff Survey 2020 Whole Organization Report*, 2020. https://unicef.sharepoint.com/teams/DHR-Analytics/SitePages/HR-Analytics.aspx
109 UNICEF, *Country Office Annual Report 2021*, Peru, 2021.
110 UNICEF, *Country Office Annual Report 2020*, Zimbabwe, 2020.

Diverse attitudes to remote working: Interviews with staff, however, indicated a schism in attitudes to remote working, with those from emergency and humanitarian backgrounds concerned that UNICEF had lacked the strong 'Stay and deliver' message articulated by some other agencies,[111] potentially impacting on credibility with national stakeholders. Those from a more development-focused background, by contrast, strongly praised the 'people first' approach adopted to staffing.

The evaluation has not found any robust linkage between UNICEF's approach to human resource management and the corporate results achieved during the pandemic (see section 2.4). Its business continuity was sustained throughout. However, the evaluation observes that UNICEF's approach to personnel management enabled it to avoid the strained relationships between the organization and its staff experienced by some other agencies during the pandemic response.[112]

111 See, for example, WFP, *Evaluation of the WFP COVID-19 response*, 2021; United Nations High Commissioner for Refugees (UNHCR), *Evaluative Synthesis of UNHCR's COVID-19 response*, 2022.

112 Ibid.

2.2 How well did UNICEF respond to population needs, especially those of the most vulnerable?

SUMMARY

UNICEF invested in analysing needs during the pandemic, both contributing to the global evidence base and supporting countries to analyse their own population needs. Disaggregation was inconsistent, and a gap emerged between analysis and programmatic response. Targeting was not consistently aligned with intended groups, while gender and equity concerns were corporately prioritized but received uneven programmatic attention.

Although country offices found the volume of guidance on programmatic adaptation overwhelming, extensive adaptation took place on the ground. RCCE, Social Protection and Mental Health and Psychosocial Support programming expanded considerably. Education supported remote delivery, and health/WASH and nutrition programming delivered both operational and policy-level support. Uncertain UNICEF positioning in the early phase of the pandemic response negatively affected advocacy, but eventual successes included vaccine provision, schools re-opening, and the release of children in detention. Timeliness was mixed, with most country programmes experiencing delays, and Accountability to Affected Populations (AAP) strategies and approaches inconsistent.

The supply chain played a major role in the response, particularly around the provision of PPE and other equipment as well as cold chain infrastructure strengthening. Many adaptations were made, but external difficulties and the challenges of a centralized approach created delays on the ground, with UNICEF incurring some reputational risk due to a lack of promised delivery.

UNICEF adapted its monitoring and evaluation systems to pandemic conditions. The comprehensive approach to learning validates its aim of a 'learning culture'.

2.2.i How well did UNICEF analyse and target the needs created by COVID-19?

Early definition of target groups: UNICEF set out its defined target groups in April 2020, in its revised Programming Guidance for COVID-19.[113] Specific groups identified were:

- Children living in high-density environments and slums.
- Children outside of family care or at risk of separation.
- Children deprived of their liberty.
- Children on the move.
- Children living in conflict-affected and fragile settings.
- Children living with vulnerable parents or care providers.
- Children with disabilities.

UNICEF also voiced an early commitment to gender and equity within the response, with the April 2020 Programming Guidance committing to "engage with women, adolescents and youth to understand their specific needs, amplify their voices, and discuss and plan how they can take action, including advocacy to advance children's and women's rights."[114] Specific commitments were made also regarding persons with disabilities.[115]

Strong emphasis on analysing and understanding population needs: UNICEF conducted[116] an extensive range of needs analyses, assessments and reviews to assess the effects of COVID-19 on target populations. Areas covered included:

- Effects of COVID-19 on child poverty, health and nutrition.
- Sectoral assessments of the effect of COVID-19 on areas of service delivery, e.g., education.

113 UNICEF, *Guidance Note on Programming Approaches and Priorities to Prevent, Mitigate and Address Immediate Health and Socio-economic Impacts of the COVID-19 Global Pandemic on Children*, 2020.
114 Ibid.
115 Ibid.
116 Reporting from 49 out of 53 evaluations.

- Socio-economic effects of COVID-19 on different population groups including women and girls, indigenous groups, refugees and Internally Displaced Persons (IDPs), and others.
- Access of different population groups to vaccination programmes.
- Psychosocial support needs for those experiencing lockdowns.
- Knowledge, Attitudes and Practices (KAP) assessments under the conditions of COVID-19.

BOX 4

UNICEF country office analysis, review and studies 2020 and 2021

- **Indonesia:** Case Study Situation Analysis of the Effect of and Response to COVID-19 in Asia.
- **Lao PDR:** Impact of COVID-19 on Children, Adolescents and their Families in Lao PDR, exploring the benefits of potential action by the Government of Lao PDR as part of its COVID-19 response.
- **Kyrgyzstan:** A rapid assessment of the impact of COVID-19 on Kyrgyzstan's youth.
- **State of Palestine:** Knowledge, Attitudes and Practices survey to better understand the factors driving Palestinians' behaviours concerning COVID-19.
- **Afghanistan:** Assessment of the impact of COVID-19 on the lives of young people.
- **Colombia:** Rapid Needs assessment to measure the living conditions of Venezuelan refugee and migrant households in Colombia during the pandemic.
- **Burundi:** Socio-anthropological study understanding of community practices and generation of data and evidence for COVID-19-related programming and advocacy.
- **Mongolia:** Two assessments of the mental health impacts on children during COVID-19 and the effectiveness of TV lessons for children.
- **Tanzania:** Knowledge, Attitudes and Practices (KAP) surveys on COVID-19 prevention and readiness to accept COVID-19 vaccines.

- **Peru:** Two studies: (i) The impact of COVID-19 on the levels of monetary poverty and inequality in children and adolescents in Peru; and (ii) Effects of COVID-19 on selected health and educational indicators on children.
- **DRC:** Use of Integrated Outbreak Analytics, based on learning from the 2018 Ebola outbreak in DRC, which integrated epidemiological data, evidence on perceptions and factors influencing behaviours and other available data to explain trends in health outcomes and epidemiological trends.[117]

Example: In Pakistan, during 2021, UNICEF supported 11 KAP surveys; 4 direct-observation surveys; 48 weekly social media analytics and media monitoring; and 7 anthropological studies aimed at improving pandemic response plans and strategies to increase vaccination uptake among women and adolescents.[118] It also provided a 2021 Annual Status of Education Report, *Measuring the Impact of COVID-19 on Education in Pakistan* and a Safe School Reopening Simulation & Costing Model for the government.[119]

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117 See https://www.corecommitments.unicef.org/kp/integrated-outbreak-analytics%3A-from-ebola-to-covid-19-in-the-democratic-republic-of-congo-(drc), accessed 05-09-2022

118 UNICEF, *Pakistan Country Office Country Office Annual Report 2021.*

119 Data supplied by Pakistan Country Office.

Building the national evidence base: UNICEF also played a key role in supporting national data needs[120] (see Box 5):

BOX 5
Examples of UNICEF support to national data needs in 2020 and 2021

- **Georgia:** UNICEF supported the government with research, the results of which were used for adjusting targeted social assistance under pandemic conditions.
- **Madagascar:** UNICEF and the National Institute of Statistics supplied the government with the results of a socio-demographic survey to inform national decision-making on the COVID-19 response.
- **Myanmar:** In 2020, UNICEF contributed to strengthening national systems for data generation on the situation of children to inform policies and budget allocations on COVID-19.
- **Indonesia:** UNICEF supported the government's analytical capacities for the pandemic response, e.g., with mobile assessments of all health facilities and tracking immunization rates.
- **Zimbabwe:** UNICEF, World Bank and Zimbabwe National Statistical Agency worked together to build household survey data on the socio-economic impacts of COVID-19.

Research as global public good: Many of UNICEF's knowledge products have contributed to the global evidence base on COVID-19. Regional and global level examples are shown in Box 6. Corporately, UNICEF also created a series of dashboards on COVID-19 and the situation of children, which were globally accessible.[121]

120 As evidenced by 23 evaluations, 12 out of 21 desk studies (Haiti, Bangladesh, Sierra Leone, Cambodia, Somalia, Zimbabwe, Niger, Uzbekistan, DPRK, Greece, Afghanistan, Nepal) and all seven desk studies.

121 https://unicef.sharepoint.com/sites/DAPM/SitePages/Dashboard-tracking-the-situation-of-children-in-COVID-19.aspx

BOX 6
Regional and global studies

Regional

- Regional Situation Reports issued quarterly, providing updated overviews of the COVID-19 situations, national responses and UNICEF's role in supporting them, and needs estimations. Some regions produced 'weekly digests' on the COVID-19 response in 2020, e.g., East Asia and Pacific Regional Office (EAPRO).
- **ROSA:** Learning from undertaking rapid assessments in the COVID-19 context.
- **EAPRO:** Rapid Gender Analysis during COVID-19 Pandemic Mekong Sub-Regional Report: Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam (September 2020).
- **LACRO:** Thirty national surveys on the pandemic's impact on families and children.
- **WCARO:** West and Central Africa Key Results for Children, Accelerator Practices, COVID-19 response, KRC#9. Evidence Generation & Knowledge Management, June 2021.
- **ESARO:** Community Rapid Assessments on COVID-19: Behavioural Findings and Insights.

Global

- Understanding the interruption of essential health services by COVID-19 to guide recovery (10 October 2020).
- Review of global social protection responses to the COVID-19 pandemic.
- COVID-19 Impact Assessment on Global Logistics and Supplies (September 2021).
- COVID-19: A threat to progress against child marriage (September 2021).
- The Impact of COVID-19 on the welfare of households with children: An overview based on High Frequency Phone Surveys (with the World Bank Group).

Strategies implemented to navigate access challenges: Access restrictions challenged data gathering during the early phase of the response, as did government reticence to provide data or research permissions and limited national data on COVID-19 incidence.[122] UNICEF offices responded with mobile data collection, and by establishing data collection platforms for partners to insert the relevant information. In Tanzania, for example, UNICEF provided community health workers with smartphones, including a purposely designed mobile health application.[123] In the Democratic People's Republic of Korea, UNICEF developed a remote monitoring plan, which applied the triangulation of various data points including child welfare indicators, supply distribution plans and asset registries.[124] In Haiti, performance monitoring was adapted to use real-time partner reporting and monitoring of specific priority indicators via Google sheets and, in some locations, paper-based monitoring tools.[125] Some offices used qualitative techniques, such as Appreciative Enquiry to understand the effects of COVID-19 on children and young people in Afghanistan.[126]

BOX 7

Example use of remote methods: Data gathering in Eastern and Southern Africa Regional Office (ESARO)

The Community Rapid Assessment in ESARO used mobile phone-based surveying methods to generate more accurate estimates than social network surveys, with wider population representation than SMS-based surveys. The method also allowed results to be adjusted to national populations more accurately than smaller in-person targeted surveys.[127]

122 Reported in 16 evaluations.
123 UNICEF, *Tanzania Humanitarian Situation Report No. 4, Reporting Period: January-December 2020,* 2020.
124 UNICEF, *Country Office Annual Report 2020: Democratic People's Republic of Korea (North Korea),* page 6, 2020.
125 UNICEF, *Haiti Humanitarian Situation Report January-December 2020*, 2020.
126 UNICEF Afghanistan, *Country Office Annual Report 2021, Afghanistan*, 2021. Available at: https://www.unicef.org/media/115271/file/Afghanistan-2021-COAR.pdf (Accessed: 6 April 2022).
127 UNICEF, *Community Rapid Assessment on COVID-19 End line Report: Behavioural Findings and Insights from 8 Eastern and Southern African Countries,* 2021.

Inconsistent disaggregation: Some country offices undertook detailed and granular disaggregation of populations of concern. For example, in Zimbabwe, UNICEF conducted detailed analysis of disability inclusion, mapping against human rights standards. In Bangladesh, analysis was disaggregated by gender, disabilities, 'marginalized adolescents' and 'Rohingya children'.[128]

This disaggregation was not fully consistent, however. At least 21 evaluations reviewed noted disaggregation concerns within categories of disadvantage,[129] leading to gaps in knowledge of the response on particular populations. Vulnerable groups on which data were missing included:

- Children with disabilities, ultra-poor street children, and those who drop out from school, e.g., in Malawi.
- Female-headed households, e.g., in South Asia.
- Indigenous people, e.g., in Peru.
- Special needs of boys, e.g., in South Asia.

The limited availability of intersectional indicators (e.g., disability, ethnicity, caste and class), even where sex- and age-disaggregation was available, was also noted.[130] These gaps are critically important given the disproportionate effects of the pandemic on societies that are most vulnerable (see page 21).

128 Zimbabwe and Bangladesh desk study.

129 At least 21 evaluations, 9 desk studies (Greece, DPRK, Haiti, DRC, Sierra Leone, Cambodia, Somalia, Uzbekistan, Afghanistan) and four case studies (Pakistan, State of Palestine, Burundi, Ghana).

130 Oxford Policy Management, *Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Region of South Asia, Regional Analysis*, 2021.

Gaps between analysis and programming: Moreover, a significant gap existed[131] in converting the findings from studies and research to programmatic adaptations targeting specific groups. In some contexts, therefore, the programmatic response was blunter than desirable. For example, the independently conducted Real-Time Assessment of the response in Eastern and Southern Africa reported in June 2021 that, "For most country offices, interventions appear to target only some of the populations identified as vulnerable."[132] Recurring concerns across the evidence base were:

- Gender inequalities.
- Indigenous groups.
- People without ID cards and stateless populations.
- Border populations.
- Persons with disabilities.

Targeting not consistently aligned with articulated targeted groups: Analysis of corporate data finds that, despite incomplete data on some groups, targeting was not fully consistent with the target groups set out on page 60. Children with disabilities, children in conflict-affected and fragile settings, and children deprived of their liberty were, however, targeted in 2021 especially (see Table 4).[133]

131 In 38/59 reporting evaluations.

132 Oxford Policy Management, *Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa, Regional Analysis*, 17 March 2021.

133 Using data from UNICEF internal management information systems and Annual Reports for 2020 and 2021.

TABLE 4

UNICEF COVID-19 targeting against intentions

TARGET GROUP	2020	2021
Children living in high-density environments and slums	No data	No data
Children outside of family care or at risk of separation	No data	No data
Children deprived of their liberty	No data	UNICEF's advocacy led to 45,000 children across 84 countries being released from detention[134]
Children on the move	No data	6.4 million children on the move supported with education interventions
Children living in conflict-affected and fragile settings	Responding to 455 new and ongoing humanitarian crises in 153 countries	Responding to 483 new and ongoing humanitarian crises in 153 countries in 2021
Children living with vulnerable parents or care providers	No data	No data
Children with disabilities	2.2 million children with disabilities supported with disability-inclusive programming including in humanitarian situations	More than 4.8 million children with disabilities reached across 148 countries through disability-inclusive programming, including in humanitarian situations

Evaluations and other evidence,[135] however, found additional targeted vulnerable groups were not always reflected in the corporate priorities for COVID-19. Examples included:

- Children in religious institutions, e.g., in Nigeria.
- Border populations, e.g., in Kazakhstan, Colombia, Haiti.

134 *UNICEF Annual Report 2021*.
135 Including desk studies in all 21 countries and case studies in seven.

- Women and children in quarantine facilities, e.g., in Cambodia and Zimbabwe.
- Indigenous communities in Venezuela and Peru.
- Venezuelan migrants in Peru.
- Marginalized urban areas in Buenos Aires and Caracas.

Early strategic prioritization of gender and equity concerns: Gender equality concerns – in the sense of targeting women and girls – were a main focus of the early programmatic response above (para. 72). Guidance was also developed relatively quickly, with more than 20 Headquarters' guidance documents produced on gender and equity, including some developed by regional offices, such as the Regional Office for South Asia (ROSA) and ESARO.

Gender-related indicators were introduced to the corporate standard indicators for COVID-19 in June 2020, but staff described a challenging process to confirm their inclusion.[136] Country staff also indicated that reporting on gender was 'optional'.[137]

Uneven programmatic attention to gender and equity: Programmatically, however, momentum to address gender and equity concerns grew only slowly over time.[138] Country- and regional-level staff reported variable attention to the issue, often dependent on senior management engagement and interest.[139] Evaluations and UNICEF's Real-Time Assessment of the COVID-19 response[140] noted gaps in the early response, with all country offices implementing some form of gender equality or gender-based violence programming, but fewer making efforts to mainstream the issue.[141] Limited funding and technical expertise were also noted. At regional level, reports in ESARO, EAPRO, ROSA, and West and Central Africa Regional Office (WCARO) noted a gradual improvement over late 2020

136 Interviews with six HQ staff, May 2022.
137 UNICEF, *Real-Time Evaluation of gender integration in the UNICEF COVID-19 response in South Asia,* 2021.
138 Note that from October 2020, UNICEF's revised Core Commitments to Children in Humanitarian Action commit UNICEF to (i) including GBV prevention and risk mitigation for all in programmes, with a focus on the safety and resilience of girls and women, (ii) Actively engaging adolescent girls, women and their respective organizations in the design and delivery of programmes, and (iii) conducting gender-responsive programming, including a lens on adolescent girls. See UNICEF, *Core Commitments for Children in Humanitarian Action*, October 2020.
139 Interviews with CO and regional level staff, April–May 2022.
140 Nineteen evaluations out of 29 reported finding that UNICEF adequately mainstreamed gender, age and disability into its COVID-19 response programming, while 10 found that inadequate attention had been paid to these issues.
141 UNICEF, *Real-Time Assessment of the COVID-19 response*, Global Synthesis Report, 2021.

and early 2021. "By 2021, UNICEF in ROSA recognized and understood that the response needed to be far more gender responsive and transformative. This resulted in increased expenditure and GBV programming was integrated in all CO planning."[142] Questions were raised, however, on the 'women and girls' focus, and whether adequate programmatic attention was being paid to the needs of men and boys.[143]

This uneven response is reflected in gender expenditure data. In 2020, UNICEF did not achieve its budget target of a minimum of 15 per cent of funding to have a gender tag. In the COVID-19 response, only 1 per cent of all COVID-19-related funding was allocated to gender-responsive priorities.[144]

At times these concerns reflect pre-existing fault lines in UNICEF's existing mechanisms to address gender equality, age and disability concerns. For example, the evaluation of female genital mutilation (FGM) reported a substantial gap in humanitarian gender-based violence preparedness planning prior to 2020.[145]

2.2.ii How well did UNICEF adapt its programming to respond to COVID-19?

Early recognition of the need for adaptation: UNICEF issued comprehensive programme adaptation guidance from January 2020, adapted on an ongoing basis in April 2020,[146] revising this in November of the same year.[147] The guidance set out programmatic adaptation and prioritization measures to be adopted by UNICEF offices to address the pandemic.[148] The main programmatic strategies identified are shown in Table 5.

142 UNICEF, *Real-Time Evaluation of gender integration in the UNICEF COVID-19 response in South Asia,* 2021.
143 Oxford Policy Management, *Real-Time Assessment of COVID-19 response in ESARO region,* 2021.
144 As per internal management data (insight) – though this may not reflect all gender-mainstreamed work reflected in sectoral budgets.
145 UNFPA and UNICEF, *Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change Phase III (2018-2021)*, 2021.
146 UNICEF, *Guidance Note on Programming Approaches and Priorities to Prevent, Mitigate and Address Immediate Health and Socio-economic Impacts of the COVID-19 Global Pandemic on Children*, 2020.
147 UNICEF, *Updated COVID-19 Programme Approach and Prioritization Guidance Note,* 2020.
148 The two guidance notes are mostly the same. The November 2020 guidance note did not remove anything from the original guidance. The few additions made in November are indicated in the table.

TABLE 5

Programmatic strategies for adaptation

SCALING UP & DOWN PROGRAMMES	Overall increase in the scale of delivery and coverage (all regions), supported by relatively successful resource-raising
INCREASING RCCE	To include use of online platforms and digital access for frontline ministries
PROCURING ESSENTIAL SUPPLIES	Setting up new procurement arrangements to acquire PPE and other items at scale
ENSURING CONTINUITY OF VITAL PROGRAMMES	Mitigate disruptions in regular healthcare, nutrition, education, social protection, and inclusive public programmes
EXPANDING COVERAGE	Target new groups and areas
SUPPORTING THE MOST VULNERABLE GROUPS	Targeting those most in need of support in the context

Below this broad 'chapeau', however, UNICEF programming areas and sectors issued their own guidance for adaptation. At least 116 sector-specific guidance notes were issued between January 2020 and September 2021 (see Annex 5 for a full list). The large majority (75 per cent) were issued early in the pandemic, between March and May 2020 (see Table 6).

TABLE 6

Guidance items produced

DATE	NUMBER OF GUIDANCE ITEMS
JANUARY 2020	2
FEBRUARY 2020	2
MARCH 2020	29
APRIL 2020	43
MAY 2020	15
JUNE 2020	7
JULY 2020	1
AUGUST 2020	3
SEPTEMBER 2020	2
OCTOBER 2020	1
NOVEMBER 2020	1
DECEMBER 2020	1
NO DATE	9
TOTAL	**116**

Source: Evaluation team analysis based on UNICEF guidance produced

Country offices appreciated the guidance in place but, in common with findings from other evaluations,[149] spoke also of its overwhelming volume, "There was just so much; we couldn't absorb it." At the same time, internal webpages and intranet sites were also being developed; at one count, over 20 were in place.[150] No corporate-level internal system exists within UNICEF to prioritize, validate or quality control guidance issuing from Headquarters or regional offices; the Innovation Division in UNICEF was tasked to bring some coherence to the plethora of information being produced, but this took some time to come to fruition.[151]

Meanwhile, at field level, extensive programmatic adaptation was underway. All 49 relevant evaluations, desk and case studies confirmed swift and extensive adjustment at country level. Table 7 sets out the main areas of adjustment adopted and provides some illustrative country examples from the evidence. In all of UNICEF's regions, activities scaled up, with Social Protection and RCCE being the major areas of expansion.

149 See, for example, UNICEF, *Evaluation of the UNICEF Role as Cluster Lead (Co-Lead) Agency (CLARE II)*, 2022.
150 Interviews with 68 UNICEF staff and management, June 2022.
151 Interviews with 68 UNICEF staff and management, June 2022.

TABLE 7

Programmatic adjustment

PROGRAMMATIC PRIORITIES (AS PER PROGRAMMATIC GUIDANCE NOTES, APRIL/NOVEMBER 2020)	ADAPTATIONS MADE IN COUNTRIES/REGIONS	COUNTRY/REGIONAL EXAMPLES
Health Three-pronged approach: **1. Immediate response to COVID-19:** (i) Limit human to human transmission and protect individuals from exposure to COVID-19. (ii) Minimize morbidity and mortality. (iii) Provide and deliver supplies for prevention and treatment of COVID-19. **2. Ensure continuation of health services for mothers, newborns, children and adolescents.** **3. Strengthen health systems.**	• Delivery of medical kits • Training local frontline workers • Providing supplies, e.g., PPE and other medical equipment • Supporting government analysis and M&E • Advocating and delivering immunization programmes where these closed • Supporting vaccination (major efforts) • Support to real-time data systems and platforms on COVID-19 • Adaptation of national protocols and guidelines	• Procuring essential supplies, e.g., oxygen concentrators in Burundi and Pakistan and ultra-cold chain freezers in Pakistan • Adapting existing immunization programmes to support COVID-19 vaccination, e.g., in Pakistan and Afghanistan • Responding to vaccine hesitancy, e.g., in Kazakhstan • Expanding social media channels, e.g., in Turkey through a partnership with Facebook, reaching over 78 million individuals with COVID-19-related information • Using technology (tele-medicine) to support the continuation of essential health services, e.g., in Pakistan
WASH Ensure that all children and their families directly impacted by COVID-19 have access to safe and affordable services, menstrual health management, and hygiene supplies, including menstrual supplies for girls and women. Three main areas of work: ◦ Hygiene. ◦ Continuity and affordability of essential WASH services and products. ◦ IPC.	• Provision of services in health centres, schools and early childhood development (ECD) centres • Technical support to governments • Support to M&E systems	• Setting up WASH points in public spaces with heavier traffic, including markets and hospitals in Colombia • Developing the 'Blue Soap Initiative' in Burundi to be sold at half the market price • Providing hands-free handwashing stations in Pakistan • Providing foot-operated handwashing facilities in Zimbabwe

Nutrition Ensure access to nutritious and affordable diets, adequate nutrition services, life-saving emergency interventions and information on nutrition services and practices to protect, promote and support adequate nutrition. Three main areas of work: ◦ Infant and young child feeding and related maternal and child nutrition. ◦ Cash-based and other safety-net programmes coupled with social behaviour change communication for nutrition. ◦ Early detection and treatment of wasting.	• Direct provision of nutrition supplies • Expanding storage capacity • Providing guidance and technical support	• In Iraq, developing detailed budgeted national plans to promote continuity of care for immunization, nutrition and maternal, newborn and child health (MNCH) programmes • In Sudan, guidelines on the Management of Acute Watery Diarrhoea/Cholera in Children with Acute Malnutrition within the COVID-19 context • Supporting accelerated implementation of the second National Strategy for Food Security and Nutrition to mitigate the secondary impacts of COVID-19 in Cambodia • Adjusting emergency nutrition protocols for the treatment of both severe and moderate wasting in Zimbabwe
Education Ensure the continuity of learning through remote learning or the safe return to improved school operations. Main areas of work: ◦ School-related gender-based violence. ◦ Psychosocial support to help children, teachers and communities. ◦ School-based health, nutrition services and standards-based WASH facilities. ◦ (November 2020) Pedagogical and financial support to teachers.	• Supporting remote learning • Direct provision of education to remote communities • Developing digital platforms • Advocating with governments for the opening of schools (from April 2020) • Direct support to families (cash) • Skills support to Out of School adolescents and others • Revision of Technical and Vocational Education and Training (TVET) programmes	• Adapting the Learning Circles intervention to ensure the continuity of learning for migrant and host communities children in Colombia • In Kazakhstan, connecting schools to the internet, providing content for teachers in delivering digital blended learning • Setting up a new television station in Lao PDR, serving 2 million children • Co-drafting with UNESCO, the World Bank and Inter-American Development Bank (IADB) a plan for the government to progressively re-open schools in Peru • Improving the infrastructure for online platforms and providing self-learning materials for primary-grade children, especially in IDP and refugee camps in Iraq

		• Providing distance learning systems including tablets loaded with offline self-paced interactive learning materials in State of Palestine • Providing learning modes that blended remote learning through high-tech (apps, online platforms), low-tech (television, SMS) and no-tech (worksheets, homework) modalities in Pakistan
Social Protection Ensure the continuity of routine social protection measures and expand social protection programmes, especially cash transfers, for all children and their families directly impacted by COVID-19.	• Vertical and horizontal expansion of government-led Social Protection programmes (cash transfers) • Advocacy support for excluded groups • Also 'diagonal' expansion by integrating messaging on hygiene, nutrition and other protective communication • Piloting new modalities, such as through mobile phones and virtual cards • Use of digitalized cash transfers	• Supporting the planning and coordination of Social Protection payments for households made vulnerable by COVID-19 in Ghana; including homeless people, women and children living on the street, persons with disabilities and extremely poor households • In Cambodia, supporting the government to design and deliver a one-off Lockdown Cash Transfer Programme for Phnom Penh, Takeo and Sihanoukville • In the Dominican Republic, providing data, technical, and financial support for cash transfers to 2,700 families with children living with disabilities, in coordination with the national social inclusion system
Child Protection Strengthen and scale up child protection and gender-based violence services to better protect all children and women at increased risk of violence, exploitation, abuse and neglect due to COVID-19.	• Working globally (through Global Alliance on CP) to advocate for child protection (CP) as part of global response • Advocating with governments/globally to see CP staff as essential workers (including social workers) • Publication of global guidance on positive parenting • Setting up 'online courts'	• Advocacy on releasing children from detention, e.g., in the Middle East and North Africa (MENA) region • In Greece, developing national guidelines on child protection programmes in the COVID-19 context, for example, on residential care facilities housing unaccompanied and separated children (UASC) and GBV survivors

	• Development/adaptation of national guidelines on child protection during COVID-19	• Providing child protection training to COVID-19 quarantine facility staff, positioning volunteer social workers in quarantine centres in Zimbabwe • Deploying student social workers in Somalia
Mental Health and Psychosocial Support Ensure that children, adolescents and caregivers have sustained access to continuous, scaled-up and quality mental health and psychosocial support services, including available helplines, virtual services and adapted one-to-one counselling.	• Direct provision of MHPSS services • Providing capacity strengthening for national authorities/civil society • Using social networks for monitoring mental health during the lockdown	• Providing psychosocial support (face to face, home visits and community announcements) in Ghana • Conducing an analysis of mental health through Facebook to inform the government on addressing the issue during the lockdown in Peru • Supporting the Government of Tanzania to train mental health and psychosocial support teams • Building the capacities of psychologists in the local departments of the Ministry of Emergencies in Kazakhstan
RCCE Build the capacity of key influencers, community groups, women and youth groups, health workers and community volunteers for awareness-raising and promotion of healthy practices and help-seeking behaviour. • Improve the communication of accurate information and messaging. • Launch population-wide handwashing campaigns. • Support the implementation of physical distancing measures through community mobilization.	• Founding and co-leading the Collective Service on RCCE, providing support to the consolidation of structures and mechanisms for a collective approach to RCCE • Supporting national RCCE strategies and plans • Guidance, combating misinformation, etc. • Expanding delivery through remote methods	• An exponential increase in the coverage of RCCE activities across all regions, including through online platforms and Facebook, WhatsApp, WeChat, TikTok, Telegram, LINE), as part of RCCE strategies • In Ghana, UNICEF partnered with four local Civil Society Organizations to disseminate COVID-19 preventive messages • In Colombia, UNICEF partnered with local, community and youth-based organizations to roll out a communication strategy with information on COVID-19 prevention

Source: Evaluation team drawing on evaluations and UNICEF documentation including Country Office Annual Reports, Corporate Annual Reports and other documents

Multi-sectoral approaches in practice not reflected in corporate guidance: Although UNICEF's initial Programming Guidance of April 2020 voiced a commitment to an integrated approach in the "best interests of the child", this was not reflected in the quantity of guidance issuing from HQ, which adopted the sectoralized approach of UNICEF's organizational arrangements. In this, corporate guidance was "out of sync" with country realities, where multi-sectoral programming was frequently being realized on the ground.[152]

The integrated approach gained momentum as the multivariate effects of the pandemic took hold, affecting children's lives across many dimensions. Across the evidence base, integrated approaches were notable in two areas: education and RCCE.

TABLE 8

Integrated approaches in education and RCCE

EDUCATION	• In China, UNICEF established a back-to-school working group with focal points from education, health, child protection, gender, communications, and monitoring & evaluation.[153] • In Pakistan, UNICEF supported provincial Disaster Risk Reduction and COVID-19 task teams at the federal and provincial levels for an integrated response to safe school re-opening operations.[154] • In Bangladesh, adolescent nutrition interventions were linked with education inputs.[155] • In Peru, the plan for school re-opening co-drafted by UNICEF addressed topics including safety (infection prevention and control (IPC) protocols); pedagogy; socio-emotional education; equity; inclusion and diversity; funding and governance; norms.[156]
RCCE	• In Somalia, UNICEF integrated Communication for Development (C4D) for Social and Behaviour Change (SBC) with a range of other sections for risk communication and community engagement as part of the response to COVID-19.[157] • In Malawi, UNICEF integrated RCCE as a key component for all elements of the response.[158] • In Kenya, UNICEF was praised for combining RCCE on COVID-19 with encouraging uptake of essential services.[159]

152 Analysis of 21 desk studies and 7 case study countries.
153 UNICEF, *UNICEF Education COVID-19 Case Study: China.*
154 Data supplied by UNICEF Pakistan Country Office.
155 UNICEF Bangladesh, *Country Office Annual Report 2020*, 2020
156 Case study, Peru.
157 UNICEF, *Evaluation of UNICEF's coverage and quality in complex humanitarian situations: Somalia,* June 2021.
158 Oxford Policy Management, *Real-Time Assessment of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa, Malawi*, January 2021.
159 Oxford Policy Management, *Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa, Kenya,* January 2021.

In the ESARO region, UNICEF's own self-reflection noted that, "Pandemic programming has underscored the value of collaborative, integrated, multi-sectoral programming as well as its challenges. This involves the reinforcement of human-centered/child-centered/human rights-based approaches, supportive of strategic and well-coordinated multi-sectoral programming with holistic solutions and results for all children, with a special focus on inclusion of the most vulnerable."[160]

Inconsistent approaches to Accountability to Affected Populations (AAP): As for gender, UNICEF set out its programmatic intentions for AAP early, listing three pillars of work in its April 2020 guidance:

- At-risk populations receive the most relevant information they can act on, and in the most appropriate format.
- Affected populations are engaged and participate in decisions around prevention, containment and response to COVID-19.
- Complaints and feedback mechanisms established.[161]

These aims were addressed inconsistently, however. Of the 14 evaluations reporting on AAP, 7 found positive integration of AAP into UNICEF's planning and activities, including the use of structured feedback and complaint mechanisms, as in Venezuela, Somalia and Argentina.[162] Supporting factors included having systems in place prior to the pandemic, adequacy of funding, and senior management prioritization of these concerns. Desk and case studies found similarly: in Yemen, UNICEF supported COVID-19 hotlines managed by the Ministry of Public Health and Population for accountability and community feedback mechanisms, through which health professionals responded to people's queries, concerns, and medical consultations on COVID-19.[163] In Afghanistan, UNICEF conducted two rapid assessments, in part to gather data on preferred complaint and feedback mechanisms. Based on the findings, UNICEF developed a chatbot on how and where to obtain food, water and

160 UNICEF ESARO, *Report on the Eastern & Southern Africa Regional Office (ESARO) Self-Assessment of its Response to COVID-19 and Lessons Learne*d, November 2020.

161 UNICEF, *Accountability to Affected Populations in COVID-19 Response,* pages 1-3, 2020.

162 UNICEF Venezuela and UNICEF Argentina; Oxford Policy Management, *Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa, Somalia, January 2021;* UNICEF, *Evaluation of UNICEF's coverage and quality in complex humanitarian situations: Somalia*, June 2021.

163 Yemen desk study.


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other humanitarian services, and how and where to complain about services provided.[164] In Pakistan, with funding for the COVID-19 helpline, UNICEF received 6,000 calls per day.[165]

Seven evaluations, alongside the remaining desk and case studies, however, found that AAP had not been effectively integrated into the UNICEF COVID-19 response and programming. Reasons included, in part, the absence of the supporting factors above, but with specific nuances. In the Dominican Republic, for example, UNICEF tried to implement AAP but found it difficult to maintain stable feedback mechanisms remotely, particularly among border populations and low-income families.[166] In Malawi, UNICEF established an internal mechanism to integrate AAP and attempted to monitor constraints to critical services. However, efforts were constrained by challenges including community engagement and limited feedback from vulnerable populations and rural areas.[167]

164 Afghanistan desk study.
165 UNICEF Pakistan, *Country Office Annual Report 2021*, 2021.
166 UNICEF, *Valoración en Tiempo Real de la Respuesta de UNICEF a COVID-19 en República Dominicana*, 2021.
167 UNICEF, *Real-Time Evaluation of UNICEF'S Response to the COVID-19 Outbreak Crisis in Malawi, Final Evaluation Report*, 27 January 2021.

2.2.iii What adaptations did UNICEF make to its Supply Chain area of work?

A key role in the response: As a key actor in the health dimensions of the response, UNICEF's Supply Chain activities had to both meet UNICEF'S commitments under the GHRP and provide HQ, regional and country offices with adequate supplies of health and other equipment. In 2020, as COVID-19 unfolded, all affected countries – whether usually a donor or an aid-receiving government – were competing for supplies, particularly of PPE, on the international market, and particularly from China, itself grappling with the earliest phases of the pandemic and the vast quantities of material needed.

For UNICEF, this involved large-scale procurement arrangements of PPE, test kits (diagnostics) and related therapeutic support (such as hospital beds, oxygen concentrators and ventilators). Such procurement took place through UNICEF's central Supply Division in Copenhagen, to supply UNICEF's country and regional offices, and through UNICEF's own regional and country procurement systems.

A centralized approach using adapted procedures: Following challenges reported by country offices in accessing sufficient supplies, UNICEF's Supply Division decided to support the response through its centralized approach and to work on global sourcing for direct procurement and delivery – in part to ensure availability and in part to ensure the quality of PPE in particular. It undertook some major adaptations early in the response, by March 2021. These included:

- Use of Special Contracting procedures to expedite processes and payments.
- Deployment of financing tools to make advance payments or firm commitments to suppliers.
- Development and use of a Joint Tender for PPE purchase with other UN agencies.
- Use of a Warehouse budget to finance pre-positioning of PPE and other supplies such as therapeutics.
- Creation of additional warehouse space to pre-position PPE supplies, through private sector partnerships which provided UNICEF with 50,000 additional cubic metres of warehousing space in Dubai, and facilities supplied in Denmark.

- Creation of logistics partnerships to support timely delivery.
- Decentralizing some stocks for regular programmes from Copenhagen to supply hubs in Accra, Dubai, Panama City and Shanghai.[168]

Responding to national requests: As the pandemic proceeded, UNICEF also diversified its supplier base, by looking to diversify manufacturing in some countries, and in others seeking out new local partnerships to produce key products such as 'Blue Soap' to support hygiene practice in Burundi. It also provided supply chain and logistics support to governments, where requested, as, for example, in Haiti,[169] and supported cold-chain infrastructure strengthening in 70 countries throughout 2021; 850 million syringes were also delivered in 2021, to 92 countries.[170]

System-wide approaches: At inter-agency level, UNICEF also participated in the WHO-led COVID-19 Supply Chain System which arose from a March 2020 UN Secretary General order for all UN agencies to collaborate on pandemic response. As part of this mechanism, UNICEF and other agencies collaborated on a joint tender for PPE procurement. Although this process met challenges, notably linked to forming agreements within an inter-agency coordination process, as of March 2022, 58 countries (and UNICEF warehouses) had been provided with US$14.8 million worth of PPE, procured through purchase orders issued by six agencies.[171] UNICEF also established the ACT-A Supplies Financing Facility, a pooled fund aiming to support low- and middle-income countries' access to immunization-related supplies, COVID-19 diagnostics, and COVID-19 therapeutics. The fund had raised US$1.24 billion against a target of US$2.465 billion by 23 September 2022.[172]

Challenges of centralization: The centralized model aimed at maximizing efficiencies of scale and ensuring a harmonized approach. However, given globally constrained supply chains and the effective shutdown of most transport routes, UNICEF's supply function encountered some major challenges.

168 UNICEF, *Supply Division COVID-19 Internal Review and Lessons Learned Exercise*, Synthesis Report, 2021.
169 UNICEF, *Country Office Annual Report 2020: Haiti,* page 3, 2020.
170 UNICEF, *Supply Chain Annual Report,* 2021.
171 IOM, PAHO, UNDP, UNFPA, UNICEF, UNOPS. Personal Communication, E-mail dated 19 April 2022 from Supply Division.
172 https://www.unicef.org/supply/unicefs-act-supplies-financing-facility

Firstly, under the Core Commitments to Children in Humanitarian Action, UNICEF retains a stockpile of items in its Copenhagen warehouse sufficient to address the needs of a population of 250,000 for three months. The scale of the COVID-19 response requirements dwarfed these available supplies. Secondly, logistical delays or difficulties related to the quality of deliverables offered by suppliers impacted the timeliness (see section 2.2.v), quality and coverage of the response in some countries. Thirdly, these difficulties with procurement timeline estimates were compounded by limited visibility to manufacturing pipeline and capacity issues. Country offices reported that procurement time estimates were not always transparently communicated internally, which limited their ability to share accurate timelines with national and government partners. In some cases, negotiations and agreements reached at HQ level were not clearly communicated to agencies in-country, creating confusion and delays.[173]

These challenges are reflected in UNICEF's own reporting of Supply Chain results; in 2020–2021, on-time deliveries were 68 per cent of the total, compared to 84 per cent in 2019.[174]

Reputational risk incurred: Despite the centralized approach providing availability and quality of supplies, delays in their provision (particularly PPE) created reputational risk. Some donors turned to other UN entities, such as the United Nations Development Programme (UNDP) and United Nations Office for Project Services (UNOPS), which they felt had quicker systems to source supplies and charter flights for their delivery. Some UNICEF country offices reverted to local procurement measures, even before a local procurement directive was issued.[175] In South Asia, for example, UNICEF's country offices felt that other UN agencies had more latitude, agility and creativity to meet the challenges through direct procurement from countries. In Peru, staff felt that it would have been faster and cheaper to procure PPE nationally.[176] There

173 UNICEF, *Real-Time Assessment of the UNICEF Response to COVID-19: Global Synthesis Report*, 2021, triangulated with UNICEF, *Supply Division COVID-19 Internal Review and Lessons Learned Exercise*, Synthesis Report, 2021, and interviews with HQ staff, March 2022.

174 Data supplied by Supply Chain Division, April 2022.

175 UNICEF, *Real-Time Assessment of the UNICEF Response to COVID-19: Global Synthesis Report*, 2021, triangulated with UNICEF, *Supply Division COVID-19 Internal Review and Lessons Learned Exercise*, Synthesis Report, 2021, and interviews with HQ staff, March 2022.

176 Interviews with 17 CO staff (April 2022).

were calls for UNICEF to take steps to review its arrangements for ensuring effective supplies and logistics arrangements so that a more flexible, responsive and less centralized approach can be adopted in the future.[177]

2.2.iv How well did UNICEF adapt its advocacy to respond to COVID-19?

Corporately uncertain positions in the initial period: The early phase of internal debate on UNICEF positioning within the COVID-19 crisis (see section 2.1) meant that some of UNICEF's advocacy positions – for example, regarding the effects of the crisis on child poverty, or maintaining schools open – were uncertain. In this period, the predominantly health-flavoured corporate narrative constrained focused advocacy on the wider dimensions of the crisis.

Gaining momentum over time: After June 2020, UNICEF's external advocacy positions began to consolidate, reflecting the internal clarification of its strategic positioning in the crisis. Here, UNICEF's existing networks and engagement within the international system provided valuable entry points. Examples include:

- Work with the Global Alliance for Child Protection on issues such as children in detention, and children in religious institutions from May 2020.
- Working with the World Bank, UNESCO, UNHCR and WFP to develop a framework for re-opening schools (UNICEF-led), from June 2020.
- From 2021, playing a lead role in vaccine advocacy within the COVAX facility.

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177 UNICEF, *Real-Time Assessment of the UNICEF South Asia Response to COVID-19,* January 2021.

Notable successes were achieved in vaccine advocacy through the COVAX facility in 2021; its clear statement on the re-opening of schools from April 2020; and its lobbying for the release of children in detention from July 2020, all of which generated significant results (see section 2.4). It also prioritized the mental health dimensions of the pandemic, as its external Twitter communications reflect (see Figure 13):


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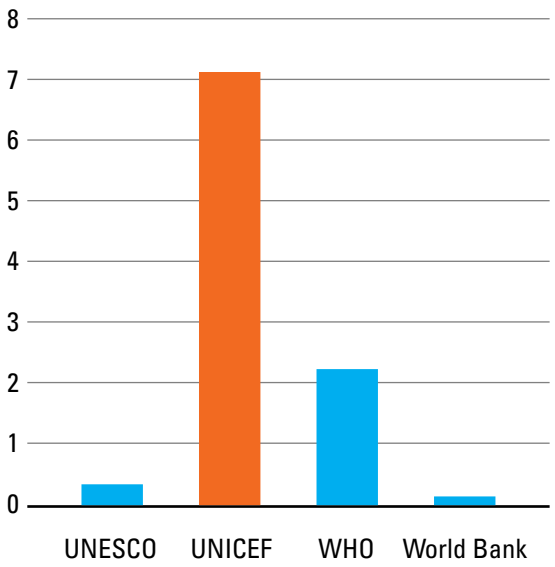
FIGURE 13

Number of references to mental health per 100 tweets (based on the last 3,200 tweets of official accounts)



Source: Evaluation team, generated from comparative analysis of Twitter accounts[178]

Upscaling advocacy at national level: At national level, UNICEF's reputational capital and existing entry points with government provided fertile ground for strong advocacy. Country examples include (see Box 8):

178 Generated by (1) measuring the salience of a series of words related to mental health (depression, mental health, mental well-being, suicide) in the last 3,200 tweets of the official account of UNICEF (as per 24 June 2022) and (2) comparing the last 3,200 tweets produced by other relevant cooperation bodies (UNESCO, WHO, the World Bank).

BOX 8
Country and regional level advocacy

- In **Kenya**, advocating for the government to maintain its focus on essential services during the COVID-19 response, to safeguard against the erosion of gains made in health and nutrition.
- In **Kazakhstan**, advocating on safe school re-opening and supporting the Ministries of Education and Health in introducing new guidelines for school-related public health.
- In **El Salvador**, co-hosting a 2021 Public Policies Week as a platform to present evidence of the impacts of COVID-19 on school achievements and developmental milestones.
- In **Mongolia**, advocating for flexible working arrangements for parents to enable them to take care of their children when the schools were shut down (January to August 2020). Advocating with government to top up the child grant programme, resulting in extra cash to all 1.3 million children from April to December 2020.
- In **Brazil**, engaging with the five largest telecommunication companies in Brazil, Congress and the Minister of Telecommunications to increase school connectivity and provide free broadband to students and the most vulnerable groups. The Brazilian Federal Senate approved a landmark bill to allocate US$270 million for this purpose.
- In **Argentina**, advocating successfully to increase the number of children and adolescents incorporated into the social protection system and to integrate some key services (e.g., Sexual and Reproductive Health) into the Social Protection catalogue of essential rights and services during the pandemic.
- In **Afghanistan**, UNICEF advocacy resulted in the Humanitarian Response Plan highlighting the need to link social protection to humanitarian response to ensure complementarity and minimize people at risk from becoming part of the humanitarian caseload.
- In the Democratic People's Republic of Korea (**DPRK**), UNICEF's advocacy with high-level government officials on the importance of joining the COVAX Facility led to the government securing at least 20 per cent of COVID-19 vaccines for 2021.

2.2.v How timely was the response?

UNICEF's Real-Time Assessment of the COVID-19 response found a broadly timely response in all regions, though covered the period only from October 2020 to April 2021.[179] This evaluation finds more mixed performance, though some delays were caused by factors beyond UNICEF's control.

A timely strategic response: The corporate structures and machinery of UNICEF's response to COVID-19 were timely, as per section 2.1. Strategic frameworks, funding appeals and emergency procedures were set in place swiftly. Key supportive factors were:

- The co-location of a UNICEF PHE team staff member within the WHO in Geneva, which provided early access to WHO internal alerts and facilitated corporate escalation.
- The maturity of UNICEF's decentralized structures, which allowed for rapid establishment of well-established oversight and accountability role in emergencies.
- An early funding appeal in the COVID-19 HAC, which was issued in early February 2020, before those of many other agencies.
- The adoption of Emergency Procedures in March 2020, which allowed Country Representatives to make the necessary adjustments to their country programmes.

179 UNICEF, *Real-Time Assessment of the UNICEF Response to COVID-19: Global Synthesis Report*, 2021.

Challenges to timeliness at country level and internal factors: Closer to the ground, however, UNICEF's programmatic response was affected by challenges in the wider context. Most countries experienced at least some delay.[180] Three main internal factors impeded timeliness:

i. The supply chain (see section 2.2.iii), with almost all regions reporting late delivery of supplies due to overburdened supply chains as well as internal UNICEF communication, procurement and transportation issues, and country-level regulatory and logistics challenges.[181] In Peru, for example, UNICEF encountered delays of a year in the provision of PPE for Amazonian communities.

ii. Risk aversion, with UNICEF's Internal Audit function noting in 2020 that "financial controls and practices remained risk averse, which means that certain processes, especially those related to partnerships, are still too heavy to support a swift response."[182]

iii. Perceived burdensome reporting requirements from HQ and a sense of a proliferation of ad-hoc and duplicative coordination mechanisms.[183]

Emergency experience helped to facilitate timeliness: Timeliness was also shaped by country office experience with emergency management and practice, as found by other agencies.[184] Offices with an emergency background had the systems, capacities and culture to adjust rapidly into emergency mode when required. Offices lacking this experience frequently encountered difficulty trying to absorb new ways of working at the same time as adapting to national conditions. Several spoke of "high transaction costs" and "triple burdens" in trying to absorb and assimilate new procedures.[185] Some found that the absorption challenges, along with the large amount of guidance being provided by HQ and regional offices (see page 71), were simply too much to allow them to benefit from the Level 3 procedural simplifications.

180 Of 32 evaluations reporting, 27 noted delays, as did 6 out of 10 desk studies (Greece, Tanzania, Myanmar, Turkey, Sierra Leone, DRC) and 6 out of 7 case studies (Kazakhstan, State of Palestine, Ghana, Laos, Peru, Burundi).

181 Thirty-two evaluations, including *Real-Time Assessment of the UNICEF Response to COVID-19, Global Synthesis Report*, triangulated with desk and case studies; interviews with UNICEF management and staff.

182 UNICEF Office of Internal Audit and Investigations (OIAI), *Advisory Report on UNICEF's Emergency Procedures for COVID-19 Response (Report 2020/A04)*, 22 December 2020.

183 Global RTA, triangulated by interviews with country office staff (March-May 2022).

184 See World Food Programme, *WFP Response to COVID-19*, 2021.

185 Interviews with UNICEF country offices and regional offices, May–June 2022.

These challenges were reflected in an Internal Audit Services survey in 2020, which found that, of 77 per cent of offices which used the emergency procedures, 70 per cent felt that they had contributed to a rapid and effective response, while 30 per cent did not. Factors impeding use included a risk-averse culture, and a lack of prior definition of UNICEF risk tolerance or appetite regarding the utilization and adherence to COVID-19 procedures.[186] The UN Office of Internal Oversight Services (OIOS) recommended that all offices familiarize themselves and use the procedures, to mitigate the risk of slow and ineffective delivery in emergency contexts.[187]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Emergency-focused offices also had strong preparedness measures in place, and in many cases had been able to implement pre-emptive actions through existing systems and procedures. In Burundi, for example, where UNICEF anticipated shortages of PPE and testing kits, the office proceeded to secure stocks well in advance. In Pakistan, a simulation of the Business Continuity Plan helped to support very swift pivoting and adaptation. In Lao PDR – which had faced a flooding crisis in 2018 – emergency preparedness plans were in place and ready for use: "The staff knew what the priorities were, who needed to be in the office and who needed to stay at home."[188]

Systemic supporting factors: Evidence finds a set of systemic factors which supported adaptive capacity, and therefore timeliness (see Box 9).

186 UNICEF OIAI, *Advisory Report on UNICEF's Emergency Procedures for COVID-19 Response (Report 2020/A04)*, 22 December 2020.
187 Ibid.
188 Interviews with country office staff.

BOX 9
Factors supporting timeliness

- Flexible working systems alongside prior investment in IT systems, which supported the transition to remote working.
- Pre-existing relationships with government and donors, with trust already in place allowing access and leverage – with relationships not needing to be built anew.[189]
- Pre-existing Programme Cooperation Agreements with national and international NGOs and Long-Term Agreements (LTA) with suppliers, which facilitated rapid programmatic action.
- Entry points into multiple line ministries.
- Flexibility to adapt and re-prioritize development programming (and funding) to meet the needs of the COVID-19 response.
- Flexibility in support systems, e.g., human resources, finance, supply and reporting functions.
- Existing partnerships with the private sector, e.g., for procurement of supplies.
- Strong relationships with local implementing partners.
- Previous investment in IT systems and remote working tools.
- UNICEF's ability to leverage TV, social media and other mechanisms to convey messages and communications.
- Prior engagement in systems-strengthening work.

Source: Drawn from evaluations and desk/case study evidence

189 UNICEF, *Real-Time Assessment of the UNICEF Response to COVID-19: Global Synthesis Report*, 2021.

At country level, staff in Kazakhstan and Lao PDR described some common factors which supported a timely response (see Box 10).

BOX 10
Timeliness in Kazakhstan and Lao PDR

- Strong internal communications with staff.
- Strong leadership that could actually facilitate the repositioning and reprioritization within the programme.
- Ability to shift to online service provision via investment in IT.
- Cross-learning from other country offices.
- Swift hiring of consultants due to the Level 3 CEAP procedures.
- UNICEF convening power to engage with partnership such as NGOs.

Regional engagement supporting timeliness: Regional offices provided support for operational pivots,[190] reflective of UNICEF's mature decentralization (see page 45). Aspects of support included:

- Resource mobilization including proposal development.
- Technical support, including with surge deployments where available.
- Equipment supply, e.g., PPE and oxygen.
- Technical advice including missions and surge deployments.
- Facilitating information sharing within regions.

190 Based on 19 evaluations, 3 case studies (Burundi, Peru, Pakistan), 3 desk studies (DRC, Sierra Leone, Niger).

BOX 11

Regional office support to Peru Country Office

In Peru, the Latin America and Caribbean Regional Office (LACRO) provided support in:

- Country HAC drafting and monitoring, including the regional alignment of indicators.
- Providing additional funds through regional HACs and the COVAX facility.
- Promoting information and good practice sharing, for example, on COVID-19 in schools and cash transfers across countries.
- Facilitating meetings between policymakers from different countries.

Where UNICEF had been able to pivot swiftly, it was, in turn, able to support national efficiency, as, for example, in Burundi, where it helped to establish a website to support the booking of online vaccine appointments and certification.

2.2.vi How well did UNICEF monitor and learn from its experience during COVID-19?

Mature monitoring and evaluation systems: UNICEF has comparatively mature monitoring and evaluation systems, with a well-established process for corporate monitoring through internal databases, which employ a set of standard indicators. It has a robust mechanism to ensure quality country data feed into corporate reporting processes.[191] Its evaluation function was assessed in 2021 as "strong…with a high degree of independence and a robust system in place to ensure the quality of its evaluations."[192]

Efforts at ongoing data capture but operational challenges: In June 2020, UNICEF launched a set of 32 corporate indicators

191 MOPAN, *Assessment of UNICEF*, 2021.
192 Ibid.

(reduced from an initial 400) on which country offices were requested to report.[193] These were collected in an online database, to enable performance and situation reporting to stakeholders in close to real time. While laudable in intent, data gathering under pandemic conditions proved challenging. Country offices struggled to report against a perceived 'new' set of indicators while grappling with emergency conditions, and the indicators became wrapped into the perceived 'heavy burden' of reporting requirements from HQ (see page 87). They were variably understood and applied by country level staff,[194] and, in their quantitative nature, could not consider aspects such as programme quality. The resulting data provided a valuable information base, therefore, but could not allow UNICEF to report comprehensively on its performance.

Standard monitoring procedures under strain: Under COVID-19 conditions, sustaining even standard monitoring procedures proved challenging. Difficulties included access restrictions arising from lockdown conditions, funding gaps, the need to divert human resources from the monitoring function to the immediate programmatic response, and gaps in receiving information from national partners.[195] As well as remote mechanisms (see page 65), existing partnerships helped to facilitate continuation. For example, in the Sudan, UNICEF's partnerships with the Central Bureau of Statistics and the Ministry of Education helped to support joint monitoring activities.[196] Where country offices were part of wider inter-agency monitoring mechanisms, such as in Somalia, these were found to largely continue even under pandemic conditions, though with greater reliance on implementing partners.[197]

Participation in wider UN monitoring platforms: UNICEF was also a significant contributor to wider UN attempts to generate monitoring data on the system-wide response. The most notable were those for the Global Humanitarian Response Plan (GHRP), for the UN's immediate socio-economic response plan for COVID-19, and a linked database for the latter.

193 UNICEF, 'COVID-19 Programme Monitoring and Analysis Framework', 18 June 2020.
194 Interviews with country office and HQ staff.
195 At least 32 out of 61 evaluations reported difficulties, with case and desk studies finding similarly.
196 Sudan desk study.
197 UNICEF Somalia, *Country Office Annual Report 2020*, 2020.

The considerable proliferation of these systems during 2020 and into 2021 placed a strain on UNICEF's own internal systems management, as it tried to harmonize its own indicators and data gathering – itself meeting the contextual challenges above – with those being generated by the wider UN system.

Evaluation: UNICEF's evaluation function also faced the challenges of lockdowns and access constraints. Nine evaluations were suspended during 2020 and 2021, while five were placed on hold and 214 at least partially delayed.[198] UNICEF issued guidance stressing the importance of the evaluation function, and the associated evidence agenda, remaining 'open for business' during the crisis. The guidance advocated the use of remote (virtual) methods, using secondary evidence where feasible, and stressed that de-emphasizing evaluative work in other ongoing emergencies was simply not an option.[199]

At the same time, UNICEF launched a set of major exercises to generate learning from the pandemic in as close to real time as feasible. These included:

- The Real-Time Assessment of UNICEF's COVID-19 response, which generated a set of regional-level reports and in some cases a focus on country narratives and a subsequent Global Synthesis Report, was issued in June 2021.
- Corporate COVID-19 learning evaluation, conducted from May 2020 to February 2021, which covered areas of operations (e.g., supply, communications and advocacy, programming, human resources, monitoring and reporting, coordination, resource mobilization, and partnerships) as well as strategy and technical response.
- A Programme Effectiveness Report, generated from monitoring data in April 2021, which provided an overview of UNICEF's programmatic reach and likely contributions to priority outcomes related to the COVID-19 pandemic based on early monitoring evidence.
- Supply Division commissioned a series of lesson learning reviews which provided lessons on various aspects and processes of the Supply Division response.[200]

198 Figures supplied by UNICEF Evaluation Office, June 2022.
199 UNICEF, *Response of the UNICEF Evaluation Function to the COVID-19 crisis,* Technical Note, 30 March 2020.
200 UNICEF, *Lessons Learned from UNICEF's Supply Division: Supply Division's Response to COVID-19. Response Tier 1: Protecting SD Staff and maintaining regular supply operations.* Lessons Learned Report Series, Undated.

- Reviews and internal assessments of, e.g., UNICEF's Human Resource Special Measures and its use of emergency procedures for COVID-19.[201]

UNICEF and a learning culture: The volume of these evaluations and reviews was high, particularly at a time of considerable burden on country and regional offices. Nonetheless, their generation provided valuable insights into UNICEF's ongoing programmatic performance, as well as an opportunity for country and regional offices to learn from their ongoing performance. They help to validate UNICEF's articulated aim of a learning culture.[202]

201 UNICEF, *Review of UNICEF's COVID-19 HR Special Measures: Humans who helped humans, March 2021*, Draft 19 April 2022; UNICEF, *Advisory Report on UNICEF's Emergency Procedures for COVID-19 Response,* Report 2020/A04, 22 December 2020.

202 UNICEF, *Evaluation Policy,* 2018.

2.3 How well did UNICEF engage in partnership in the global response to COVID-19?

SUMMARY

UNICEF played a critical role in the global response to COVID-19, with contributions directed via the GHRP, the UN Socio-Economic Response Framework and ACT-A, including COVAX. UNICEF's at-scale response rendered it an essential partner, though some global-level relationships, particularly on vaccine delivery, remain challenged. External partners also perceived UNICEF's COVID-19 response in 2022 to be largely focused on vaccine delivery. At country level, relationships were more positive, and UNICEF played a central role in vaccine delivery and supporting preparedness at national level.

Development and humanitarian citizenship: The global scale of the pandemic required collective international action. As an agency with both some key comparative advantages to the international response and a high external profile, UNICEF needed to position itself strategically at both country and global levels.

Global contributions: UNICEF's multi-sectoral role and the scale of its activity located it as a central player in the plethora of coordination forums for the international response to COVID-19. As well as participating in the UN's Crisis Management Team, the Inter-Agency Steering Committee (IASC) functions for the response and the cluster system, where it (co-) leads the Education, WASH, and Nutrition clusters and the Child Protection Area of Responsibility. In 2020, it performed a central role within the UN OCHA-coordinated GHRP, the Supply-Chain Platforms for procurement and delivery of Therapeutics, PPE and Diagnostics and the UN's Socio-Economic Response Framework. From 2021 (and following lobbying for its engagement), it gained formal involvement in the governance structures of the ACT-A partnership and specifically the COVAX (vaccine access) pillar and health system and response connector. It was also closely involved in, and leading, many sector-specific collaborative forums such as the Global Alliance for Child Protection. Table 9 provides key areas of contribution to the first three of these.

TABLE 9

UNICEF contributions to global coordination response mechanisms

SYSTEM-WIDE PLAN	UNICEF ROLES AND CONTRIBUTIONS
GHRP • Public health response • Continuity of services • Cluster/sector coordination	• Sustaining public health services, including immunization campaigns and procurement of health supplies, maternal and child health and nutrition (MCHN) support • RCCE Collective Service • Education, WASH, social services, social protection, child poverty and socio-economic support • Vaccine preparedness and delivery • Leadership of education, WASH and nutrition clusters, and Child Protection Area of Responsibility
UN Socio-Economic Response Framework • Protecting health services and systems • Social protection and basic services • Social cohesion and community resilience	• Sustaining public health services, including immunization campaigns and procurement of health supplies, MCHN support • RCCE • Education, WASH, social services, social protection, child poverty and socio-economic support • Resilience activities at community level (livelihoods, social protection, etc)
ACT-A (COVAX)	• Procurement of vaccines and immunization supplies, diagnostics, treatments (medicines and oxygen), and PPE • Logistics, supply chain and storage • Country preparedness and readiness • Supporting rollout, including but not limited to RCCE

Partnerships and relationships variable at global level: At global level, not all relationships ran smoothly. Many of UNICEF's global partners praised its responsiveness and supportive approaches, particularly in areas such as social protection, health campaigns and education.[203] Cluster partners spoke positively of UNICEF's leadership, particularly in education and WASH, praising its proactive and supportive

203 Interviews with 12 UNICEF partners at global level.

approach, reflective of positive evaluation findings on its Cluster Lead Agency role.[204] UNICEF's well-established relationships with WHO through the PHE/EMOPS function provided a valuable flow of information and sustained cooperation, facilitated through established working practices by the time the pandemic began.

However, two issues arose with corporate-level external partnerships. Firstly, with COVID-19 concerns mainstreamed into HACs from 2021, and UNICEF's parallel ACT-A management structure (and its attendant staffing and resources) being focused on COVAX, external stakeholders perceived that UNICEF's COVID-19 response in 2022 was largely focused on vaccination. Stakeholders involved in the wider international COVID-19 response spoke of UNICEF becoming 'quiet' on COVID-19 from late 2021, and of struggles to generate wider engagement beyond vaccination.[205] Internally, stakeholders spoke of challenges to communicate a 'whole of UNICEF' response externally.[206]

Secondly, relationships on the humanitarian elements of the global response came under strain, mainly related to vaccine delivery. Here, territorial issues came into play. While UNICEF unquestionably holds the greatest UN expertise and capacity in vaccine supply chains, and particularly cold chain systems, concern arose that its determination to 'hold on' to this area of work, even despite offers of support from other agencies, was coming at a cost to delivery – and thus, the provision of vaccines to countries and people in need. UNICEF's hesitation here, and the proactive nature of other agencies challenging this area, reflects a clear mindset difference. For UNICEF, the critical rationale lay in its long-standing expertise and experience, and its mandated role within the international system. For some other agencies, the concern was less systemic than pragmatic, with the needs of affected populations, and humanitarian outcomes, to the fore.[207]

Tensions here continue unresolved. While conscious of its powerful role within the humanitarian system – and its centrality in

204 See, for example, UNICEF, *Evaluation of the UNICEF Role as Cluster Lead (Co-Lead) Agency (CLARE II),* which found that "The response to the COVID-19 pandemic has been a 'stress test' for the clusters, which they have passed, thanks to adjustments in the ways of working, the specific guidance materials produced and the resources mobilized.", 2022.

205 Interviews with 12 UNICEF partners at global level.

206 Interviews with internal UNICEF staff and management.

207 Ibid.

delivering essential support to millions – vaccine delivery is one area where individual agency mandates, at a time of pressure, trumped collectivity and collaboration. Work is still needed here to transcend boundaries, to overcome territorial concerns, and to place the greater good to the fore of international action.

Positive UN partnerships at country level: Overall, evidence finds mostly positive UN partnerships at country level, including UNICEF's role in cluster coordination mechanisms where activated, as well as in wider country coordination forums. All 37 evaluations reporting reflected the findings of the Real-Time Assessment that "partners repeatedly recorded generally 'positive' or 'very positive' experiences in their partnership with UNICEF across regions."[208] The key areas identified were (i) cluster and other coordination structure engagement, (ii) joint advocacy, (iii) joint strategy and programming preparation, and (iv) vaccine support. Table 10 provides examples of UNICEF's partnership engagement in these areas.

TABLE 10

Country level coordination and partnership

UN SECTORAL AND CLUSTER COORDINATION AND LEADERSHIP
• In Zimbabwe, UNICEF convened bi-weekly meetings to enhance the coordination of the national response to the effects of COVID-19 in the education sector. It also led the Child Protection Sub-Cluster, developing and implementing a COVID-19 response plan, and trained UNICEF-led clusters on GBV in emergencies risk mitigation. • In Somalia, UNICEF played a key role in the Inter-Cluster Coordination Group, which commissioned an analysis in 2020 of those at most risk of being left behind during the COVID-19 pandemic. • In Tanzania, UNICEF chaired the Development Partners Group – Health, tasked to ensure continuity of primary health services during the pandemic.

208 Oxford Policy Management, *Real-Time Assessment of UNICEF's Response to the COVID-19 Pandemic*, 2021.

- In Pakistan, UNICEF co-chaired the IPC-WASH Sector working group with the government, convening 70 partners to develop and roll out the COVID-19 response plan in the country.
- In the MENA region, UNICEF convened agencies to carry out a pre-emptive bundling response, so that vulnerable populations received supplies, e.g., WASH supplies, along with other agency delivery. For example, in Syria and Sudan, populations received soap along with WFP food rations.

JOINT ADVOCACY

- In Lao PDR, UNICEF partnered with the International Labour Organization (ILO) and United Nations Capital Development Fund (UNCDF) to develop a UN position paper on a shock responsive social protection system to help reduce the impact of the pandemic on the population.
- In Peru, UNICEF led the 'Coalición por la Educación' (Coalition for Education) which successfully advocated for schools re-opening in the country.
- In Kazakhstan, UNICEF led the COVID-19 UN Communication Group and supported UN COVID-19 monitoring with daily media monitoring reports disseminated to the UN Country Team.

JOINT STRATEGIZING/PLANNING/PROGRAMMING

- In Yemen, UNICEF worked with the WFP, the World Bank and Save the Children to generate a US$153 million 'Restoring Education and Learning' project, as well as a joint Back-to-Learning framework.
- In Uzbekistan, UNICEF worked with the United Nations Population Fund (UNFPA) and United Nations Office on Drugs and Crime (UNODC) to generate a joint programme for adolescents and young people to help mitigate the negative consequences of COVID-19 in the Republic of Karakalpak.
- In Cambodia, under the Multi-Partner Trust Fund for COVID-19, UNICEF formed a partnership with IOM, UNFPA and WHO to protect around 200,000 returning migrants and host communities from the risk of large-scale transmission of COVID-19, and to provide essential socio-economic services.
- In DPRK, UNICEF and WHO extensively cooperated on the successful application of the Cold Chain Equipment Optimization Platform.

Partnerships with national governments: Relationships with national governments were mostly positive along the different dimensions of the response.[209] UNICEF's multi-sectoral nature provided a strong comparative advantage, in that (i) in many countries, it had established entry points across a range of government departments and units, and (ii) working across multiple sectors made it a critical partner for many governments.

Central role in vaccination rollout in many countries: UNICEF played an extensive role across the spectrum of vaccine-related issues in countries, fulfilling a range of functions in support of government, including supply and logistics (cold chain, development and rollout of national COVID-19 vaccination plans, and demand generation). Examples are shown in Box 12.

BOX 12
Support for vaccination at country level

- In the **ESARO region**, UNICEF engaged in all areas of vaccine management, including the provision of staff to increase capacity for new vaccine rollout; equity in planning for vaccine targeting; support for service delivery, planning and coordination; promotion of vaccine demand and support for addressing misinformation and rumours management; and support for continuity of essential health services including routine immunization even while conducting the COVID-19 vaccine rollout.
- In **Uzbekistan**, UNICEF worked to improve the cold chain system and implement demand generation and community engagement for COVID-19 vaccines, and supported the development of Uzbekistan's national vaccine deployment plan.
- In **Haiti**, UNICEF collaborated with the government in developing a plan aimed at vaccinating 62 per cent of the total population, and provided logistical and financial support for the distribution of vaccines and the preparation and implementation of vaccination.

209 61 evaluations reporting, 21 desk studies and 7 case studies.

- In **Nepal**, as COVAX implementing partner, UNICEF delivered the majority of all 40 million COVID-19 vaccines.
- In **El Salvador**, UNICEF, Pan American Health Organization (PAHO) and WHO provided technical and financial support to implement the national COVID-19 vaccination programme, supporting the vaccination registry, targeted C4D initiatives to promote prevention measures and vaccination, strengthening the vaccination cold chain and helping to monitor vaccination coverage.
- In **Lao PDR**, UNICEF supported the establishment and regular convening of a high-level COVAX partner forum, facilitating information sharing and joint advocacy.
- In **Kazakhstan**, in partnership with WHO and the Ministry of Health, UNICEF launched a country-wide COVID-19 vaccine demand generation campaign.
- In **Burundi**, UNICEF helped the government to develop an electronic platform for COVID-19 testing and vaccination.

However, some evaluations[210] found evidence that, in the area of supply chain and procurement particularly, UNICEF's attempts at speed undermined the scope for consultation with government. The Real-Time Assessment of the South Asia Response to COVID-19 reports, for example, that: "In some cases the urgency to prepare… proposals [for procurement] came at the expense of consultations with Governments and other stakeholders."

UNICEF also provided support to national authorities in seven other main areas of their COVID-19 responses, as per Table 11. All were positively assessed by evaluations as relevant and useful interventions.

210 Sixteen evaluations reporting.

TABLE 11

Support to national authorities

SUPPORTING NATIONAL DATA PRODUCTION/NEEDS ASSESSMENTS UNDER COVID-19

- In Zimbabwe, UNICEF worked with the Zimbabwe National Statistical Agency to conduct household surveys of the effects of COVID-19 on the population. This helped to influence policy decisions and government allocation of social sector spending.

SUPPORTING GOVERNMENT RCCE STRATEGIES

- In Iraq, UNICEF coordinated and led the UN COVID-19 RCCE plan, in partnership with the Federal Ministry of Health and UN partners.
- In the State of Palestine, the Ministry of Health, WHO and UNICEF co-led the COVID-19 RCCE taskforce, whose messages reached an estimated 4 million people.
- In Nepal, UNICEF initiated and co-led the government's Crisis Media Hub and developed more than 500 multi-media assets, shared across government and RCCE member channels.

HELPING TO DEVELOP NATIONAL COVID-19 RESPONSE PLANS

- In Tanzania, UNICEF and partners supported the government to develop and implement the National COVID-19 Response Plan.
- In Somalia, UNICEF supported the Ministry of Education in the development of the 'COVID-19 Education Response' and Safe-School re-opening plans.
- In Myanmar, UNICEF supported the development of the Ministry of Education's COVID-19 response and recovery plan, in collaboration with other partners, and a State-level response in Shan state and resource mobilization plan.
- In Bangladesh, UNICEF supported the government to implement the Bangladesh Preparedness and Response Plan for COVID-19.

DEVELOPING GUIDANCE WITH MINISTRY PARTNERS

- In Peru, UNICEF co-drafted protocols for schools' re-opening.
- In Malawi, UNICEF supported the development of business continuity plans for all five water boards in the country, to help sustain continuity of service during COVID-19.
- In Ghana, UNICEF supported the Ghana Health Service with the development of food and nutrition guidelines for COVID-19 Isolation Centres.
- In Pakistan, UNICEF supported the rollout of standard operating procedures, guidelines and training manuals for safe school operations.

SUPPORTING NATIONAL MENTAL HEALTH SERVICES

- In Kazakhstan, UNICEF partnered with key government ministries and the Citibank Foundation to train school and kindergarten psychologists to provide remote psychological support to families and adolescents experiencing the effects of COVID-19.
- In Cambodia, UNICEF provided television and radio spots and videos to support information campaigns by the Ministry of Health.

CAPACITY STRENGTHENING/TECHNICAL ASSISTANCE

- In Iraq, UNICEF, along with WHO, helped the national authorities to develop a series of trainings on COVID-19 and IPC for health workers.
- In Colombia, UNICEF provided technical assistance to seven public health institutions to adapt interventions to the COVID-19 context in the provision of primary healthcare.
- In Kazakhstan, UNICEF trained over 900 education/health professionals on safe school re-openings, building resilient school systems, and ensuring inclusion.
- In Malawi, UNICEF built the capacity of ward and city councils for the COVID-19 Urban Cash Initiative (CUCI) in Zomba and Mzuzu districts.

SUPPORTING NATIONAL EFFORTS AT DIGITALIZATION IN SUPPORT OF SERVICE DELIVERY

- In El Salvador, UNICEF created virtual and hybrid accelerated education modalities to prevent dropout and facilitate the reintegration of excluded students into the education system, including returnee and displaced children, victims of violence, children from rural areas and pregnant adolescents.[211]
- In Colombia, UNICEF developed support groups on WhatsApp and Facebook to share key messages on the prevention of COVID-19, psychosocial care, health and nutrition care, and activation of GBV and child protection protocols.

Supporting national preparedness planning: In some contexts, UNICEF helped to strengthen national governments' preparedness and response actions. Only eight evaluations report on this, but all found positively, along with nine desk and four case studies.[212] Areas of support and country examples included are shown in Table 12.

211 UNICEF El Salvador, *Country Office Annual Report 2021*, 2021.
212 Cambodia, Tanzania, Somalia, Zimbabwe, Myanmar, Ghana, DPRK, Iraq, Yemen, Niger, Peru, Burundi, Kazakhstan.

TABLE 12

Supporting national preparedness planning

AREAS OF SUPPORT	COUNTRY EXAMPLES
• Social protection system strengthening • WASH and health systems strengthening/delivery • RCCE planning and delivery • Child protection preparedness • Health and nutrition guidelines/technical support	• In Tanzania, UNICEF worked with UN agencies and other government and development partners to support COVID-19 preparedness and response efforts, with a particular focus on supporting the continuation of essential health services. • In Zimbabwe, UNICEF trained 81 government officials on emergency preparedness and 51 on information management to improve national capacity for preparedness planning. • In Namibia, UNICEF supported community engagement and systems strengthening in four priority regions to build preparedness to contain the spread of COVID-19 and minimize loss of life.

Evaluations and reviews identified some institutional comparative advantages that positioned UNICEF well for partnership work during COVID-19 (see Box 13).

BOX 13

Comparative advantages

- Organizational credibility and recognition by partners (reputational capital).
- Convening power.
- Ability to second UNICEF staff to be embedded during key ministries during the response.
- Existing partnerships which helped to facilitate entry points to governments and others.
- Cross-sectoral ethos and ability to apply in practice.

Implementing partners – Expanded co-operation: UNICEF's engagement with its implementing partners intensified under the pandemic conditions, recognizing the dependency on them for the delivery of the response.[213] Evaluations found that UNICEF expanded its implementing partnerships during COVID-19, notably with the private sector and civil society organizations. These expanded partnerships supported the delivery of the response and enabled UNICEF to expand its working modalities for response delivery, including through new technologies, shown in Table 13.

TABLE 13

Cooperation with implementing partners

AREAS OF SUPPORT	COUNTRY EXAMPLES
PRIVATE SECTOR PARTNERS	
Restaurant associations Technology companies Telecoms providers Media companies – TV/radio	• **Sudan** – Partnerships with TV and radio stations enabled children's access to virtual lessons and learning opportunities. • **Colombia** – New corporate partners include Google and Baxter. • **Burundi** – UNICEF contracted with Burundi's biggest private soap manufacturer to produce 10 million bars of 'Blue Soap' per month. • **Iraq** – Partnership with Zain, a major telecoms service provider, allowed Wi-Fi devices and annual subscriptions to be provided for all COVID-19 vaccination service delivery points, health districts and provincial vaccine stores. • **Myanmar** – UNICEF built partnerships with celebrities and influencers to target young people with COVID-19 messaging.

213 37 evaluations, along with 17 desk studies (Somalia, Zimbabwe, Turkey, DRC, Niger, Iraq, Yemen, Sudan, Iraq, Afghanistan, Bangladesh, Uzbekistan, Tanzania, Cambodia, Colombia, DPRK, El Salvador and Haiti) and all 7 case studies.

Local musicians, arts figures, social media influencers Google Baxter Soap manufacturers Diagnostics firms Suppliers of healthcare items, PPE Supermarket chains Insurance companies Banks	• **Peru** – A partnership with a major insurance company facilitated PPE provision. An existing partnership with a bank was adapted to facilitate PPE provision and audio speakers in rural areas for children who could not attend face-to-face classes. • **Tanzania** – Partnership with the Tanzania Women Chamber of Commerce reached 20,000 women entrepreneurs with COVID-19 prevention awareness messages. • **Zimbabwe** – Collaboration with large telecoms providers Econet and TelOne supported COVID-19 information hub access. • **Pakistan** – UNICEF partnered with Unilever to distribute 8,000 bottles of bleach and 140,000 bars of soap to healthcare facilities and supported the creation of educational episodes created by private educational technology partners for the government's national TeleSchool. • **Uzbekistan** – Partnership with a large supermarket chain enabled UNICEF's communication materials to air in 80 stores that serve thousands of customers daily.
CIVIL SOCIETY	
Diaspora Faith groups/religious leaders Local CSOs/CBOs National networks/federations, e.g., of medical staff	• **Burundi** – UNICEF partnered with Interfaith of Burundi to engage religious leaders in the promotion of good behavioural practices regarding COVID-19. • **Myanmar** – UNICEF expanded partnerships with local CSOs to extend WASH assistance for IDPs and prevention of COVID-19 activities in Chin, Kayah, Kayin and Yangon areas. • **Tanzania** – UNICEF amplified its strategic partnerships with key influencer platforms – faith leaders, media, the private sector – to spread COVID-19 prevention and awareness messaging. • **Madagascar** – A public-private partnership between UNICEF and the National Order of Medical Doctors allowed for nearly 150,000 consultations to take place, identifying nearly 9,000 suspected COVID-19 cases. • **Pakistan** – the Pakistan Paediatrics Association collaborated with UNICEF on producing and disseminating training materials on COVID-19.


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Implementing partners interviewed highly valued (i) open communication between themselves and UNICEF, and a sense of being seen as an 'equal partner'; (ii) UNICEF's willingness to support programme adaptation during the pandemic; (iii) UNICEF's forging of links between themselves, governments and other partners as part of the response; (iv) the provision of PPE and other equipment where available/necessary; and (v) in some cases, strong monitoring of products generated by the partnership (though in other cases, partners critiqued 'outsourced' performance monitoring as detrimental to the quality of interventions).[214] Partners felt that the '10 per cent local contribution' requirement from implementing partners had not always been feasible during the pandemic, and stressed the continued need for UNICEF to strengthen its focus on the capacity-building of local actors, particularly those new to UNICEF procedures.

Ownership and strengthening of local partnerships across the response: There is little evidence on how UNICEF strengthened local partnerships as part of the localization agenda.[215] Overall, evidence finds positively, though no missed opportunities are identified. Where local partnerships were strengthened, this normally occurred through UNICEF's convening power (see Box 13) mobilizing sector partners to, for example, work on WASH messaging (as in Haiti) or on the effects of COVID-19 on education, as in El Salvador. In Ethiopia, UNICEF built partnerships among sub-national structures for vaccine rollout.

214 Interviews with 31 implementing partners.

215 Only 14 evaluations, 9 desk studies and 4 case studies (Zimbabwe, Myanmar, El Salvador, Haiti, DRC, Sierra Leone, Turkey, Iraq, Yemen, State of Palestine, Kazakhstan, Lao PDR, Peru). However, UNICEF is helping to define Terms of Reference for a Localisation learning paper in the framework of the Inter-Agency Humanitarian Evaluation on COVID-19 currently (September 2022).

2.4 What did the response achieve for populations in need during COVID-19?

SUMMARY

UNICEF delivered significant and at-scale results during 2020 and 2021 in response to the pandemic. It scaled up extensively in education, MHPSS, RCCE, cash assistance and treatment of malnutrition in 2020, and built on these achievements in 2021. Vaccine delivery expanded greatly in 2021, with nearly 1 billion doses delivered to countries requiring support. UNICEF also made significant contributions under the GHRP in health and other areas. Evaluations identified some areas of programmatic strength, including RCCE, social protection, MHPSS, evidence and data, and health systems strengthening, alongside some which could be enhanced for results achievement, including gender and disability, ensuring a multi-sectoral approach, and working on digital inclusion.

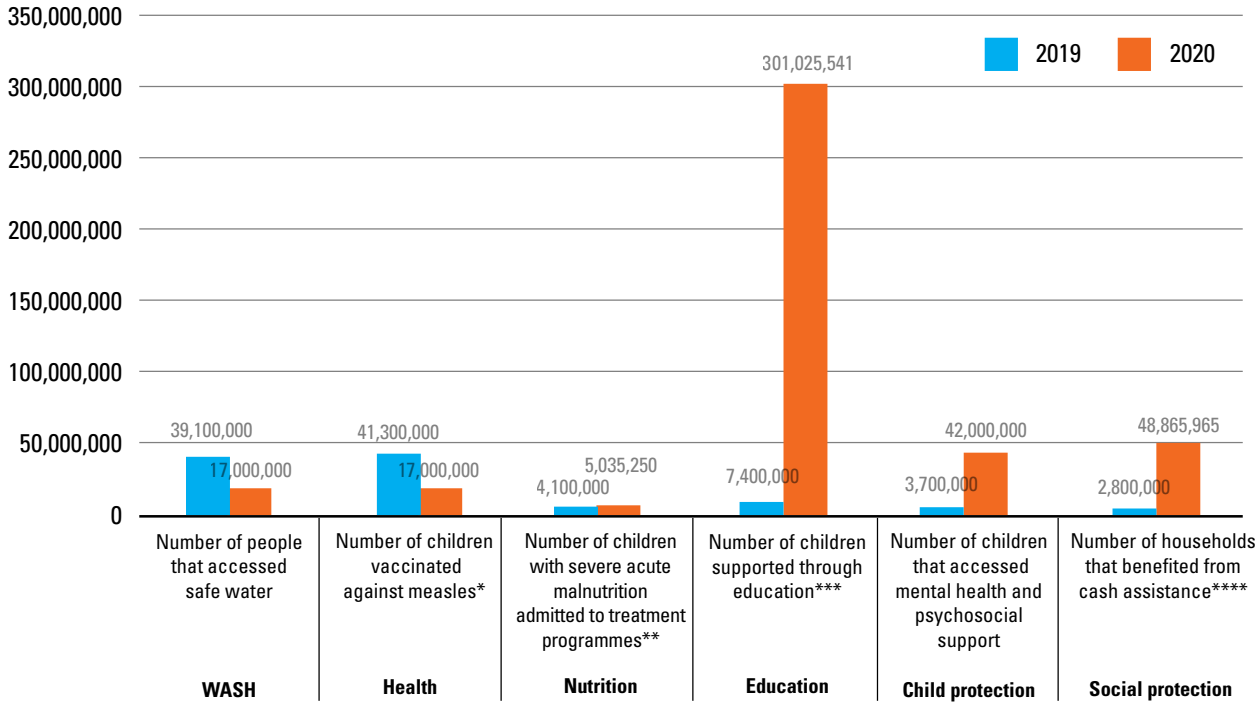
UNICEF's achievements during the response fall into two main categories: (i) meeting the needs of its target populations on the ground, and (ii) supporting the international response to COVID-19.

2.4.i Meeting the needs of its target populations on the ground

The scale-up of UNICEF's response in 2020 to meet the needs of populations is reflected in Figure 14, which shows the extent of scale-up in education, MHPSS, cash assistance and malnutrition treatment. It also indicates a reduction in access to safe water and measles vaccination (potentially due to the shift from community-based WASH supply to facility-based service provision).

FIGURE 14

Comparison of selected key programme indicator results 2019–2020



* Aged 6 months to 15 years in 2019; not specified for 2020.

** Aged 6-59 months in 2020; not specified for 2019.

*** In 2019, the figure represents the number of children that accessed formal or non-formal basic education, including early learning. In 2020, the figure accounts for the number of children supported with distance/home learning.

**** In 2020, this includes 47,109,287 households benefitting from new or additional social assistance measures provided by governments to respond to COVID-19 with UNICEF support.

Source: inSight (COVID-19 SitRep Indicators Dashboard) and UNICEF, 'Responding to COVID-19. UNICEF Annual Report 2020', 2021. Available at: www.unicef.org/publications

Results against the four strategic priorities of the 2020 COVID-19 specific HAC are set out in Table 14 below. Overall, UNICEF met or mostly met its HAC strategic priority targets in three of four areas. No 2020 data were available for Supporting the Access to COVID-19 Tools (ACT) Accelerator partnership.

TABLE 14

Global COVID-19 HAC results

HAC STRATEGIC PRIORITY	PERFORMANCE
1. Supporting the public health response to reduce Coronavirus transmission and mortality.	All targets met except AAP (use of established feedback mechanisms).
2. Continuity of health, HIV, nutrition, education, WASH, child protection, GBV, social protection and other social services; assessing and responding to the immediate socio-economic impacts of the COVID-19 response.	Targets mostly met (above 80%), with four areas of underperformance: • Households benefiting from social assistance (75% of target). • Children with safe & accessible channel to report sexual exploitation and abuse (75% of target). • Number of schools implementing safe school protocols (COVID-19 prevention and control) (46% of target).[216] • Number of children (6–59 months) admitted for treatment of severe acute malnutrition (SAM) (53% of target).

216 Owing in large part to a very ambitious target by one country, which was not realized.

3. Advocating for child rights.	• Global COVID-19 Advocacy Framework backed by 172 Member States. • 81% of countries made positive changes in national child-focused priorities, including changes linked to end violence against children (97%), early childhood development (87%), child survival (56%), children uprooted (30%). • At least 6.9 million children reached through child rights education. • UNICEF featured in more than 240,000 online and over 16,000 pieces in media outlets on critical issues affecting children's rights. • UNICEF's global and country office web platforms had 107 million users and 156 million unique page views. • In 106 countries, UNICEF actively engaged with young people on various topics, including climate advocacy, through U-Report, Voices of Youth and Generation Unlimited (GenU) platforms.
4. Supporting the Access to COVID-19 Tools (ACT) Accelerator partnership.	Supported, through first situation report on ACT-A dated 2021,[217] and refers to the ACT-A HAC for 2021 – no specific results available for 2020.

Source: Analysis of UNICEF, 'Responding to COVID-19', UNICEF Annual Report 2020, 2021

Corporate results for 2021, when matched against 2020, also indicate the size of scale-up in these years, with increases in live births delivered in UNICEF-supported health facilities in 2021, children supported to prevent stunting and other forms of malnutrition, children reached with disability-inclusive programming and provided with skills development programmes, and people gaining or regaining access to water services for drinking and hygiene. However, there were declines in the numbers of children receiving community-based mental health and psychosocial support; women, girls and boys accessing GBV risk mitigation, prevention or response interventions; and people gaining or regaining access to sanitation services (see Table 15 below).

217 UNICEF, *Access to COVID-19 Tools Accelerator (ACT-A*), Humanitarian Situation Report No. 1, 2021. Available at: https://www.unicef.org/appeals/access-covid-19-tools-accelerator-act (Accessed: 10 March 2022).

TABLE 15

Comparison of selected key programme indicator results 2020 and 2021 (where compatible data available)

GLOBAL RESULTS AREA	SELECTED RESULTS 2020	RESULTS 2021
Health	**30.5 million** live births delivered in health facilities with support from UNICEF.	**38.9 million** live births delivered in health facilities supported by UNICEF.
	8.7 million children with suspected pneumonia received antibiotics.	**8.75 million** children with suspected pneumonia received antibiotics.
	Almost 244 million children received services for the prevention of stunting and other forms of malnutrition.	**Nearly 336 million** children received services to prevent stunting and other forms of malnutrition.
	5 million children with severe acute malnutrition treated.	**2.4 million** children with severe acute malnutrition admitted for treatment.
Education	**48 million** out-of-school children participated in early learning, primary or secondary education.	**48.6 million** out-of-school children accessed education.
	More than 43 million children were provided with learning materials.	**42 million children** (18.1 million in humanitarian settings) received learning materials.
	7.7 million children participated in skills development programmes for learning.	**33 million** children benefited from skills development programmes.
Protection from violence and exploitation	**47.2 million** children, adolescents and caregivers were provided with community-based mental health and psychosocial support.	**12 million** children, adolescents and caregivers were provided with community-based mental health and psychosocial support (8.4 million children and adolescents; 3.6 million parents and caregivers).
	6 million adolescent girls received prevention and care interventions to address child marriage through joint programming with UNFPA.	**7.6 million** adolescent girls received prevention and care interventions to address child marriage through joint programming with UNFPA.
	4.2 million children in 126 countries who experienced violence were provided with health, social work and justice services.	**4.4 million** children who had experienced violence reached across 129 countries with health, social work and justice services.

	Approximately 17.8 million people reached with gender-based violence risk mitigation, prevention or response interventions in 84 countries.	**8.6 million** women, girls and boys accessing GBV risk mitigation, prevention or response interventions.
	Close to 4.2 million children and women across 126 countries were afforded with safe and accessible channels for reporting sexual exploitation and abuse, a five-fold increase from 2019.	**3.2 million** people with access to safe channels to report sexual exploitation and abuse.
Living in a safe and clean environment	**17 million** additional people gained access to safe drinking water.	**33.3 million** people gained or regained access to water services for drinking and hygiene.
	13.4 million additional people gained access to basic sanitation services.	**8.4 million** people gained or regained access to sanitation services.
Having an equitable change in life	**31 countries** reported that measurement, analysis or advocacy led to policies and programmes that reduced child poverty.	**33 countries** reported that measurement, analysis or advocacy led to policies and programmes that reduced child poverty.
	UNICEF-supported cash-transfer programmes reached over **130 million children in 93 countries.**	UNICEF-supported cash-transfer programmes reached nearly **133 million** children in **95 countries**.
	In 2020, UNICEF reached more than **2.2 million children with disabilities across 144 countries** through disability-inclusive development and humanitarian programmes.	UNICEF reached more than **4.8 million children with disabilities across 148 countries** through disability-inclusive programming, including in humanitarian situations.

Source: UNICEF Annual Reports 2020 and 2021

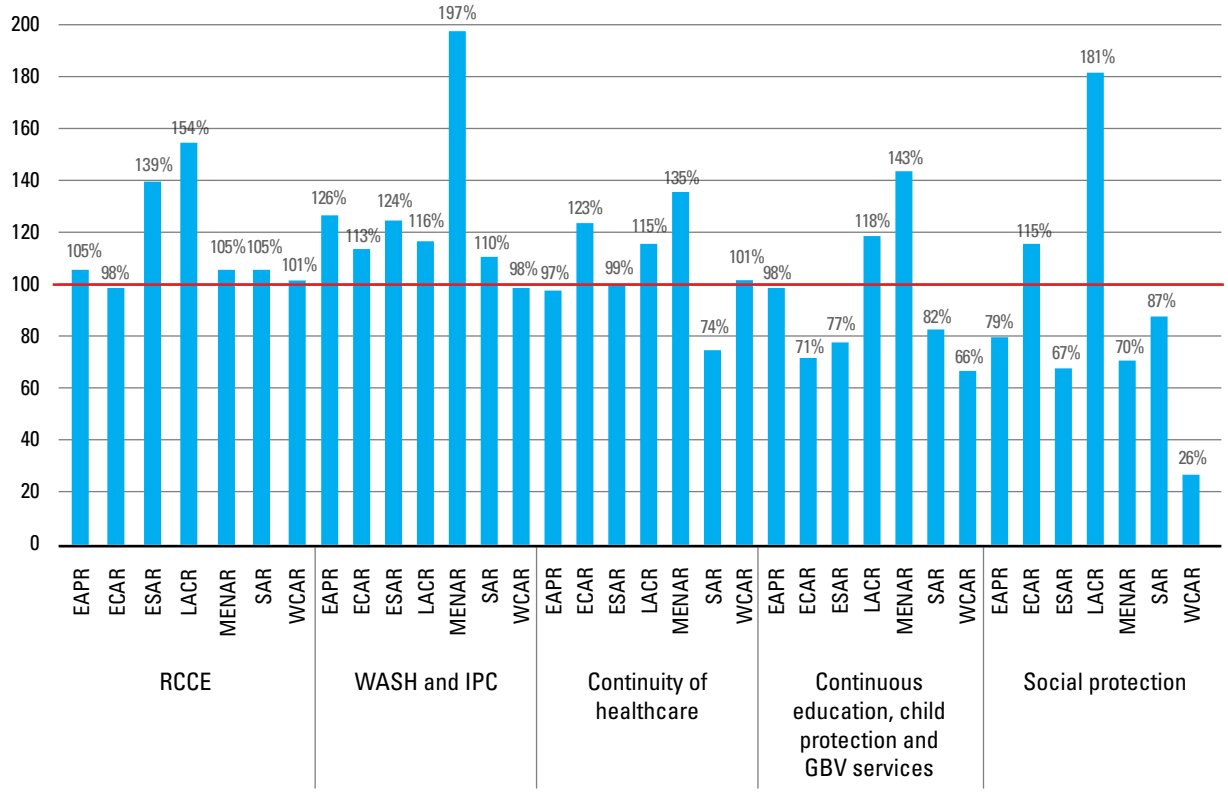
Results in 2020 by region: In 2020, results reflect the global results achievements above, but highlight regional variability:

- Almost all regions exceeded targets for RCCE, with the exception of Europe and Central Asia Regional Office (ECARO) which reached 98 per cent of the RCCE target, while WCARO was the only region not to exceed IPC and WASH targets.
- UNICEF met targets with regards to continuity of healthcare for women and children in most regions; however, the ESARO region reached only 74 per cent of its target here.
- Continuity of education, child protection and GBV services, and social protection were consistently below target,[218] except for social protection in ECARO and LACRO.

218 With one country, in particular, posting extremely ambitious targets which were not realized (see footnote 216).

FIGURE 15

Results achieved by region and sector, 2020



Source: inSight (COVID-19 SitRep Indicators Dashboard)

Some results areas were affected by government policies and decisions, such as on school closures and social protection, with national systems not always prepared for horizontal expansion.[219] ECARO and LACRO regions exceeded Social Protection targets – reflective of the relatively well-developed and well-delivered social protection mechanisms across those regions.

219 UNICEF, *An evaluation of approaches to social protection programming in humanitarian situations, focusing on cash-based programming*, 2021.

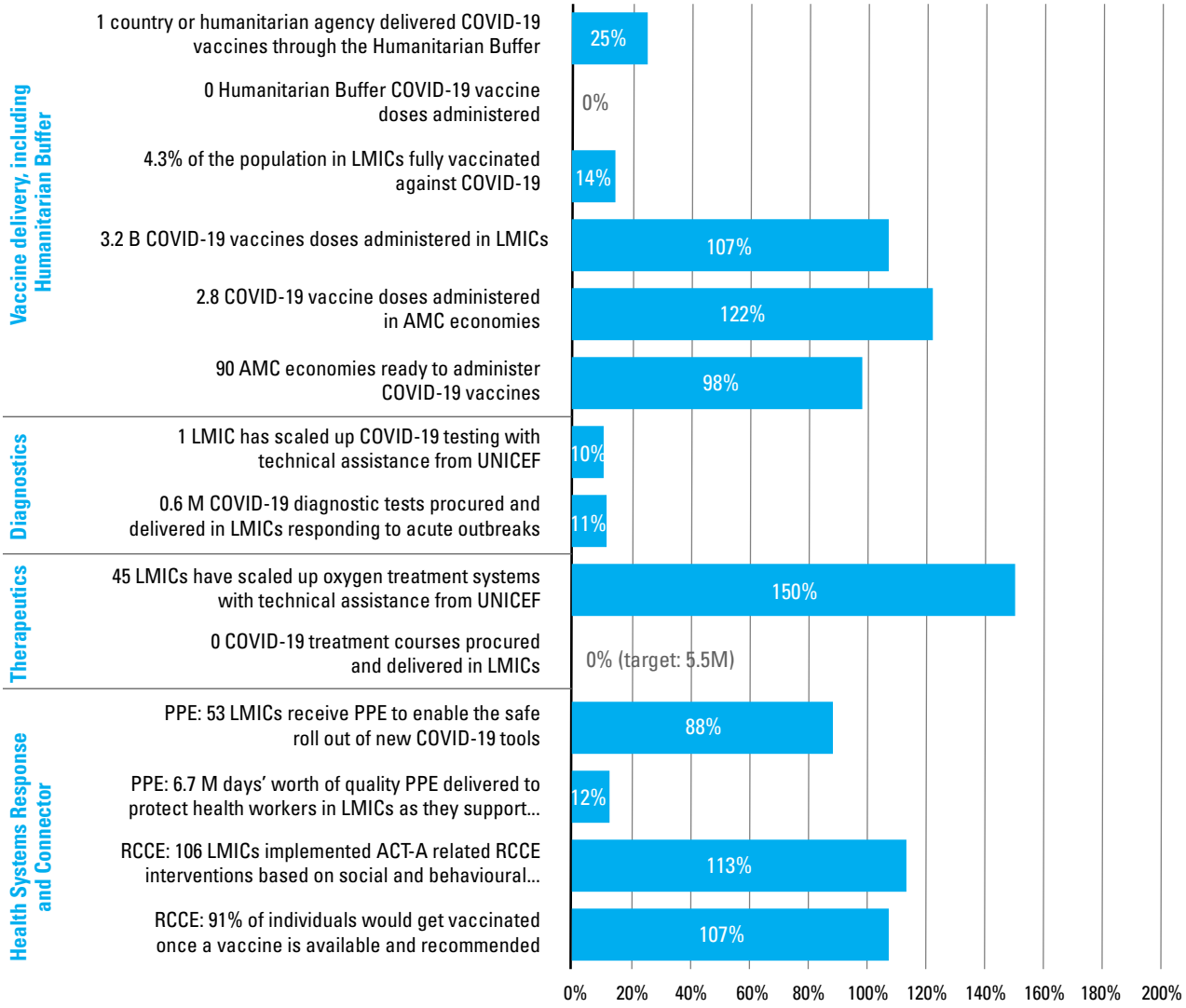
2.4.ii Supporting the international response to COVID-19

The majority of results are available from 2021 and reflect UNICEF's role in vaccination supply and the vaccine pillar (COVAX) of ACT-A, as follows:

ACT-A: Some gaps in funding[220] and procurement challenges for the COVAX facility impeded progress under ACT-A in 2021 (see Figure 16).

220 As of December 2021, UNICEF received US$776.8 million against the 2021 ACT-A appeal, leaving a funding gap of US$194.9 million in the vaccine, diagnostics, and therapeutics pillars. Access to *COVID-19 Tools Accelerator (ACT-A) Humanitarian Situation Report No. 4*, December 2021.

FIGURE 16
ACT-A results against target 2021



Source: UNICEF, 'Access-to-COVID-19-Accelerator (ACT-A) Situation Report No. 4', 2021

Progress was strong on the scale-up of cold chain and vaccines delivery, with COVAX delivering 958 million doses (including donated doses) to 144 countries over 2021 (mostly in the last quarter of 2021). Targets were exceeded in terms of lower middle-income countries having scaled-up oxygen treatment systems. Remaining weaknesses related mainly to some aspects of PPE provision (only 12 per cent of target to protect health workers achieved at the time of data collection)[221] and limitations in scaled-up COVID-19 testing and diagnostics.

Global Humanitarian Response Plan results: UNICEF also made a significant and at-scale contribution to the wider results delivered by the humanitarian system for COVID-19 in the form of the GHRP (see Table 16). Overall, results are aligned with UNICEF's own corporate reporting, with most results achieved under Strategic Priority (i) containing the spread of COVID-19 and decreasing morbidity/mortality and (ii) decreasing the deterioration of human assets and rights, social cohesion and livelihoods.

TABLE 16

Contributing to the international humanitarian response

GHRP STRATEGIC PRIORITY AND RESULTS AREA	UNICEF CONTRIBUTION[222]
1. Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality.	• By February 2021, over 17 million caregivers of children under 2 years old reached with messages on breastfeeding, young child feeding or healthy diets in the context of COVID-19 through national communication campaigns. • Over 1.5 million health workers provided with PPE. • 60 countries with costed plans in place to promote hygiene and handwashing in response to COVID-19. • 59 countries with COVID-19 RCCE programming.
2. Decrease the deterioration of human assets and rights, social cohesion and livelihoods.	• 1.7 million households most vulnerable to/affected by COVID-19 received livelihood support, e.g., cash transfers, inputs and technical assistance. • 9.7 million households most vulnerable to/affected by COVID-19 benefited from increased or expanded social protection. • 56.8 million people received essential healthcare services

221 However, a footnote explains that this result does not include PPE en route but not yet delivered by the end of 2021.
222 As per *GHRP Final Report*, February 2021.

	• 129 million children and youth supported with distance/home-based learning. • 72.8 million people reached with critical WASH supplies (including hygiene items) and services. • 20.6 million people provided with mental health and psychosocial support services. • 3 million children 6–59 months admitted for treatment of severe acute malnutrition (SAM).[223] • 30 countries where messages on gender-based violence risk and available gender-based violence services were disseminated.
3. Protect, assist and advocate for refugees, internally displaced people, migrants and host communities particularly vulnerable to the pandemic.	• Six countries[224] where areas inhabited by refugees, IDPs, migrants and host communities are reached by information campaigns about COVID-19 pandemic risks.

Source: Evaluation team, based on UN OCHA, 'GHRP final report', February 2021

223 Note: The target was 7.2 million.
224 Noting that most country reporting does not disaggregate by refugee/IDP/displaced, migrant and host communities.

Key areas of strength: Evaluations indicate some recurring areas of programmatic upscaling, which played a significant role in generating results. These included:

- RCCE.
- Social Protection.
- Technical support to governments on vaccination plans and COVID-19 responses.
- Producing evidence and data.
- Raising the issue of mental health, particularly for children who were not in the first line of affected populations by the pandemic.
- Health systems strengthening which resulted from COVID-19 responses including oxygen plants, ultra cold chain infrastructure, and capacity strengthening of health workforce.
- Expanding educational access, including through distance learning.

Areas for improved results: Evaluations, however, also indicate some recurring areas where programming can be enhanced for improved results. These include:

- Child poverty within health emergencies.
- Gender and disability.
- Digital inclusion for the most marginalized, such as migrants.
- Adopting a multi-sectoral approach.

3
CONCLUSIONS

The unprecedented nature of the COVID-19 pandemic – occurring as it did among a range of other challenging global events – challenged the global development and humanitarian system in wholly new directions. For agencies such as UNICEF, it posed the most complex 'stress test' ever confronted.

UNICEF was comparatively well-positioned to meet demands. Learning from the previous Ebola crisis, its Public Health Emergencies team was already positioned in what was to prove a pivotal role within WHO. Early sight of information, and its immediate escalation to senior management – and their treatment of it with due seriousness – was to prove pivotal. Prior investment in remote working systems and technology, alongside early corporate discussion, saved immense time and cost, as lockdowns spread across the world.

However, the road from preparedness to corporate response was neither straightforward nor easily achieved. Early corporate attention – mindful of the limited information in early 2020 – could not decisively determine UNICEF's role in a pandemic which, at the time, appeared to affect mainly vulnerable adults. Although programmatic divisions were already planning their response, formal emergency coordination mechanisms were not set in place until March 2020. Once established, these provided a valuable framework for the organizational response, though some internal fragmentation persisted.

As the 'indirect effects' of the pandemic rapidly became clear, and UNICEF's pivotal role in the crisis response emerged, the organization's mature and comprehensive emergency systems gathered pace. Emergency procedures played to the strengths of UNICEF's mature decentralized structures, and adaptive capacity proved to be strong, supported by well-established systems and mechanisms. Remote working moved more smoothly than in some organizations.

UNICEF successfully scaled up its response to meet demand, particularly in the areas of vaccine provision, RCCE and social protection. Its strength in vaccine provision has confirmed its role as a global leader, with expertise, experience and reach few other organizations can match. Similarly, its comparative advantage in RCCE – also built up from lessons learned during the Ebola response of 2014–2015 – proved to be an immensely valuable asset to the global response, with UNICEF positioned and able to respond to governments' needs on the ground. Its social protection capability came to the fore from the second half of 2020, as governments increasingly recognized

the need for shock-responsive systems to protect vulnerable populations.

The scale of the UNICEF response, with millions of beneficiaries across the world, has reinforced its centrality in the international response. A significant proportion of global vaccine delivery can be attributed to UNICEF's actions, and the agency's role in providing RCCE and social protection services has shielded many from both disease transmission and social and economic disaster. Its advocacy work has supported the re-opening of schools and with it, enabled millions of children to continue their education in comparative safety.

UNICEF also demonstrated maturity in its approach to lesson-learning. Again, systems which had previously proved to be valuable were applied to strong effect within the COVID-19 response, validating its 'learning culture'. Real-time assessments, reviews and lesson-learning exercises were complemented with analysis of monitoring data which, despite encountering challenges under lockdown conditions, managed to pivot and adapt. Greater attention to disaggregation in future will, however, be needed.

Like any organization undergoing a rapid change under conditions of acute stress, however, the path to adaptation encountered challenges. It took time for the corporate narrative to reflect the full spectrum of programmatic dimensions of the pandemic – and, therefore, to reflect an appropriately rounded response. Supply chain systems faced acute global difficulties and though many adaptations were made, they struggled to meet demands on the ground. In efforts to provide an adequate steer to country offices and reassure its partners, UNICEF HQ and regional offices issued vast reams of guidance and demanded reporting levels that placed burdens on immensely challenged country offices.

Notably, those offices with long emergency experience, capacity and instinct, and with relevant preparedness plans in place, responded swiftly, and fared better, than those without. Such offices, in many cases, had been able to implement pre-emptive actions through existing systems and procedures. Risk aversion, particularly in country offices without an emergency experience and culture, also played a role, with hesitancy in some cases to experiment with new ways of working.

UNICEF's human resources systems were largely supportive of staff, working around personal needs and providing a clear route to remote working where required. In common with other UN agencies, however,

a significant strain has been placed on its personnel, at all levels and in all locations. Moreover, a cultural disjunction has emerged. Those with emergency backgrounds, accustomed to the firm 'stay and deliver' ethos of humanitarian assistance, found the scope for remote working to be challenging, fearing reputational damage and reduced effectiveness. Conversely, those more accustomed to the development 'side of the house' appreciated the human-centred approach adopted by UNICEF to its staff. In this sense, COVID-19 has shone a light on the tensions that exist in a double-mandated organization, where boundaries are – as the pandemic has shown – increasingly blurred. An organization which confronts a wide range of challenges on a daily basis, with proliferating protracted crises, requires full emergency capacity 'across the house'.

The area where UNICEF has perhaps been most challenged is in its global partnerships. While at country level, pre-existing relationships with government, implementing partners and the private sector have played a major role in supporting the response, at international level, the story is more complex. UNICEF's absence from the initial ACT-A structures was an international system omission, which did not maximize its role and comparative advantage in the international system. Subsequently, a sense of territorialism has crept into the issue of vaccines delivery. This has direct and immediate effects on the most vulnerable; it actively detracts from the humanitarian action whose aim is surely to serve those with no other form of support.

Finally, there is a sense from external partners, at global level at least, that UNICEF's corporate response to COVID-19 has become concentrated largely on vaccination, and that the wider dimensions of the response have, in being 'mainstreamed', risked being lost. Given UNICEF's mandate, prominent role in the international system and very public brand, this is a concern.

Overall, UNICEF has demonstrated its confidence in launching a complex response at global scale. In this, its existing systems have been stress-tested and responded with capability. Going forward, however, lessons can still be learned and improvements made. The recommendations which close this evaluation aim to support UNICEF going forward in its continued journey of organizational improvement.

4
RECOMMENDATIONS

The evaluation makes eight recommendations for UNICEF to consider. These recognize the strength and maturity of UNICEF's response to the COVID-19 pandemic and propose some measures for future qualitative enhancement.

RECOMMENDATION 1

In line with recommendations from the 2020 Humanitarian Review,[225] develop a clear corporate narrative for UNICEF's role in public health emergencies

RATIONALE

The early phase of the response experienced a period of internal debate while the role of UNICEF was clarified, with diverse opinions on all sides. A clearer corporate understanding of UNICEF's role within public health emergencies which recognizes the wider effects of such crises, as per the Core Commitments for Children (CCCs) and the findings of the Humanitarian Review, will support preparedness and generate a stronger sense of 'one organization' under conditions of acute pressure.

SPECIFIC ACTIONS

- At senior management level, conduct an emergency preparedness exercise, mapping out UNICEF's corporate positioning in public health emergencies, and building on the CCCs for public health emergencies. Clearly articulate commitments and response modalities, notably when such an emergency happens in a conflict setting vs. non-conflict setting.
- Prepare contingency plans and corporate communication narratives on the 'whole of UNICEF' role in such an emergency situation.
- Ensure that all divisions/units are sighted on their role in public health emergency response, to ensure a more cohesive internal and external narrative.
- Develop protocols for pre-financing commitments for both procurement and programming, in future PHE responses.

RESPONSIBLE

Office of Emergency Programmes (EMOPS), Programme Group (PG), Public Partnerships Division (PPD)/ Private Fundraising and Partnerships (PFP), Supply Division (SD), Division of Financial and Administrative Management (DFAM)

225 UNICEF, *Strengthening UNICEF's Humanitarian Action: The Humanitarian Review: Findings and Recommendations*, 2020.

RECOMMENDATION 2

Refresh the corporate narrative on the priority of COVID-19

RATIONALE

External perceptions from UN partners particularly are that UNICEF's response to COVID-19 has become focused on vaccination, and that the wider dimensions of the response risk losing momentum. It will be important to ensure that the corporate narrative reflects the significance of COVID-19 in the programmatic work still to be undertaken on the ground.

SPECIFIC ACTIONS

- Internally, consider how a more consistent approach and narrative can be adopted to partners across different parts of the UNICEF 'house'.
- Reflect the continued social and economic effects of COVID-19 in corporate external communications and reporting, including the 2023 Annual Report.
- Ensure their reflection in Executive Board meetings and agenda items.

RESPONSIBLE

Office of Emergency Programmes (EMOPS), Programme Group (PG), Public Partnerships Division (PPD)/ Private Fundraising and Partnerships (PFP), Division of Global Communication and Advocacy (DGCA)

RECOMMENDATION 3

Consider undertaking a functional review of UNICEF's public health emergency capacity across the organization

RATIONALE

Currently, UNICEF, like many international agencies, is battling both humanitarian and development crises on multiple fronts. Many crises are now protracted, with the boundaries between 'development' and 'humanitarian' action increasingly unclear. Public health emergencies span these boundaries.

The 2020 Humanitarian Review recommended increased technical capacity at all levels for public health emergencies.[226] For any future pandemic, it is clear that both development and humanitarian action will be needed. UNICEF staff corporately, therefore, need to possess emergency response skills and be able to respond to public health emergencies at different levels.

SPECIFIC ACTIONS

- Conduct a functional review of public health emergency capacity across UNICEF as an organization, its skills and expertise, with a view to considering how its existing emergency capacities can be broadly extended across the UNICEF 'house'.
- Seek to build emergency response capacity in all UNICEF staff, as applicable to their working area.

RESPONSIBLE

Office of Emergency Programmes (EMOPS), Programme Group (PG), Supply Division (SD)

226 Ibid.

RECOMMENDATION 4

Build preparedness for public health emergency response across UNICEF

RATIONALE

The pandemic has highlighted the varying degrees of preparedness for public health crises across UNICEF's country offices. It is critical that staff in all country offices are trained in emergency preparedness and that all have appropriate emergency preparedness plans in place.

SPECIFIC ACTIONS

- Ensure that each country office/regional office has a preparedness plan in place for public health emergencies.
- Require each country office/regional office to conduct a simulation exercise of its Business Continuity Plan.
- Clarify UNICEF's positioning on risk during public health emergencies – whether risk-averse, risk-tolerant or risk-hungry.

RESPONSIBLE

Country offices (COs), with the support of regional offices (ROs) and Office of Emergency Programmes (EMOPS)

RECOMMENDATION 5

Revisit the global ethos of partnership in vaccines particularly

RATIONALE

COVID-19 has highlighted both the strengths and weaknesses of UNICEF's international partnerships in the pandemic response. In the specific area of vaccine provision, reconsidering the ethos of partnership will help to rebuild relationships and maximize outcomes for those who still badly need UNICEF's support.

SPECIFIC ACTIONS

→ Engage with partners to discuss – with an open mind – respective comparative advantages and opportunities for collaboration and partnership in both vaccine delivery and country preparedness. Approach roles from the perspective of 'greatest benefit to those in need' rather than territorial concerns.

RESPONSIBLE

Supply Division (SD), Programme Group (PG), Public Partnerships Division (PPD)/ Private Fundraising and Partnerships (PFP), Office of Emergency Programmes (EMOPS)

RECOMMENDATION 6

Also in line with findings from the Humanitarian Review, reassess supply chain and procurement requirements and procedures for public health emergencies

RATIONALE

UNICEF's Supply Chain function has undergone considerable reflection and lesson-learning since the COVID-19 response. As the Humanitarian Review notes, however,[227] improvement can still be undertaken, and most specifically on local procurement, where UNICEF has room to enhance scope for country offices to undertake their own procurement, particularly under emergency conditions.

SPECIFIC ACTIONS

→ Reconsider the CCC levels of preparedness, potentially expanding these to enable large-scale public health responses where needed.

→ Specifically consider how local procurement and other adaptations could help to maximize emergency response under pandemic conditions.

→ Redress reputational effects at country level by communicating externally lessons UNICEF has learned in its Supply Chain function since COVID-19.

227 The Humanitarian Review recommends that UNICEF "Strengthen the integration of supply needs in programme planning and response, especially on supply-driven programming in public health emergencies." Ibid.

RESPONSIBLE

Supply Division (SD), country offices (COs)

RECOMMENDATION 7

Intensify the focus on equity and gender in emergency response

RATIONALE

The response to the emergency conditions of COVID-19 has shown an unsystematic approach to gender and equity at best. A clearer articulation of why equity and gender matters in public health emergency response, and how it should be considered at all levels, will support equitable outcomes.

SPECIFIC ACTIONS

- Clarify the role of gender in public health emergency response by creating an EMOPS-led initiative to communicate the role of gender and equity in all emergency responses.
- Embed gender and equity considerations in all HACs and their approval processes, more from a 'transformative' perspective than from a 'quantitative' one.
- Require corporate reporting on HACs to include gender and equity considerations.

RESPONSIBLE

Programme Group (PG), Office of Emergency Programmes (EMOPS), country offices (COs) with the support of regional offices (ROs)

RECOMMENDATION 8

Define and establish the corporate-level knowledge management and learning system for public health emergencies

RATIONALE

The pandemic response has shown up several fault lines in UNICEF's knowledge management, guidance and learning systems for emergencies – ranging from the volume to the quality of learning products and guidance produced.

SPECIFIC ACTIONS

- Conduct a consultation exercise with country offices regarding the volume, quality and relevance of guidance and learning products generated during 2020 and 2021, with a view to mapping out real-world demands during corporate emergency conditions.
- Map the range of learning products produced internally during the pandemic, including internal websites, guidance, learning and other exercises, and review scope for their rationalization in light of demands in any future event.
- Develop, for emergency situations which require rapid adaptation and innovation at corporate level, an organization-wide 'clearing house' or vetting system to ensure that learning and guidance produced is a) demand driven, b) relevant to needs, and c) of a quality and design that speaks to country office needs on the ground. Define the role of regional offices within this system.

RESPONSIBLE

Office of Emergency Programmes (EMOPS), Programme Group (PG), Data Analytics Planning and Monitoring (DAPM)/Organizational Learning and Knowledge Management (OLKM)

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