SYNTHESIS REPORT
June 2021

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for every child

Real-Time Assessment of the UNICEF Response to COVID-19: **Global synthesis report**

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LIST OF ACRONYMS

AAP	Accountability to Affected Populations
C4D	Communication for Development
CEAP	Corporate Emergency Activation Procedure
CE	Community Engagement
CO	Country Office
COVID-19	Coronavirus Disease 2019
CP	Child Protection
CSO	Civil Society Organization
EAPR(O)	East Asia and Pacific Region(al Office)
ECAR(O)	Europe and Central Asia Region(al Office)
EPP	Emergency Preparedness Planning
ESAR(O)	Eastern and Southern Africa Region(al Office)
EMOPS	Office of Emergency Programmes
EO	Evaluation Office
HAC	Humanitarian Action for Children
HR	Human Resources
HQ	Headquarters
ICT	Information and Communications Technology
IDP	Internally Displaced Person
IFI	International Financial Institution
ILO	International Labour Organization
IMF	International Monetary Fund
IP	Implementing Partner
IPC	Infection Prevention and Control
LACR(O)	Latin America and the Caribbean Region(al Office)
LNCB	Leave No Child Behind
LTA	Long Term Agreement
MENA(RO)	Middle East and North Africa (Regional Office)
MHPSS	Mental Health and Psychosocial Support
MICS	Multiple Indicator Cluster Surveys
PCA	Programme Cooperation Agreement
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
REvA	Regional Evaluation Adviser
RMT	Regional Management Team
ROSA	Regional Office for South Asia
RTA	Real-Time Assessment
RO	Regional Office
SAM	Severe Acute Malnutrition
SAR	South Asia Region
SDGs	Sustainable Development Goals
SitRep	Situation Report
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
WASH	Water Sanitation and Hygiene
WCAR(O)	West and Central Africa Region(al Office)
WFP	World Food Programme
WHO	World Health Organization

1 INTRODUCTION AND METHODS

Photo: © UNICEF/UN0409708/Urdaneta

1.1 Background

On 11 March 2020, the World Health Organization (WHO) formally declared the novel coronavirus (COVID-19) a global pandemic. By April 2020, it was clear to UNICEF senior management that **COVID-19 containment measures and response would have a significant impact on 'business as usual'** and that delivering **on the commitment to Leave No Child Behind (LNCB) would be more challenging than expected**. In addition, since many of the hardest-hit countries were traditional donor-recipient countries, **concerns about the threat of decreased funding became more real over time.**

Additional concerns centred around potential 'blind spots' that might arise due to reliance on remote working modalities, the rapidly changing operating environment and the cessation of international – and often national – travel. UNICEF quickly determined that **"all children were being affected** including by socio-economic impacts and, in some cases, by mitigation measures that may inadvertently do more harm than good"[1] and, accordingly, by the first half of April 2020 the Executive Director had triggered the Corporate Emergency Activation Procedure (CEAP), declaring a Level 3 (L3) global emergency [2].

Country offices were forced to adapt quickly in order to respond to an emergency of unprecedented scale and complexity. The evaluation function also repurposed its approach, issuing two technical notes in March and April 2020 to guide evaluative initiatives aimed at generating evidence as the organization's response evolved. In July of the same year, the UNICEF Executive Board recognized the unprecedented challenges posed by the pandemic and openly encouraged the commissioning of "different kinds of evaluative work that contribute to evidence on the effect of COVID-19 on the programmatic work of UNICEF and that enable adaptive programme management and organizational learning".[3]

Responding to this call, the UNICEF evaluation function has undertaken several evaluative initiatives to better support real-time learning on experiences of the response and to provide strategic and operational suggestions to leadership at all levels to guide future work.

This **real-time assessment (RTA) of the UNICEF response to COVID-19 at the country level** (Phase 1) was conceived to support regional offices (ROs) in their oversight role and is a good illustration of how the evaluation function sought to work differently. The RTA process was intended to foster a forward-looking reflection based on how UNICEF country offices (COs) have been responding to the pandemic as it unfolds, allowing learning to occur in real-time. For more detail, please see the concept note for RTA Phase 1 in Annex 1.

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1 United Nations Children's Fund, 'The Impact of COVID-19 on Children', policy brief, UNICEF, New York, April 2020.

2 UNICEF emergency procedures include the simplified standard operating procedures (SSOPs) for Level 3 emergencies, the UNICEF procedure on corporate emergency activation for Level 3 emergencies, the UNICEF procedure on regional emergency activation for Level 2 emergencies and the UNICEF procedure for Level 2 emergencies. The SSOPs are undergoing a comprehensive review with a view to developing new emergency procedures for all crises, with certain provisions specific to L2 and L3 emergencies. On 20 March 2020, new emergency procedures were developed for COVID-19 building on the existing L3 SSOPs, as well as new COVID-19 specific guidance.

3 United Nations Children's Fund, Executive Board Decision E/ICEF/2020/L.12, UNICEF, New York, 2020.

The RTA process has delivered multiple products (at regional, country and global level),[4] including interim reports that informed global reporting and planning processes.[5]

This final report, **based on regional findings from Phase 1 (October 2020 and April 2021)**, was produced in April 2021 and provides a summary of the real-time process. It is structured as follows:

- **Section 1** - Introduction and methods: A brief outline of the purpose, objectives and scope of the RTA, as well as its approach, principles, global tools proposed and how these were customized at regional level.
- **Section 2** - The impact of COVID-19 on children: A brief description of the impact of the pandemic on children based on the 2020 annual reports and 2021 HAC.
- **Section 3** - Findings: Structured around thematic issues related to adaptivity, implementation and quality of the response (the three overarching questions and focus areas of the RTA).
- **Sections 4 and 5** - Conclusions and key issues: A consolidation of themes that have emerged from the regional RTAs.

Photo: © UNICEF/UN0418184/Vincent Tr

[4] Regional RTA reports and country RTA reports, where available, can be accessed on EISI: EISI (unicef.org).
[5] E.g. UNICEF Executive Board meeting (February 2021) and 2021 HAC planning processes.

1.2 Purpose, objectives and scope

The purpose of the RTA was to distil contextualized challenges, opportunities, and lessons learned at the regional level and to identify possible actions to support the organization's ongoing response to COVID-19 and inform preparation for future emergencies.

The RTA was centred upon the following **four overarching questions**, which were developed in coordination with the COVID-19 Secretariat and ROs, to ensure relevance and utility of the exercise:

1. How effectively is the CO implementing the response to COVID-19 so far?[6] How is the **quality** of the response to COVID-19 being affected by remote working modalities and the generally constrained operating environment?
2. How well is the CO adapting to the needs of the population, including the **socio-economic impact** of the pandemic?[7] How have these **needs been determined** in each country? (Will include gauging issues such as target-setting, required capacity, early insights on results achieved so far and where most value is added);
3. What **early lessons** (for CO/RO/HQ) are emerging from the implementation of the response? What are the emerging 'positives' from the response and what have been the greatest challenges in responding to COVID-19 so far? Are there discernible trends that are applicable to **different settings** (e.g. urban/rural; low-resource/high-resource settings, etc.)?
4. What **more** should be done? What should be done **differently** to enhance COVID-19 response programming for children and their communities?

Thematically, the RTA focused on the **public health response** and the early stages of the **socio-economic response** of UNICEF. Designed as a **global exercise** to be rolled out and **customized across the seven regions** in a selection of countries, the geographical scope of this exercise also offered an opportunity for **cross-country** and **cross-regional learning**.

This global synthesis report includes all **seven regions and 41 focus countries** and **COs** where the RTA Phase 1 was rolled out (see Table 1 and Figure 1 below). The regional RTA Phase 1 reports (and presentations to regional management teams in Q4 2020) include an assessment of the effect of the COVID-19 pandemic on **basic services** across the regions and upon **regular/pre-COVID-19 programme delivery**. As importantly, they provide insights into the **internal** and **external (where available) perceptions** on the **quality** of delivery.

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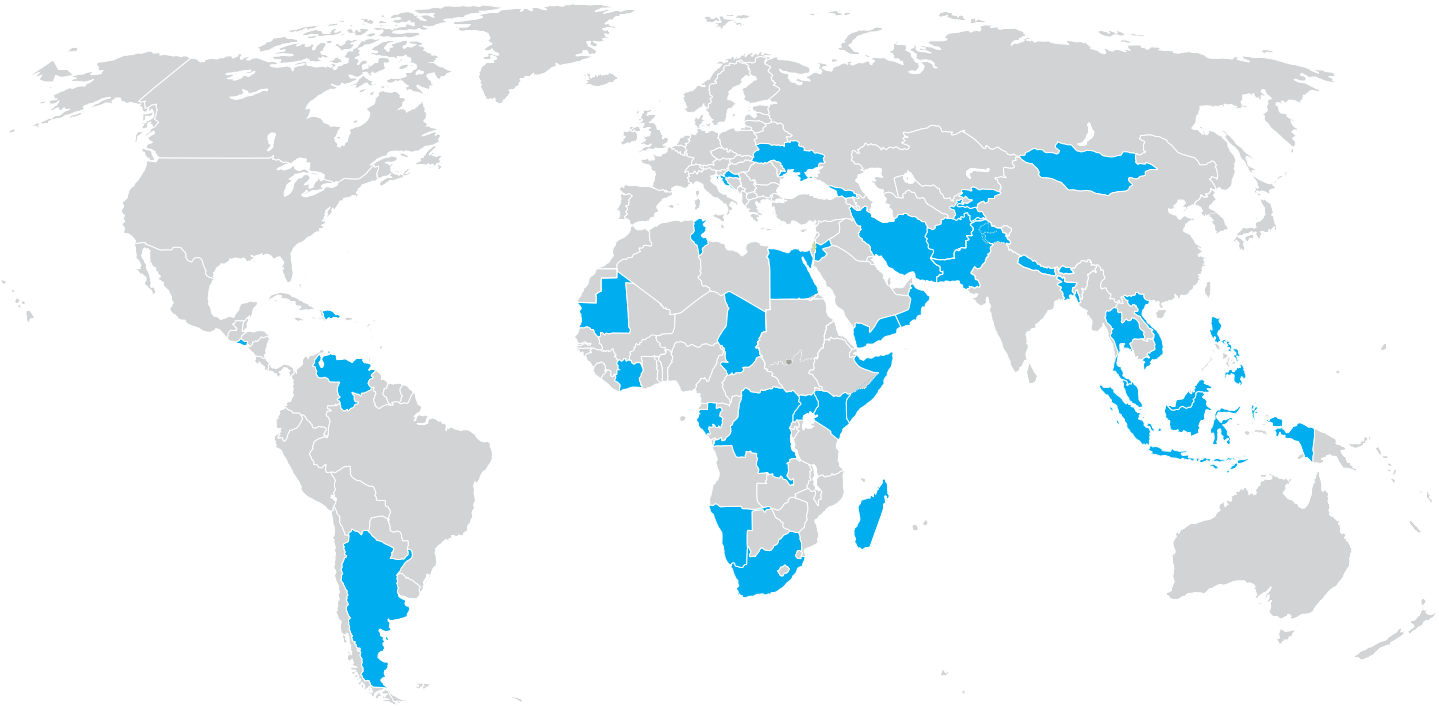
[6] Due to the fluid operating context, the use of COVID-19 country response plans as the 'unit of analysis'/reference point in the RTA was not deemed appropriate. Following discussions, the focus of the question therefore shifted from the implementation of COVID-19 **plans** to the implementation of the **response** to COVID-19. This question will entail gauging the adaptation of the response over time, including vis-à-vis pre-COVID programme delivery.

[7] This question will include an assessment of the effects of COVID-19 on access to basic services, including for the most vulnerable segments, to the extent possible.

Table 1: Focus countries selected for the RTA Phase 1

Regions	Countries						
East Asia and Pacific (EAP)	Malaysia	Philippines	Indonesia	Thailand	Vietnam	Mongolia	
Europe and Central Asia (ECA)	Croatia	Georgia	Moldova	Ukraine	Tajikistan	Kyrgyzstan	
Eastern and Southern Africa (ESA)	Uganda	Kenya	Madagascar	Namibia	South Africa	Somalia	
Latin America and Caribbean (LAC)	Argentina	El Salvador	Dominican Republic	Venezuela			
Middle East North Africa (MENA)	Egypt	Iran	Jordan	Oman	Tunisia	Yemen	
South Asia (SA)	Afghanistan	Bangladesh	Bhutan	Maldives	Nepal	Pakistan	Sri Lanka
West and Central Africa (WCA)	Côte d'Ivoire	DRC	Chad	Gabon	Mauritania	São Tomé and Príncipe	

Figure 1: Focus countries selected for the RTA Phase 1



1.2.1 Principles

Given the extreme pressures and workloads that CO staff experienced due to the pandemic, the RTA was designed to be useful and timely at CO and RO level in the first instance. Hence, the regions were provided with maximum **flexibility to customize the approach**. This included the freedom to decide **how many COs** in the region would become focus countries for the RTA; what adaptations were required to the **scope** of the exercise and related data-collection tools (see following section for further details); **how many informants** to engage with through the various data-collection methods; **how to implement** the RTA (whether through existing capacity within each evaluation unit or outsourcing to external teams); how to work with **key users** throughout the process, validating and disseminating findings; and the **timeline** of the exercise at the regional level. RO decisions on customization were based on a variety of criteria including:

- The state of the COVID-19 outbreak in different countries across their region.
- The expected level of access to frontline workers contributing to the delivery of the response and to the population groups that were expected to be served by UNICEF and partners.
- The strength of previous and current linkages with, and expected access to, governments.
- The number and type of opportunities available to ensure data gathering in concurrence with other processes underway in the CO.
- The amount of relevant and timely data on the response already in place at the CO level.

While the **regional customization** was pivotal to enhancing the relevance and utility of this exercise, the RTA was also designed to add value and complementarity to other global learning mechanisms by:

- Striving to ensure the incorporation of **external voices** from key stakeholder groups at the country level.
- Focusing on gathering information about quality, with a particular emphasis on the challenges of **ensuring equity** at a time when vulnerability patterns and dynamics have been altered by the pandemic.

1.3 Global tools and regional approaches

1.3.1 Global tools

A task team of Evaluation Office (EO) representatives and Regional Evaluation Advisers (REvAs) agreed on the general 'global' approach to adopt for the RTA which would, in turn, be customized and operationalized in each region. The following global tools and approaches were agreed:

- An **online survey** to be administered to UNICEF COs,[8] structured around the four overarching questions of the RTA. Regions had the option to further customize the survey questions and to determine whether the survey would be rolled out across all COs in the region or only the focus COs. Regions

[8] 1 survey per CO.

also determined whether they preferred to administer the survey directly at RO level or to have the standardized survey administered for them by headquarters (HQ).

- **Key informant semi-structured interviews** with the following actors:
  - **UNICEF CO key personnel:** An interview guide was designed with a focus on **all four overarching questions as well as lessons identified**.
  - **Government and implementing partners (IPs) at the national level:** An interview guide was designed with an emphasis upon **UNICEF adaptability, implementation, responsiveness** and **quality of response**. Questions were also asked about lessons and what should be done differently.
  - **Front-line field workers** (government, local authorities, non-governmental organizations, civil society): A separate interview guide was prepared which, in addition to the questions asked at the national level, also sought views on **needs assessment, equity, supplies and what should be done differently going forward**.
  - **Members of the communities** being served through the response: Recognizing the challenges of access, the interview guide designed for this group was focused primarily on **issues of implementation** and **quality**, while gauging views about what should be done differently. In one region, pairs of national consultants (one senior and one emerging evaluator; one male and one female) engaged with youth and their caregivers through the use of focus group discussions and other participatory methods (e.g. body mapping[9]).
- **Global desk review**: To minimize duplication of data gathering, and to further triangulate data in regional reports for synthesis report, the EO undertook a desk review of UNICEF material pertaining to the COVID-19 response available at the global level.
- This final synthesis report to draw out findings against the headline questions and trace themes.

Global synthesis report process

With the region adopting the range of methods most suited to their context, the global synthesis did not focus on weighting the various approaches used or determining trends and patterns among CO experiences.

As the regional reports were submitted, the information and analysis was collected under headings derived from the four overarching RTA questions. Underneath this, the information contained in the regional reports was further organized by the major areas of enquiry within the globally designed CO survey. These are represented in the headings and subheadings in this report.

1.3.2 Regional approaches

Regions applied a mixed-methods approach. While building on the global tools listed above, locally appropriate and different emphases have been placed on the methods utilized, and

[9] Research method used to tell a story that visually reflects social, political and economic processes and individual experiences. See for example https://www.qualitative-research.net/index.php/fqs/article/view/2858.

a variety of approaches have been used to structure data collection and analysis across the regions.

With the exception of the West and Central Africa region (WCAR), all primary data collection took place **remotely** due to lockdown restrictions.

Some regions used their own staff to conduct the RTA, others a mix of staff and consultants, whilst some outsourced completely. Recruited consultants were mostly international professionals, with the exception of one region (WCAR) which recruited pairs of national consultants in each focus country to deliver the country-level reports, while the RO provided real-time capacity building support.

In all cases, the regions presented their findings and recommended actions to RMTs prior to the regional reports being finalized. The EO supported and advised the regions as they interpreted the RTA guidance to customize it for the local context, balancing the demands of the RTA with ongoing commitments and evaluative capacities. The EO also supported the administration of the online survey for COs in some regions, the sourcing and contracting of consultants in other regions, coordinated the ethics review process, and participated in regional meetings and presentations of the regional RTA findings and reports. It also managed the consolidation of this synthesis report.

Table 2 below provides an overview of the approach adopted by each region for implementing the RTA. Further details can be found in Annex 3 and in the regional RTA reports.

Limitations

The RTA was an innovative way to help UNICEF navigate the unchartered territories of the pandemic, supporting unprecedented evidence-generation needs. And while it was a successful exercise overall, it could not be expected to yield the sort of in-depth evidence associated with a full-fledged evaluation. One core limitation of the RTA is the **depth of triangulation** which, as noted by some regions, was typically **more limited due to the real-time nature of the work and the pandemic constraints**. For several reasons, including the point in time during which the RTA unfolded, findings have more effectively responded to the descriptive questions driving the RTA rather than the more evaluative ones. The RTA reports and this synthesis should be read with this in mind.

The impacts of the pandemic varied from region to region, and this diversity inevitably affected not only how the different regions were able to collect data, but also what areas of focus were deemed to be of greatest priority. The differing timelines of COVID-19 outbreaks also influenced the time periods during which regions were able to conduct their real-time data collection. This **diversity in priority areas of focus and timelines limits the extent to which results can be compared across regions**. This report seeks to highlight **the most illustrative example**s of CO adaptation, implementation and quality as presented in the regional reports. As such, this report is not exhaustive and does not claim to be fully representative of findings.

Examples and illustrations provided by regions do not always align, and indeed sometimes point in very different directions. The RTA global synthesis process did not allow for comparative analysis or validation of regional products. Comments provided by the REvAs to earlier drafts of this synthesis report have been incorporated in this final version of this report.

The following table summarizes the various regional approaches to the RTA.

Table 2: Variations in regional approaches to the RTA

Region	Focus countries	Surveys				Key informant interviews					Desk review	
		Country offices (COs)	Government counterparts	Implementing Partners	Administered by	UNICEF	Gov't	Implementing partners	Frontline workers	Community members	Documents	Secondary data
EAP	6 - Indonesia, Malaysia, Mongolia, Philippines, Thailand, Viet Nam	√ 14/14 COs in region	√ 20 in 5 focus countries [+9 AAR shorter surveys Thailand only]	√ 21 in 6 focus countries [+28 AAR shorter surveys Thailand only]	Region	NA	NA	NA	√ 26 in 6 focus countries	√ 15 in 4 focus countries	Desk review for all focus countries, excluding Thailand but including China Full after action review Thailand Cambodia RCCE study	NA
ECA	6 - Croatia, Georgia, Moldova, Ukraine, Tajikistan, Kyrgyzstan	√ 6 focus COs	√ 15 in 6 focus countries	√ 15 CSOs in 6 focus countries and 5 private sector partners	Region	NA/Dialogue through presentations, discussions etc.		Surveys were conducted over the phone therefore are sometimes referred to as interviews in the regional report.	NA	NA	Response plans, sitreps, socio-economic assessments, donor reports	U-report polls in Moldova and Ukraine, humanitarian performance monitoring (HPM) data
ESA	6 - Kenya, Madagascar, Namibia, South Africa, Somalia, Uganda	√ 21/21 (all COs in region)	√ 46 across government, NGO, UN agencies, private sector partners in 15 non-focus countries		Region	√ 40 across CO staff and partners in 6 focus countries			NA	NA	Programming guidance, response plans, sitreps, socio-economic assessments	Funding and performance data
LAC	4 - Argentina, El Salvador, Dominican Republic, Venezuela	√ 4 focus COs	NA	NA	EO	√ 61 in 4 focus countries	√ 21 in 4 focus countries	√ 31 in 4 focus countries	NA	NA	Progress reports	Data on frontline workers & community members, COVID-19 response M&E framework

Table 2 continued

Region	Focus countries	Surveys				Key informant interviews					Desk review	
		Country offices (COs)	Government counterparts	Implementing Partners	Administered by	UNICEF	Gov't	Implementing partners	Frontline workers	Community members	Documents	Secondary data
MENA	6 - Egypt, Iran, Jordan, Oman, Tunisia, Yemen	√ 14 /16 COs in region (excluding Sudan and Gulf Area)	NA	NA	EO	NA	NA	NA	NA	NA		
SA	7 - Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka	√ 8/8 COs in region (separate process for India)	√ 30 in 6 focus countries (Nepal no response)	√ 31 in 6 focus countries (Maldives no response)	Region	√ 7 in 7 focus countries (Rep/Deputy Reps) (plus 6 ROSA Advisors targeted through an ad-hoc online survey)	NA	NA	√ 31 in 6 focus countries	√ 10 in 4 focus countries	Sitreps, online repository	U-report
WCAR	7 - Cote d'Ivoire, Mauritania, Gabon, DR Congo, Chad, São Tomé & Príncipe, Senegal	√ 7 COs in region	NA	NA	Region	61 in 6 focus countries (Section staff)	Government & implementing partners 57 in 6 focus countries		172 in 5 focus countries	440 community members, out of whom 150 were children In 6 focus countries	Sitreps, response plans, donor reports, financial reports	U-report, press review

2 THE IMPACT OF COVID-19 ON CHILDREN

Photo:© UNICEF/UN0384289/Cabral

This snapshot of the impact of the COVID-19 on children was updated regularly during the timeline of the RTA – i.e. reflects developments up to December 2020 and includes information from the COVID-19 chapeau of the global UNICEF HAC report, the regional HAC appeals for 2021, global situation reports (sitreps) and thematic sitreps, and select country RTA reports.

UNICEF reported that during 2020, working with partners, it assisted 153 countries and territories with critical supplies and financial/technical support and had reached 261 million children with vital health, nutrition, education, child protection, water, sanitation and hygiene (WASH), and services to address gender-based violence and social protection.[10]

The pandemic exacerbated existing vulnerabilities, discrimination and exclusion, reversing **decades of hard-won development gains** for children jeopardizing progress toward the Sustainable Development Goals (SDGs).

Poverty

Globally, estimates suggested that the number of people living on less than US$1.90 a day could rise to 150 million (from a range of 88-115 million pre-pandemic). The number of children living in multidimensional poverty increased by 15 per cent in 2020, up to 1.2 billion globally.[11] In **East Asia and the Pacific** region (EAPR), an additional 21 million children were estimated to be at acute risk of falling into poverty,[12] and **Europe and Central Asia** region (ECAR) expects to see an increase of up to 44 per cent in poverty levels.[13] In **South Asia** region (SAR), gross domestic product (GDP) was expected to decline by 7.7 per cent in 2021, the largest contraction in the region's history.[14]

Unemployment rates have also significantly increased because of the pandemic. The International Labour Organization (ILO) estimates that 41 million full-time jobs were lost in the **Middle East and North Africa** (MENA) in the first three quarters of 2020,[15] while in **Latin America and the Caribbean** region (LACR), unemployment levels reached 13.5 per cent, pushing approximately 118 million women into poverty.[16]

[10] UNICEF, Humanitarian Action for Children, 2021.
[11] United Nations Children's Fund, 'UNICEF Global COVID-19 Final Report, February-December 2020', UNICEF, New York, 2021.
[12] UNICEF, Humanitarian Action for Children, 2021.
[13] UNICEF Global COVID-19 Final Report.
[14] UNICEF Global COVID-19 Final Report.
[15] *Ibid.*
[16] UNICEF, Humanitarian Action for Children, 2021.

Health and nutrition

Surveillance/access to healthcare:

The pandemic has had a severe impact on people's access to healthcare. Services such as routine vaccination, outpatient care, antenatal and postnatal services, births attended by a skilled attendant, and health campaigns were reported to be most affected.[17] In South Asia, for example, a minimum of 500,000 people were estimated to be lacking access to health services in 2021.[18]

Coverage for the most important childhood vaccines, especially the pentavalent 3, was severely disrupted, affecting an estimated 6.9 million children in EAP, 5 million children in LAC, and 15 million children in MENA.[19]

Nutrition:

Global coverage of nutrition services to children, adolescents and women declined by nearly 40 per cent in 2020.[20] This led to the postponement of many integrated child and health nutrition interventions, such as vitamin A supplementation and deworming campaigns. An additional 6.7 children are predicted to have experienced wasting over the first 12 months of the pandemic, 80 per cent of whom live in sub-Saharan Africa and South Asia.[21] In Eastern and Southern Africa region (ESAR), the number of severely wasted children was projected to increase by 25 per cent in 2021 (from 2.6 million children to 3.3 million children), while in MENA malnutrition increased nearly 40 per cent compared to the same period last year.[22]

Health service disruption and increases in malnutrition could contribute to over 56,000 additional maternal deaths and 1.5 million child deaths over a six-month period across 118 middle low- and middle-income countries.[23] In West and Central Africa region (WCAR), 1.2 million children under 5 with severe acute malnutrition (SAM) were admitted for treatment – an 18 per cent decrease compared to the previous year prior to COVID-19[24], suggesting that many children suffering from SAM were not referred to health facilities. In total, 4.9 million children under 5 are at risk of severe malnutrition in the WCAR, while 1.7 million children in EAPR, 3.1 million children in ECAR, and 700,000 in LACR are in a similar position.[25]

These trends have been compounded by the socio-economic impacts of COVID-19.

Mental health:

Across all regions there have been reports of mental health deteriorating as people face prolonged periods of lockdown and an array of multi-dimensional pressures. According to one UNICEF survey, over a quarter of respondents had experienced feelings of anxiety because of COVID-19.[26]

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17 *Ibid.*
18 UNICEF, Humanitarian Action for Children, 2021.
19 UNICEF, Humanitarian Action for Children, 2021.
20 UNICEF Global COVID-19 Final Report.
21 United Nations Children's Fund, 'Global COVID-19 Situation Report: Health/Nutrition', UNICEF, New York, 2020.
22 UNICEF Global COVID-19 Final Report.
23 *Ibid.*
24 UNICEF Global COVID-19 Situation Report: Health/Nutrition.
25 UNICEF, Humanitarian Action for Children, 2021.
26 UNICEF Global COVID-19 Situation Report: Health/Nutrition.

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WASH

At the start of the pandemic, 40 per cent of people globally did not have access to hand-washing facilities with soap and water at home – a key preventative measure to contain the spread of the virus.[27] As of the end of 2020, 49 million people in MENA, 1 million people in SA, and 30.5 million people in WCAR lacked access to basic WASH services.[28]

The pandemic has also affected service coverage in key institutions. For example, in LACR, 9 per cent of healthcare facilities have no water services and 10 per cent have no sanitation services. Out of 830,000 primary and secondary schools, 16 per cent have no water services and 40 per cent have either no or limited (water but no soap) handwashing facilities.[29]

Education

COVID-19 has caused the **largest disruption of education in history**, affecting nearly 1.6 billion learners in over 190 countries. School closures have impacted 94 per cent of the world's student population, and up to 99 per cent in low and lower-middle income countries.[30] Many still lack access to formal education, including 114 million children in EAPR, 50 million in ECAR, 110 million in MENA, and 128 million in WCAR.[31]

27 United Nations Children's Fund, 'Global COVID-19 Situation Report: WASH', UNICEF, New York, 2020.
28 UNICEF, Humanitarian Action for Children, 2021.
29 *Ibid.*
30 UNICEF Global COVID-19 Final Report.
31 Humanitarian Action for Children, West and Central Africa Report, UNICEF (2021).

The so-called 'digital divide' – that is, unequal access to information technology and virtual learning opportunities – has exacerbated inequalities during the course of the response, particularly in regard to education opportunities for children. In ECAR, U-Report surveys indicate that over 35 per cent of young people have faced difficulties accessing online learning due to a lack of devices or internet connectivity.[32] In LACR, despite the efforts of governments and partners since the pandemic began, one-third of all children and adolescents do not have access to quality distance/online learning.

Across the globe, 7.6 million girls from pre-primary to secondary school are at risk of not returning to school as a result of COVID-19-related restrictions and consequences.[33]

School closures have also prevented 370 million children from receiving free or subsidized school meals.[34]

Gender and protection

The COVID-19 pandemic has a distinct gender dimension. As highlighted in the ECAR RTA report, women account for 83 per cent of the frontline workers involved in pandemic response in the region, yet few are represented in COVID-19 response decision-making bodies. Women are more likely to report having to reduce food consumption and struggling paying utilities and rent. They have experienced a roughly 55 per cent increase in domestic work (against 37 per cent for men) and have faced additional challenges as a result of the closure of educational institutions (74 per cent of women in ECAR arrange their children's education, versus 32 per cent of men).

Alongside increases in child marriage and pregnancies during the COVID-19 response period, data continue to show a significant increase in the cases of violence against women and girls. In Mauritania, for instance, calls relating to gender-based violence cases tripled from 2019 to 2020.[35] In Lebanon, 57 per cent of women and girls reported feeling less safe in their communities; 44 per cent also felt less safe in their homes.[36] While cases of sexual and gender-based violence (including domestic violence) have increased due to lockdown, the ability to provide support to victims has been curtailed. Studies conducted by UNICEF have found that violence prevention and responses were disrupted or curtailed due to COVID-19 measures in over 100 countries.[37] Of the 136 countries that responded to a UNICEF socio-economic impact survey, 104 countries (home to over 1.8 billion children) reported a disruption in services related to violence against children.[38]

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32 United Nations Children's Fund, 'Global COVID-19 Situation Report: Education/Early Childhood Development, UNICEF, New York, 2020.
33 UNICEF Global COVID-19 Situation Report: Health/Nutrition.
34 UNICEF Global COVID-19 Situation Report: Education/Early Childhood Development.
35 United Nations Children's Fund, 'Mauritania Real-Time Assessment: Key points', UNICEF, 2021.
36 UNICEF Global COVID-19 Final Report.
37 *Ibid.*
38 UNICEF Global COVID-19 Situation Report: Education/Early Childhood Development.

3 FINDINGS

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Section 3 of this global synthesis report is structured around the RTA questions under the headings of 'adaptation' (3.1), 'implementation' (3.2) and 'quality' (3.3).

3.1 Adaptation

For the purposes of this report, "adaptation" is defined as how UNICEF changed priorities and working modalities (primarily at the country level) to be able to respond more effectively to the challenges brought about by the pandemic.[39]

SUMMARY

To address the health and socio-economic impacts of the COVID-19 pandemic upon children, UNICEF has supported adaptations to service delivery systems to support continuity, facilitate reopening and enable equitable access. All regions reported an overall increase in the scale of delivery and coverage (adaptation included the setting up of COVID-19 response interventions in sectors and geographical areas that were new for some COs). The need to procure (mainly) health-related supplies at scale was new for most COs, and while it provided opportunities for UNICEF, it was also extremely challenging. Most regions also saw a scaling up of upstream work, with a clear focus on supporting governments in initiating or expanding social protection activity. Several regions found that the organization's competence and experience in risk communication and community engagement (RCCE) offered an entry point for UNICEF to collaborate more closely with a wide range of United Nations agencies, government and local partners, though there were also challenges securing capacity to deliver this at scale. Regions are asking questions about how UNICEF should respond to mental health needs, how psychosocial support should be aligned with other programming, and whether UNICEF can ensure capacity to respond at scale. A general point observed was that COs were required to become more operational at a time when pressures on staff and partners were extreme and that this should be better recognized as the situation becomes prolonged.

[39] Drawn from the ECAR RCA report.

3.1.1 Scaling up programmes

Scaling up of both downstream and upstream programming was reported to be the most significant form of adaptation by almost all COs that responded to the survey.[40]

This implied **increasing coverage**, including efforts to reach the most vulnerable, and **procurement** of essential supplies. Regions also consistently reported **repurposing of programming towards risk communication and community engagement (RCCE) and the scaling up of digital programming** (including the facilitation of digital access for frontline ministries), as well as **scaling up in social protection activity/advocacy** with the provision of upstream advice to national governments. The EAPR report noted that "the established modus operandi of upstream work with government in upper- and middle-income countries remained appropriate, and much was achieved in supporting government efforts and advocating for improvements. **Switching to a twin-track of maintaining this focus and adding greater effort on downstream working with partners at sub-national levels was challenging for some UNICEF COs".**[41]

RCCE and digital programming

A particularly salient feature of the response was the **exponential increase in the coverage of RCCE activities across all regions, including through online platforms**. Country offices reported that their expertise in RCCE, and ability to support governments in their own efforts, **provided them with an entry point, voice, and leadership role in many international coordination fora and with international financial institutions (IFIs). MENA found it to be "a door opener" for deeper and new partnerships with a wide range of actors**. EAPR found that UNICEF support to timely and scaled-up RCCE allowed **extremely vulnerable and excluded groups to be targeted**, and this finding was replicated across other regions, such as MENA, where "partnering with grassroots organizations, like the scouts in Algeria and Tunisia, allowed UNICEF to stay in regular contact with these populations".[42] In Cote d'Ivoire, the CO made extensive use of digital platforms to sensitize the population through the creation of a web channel called "Miraculous" in a bid to occupy the social media space, track views, and provide a credible source of accurate news. And in LACR, the RTA suggested that UNICEF is widely considered to be **a reliable institution in risk communication** in the region. Despite the difficulties in measuring these activities, there is a consensus that UNICEF has become a **vital organization** in this field, especially when it comes to advising public institutions.

Regional RTA reports repeatedly highlighted the **increased use of social media platforms and information and communications technology (ICT) tools** (e.g. Facebook, WhatsApp, WeChat, TikTok, Telegram, LINE) as part of UNICEF RCCE strategies. In addition, partnerships with **private sector** partners such as Google and mobile phone network providers were repeatedly reported. Several reports however highlighted the need to better understand how to more effectively engage young people through such platforms.

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40 The online survey was administered to a much broader group than the 'focus' COs, as shown in Table 2.
41 United Nations Children's Fund, COVID-19 response Real Time Assessment Report, April 2021, UNICEF EAPRO, p.42.
42 United Nations Children's Fund, 'MENA Real-Time Assessment COVID-19 Report, January 2021', UNICEF, Amman, p.5.

Cash transfers and social protection

Cash transfer programming was expanded and newly implemented across several countries. Zimbabwe, Yemen, Sudan, Syria and Jordan all reported an **expansion of pre-existing cash transfer initiatives**. In LACR, efforts were targeted at reaching migrant populations and marginalized communities with cash-based support. Several countries also launched **new cash transfer programmes**, such as Cote d'Ivoire, where 70,000 households were reached in the Greater Abidjan area, and Tunisia, where a universal child grant scheme was started. Angola initiated the country's first-ever cash transfer programme, supported by UNICEF and other private sector partners. In WCAR, support was provided to widen the scope of social protection programmes to include families suffering from HIV/AIDS and otherwise non-identified vulnerable groups to ensure continuity of treatment. In Bangladesh, UNICEF provided support to detained children to digitally access courts, and provided cash grants for released children who were not able to return to their homes.

Photo: © UNICEF/UN0399677/Jibuti

Funding for such initiatives has however proven difficult in some countries, such as in Chad, where the CO has been unable to raise enough money to implement a planned cash transfer programme.

In addition to the direct cash transfer activity, UNICEF has **advocated with governments to implement and scale up cash transfers and social protection activity** in a range of countries. The EAPR report found that countries with experience in cash-based programming had greater success in **advocacy efforts with governments and mobilizing financial resources to launch child-sensitive schemes**. In Thailand, sustained advocacy by UNICEF and its partners led to the government spending almost 40 billion Thai Baht[43] to top-up its cash transfer programme for extremely vulnerable people, poor children, and children with disabilities. In Cote d'Ivoire, support for parents of street children in the process of re-socialization and support for the national cash transfer programme were regarded as key UNICEF achievements.

Advocacy efforts for cash-based support were reported in Ukraine, Kyrgyzstan, Thailand, Myanmar, Mongolia, as well as in Sudan, where UNICEF pushed for targeted support to nutritionally vulnerable groups, particularly pregnant women and young mothers. In EAPR, UNICEF suggested building on existing systems to help facilitate the scale-up of social protection services. In the Dominican Republic, UNICEF provided data, technical, financial support for cash transfers to 2,700 families with children living with disabilities, in coordination with the national social inclusion system. An ad-hoc emergency measure has secured coverage of families with disabilities.

[43] Approximately USD 1.3 million.

Mental health

Psychosocial support has been an increasingly key activity in the UNICEF response to COVID-19. A variety of examples were provided, **particularly targeted at youth and those who have suffered from domestic abuse**, where COs launched support services to address mental health concerns.

In Morocco, UNICEF initiated a partnership with the Mohamed V University to provide remote psychosocial support via RCCE messaging and frontline workers, who initiated WhatsApp groups to engage with people. Moldova CO invested in 'soft skills' for youth related to stress and anxiety management, and Kyrgyzstan CO ran an education programme involving 'social pedagogues' to ensure girls were protected when studying remotely. Croatia CO developed specific platforms and communication tools for engagement with adolescents and young people. In Tajikistan, a digital platform for adolescents provides peer-to-peer support. The regional report from ECAR recommended that UNICEF could look at **expanding the range of psychosocial services and the format in which they are offered**, noting that many programmes were built around the hotline model.

Similarly, most UNICEF country offices in South Asia were found to be supporting mental health and psychosocial support interventions. These were often based on needs indicated by local partners, and it was not clear in the regional report if all COs were working to proactively identify needs. **A parallel real-time assessment on mental health support services in SAR found that not all mental health needs assessment data are disaggregated for age and gender, and less attention is paid to specific needs of children with a disability and/or mental health condition**. The SAR mental health RTA also found that, while there was diversity in mental health and psychosocial support modalities across countries, the main weakness was in the failure to integrate this work in routine health and other sectors. **Interventions tended to be siloed, limiting their potential to reach more people**. The way mental health and psychosocial support is institutionally organized in UNICEF is also somewhat limiting; the report recommended that it be **re-organized to better reflect its cross-cutting nature**. Currently, South Asia COs are training frontline workers, health professionals and teachers in psychological first aid; offering remote support, online and through helplines; and integrating mental health and psychosocial support into some RCCE activity.

In LACR, UNICEF supported El Salvador and the Dominican Republic with the set-up of psychosocial support helplines, facilitating access to essential and individualized care for children, families and protection professionals using available technologies (mobile phone, WhatsApp). These services can operate in Haitian Creole and sign language and are integrated with the national network of mental health or juvenile justice services.

Other forms of new or scaled-up service delivery

Regional reports also itemized and detailed multiple examples of new or scaled-up basic service delivery, including through support to governments. This is supported by the data collected from governments, IPs and frontline workers. In WCAR, for example, several COs reported incorporating a new focus on **street children** and gender-based violence. Similarly, in some focus COs in LACR, there was increased emphasis on downstream work, including **new emergency WASH response**. In ESAR, through its HIV/AIDS programme, Uganda CO is supporting multi-month

dispensing of antiretroviral drugs to mitigate the impact of movement restrictions on the supply chain. In the MENA region, COs led a mostly facility-based infection prevention and control (IPC) and WASH response, focusing on health and quarantine centres. However, once it became clear that the response would need to extend beyond primary healthcare facilities, COs adapted, making a concerted effort to transition **from a facility-based WASH and IPC response to a community-based one**. Many COs supported the adaptation of protocols and guidelines and provided training for staff, especially frontline staff, on their own or in partnership with the Ministry of Health (Yemen, Syria, Tunisia, Sudan, Egypt, Iran).

Increasing geographic coverage and reaching the most vulnerable

In some countries the geography of interventions shifted considerably in response to the pandemic. In Ukraine, for instance, coverage shifted from a near-exclusive focus on eastern Ukraine to cover the entire country (which required finding new IPs with capacities outside of eastern Ukraine and building new connections with regional and local governments). LACR also reported expanded coverage to **new areas and vulnerable communities**, such as indigenous communities in Venezuela, marginalized urban areas in Buenos Aires and Caracas, the northeast of the Dominican Republic, and rural communities in El Salvador. According to the LACR RTA report, **expanded coverage helped enable the most vulnerable to be reached**. For example, LACR reported **the development of e-health strategies to extend health coverage to communities with access barriers to conventional health services**. Notably, however, the increase in geographic coverage was partly made possible by the suspension of ongoing programmes.

In contrast, ESAR reported that only three out of 14 countries reported working in new geographical areas, and the regional RTA report suggests that this was related to difficulties in establishing new presence/partnerships amid lockdowns. In EAPR, two countries said they had prioritized increased geographical coverage.

Increasing direct operationality

Reports suggest that, in the response to COVID-19, UNICEF was required to **substitute for implementing partners or peer agencies** that, for a variety of reasons, were not able to respond. There is generally insufficient information in the regional reports to understand the underlying causes for these partner gaps. The LACR RTA report stated that some UNICEF COs had **much more developed technological platforms and organizational capacities** (rapid training, committed staff) to respond to large-scale crisis than those of most partners. In many non-HAC countries, LACR COs reported that their partners had **other skills and experience**, such as human rights and social work, rather than humanitarian response. In past evaluations, this element has been found to be a limiting factor in emergency response, suggesting that further work on preparedness is required even in development contexts.

There are, however, positive examples of partners scaling up, including in WCAR, where some focus countries were able to rely on a network of implementing partners at the community level both for delivering activities on the ground and ensuring real-time surveillance and community engagement. For instance, in Gabon, civil society was able to organize itself as a coalition, which facilitated contractual management and planning and monitoring of activities.

Procurement/supplies

The procurement of supplies became a prominent feature of the UNICEF COVID-19 response. In the first phases of the response, UNICEF was involved – often for the first time – in setting up new procurement arrangements.

Country offices in all regions spoke of the **challenges** in securing personal protective equipment (PPE) and other supplies at scale for staff, partners, essential basic service providers and the most vulnerable. **The need to ensure that PPE was fit-for-purpose and child-sized appeared to be a lesson identified, as was the need to communicate better globally on pipeline blockages**. As the ECAR report noted, "the global scale of the pandemic and **sudden demand for the same products** to be procured across the globe made it difficult to redistribute procurement tasks across regions".

Some COs found exploring local procurement options to a be a time- and cost-saving approach to getting around supply constraints and rising prices. For example, the Georgia CO is now considering long-term agreements (LTAs) for further decentralization of procurement. In WCAR, the Cote d'Ivoire CO reported favouring local solutions, due to restrictions imposed by the Ivorian government and the difficulty of bringing in people as well as products from outside. **Long-term agreements with transport and storage companies** allowed supplies to be made available to beneficiaries. The RTA in Cote d'Ivoire also reported some **logistical delays or difficulties related to the quality of the deliverables offered by suppliers, thus impacting on the quality and the coverage** of the response. The CO reported that field visits and follow-up meetings were key to triggering corrective measures to the satisfaction of beneficiaries and communities.

Photo: © UNICEF/UN0468143/Mawa

Despite the operating constraints, UNICEF was also able to leverage its neutral, trusted partner status with national governments and external partners to increase resources available for procurement and technical support, even in extremely challenging contexts. In the Democratic People's Republic of Korea, for example, UNICEF was able to bring in vaccines, essential medicines and COVID-19 response supplies (PPE) by road from China after passage through ports had been restricted due to infection prevention control measures.

The LACR report noted that while overall procurement of medical equipment and PPE in the region had a slow start, **Venezuela was an exception**, since it was one of the countries prioritized by UNICEF Supply Division at a time when stock-outs and global supply chain disruptions were widespread. In EAPR, UNICEF ensured that adequate PPE, medical and health-related supplies for COVID-19 response were provided to 14 countries.

In MENA, UNICEF is reported to have engaged in significant efforts to provide PPE for UNICEF staff, implementing partners and frontline workers while also supporting many countries (Algeria, Djibouti, Morocco, Iraq, Sudan, Iran) in procuring COVID-19 tests. The MENA RTA report nonetheless also clearly explains the challenges of delivering supplies in a timely and appropriate way as the supply chain for PPE and other essential health and WASH items was overburdened, leading to significant delays. While governments were reportedly understanding of the delays, COs also reported that **procurement time estimates were not always clearly and transparently communicated internally, which limited the ability of COs to share accurate messages about procurement to national and government partners**.

Concerns were raised that this might sometimes negatively impact the trust established between UNICEF and partners.

The South Asia RTA report noted large-scale procurement arrangements of PPE, test kits and related support (hospital beds, ventilators), carried out with funds provided by external partners such as the World Bank and Asian Development Bank, as an "important win" of the response. Yet the report also suggests that, in a few cases, **the urgency to prepare these PPE and medical supply procurement proposals came at the expense of consultations (and agreements) with governments and other stakeholders.** The report suggests that **there is a need to document and take stock of the burdens that such commitments place on administrative and operational budgets, and upon country office staff**. The delays in the provision of supplies also resulted in concerns in some countries about '**reputational risk**' in terms of meeting the expectations of partners in the region such as the World Bank and the Asian Development Bank. **Some COs in the region reported that, given delays, donors turned to the United Nations Development Programme and the United Nations Office for Project Services, who had quicker systems to source supplies and charter flights for their delivery**.

Focus country reports also highlighted that in many cases, **UNICEF donated ICT equipment** to government and partners in order to overcome challenges related to remote working. It was not always clear, however, whether UNICEF was able to ensure support for training and utilization of such equipment is also in place.

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3.1.2 Scaling down or pausing pre-existing programming and implications for continuity of services

Under the circumstances outlined above, UNICEF was obliged to assume a stronger role in ensuring implementation capacities, meaning some (non-COVID-related) programmes had to scale down or be paused. Reporting on this aspect is not as systematic in the regional RTA reports, yet it was inevitable in many instances, with negative consequences for children.[44]

For the most part, scaling down appears to have occurred either because of lockdown impediments or to accommodate a new COVID-19-focused response (including reallocation of resources). In LACR, Venezuela reported scaling down in nutrition in order to accommodate scaling up in health, WASH and communications for development (C4D). In ESAR, almost all the focus countries reported scaling down planned programmes for 2020, which was described as a shift away from development objectives to meet the needs of the COVID-19 response. For example, as a result of COVID-19-related restrictions, **the child health days campaign in Uganda** was suspended, and children could not be reached with vitamin A supplementation and deworming. In South Asia, where polio had declined to only eight cases in 2018, the **pause in polio campaign activities** for six months in 2020, along with the disruption to **regular immunization services**, meant that polio outbreaks were not contained effectively, and as of 30 September 2020, Pakistan had reported 74 polio cases.

[44] Also, the RTA regional reports do not systematically record if COs have been able to monitor the implications of scale-downs.

In some countries, such as Gabon, Mauritania and Cote d'Ivoire, continuity of services seemed less affected, possibly because COVID-19 had a limited geographical spread, with most cases limited to capitals and urbanized areas.

3.1.3 Ensuring continuity of vital programmes

Another key area of adaptation for UNICEF COs was ensuring, where possible, **continuity of existing vital programmes**, many of which were disrupted or interrupted entirely by the pandemic. In MENA, projects supporting cold chains were affected by mobility restrictions but resumed as quickly as possible (such as in Syria) while preparations for COVID-19 vaccination campaigns were underway. Throughout MENA, UNICEF health, C4D and WASH sections focused on supporting the adaptation and continuity of primary healthcare services (pre- and antenatal care, immunization and nutrition services) during the second phase of the response, roughly two months after the pandemic was declared. UNICEF also worked with other agencies to carry out a pre-emptive 'bundling' response in which particularly vulnerable populations were targeted with WASH supplies in addition to other necessary materials. In LACR, although nutritional assessments were affected by restrictions in some instances, the four focus COs in the region were able to expand the distribution of complementary foods as the situation worsened. This was achieved in collaboration with civil society organizations (CSOs) in Argentina and Venezuela, and through national health services, such as in the Dominican Republic. In addition, actions were implemented to reinforce the management of severe and moderate malnutrition at community and primary care levels, such as through the establishment of human breastmilk banks in El Salvador and the nutritional surveillance system in the Dominican Republic.

In ESAR, efforts to maintain health, nutrition, HIV/AIDS, and WASH services in the region were hindered by disruptions to the supply chains for lifesaving commodities. UNICEF efforts were critical in mitigating this through tracking availability, procuring on behalf of the government, prepositioning supplies, and providing technical support to governments to enhance all aspects of procurement. COs noted that there was good support from the Supply Division in this regard.

Continuity of learning

Examples of how UNICEF COs **responded to school closures** by supporting governments in the **provision of remote learning** were repeatedly provided across regions and countries. UNICEF efforts included the distribution of educational supplies, the production of learning content for radio and television, support to remote teacher training, and the development of technology platforms for educational content.

In ESAR, where UNICEF partners highlighted **the education response as one of the main successes**, COs supported distance learning through the **production of educational radio and television broadcasts, distribution of workbooks and learner kits, and support to online educational platforms** (such as DBE with 2Enable in South Africa).

In Cote d'Ivoire, UNICEF provided technical and financial support for the national distance education programme "My School at Home", which was launched on television, radio, Web TV, and a free SMS learning system. In Mauritania, a **UNDP-UNICEF interagency collaboration** was established to provide **equipment and support the broadcast of a school**

radio programme dedicated to learning and the promotion of educational culture. **Radio sets were distributed in remote areas to vulnerable families** (targeting homes sheltering girls in particular).

In MENA, where schools remained closed in March and April 2020, COs supported governments in setting up distance learning (Algeria, Djibouti, Morocco, Iraq, Yemen) and in the **development of blended learning curricula and platform design** (Iraq, Jordan, Libya, Lebanon). COs also complemented their development and dissemination of distance learning materials by designing and in some cases conducting teacher training.

In countries such as Syria and Yemen, where continuity of education services was severely affected by the **difficulty of setting up distance learning**, UNICEF provided ITC equipment for the most vulnerable children in a variety of settings. In response to limited access to online materials, UNICEF COs supported the development of **television programmes** in countries with large access to mass media and provided **paper-based kits** to support inclusion of those without access to television (Djibouti and Syria). UNICEF also developed solutions to limit dropout and facilitate catch-up in many countries, and in Qatar, UNICEF collaborated on a learning platform for digitally isolated children.

Exclusion and widening of existing disparities were of great concern and COs took steps to address these issues with innovative solutions. In Georgia, for instance, the CO incorporated remote learning modalities that used physical communication materials and television.[45] In LACR, UNICEF used the crisis as a chance to **update educational materials for online use** that would take into account different socio-cultural contexts such as **indigenous communities and reinforce diversity** and inclusiveness. In the Rohingya refugee camps in Bangladesh, where remote learning was not accessible, **UNICEF initiated a programme of caregiver-led home-based learning education, alongside distribution of learning materials**.

Throughout the first year of the pandemic, UNICEF COs were also involved in **advocating for the safe reopening of schools**. In ESAR, for example, UNICEF provided technical support for the development of standard operating procedures (Zimbabwe), training on safe school operations (Somalia) and disinfection of classrooms (Madagascar). In Syria, where no option for distance learning was identified, **UNICEF provided support for the safe reopening of schools** by providing guidance, equipment and vouchers for schoolchildren to access hygiene products. In WCAR, countries such as São Tomé and Príncipe worked with the World Food Programme (WFP) to support the return to school through providing return kits and facilitating school feeding. In the Maldives, **UNICEF was successful in advocating for a phased reopening of schools across the country, especially on COVID-free islands**.

3.1.4 Institutional adaptations and remote working modalities

A key adaptation made across most COs was a **change in delivery modes**, with an emphasis on switching to **digital platforms** for programming, management and monitoring.[46] While not all COs worked remotely for extensive periods

[45] Situation report for Georgia CO #11.
[46] More detail on remote monitoring is in the 'Quality' section below.

of time, most COs across all regions **updated business continuity plans, adopted comprehensive duty-of-care policies, reallocated budgets, negotiated with existing and new donors, identified new suppliers and activated international acquisitions of medical supplies**. Procedures such as electronic signature, the establishment of new or expanded agreements with IPs, local staff recruitment, and acquisition of local supplies facilitated administration and logistics.

The **efficiency benefits of remote and digital working were consistently noted** across the focus COs. It was also felt that this transition contributed to the ability of COs to scale up and expand programming efforts. **Evidence is still emerging, however, with regard to the overall strengths and limitations of this approach and their implications for the effectiveness and efficiency of UNICEF programmes, a point that warrants further investigation. This cost-benefit analysis is likely to vary from one context to another**. For example, as noted by EAPR, digital solutions may be practical in places such as the Pacific, where there are high costs and vast travel distances, but may be less practical elsewhere.

3.1.5 Staff welfare

UNICEF acted quickly to safeguard its staff at the onset of the pandemic. Responses in several COs indicated that putting measures in place to safeguard the occupational health of staff via working from home / PPE distribution was seen as a (positive) adaptation early in the response. For example, in Pakistan, weekly Zoom meetings were held for all staff that focused not on professional issues but rather on 'COVID and how to care for ourselves'. Additionally, a COVID task force was set up by Pakistan CO to keep track of evolving information and other issues and met three times a week to share information. Priority in Pakistan was placed on promoting a culture shift and new ways of working, which emphasized 'management by results, not presence'.

At the same time, as noted elsewhere in this report, **staff have expressed concerns about wellbeing, especially as the response became protracted**. In addition, **there has been uncertainty with regard to how safeguarding policies apply to external contractors**. In Nepal, for example, questions were asked as to whether consultants should be asked to take on risks that UNICEF staff were not being asked to expose themselves to, and efforts are ongoing to reach out to local insurance companies to resolve this. Pakistan addressed this issue by providing detailed guidance to consultants and contracted personnel to enable them to take informed risks.

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3.2 Implementation

SUMMARY

There is a renewed value placed by COs upon preparedness, providing an opportunity to evolve the emergency preparedness planning mechanism further. Preparedness should include upstream work such as advocating for social protection mechanisms, and further consideration should be given to the issue of how to support non-humanitarian, middle-income contexts in preparedness and resilience planning. While the CEAP was appreciated overall, non-emergency countries lack confidence in operationalizing flexible procedures provided for through the mechanism. Several regions highlighted onerous reporting requirements from HQ and a perceived proliferation of ad-hoc and duplicative coordination mechanisms. Country offices greatly appreciated the flexibility of donors in allowing the reprogramming of funds to respond to the pandemic. The ability to raise additional resources, however, varied greatly between countries, with middle-income countries in particular struggling to marshal sufficient resources. Key aspects of the response, including RCCE, C4D and AAP were not always budgeted for or sufficiently reflected in the HAC. Some COs struggled to source surge support for HR needs, suggesting that EPP in some countries does not adequately take HR aspects into account.

3.2.1 Preparedness

A frequently-cited observation across regional RTAs has been the value of preparedness. In general, COs that rated their preparedness as higher were those with **previous emergency experience**, pre-positioned contingency stocks, extensive immunization programmes, or those which were part of pre-existing humanitarian coordination mechanisms in-country. **UNICEF was frequently able to utilize its pre-existing knowledge, expertise and partnerships to facilitate effective scale-up**. In Pakistan, for example, relationships and arrangements formed to deliver a pre-COVID-19 polio programme were quickly adapted and optimized for COVID-related procurement. Similar success was reported in Afghanistan, with an adapted immunization initiative pivoting to support the COVID-19 response. In a similar vein, the considerable expertise of the WASH team in Yemen in preparing for and responding to cholera outbreaks allowed them to react rapidly to the crisis, setting up an internal task force at the beginning of the pandemic to define the response and CO priorities. Regions such as ESAR noted that those countries with previous humanitarian experience were able to utilize their pre-existing knowledge, but noted that this was the case only in a minority of countries, **emphasizing the need to strengthen emergency preparedness in all contexts, and particularly in middle-incomes countries**.

Conversely, focus COs that had **little recent emergency** experience or that did not anticipate such a complex and fast-evolving crisis were the most critical of their own CO preparedness levels. They also recognized that their **planning had included the erroneous assumption that**

surge, or other additional external capacities, would be possible to source internationally at the time of an outbreak. The overwhelming message conveyed by respondents on the ground was that **preparedness, contingency planning and risk management are critical and essential pillars of an effective and timely response**, and the crisis has highlighted the need for UNICEF to **redouble its emergency preparedness planning (EPP) efforts**.

Country offices in some regions, however, felt that even relatively high levels of preparedness for most types of emergencies did not adequately prepare them for an emergency on the scale of COVID-19. Indeed, in South Asia there was consensus among COs, frontline workers and affected community representatives that **previous emergency preparedness and contingency planning (geared toward natural disasters like tsunamis and earthquakes as well as political upheavals) were not of major relevance in coping with the complex, multidimensional challenges of COVID-19**. The ECAR report found that **prepositioning and contingency plans were largely non-existent or ineffective**. For instance, the contingency planning in Tajikistan was built around natural disasters and conventional diseases (e.g. measles) and was not suitable for responding to the COVID-19 pandemic. In Ukraine, the existence of emergency operations in the eastern regions did offer some benefits in terms of existing warehousing capacities but was of limited relevance for expanding operations to the rest of the country. The report concluded that there were **strong reasons to consider developing low-intensity preparedness arrangements and dormant response systems and protocols that could be activated and scaled up as needed**.

The report also noted that while all COs had received preparedness training and had developed a preparedness plan before the COVID-19 outbreak, only a few staff members (those working in the emergency sections) had been involved. Further, **the language of instruction (often English) reportedly did not always make it possible for local staff to fully comprehend and retain the content of such training sessions**.

The MENA regional report, meanwhile, highlighted the **importance of investing in and enhancing preparedness for scaling up social protection programming as part of an emergency response**.

3.2.2 Corporate emergency activation procedure

The organization-wide declaration of a Level 3 (L3) corporate emergency, in accordance with the corporate emergency activation procedure (CEAP), was highly valued across many regions. The triggering of the L3 was found by EAPR to be timely and an important enabling mechanism for mobilization for funds, ensuring organizational commitment and focus, and for supporting reprogramming of funding. Regional consultations on CEAP organized by the West and Central Africa regional office (WCARO) to complement the RTA over the course of the pandemic did however identify some **constraints in the application** of emergency procedures, including issues of awareness and full understanding by staff of the procedures; presence of internal and external factors hindering their successful implementation (such as the need to be online to fill out and sign documents) and different degrees of use, depending on context.

Indeed, some COs lacked full clarity around CEAP processes, with confusion being expressed relative to supply procedures, allocation decisions and prioritization. One region suggested that generally, in countries with no or limited prior emergency experience, administrative and finance staff were reluctant to use simplified procedures due to their limited familiarity. In one country these procedures were reportedly not used, and interviews suggested that staff were concerned the CEAP procedures might contravene national laws and regulations.

Coordination and reporting requirements in an L3 emergency

A consistent theme within regional reports was the considerable **burden of reporting duties**. Many COs reported that **data demands from HQ** were somewhat extractive and 'relentless', and there was a perception that there was **duplication** across many of the requests coming from within the organization. The LACR report noted that LACRO and HQ were placing 'competing demands' for data generation and were adopting ad-hoc procedures, new tools for monitoring, and new coordination mechanisms which generated confusion for COs during the initial months of the response and required additional efforts from COs and partners.

The EAPR report called for clearer guidance for global responses, including but not limited to reporting requirements. Suggestions included **processes for mapping organizational demands and creating a central SharePoint Calendar of crisis data and reporting requests from all HQ divisions and the RO, with these being prioritized as High, Medium, and Low**. A clear mechanism could be established for consulting ROs to guide the timing, prioritization and nature of requests. Regional office sections could then liaise closely with COs to understand country-level constraints and CO data needs and priorities in order to inform HQ decision-making on data demands.

The South Asia region agreed with CO requests for **streamlining** of demand for situation reporting and budget processes. UNICEF staff, government and implementing partners consulted during the course of the RTA requested that the **volume of reporting and virtual meetings should be lessened and/or streamlined**. Many implementing partners also suggested that that the quarterly budgetary allocation process be reviewed, and reporting streamlined, as this was often time-consuming. In order to lessen the burden of COVID-19 reporting at regional and global levels, it was suggested that **UNICEF should also support the harmonization of indicators that had to be reported on to various United Nations entities**.

In many of the WCAR focus countries, this was the first experience many staff had had in an emergency (Gabon CO, for example, stated that this was the case for more than 80 per cent of its staff). They noted that **information flows received from headquarters and regional office and (the large number of) virtual meetings** were often in English and, for local offices, this **increased the workload considerably**. The work pace was sometimes difficult to maintain for CO-level staff.

RTA reports received in the fourth quarter of 2020 recommended that moving into 2021 and the planning season, consideration should be given to how these constraints can be addressed and ad hoc tools standardized. There was a repeated assertion that ongoing high demand for reporting is one central

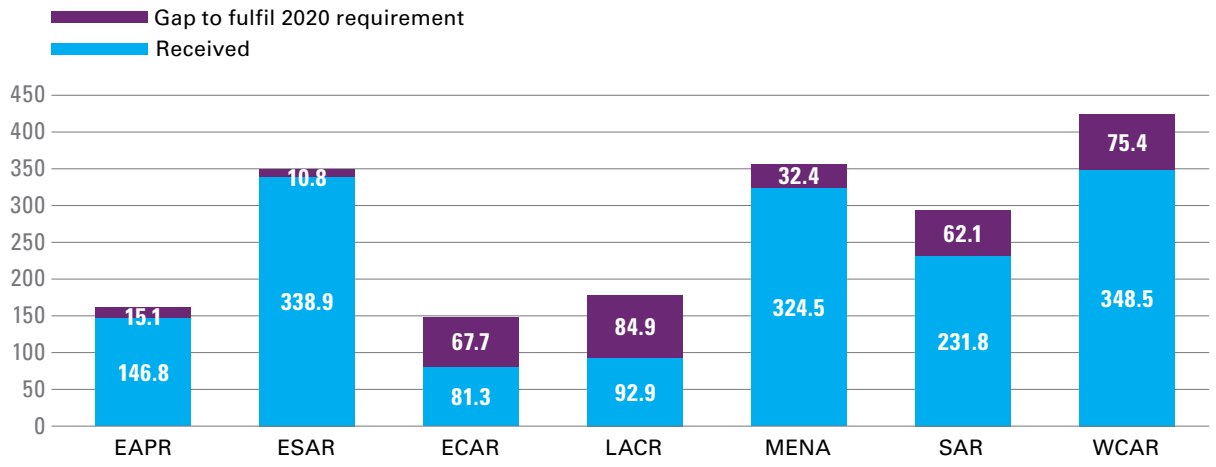
factor in **staff fatigue**. The LACR report stated in April 2021 that the transition to UNICEF Corporate Emergency Level 3 *"Sustain Phase"* for the global pandemic response represents an unprecedented decision for the organization, extending stressful working conditions for UNICEF and partner teams for almost two years. In a scenario of persistent pandemic and compounding crises, **staff resilience** may be stretched to the limit, eventually affecting the organizational capacity to maintain delivery.

3.2.3 Mobilization of financial and human resources

The funding picture for implementing the UNICEF response to COVID-19 varied greatly across regions, with some experiencing relatively larger funding gaps than others, as shown in Figure 2.

Many COs involved in the RTA have cited the **flexibility of key donors** as an enabling factor of the UNICEF response, including its timeliness. Available evidence does not yet clarify whether some sectors have had more flexibility from donors than others. The **ESAR report noted that all COs channelled available resources toward the COVID-19 response**. The Burundi, Comoros, Eritrea, Ethiopia, Kenya and Zimbabwe COs applied to reprogramme GAVI funds, including for the purchase of PPE, essential drugs, testing devices, the printing of learning modules, and C4D. **All ESAR COs also reprogrammed funds toward the child and social protection responses, which suffered from larger funding gaps**. In Moldova, **the CO was able to mobilize a sizable share of the required funding** thanks to donor flexibility, which allowed UNICEF to adjust regular programming to the newly defined needs.

Figure 2: UNICEF COVID-19 Appeal 2020 - funding status by region (USD, million)



Source: UNICEF Global COVID-19 Final Report (March 2021)

Yet cases of inequity among COs were also reported, especially in **middle-income countries** that were not identified as funding priorities. In Ukraine, for instance, inequitable distribution of resources (with most funds earmarked for eastern Ukraine) initially undermined the office's ability to undertake nationwide activities. In the Maldives, while UNICEF had greater monetary resources than other agencies, the CO felt that there were missed opportunities, and that being considered a middle-income country limited the resources available to them. Further, prioritization of countries based on overall caseloads of COVID-19, rather than the number of cases per capita, meant that the Maldives, with its relatively small population, did not feature as a priority country even though the per capita case rate was considerable.

While UNICEF benefitted from donor flexibility, it was not always flexible itself in allowing partners to reallocate or reprogramme funds. One partner in Comoros recommended that, to enhance programming for children and their communities, the CO should improve flexibility to use funds as soon as new needs are demonstrated. The implication in the report is that after the initial programming decisions were made, there were **delays in UNICEF approving adjustments or amendments as new needs emerged or needs changed.** Similar comments also emerged from frontline workers in the ESAR region.

With face-to-face fundraising contracts cancelled due to lockdown restrictions, COs had to find **creative alternatives to mobilize resources**. Many countries, such as the Dominican Republic, focused their fundraising actions via **social media** and organized **telethons**. In WCAR, despite some COs being able to repurpose existing funding, challenges were faced in **securing additional resources** to enable a response that was commensurate to newly identified needs.

Several regions raised the issue that sectors need to budget for RCCE/C4D and accountability to affected populations (AAP) and that these aspects of the response must be adequately represented in the HAC appeal. Emerging evidence of the value of RCCE activities at the community level, combined with the access and leverage it provides to UNICEF, would suggest that **improved mobilization approaches could be a transformational act for an area of work that consistently receives strong positive feedback in all RTA countries**.

With regard to human resources (HR), **some COs reported that they were not able to source surge support**. That this would be possible in all cases **was a faulty assumption underpinning CO EPPs**, which reinforces the point that EPPs were not prepared with such a pandemic in mind. Regional offices were described as responsive and flexible in trying to provide HR support. The EAPR report noted that despite overall **success in mobilizing financial resources, the number of staff at the CO level remains almost the same as it was pre-pandemic**. This may pose some effectiveness and sustainability challenges, should the need to maintain this level of delivery continue.

3.3 Quality

SUMMARY

UNICEF and external stakeholders were positive about the timeliness of UNICEF CO responses, while noting some improvements that could be made. Increasingly, COs have an enhanced understanding of new vulnerabilities related to COVID-19, although it is unclear what the implications may be for medium- and long-term priorities and targets. The existence of substantial new and innovative remote management and monitoring mechanisms in all contexts has been clearly articulated but the effectiveness of these mechanisms has not yet been established. Regions indicate that a hybrid (remote and traditional) monitoring mechanism would be desirable in the future, and accordingly an analysis of the strengths and weaknesses of the remote mechanisms in place for COVID-19 will be critical.

3.3.1 Timeliness

The UNICEF pandemic response was broadly considered timely in all regions. Both CO and external informants spoke highly about the timeliness of the UNICEF response, particularly concerning RCCE activity. Country offices often attributed this to the **flexibility and commitment of staff and partners, the fast adaptation to online working, and previously strong relationships with government and donors, allowing access and leverage**.

At the same time, in almost every region the positive messaging around timeliness was tempered by reports of **late delivery of supplies (as outlined in Section 3.1.1)**. As detailed in section 3.3.4 below, some regions also mentioned that work on **AAP and community engagement was not timely**.

3.3.2 Equity, gender and youth

Equity

Regional RTA reports indicate that **UNICEF has largely managed to continue supporting vulnerable groups**, a view supported by external informants. This was expressed with increasing confidence over time, possibly reflecting improved evidence and learning as the response progressed. For example, the LACR report mentioned that "despite the wide variety of national and sub-national contexts [...], geographical areas with pre-existing vulnerabilities [as well as] particularly vulnerable populations were identified".[47]

There are numerous examples of specific efforts made to support vulnerable groups. In ECAR, specific practical initiatives were noted, such as ensuring televised lessons were accessible for children with hearing impairments. The pandemic presented a major

[47] United Nations Children's Fund, 'Real Time Assessment of UNICEF's response to COVID-19 in Latin America and the Caribbean, Synthesis Report', UNICEF, Panama, 2021, p.9.

opportunity for MENA COs to advocate for releasing detained children: In many cases, COs had been advocating for such release prior to COVID-19, but the pandemic gave governments additional motivation to respond to these advocacy efforts. In Cote d'Ivoire, UNICEF advocated for street children by supporting their integration into social centres during the period of confinement and curfews, and also took action to support people living with HIV/AIDS. In Sudan, CO advocacy resulted in more than 10,000 children being released from Quranic schools (khalwas) across the countries and reunited with their families due to concerns around the possibility of infection in the schools.

In many countries, UNICEF is working to **improve social protection for hard-to-reach people**. For example, in Gabon, the CO lobbied for an extension period for poor communities in the **forest region** to apply for birth certificates and access social security and other benefits offered by the National Health Insurance and Social Guarantee Fund (CNAMGS).

Despite these examples, **there remains some (acknowledged) uncertainty about the impact of the pandemic on some known vulnerable groups**, which has continued to evolve throughout the pandemic. Regions report an understanding of new (and deepened) categories of vulnerable people, but this does not mean that the new hierarchy of vulnerability is understood or that it will not change further. In Cote d'Ivoire, for instance, the CO reported that the rapid humanitarian response of the CO was very beneficial at the start of the pandemic but did not take into account the risk of a redistribution of vulnerabilities. Further work appears to be needed to understand what the implications of these new vulnerabilities are and the extent to which 'vulnerable' individuals and households risk being left behind.

Neither is it clear how **identifying and targeting** the newly vulnerable will be undertaken. This is most clearly summarized in reports from ECAR, which agree that a focus on extreme poverty should remain a central feature of the next strategic plan, but that this new vulnerability requires UNICEF to deepen the consideration of how social and economic inequities in countries are best responded to.

Gender

All regions note the gendered socio-economic challenges experienced by women during the pandemic, including with regard to livelihoods, gender-based violence and domestic violence. Regions in Asia and Africa also noted concerns around early marriage and increased school dropout.

The ECAR RTA report noted that a typical gender-focused response of the COs was focused on four components, including: (a) diagnostic of the differential impact of COVID-19 on women and girls, (b) provision of psychosocial services aimed at survivors of domestic abuse; (c) communication related to pregnancy, childbirth and neonatal care and remote monitoring and advice to pregnant and breastfeeding women, and gender-positive messaging; and (d) additional gender-based violence training for CO staff and IP staff.

The MENA regional office (MENARO) Iterative Action Review conducted in July 2020 noted that the integration of gender into situation report (SitRep) reporting increased over time. Gender disaggregation was not considered at the beginning of the crisis response, except in sectors and programmes for which disaggregated data and information were already collected and available pre-crisis. Analysis against the budget target of a minimum 15 per cent of funding having

a gender tag showed that, of the overall COVID response, 15 per cent of funds utilized in MENA had a gender tag, with the majority spent on social protection. There seems to be a discrepancy, however, between gender initiatives reported and gender budgeting. While Iran, Jordan and Libya report on gender initiatives, the budget analysis shows no allocation of gender budget. Conversely, Algeria, Gulf Area Office and Tunisia mention in their reporting documents that there is an allocation for gender budget while they do not report on any gender initiatives.

In ESAR, while all COs are implementing some form of gender equality or gender-based violence programming, fewer countries appear to be making efforts to mainstream gender. Country offices are hampered from further mainstreaming gender by a **lack of reliable data on gender inequalities** and limited funding (including a lack of earmarked funding and the reprogramming of funding for addressing gender inequality). Country offices also lack dedicated gender and gender-based violence expertise: only two COs (Somalia and South Sudan) have a staff position dedicated to gender-based violence, and the gender specialist posts in Somalia and South Sudan are both vacant as at October 2020. Comoros, Ethiopia, Madagascar, Malawi, Rwanda, South Sudan, Uganda, and Zimbabwe appear to be making efforts to mainstream gender and have therefore been classified as meeting expectations related to this indicator. Between them, these eight COs have made efforts to report on sex- and age-disaggregated data and implement gender-responsive human resourcing. Eastern and Southern Africa is one of only two regions to mention in their regional reports that little was reported by COs about efforts to prevent sexual exploitation and abuse (PSEA).

The South Asia regional office (ROSA) reported that its regional gender network had, in general, found the guidance, capacity-building and technical support for ensuring a gender-effective response to COVID-19 adequate and timely. Similar feedback was also confirmed by the RTA CO survey, which assessed CO satisfaction with regard to relevance and timeliness of ROSA support on gender (score 8, on the 1-10 scale). Country office gender focal points in the region found that maintaining core health and education services were perceived to be the areas where COs were best able to deliver, followed by prevention and response to gender-based violence, with data and care for caregivers somewhat lagging.

The LACR RTA report highlighted how the UNICEF response to COVID-19 in the region incorporated gender programming priorities, as per the gender equality standards of the Core Commitments for Children in Humanitarian Action (CCCs), and gender inequalities were addressed in the RTA focus countries through different approaches. However, a lack of disaggregated data prevented consistent gender analysis and remained a critical gap for measuring effectiveness and equity.

Youth

Country offices have paid extensive attention to the situation of youth and the way the COVID-19 pandemic has affected them. The mainstreaming approach adopted by **ECAR is characteristic of the adaptations undertaken as part of the COVID-19 response**. This was done by paying special attention to the needs of youth, emphasizing their voice, soliciting their feedback, and designing data collection architecture to capture their pandemic experience and needs through the use of dedicated platforms. Additional work on the effectiveness of these interventions is needed. For instance, it is not clear how representative the data are. (Some of the available data suggest that young women are far more represented in the U-report sample than young men). An analysis of the extent to which these platforms may exclude disadvantaged youth is needed, along with designing ways to boost participation.

In several countries in ECAR (Croatia, Kyrgyzstan, Tajikistan), interventions that involve skill-building for young people have been implemented. These are especially relevant for those who are not enrolled in full-time education and are unemployed. They also represent a way to build human capital during the pandemic, with a view toward post-pandemic recovery.

3.3.3 Relevance of response/extent to which response plans reflected evolving needs

Section 3.1 outlined the ways in which UNICEF has modified its approach in the midst of COVID-19 by scaling up programming, extending coverage, repurposing planning and resources and raising additional funds. Yet whether these revised plans accurately responded to the emerging and evolving needs of affected communities is a separate and more specific question.

Most focus COs reported repurposing previous planning at the outset of the crisis, with some COs drawing from their EPP. Further, many COs reported having **updated their response plans** in the second half of 2020. Yet details on the source(s) of information and data underpinning these updates are not always clear. Indeed, there was **insufficient information** coming through SitReps or through multi-regional

responses to the RTA **to draw overarching conclusions about how evolving needs were measured and verified**.

There were both positive and negative examples of data management, with some COs articulating clear processes around data utilization for programme planning, reporting and target-setting and others suggesting clear challenges in target-setting. There were instances of programming **targets being modified several times (ESAR), as well as cases where targets were met** despite low funding mobilization (WCAR). In EAPR, the majority of COs reported that targets originally set were changed and generally increased as the original targets were met. Some changes in the COVID-19 context required commensurate changes in plans and targeting, for instance in the Philippines and Viet Nam, where the COs expanded geographic coverage to cover hotspots of COVID-19 outbreaks. In Thailand, target populations became clearer after discussions with the government on emerging gaps. In WCAR, identified needs at the beginning of the response were reportedly easy to capture, as many partners had launched studies and rapid assessments to support the government.

South Asia reported that, while there were many needs assessments, **the direct link between needs and interventions was generally not explicit, nor was the impact of interventions evident in subsequent reporting** (in, for example, SitReps). An exception was in WASH and IPC, where assessments were generally used as a tool for identifying needs and planning UNICEF support to government-led response plans. Eastern and Southern Africa reported that most COs were collecting feedback on the COVID-19 response from affected populations and adopting a variety of methods to determine population needs. **However, it is not clear from reports how this feedback was used to inform programming**.

The ECAR report confirmed that a common problem with target-setting was the **lack of quality data** on which to base targets and **the consequent reliance on support requests from various branches of government, which are often based on inaccurate data**. The ECAR report also explained that data on socio-economic impacts of the COVID-19 crisis were especially limited, making setting targets related to socio-economic outcomes particularly challenging.

3.3.4 Accountability to affected populations

Regional RTA reports did not offer sufficient detail on the **ability of COs to maintain or initiate community engagement and AAP mechanisms to provide an overall summary statement here**. Most findings related instead to RCCE, which is not a substitute.

The difficulties of accessing communities due to lockdown restrictions are well-established and the RTA itself faced similar challenges when attempting to engage targeted communities to provide feedback (except, as mentioned, for WCAR, where intra-community data was incorporated as part of the data collection).

The EAPR report found that some basic measures were undertaken on accountability to affected populations but more remains to be done. One CO RTA report found that "AAP or other type[s] of community engagement mechanisms were not used as part of the CO response".[48]

[48] This CO is not named here due to a sense that this may be true of other focus COs who have simply not reported on the issue therefore it would be unfair to single out this one CO on such a significant issue.

In São Tomé and Príncipe, while health and education professionals consulted during the RTA were able to speak well of the UNICEF response, community members consulted during the focus group meetings mentioned that their engagement in the UNICEF response was limited, as there had been no involvement of community members in identifying needs or collecting feedback since the beginning of the pandemic. In Cote d'Ivoire, meetings with partner NGOs, bloggers, and government and front-line workers made it **possible to raise complaints from beneficiaries**. Despite this, many appear to be unaware of or unwilling to use available channels for expressing complaints.

The LACR report found that the switch to remote working mode and delivering through implementing partners significantly reduced the organization's capacity to regularly engage with affected communities and the most vulnerable groups. **Ad-hoc AAP measures (e.g. complaint systems via email or WhatsApp, helplines, local consultants) have not been sufficient to reach particularly vulnerable populations, given that such populations do not always have access to email or phones**. Small COs unexpectedly operating in an L3 emergency mode, under lockdown restrictions, have experienced difficulties in combining emergency actions while, in parallel, setting up and managing AAP mechanisms. **The main challenges in implementing AAP, according to LACR, are a lack of funding, expertise, and guidance and tools for AAP**. According to a regional survey, 67 per cent of COs do not have an explicit AAP strategy or framework. Close to 70 per cent do not have a designated AAP focal point, and 51 per cent do not have a systematic way of obtaining feedback, listening to, or responding to community feedback.

The use of social media and other tools (e.g. U-Report) allowed UNICEF in some cases to obtain feedback from targeted populations in real-time and inform COVID-19 response strategies over time. Engagement with such tools led EAPR in Malaysia and Thailand, for instance, to expand RCCE efforts from COVID-19 prevention advice to mental health, wellbeing and psychosocial support, as well as the safe return to school. However, this does not appear to have been systematic. Although communities in some regions said that they had been asked about their needs at the beginning of the crisis, **only a few examples were provided of community feedback on programming being sought after the initial stages of the response, or where community feedback had resulted in a substantial modification to programming.**

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The ESAR report provided some detail on AAP programming and utilization, but this was an exception. In Mauritania, the COVID-19 surveillance relied on **pre-existing community feedback mechanisms through health community agents and youth groups**. This mechanism was also temporarily supported by a national COVID-19 helpline, supported financially by UNICEF and UNDP. However, it was not clear whether these were also used to lodge complaints or support two-way feedback.

Overall, it is not always clear in the regional RTA reports what other community engagement activities are occurring beyond the dissemination of information. Limited ongoing community engagement is a frequent concern following the early stages of crisis response, and it may be that the COVID-19 response is no different. In ESAR, concerns were expressed that the 'CE' component of RCCE was lagging and that the greater focus of response interventions was on the 'supply side' (traditional service providers and governmental entities). Efforts were made in Yemen to strike up new partnerships with individuals and groups in a bid to maintain some interaction with neighbours and communities despite mobility restrictions. This led to new relationships being established with religious leaders and community volunteers. Given the emphasis on rolling out online communications and new ways of working, opportunities for greater engagement may be present, but this may not happen without clear prioritization.

3.3.5 Partnerships

Partners repeatedly recorded generally 'positive' or 'very positive' experiences in their partnership with UNICEF across regions. While noting that partners interviewed for the RTA were recommended by COs and that in many cases options were limited by access, partners consistently felt UNICEF effectively listened, responded and supported them throughout the pandemic response, often in new activities. In EAPR, where access to IPs for interviews had been good, almost half of the partners interviewed reported that they were working/delivering differently than before with UNICEF support. In ESAR, most partners perceived that UNICEF had been flexible in supporting them to implement activities to meet new or different community needs. The exceptions were partners in Ethiopia and Comoros, who saw UNICEF performance as average in this regard.

Focus COs consistently reported examples of **secondments to support the government**. UNICEF also supplied PPE and ITC equipment in many cases to support **remote working**.

All regions were able to cite multiple cases of inter-agency cooperation with other United Nations agencies. These include **joint distributions** or use of pre-existing governance programmes, with a youth focus, as vehicles **to deliver RCCE messaging**. In Libya, UNICEF was a key convener of sister Agencies (UNDP, WFP and the United Nations High Commissioner for Refugees) as well as the World Bank in formalizing a **coordinated approach to support a national shock-responsive social protection system**. There were also examples where inter-agency cooperation was more limited, particularly in those countries where weak relationships predate the pandemic. It was noted that coordination or cooperation agreements among United Nations agencies made at HQ level are not always well communicated to the COs. Mauritania noted that the **weak flow of information** at the level of the United Nations Country Team was a constraint.

Several regions commented on the partnership and relationship with **WHO**, and were able to provide **positive examples of cooperation** and **joint activity**. The MENA report indicated that UNICEF being able to respond flexibly and swiftly, including in new sectors in a few COs, has strengthened the overall relationship with WHO in the region. New activities across regions included joint procurement, RCCE activities, health sector staff training, WASH need assessments, procurement of lab and testing equipment, food security and nutrition support activities, co-leadership of working groups and pillars. As mentioned previously, all regions felt that the organization's strength in RCCE allowed UNICEF to **position itself well in terms of advocacy for children's needs**, including where the relationship with WHO (and other United Nations entities) was not as strong pre-pandemic.

Regions also mentioned strengthening or forging of new relationships with IFIs. This enabled large-scale procurement of PPE and hospital equipment or cross-regional work to leverage resources and expertise, such as in El Salvador, where additional funds were used to mitigate the educational gaps aggravated by COVID-19. In Mongolia, the joint UNICEF/World Bank support to scaling up a major government cash transfer programme has been viewed as a very successful intervention. In Jordan, Egypt, Iraq and Lebanon UNICEF engaged with the World Bank and the International Monetary Fund (IMF) to develop new partnerships during the response.

Partnerships with the private sector have also been developed and/or reinforced. COs have built on a wide range of partnerships with private sector suppliers and service delivery agents, including some innovative relationships with mobile networks and technology companies for health surveillance, for example. The local private sector in Jordan, for instance, mobilized significant in-kind donations, including billboard space, pro-bono RCCE messaging at thousands of locations across the country, and mobile wallet support to enhance financial inclusion. In Ukraine, the emergency created new opportunities to engage with the private sector, especially with regard to local procurement/supplies; the CO now sees partnering with the private sector as a major objective.

New partnerships have also been established with civil society and community groups, and every region has an interesting new civil society portfolio to report on. The LAC RTA report states that the Argentina CO signed relevant agreements with Caritas and La Poderosa, the Venezuela CO signed agreements with 17 local implementing partners, and in Dominican Republic and El Salvador, UNICEF started working with new national bodies. In MENA, religious leaders have been pivotal in supporting the response, and in Pakistan and Afghanistan, frontline workers collaborated closely with imams and mullahs to increase COVID-19 prevention awareness in remote rural communities. In Jordan, Islamic Affairs allowed UNICEF to contribute COVID-19 messaging to Friday prayer sermons across the country (as also happened in Sudan and Yemen), while partnering with guides to hike into remote areas to deliver messages.

The regional RTA reports did not comment, however, on whether or how COs plan to invest in or sustain these partnerships.

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3.3.6 Localization

There has been an increased reliance on local partners for supply and delivery. Country offices responding to the online survey widely reported that switching to more **local supply and delivery** actors had been desirable or necessary. Country offices in ESAR described increasing the use of local solutions as significant adaptations, as did COs in South Asia.

Localization of procurement was reported in all regions, partly driven by a lack of supply in traditional manufacturing countries, especially with regard to PPE (including masks, hand sanitizers and soaps, some of which were produced by local organizations such as women's cooperatives in WCAR). The Ethiopia WASH and education sections, for instance, worked with a local metalwork supplier to develop a prototype hands-free handwashing stand and initiated local procurement of ready-to-use therapeutic food for severely wasted children. Other countries in ESAR used local procurement predominantly to ensure a constant supply of products for the IPC response, although local procurement was not possible in some countries due to limited local production. In SAR, all eight focus COs reported procuring locally. In WCAR, there was local procurement of both goods and services as local consultants were hired to carry out some COVID-19 related tasks, including monitoring of activities, which international consultants would have been normally recruited to do. In Gabon, **small-scale funding arrangements with civil society** were put in place to conduct outreach activities on preventive measures and to raise awareness around respect for children's rights in emergencies, as well as to provide psychological and social care for children and their families in vulnerable situations. Other local solutions concerned the local supply of fabric **face masks for**

populations from remote forest communities. In Iraq, UNICEF worked with the University of Karbala to support the local production of hand sanitizer and disinfectant. And in Tajikistan, the CO received approval from Supply Division to do regional procurement, which was faster and cheaper.

Several regions, including WCAR, ESAR and LACR, reported that focus COs were also increasingly relying on **local IPs** to reach target populations for needs assessments, data collection, delivery and monitoring. However, they also alluded to (unspecified) challenges resulting in a **need to backstop the work**. As detailed below, UNICEF would ideally have more information by now on the **effectiveness of remote monitoring** mechanisms, especially with regard to the organization's ability to directly support local partners and to assess the related risks over time.

3.3.7 Monitoring and evidence generation

Baselines and situational data

As noted elsewhere, the **lack of high-quality disaggregated data**, particularly on vulnerable groups, prior to the crisis has been a consistent challenge in many countries. Gaps included, for instance, data on household welfare in highly informal economies where many of the workers do not appear in the tax authority or social security databases. Even in countries with robust data collection practices, such as Croatia, the CO faced similar issues, especially for specific demographic groups. The ECAR report highlighted the need for financial and technical investment in systems strengthening with national partners, focusing on **developing administrative data collection across sectors**. Many focus COs have taken the opportunity to use their close working relationship with the government and other institutions, such as the IFIs, to generate evidence on gaps in social protection, which would help strengthen advocacy for increased social protection measures in countries across the region.

There are several **good practice examples in rapid evidence generation to inform the COVID-19 response**. In LACR, UNICEF carried out around 30 national surveys on the pandemic's impact on families and children. Together with UNDP, the regional office (LACRO) published a series on the socio-economic impact of COVID-19 in the region, which has served as a reference to support regional and national advocacy. Microsimulation analysis was carried out to estimate the impact of COVID-19 on child poverty and simulate social protection effects in Saint Lucia, Colombia, Peru, Ecuador, and El Salvador. **Results were used by the Ministry** of Finance in Peru and the IMF in Ecuador.

In Tunisia and Morocco, UNICEF generated evidence on the potential impacts of COVID-19 on monetary child poverty and this guided national social protection responses in these countries with a focus on children. In Mozambique, the CO conducted rapid assessments of COVID-19 facilities and used this data to improve accessibility to WASH, advocate for support for continuity of centralized water supply networks and develop a response plan with the WASH cluster.

In EAPR, three government informants in the Philippines noted UNICEF work in **policy advice, evidence generation and analysis through studies and research**. These initial investments in evidence generation and rapid assessments should continue, and COs are encouraged to find ways to extend support to such initiatives to the extent possible, along with ensuring sound analysis of what is working well and what

areas need to be improved. It is recognized that there are multiple adaptive initiatives (completed or ongoing) at the country level commissioned by different teams and offices, and it will be important for COs and the RO to guide coordination efforts.

Despite the successes noted above, as touched upon in Section 3.3.3, **many regions felt that it remains unclear what linkages there are between conducting assessments and data generation, and the extent to which evidence generated effectively shaped the response**.

The ROSA report suggested that UNICEF should invest in the development of a repertoire of innovative strategies to ensure accurate data on gender, economic and social inequity in health, education and protection. **The opportunity to invest in the use of artificial intelligence to review documents and make lesson learning agile and simple should also be explored in more depth**.

Programme monitoring

The pandemic allowed COs to identify issues in monitoring, data requirements and reporting. Very few of the challenges and weaknesses identified in the RTA reports were new or unique to the COVID-19 response, but regions reported quite consistently that the high demand and time pressures that came with the response tended to **exacerbate existing problems** with the monitoring and data collection systems and requirements.

Generally, as the RTAs were unfolding, in-person monitoring tended to be limited due to lockdown and access constraints, compounded by the fact that many COs were working in new geographies or with new partners that lacked established mechanisms. Indeed, approximately two-thirds of COs responding to the survey indicated a **scale-up in the use of digital platforms** as one of the most significant adaptations to the pandemic.

All regions reported on **new or expanded digital and online monitoring / programme management support**. Virtual **programme monitoring visits** have been established in most COs, and some report the existence of **third-party monitoring arrangements** (although it is not clear from the regional reports the extent to which some of these arrangements may have already been in place pre-pandemic). Several COs in South Asia asked partners to take photographs to monitor and verify services. **Several ESAR COs reported successfully using hybrid approaches** including in-person post-delivery inspections, programme visits, and spot checks to support verification through both UNICEF staff and third-party monitoring. However, this was not possible in all regions.

While over three-quarters of COs participating in the **online survey** indicated they had **verified that monitoring and verification of implementation had taken place as planned**, COs also reported cases of monitoring being conducted at a **slower pace, with reduced coverage and below required standards**. Some COs mentioned the **limited capacities of partners** to work remotely and the challenges of remote monitoring in areas of **limited internet access/ low telephone coverage**.

With some exceptions, there has been little overall assessments on the **levels of confidence in the effectiveness** of monitoring mechanisms and efforts during the pandemic. Key informants in Uganda noted that remote monitoring was not perceived to have harmed quality. The South Africa CO found that, through supervision visits, they were able to identify cases of staff shortages, inadequate training of staff in IPC, and stock-outs of key

commodities. The ECAR RTA suggests that a greater reliance on third-party monitoring **may prove a cost-effective modalit**y, yet carries with it a certain degree of **potential fiduciary risks**. For instance, the Tajikistan CO cited the inability to monitor the quality of delivered supplies as a reason for scaling back targets. The ECAR report suggested a hybrid form of monitoring may be a practical way forward.

All regions stated that challenges in maintaining reliable data were primarily due to access/lock-down but also due to inability in many cases of governments to provide data. ESAR noted that the majority of COs identified the lack of reliable data, alongside the lack of funding, as key constraints to reaching the most vulnerable.

Examples of innovative data collection practices were reported. However, the success of these efforts have yet to be analysed. U-report, which has been cited extensively as an important data source, was mentioned by ECAR as having potentially serious bias issues related to self-selection, exclusion of non-internet users, and not being representative of the totality of young people. It will require further investment to address these limitations. Social listening (applied by different stakeholders in all six focus countries in ECAR)[49] as a data collection practice is reportedly a much more promising approach, since it does not have as strong a self-selection bias, although it is still biased toward people who have access to and regularly use social media.

Concerns were also raised around the appropriateness of the monitoring framework. Focus COs in LACR reported that the **COVID-19 Programme Monitoring and Analysis Framework** provided a common ground to monitor the responses, but allowed only a **limited examination of response quality**. These constraints make it **challenging to define and update targets and adapt the response as the situation unfolds** and constrain the analysis of **coverage, scale-up and equity**. Moreover, key actions that have important implications for coverage of vulnerable populations are omitted from the monitoring system (e.g. technical expertise, advocacy and policy dialogue).

Similarly, in EAPR, it was felt that the monitoring framework was not well conceived, and that "**the indicators were driving the programme rather than the reverse**".[50]

Additional issues raised in the reports included the frequent changes in methodology and guidelines from HQ in the calculation of indicators, necessitating multiple rounds of revision (Georgia CO) and indicators and targets excessively focused on number of beneficiaries reached, which would not adequately capture the breadth of support provided in contexts where much of the work is upstream (EAPRO).

Looking ahead, as the COVID-19 response and recovery becomes a protracted response, and the need to refine targeting to respond to the increasing complexity of vulnerability becomes even more critical, the refinement of indicators and harmonization of monitoring will become increasingly important. The South Asia report stated that **UNICEF must develop more appropriate guidelines for more rigorous monitoring in crisis situations**.

[49] Social medial listening reports implemented jointly by Vaccine Confidence Project, UNICEF, and the London School of Hygiene and Tropic Medicine cover Georgia, Kyrgyzstan, Moldova, Tajikistan. Sitreps mention social medial listening in Ukraine and Croatia.
[50] United Nations Children's Fund, 'COVID-19 Response Real-Time Assessment Report', UNICEF, Bangkok, 2021, p.18.

4 CONCLUDING OBSERVATIONS

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The following section presents a set of concluding observations drawn from the RTA regional reports. Given the time-bound nature of the RTA, no recommendations are reported here.

Overall performance

- The most important finding that emerged across all regions was the substantially positive feedback from external stakeholders on **UNICEF performance** in this most difficult of responses. Regional reports repeatedly noted that **government and key partners felt UNICEF was accessible** for information sharing, responsive to requests, and open to feedback and adaptation. In some cases partners indicated that, as needs evolved, **UNICEF became less flexible to proposed new work or adaptations**. This is a common pattern in protracted crises; when the first phase of a response is complete, funding becomes less flexible and the demands of ongoing programming dominate.
- The positive feedback on UNICEF responsiveness and willingness to innovate and adapt does not however provide evidence that UNICEF has been effectively **balancing adaptation with managing risk and meeting quality standards**. As the COVID-19 response is sustained over time, more certainty is required that the **response is being measured against quality, equity and other commitments and standards**, including the revised Core Commitments for Children in Humanitarian Action.
- Several institutional **strengths were consistently identified and validated**, including **timely response, scale-up in basic service delivery, advocacy successes, procurement of essential PPE and medical supplies, partnerships, and leadership in RCCE**. The success in scaling up **social protection systems** and activities across many contexts should be particularly noted and valued. As UNICEF enters the post-pandemic recovery phase, supporting social protection will be a critical tool to addressing vulnerability in multiple contexts.
- There is a systematic pattern in all regions of **pre-existing partnerships with governments** providing entry points for UNICEF to advocate successfully for scale-up or new government-led activity, particularly in **social protection**. In addition, there are many positive examples of **new and innovative partnerships**, although it is unclear to what extent COs will capitalize on this momentum to reimagine partner portfolios or strengthen relationships with local partners to meet localization commitments.
- The UNICEF response across all regions was found to have contributed to **mitigating disruptions** in regular health care, nutrition, education, protection, and inclusive public programmes, despite the magnitude of the crisis. In many cases, UNICEF has become more operational, and scaled down or paused other programming to do this. Exit strategies were not presented as part of regional RTA reports and longer-term implications for UNICEF cannot therefore be part of this global synthesis report.

Preparedness and resilience

- Many COs have said that they were **not prepared to respond** to a pandemic or crisis on this level. All regions reported that **COs with limited or no prior emergency and humanitarian response experience** faced additional challenges. The **shortage of emergency or skilled staff** (particularly in RCCE, C4D) was repeatedly cited, though many focus COs said that the RO was able to provide some support.
- Preparedness for additional emergencies and/or new outbreaks was seen as a high priority. This may entail prioritization at the RO level or additional surge capacity (including within COs) to **support strengthened preparedness**. There should be a discussion between UNICEF, humanitarian/development counterparts, and governments as to what strengthened preparedness **in different settings** would concretely look like in the future, including in countries that do not experience regular emergencies and where maintaining a high preparedness level would be costly. As important as preparedness will be a highlighting of risk reduction and an investment in resilience of systems.
- The need to **understand new vulnerability** and the implications for ensuring that UNICEF is **working effectively from an equity and quality perspective** becomes more essential every month as the social-economic impact of COVID-19 deepens. UNICEF will have to **continue to balance COVID-19 crisis response** with the need to understand the medium to long-term implications for **vulnerable children and their communities**.
- As is typical in humanitarian crises, government response capacities are often insufficient to meet needs. Driven by the principles of "no one left behind" and "no regret", **UNICEF has in many places taken on the role of supporting essential public services and systems**. While this approach is understandable as part of the immediate response to avoid collapse of services, the transition to a Level 3 "Sustain Phase" adds institutional and operational pressure. It raises the standard questions about the limits and the sustainability of UNICEF support and the relationship between emergency response and development approaches.

Coherence and coordination

- Some concern was expressed by frontline workers that UNICEF could have done more to facilitate **multi-sectoral responses at the local level**. In some contexts, UNICEF-supported education, WASH and protection programmes were seen as having their specific local partners and there was, therefore, less coherence and sharing of information.
- A few regions felt that **UNICEF could have done more to ensure improved coordination and guidance with other United Nations agencies in-country**. However, **most regions were also able to cite multiple cases of inter-agency cooperation. In some cases, negotiations and agreements reached at HQ level were not effectively communicated to agencies in-country, creating confusion and delays**.
- A consistent theme was the **pivot to remote programming** and monitoring and a sense that, overall, UNICEF had done this in a timely fashion, seeking to ensure support for governments and other partners. It may be useful to explore ways of integrating these platforms and/or hybrid approaches

into regular (non-crisis) modes of UNICEF programming. In many cases, a limiting factor was **partners' connectivity limitations**. Some government agencies and civil society organizations did not have the same capacity for moving to teleworking modalities, and this hampered their work. In some cases, COs supported implementing partners by providing ITC equipment and connectivity and UNICEF should consider whether there is value in sustaining such support in the future.

Monitoring and accountability

- Several regions highlighted both the access challenges to monitoring and, in many cases, the previous limited experience in **remote monitoring** as a challenge, although this was not specifically identified as a barrier to action. Most regions reported that remote monitoring was now in place, but did not comment on the effectiveness of such arrangements. As it is likely that increased remote monitoring or hybrid monitoring will become the 'new normal', **being able to speak to the effectiveness of these mechanisms will be critical to retain donor trust**. Most COs felt that a **lack of reliable** data during the COVID-19 response was a barrier to decision-making and this will need to be quickly addressed.
- Regional RTA reports did not offer sufficient detail on the **ability of COs to maintain or initiate community engagement and AAP mechanisms in the context of the COVID-19 response. Ensuring that effective AAP mechanisms are in place will be critical going forward**.
- The critical importance of RCCE in the pandemic response has underscored the need for **predictable funding and support for UNICEF RCCE programming**. Part of this will involve providing evidence of how RCCE brings about community behaviour change, which means having appropriate monitoring tools in place.

Duty of care and staff welfare

- Regional RTA reports noted a **risk-averse attitude** on the part of some partners and the understandable concerns of staff and partners around COVID-19 transmission. Issues such as duty of care and providing staff and consultants with the necessary information to take 'informed risks' were raised in all regions. Some regions did not see it as a barrier to adaptation, others were neutral on the issue, and still others raised concerns.
- Respect for all that CO staff and partners have managed to accomplish in response to the pandemic was consistently expressed in all regional RTA reports. There were, however, concerns that staff were starting to experience burn out, particularly in countries and regions facing a third wave. There were also **feelings of fatigue expressed in relation to corporate data and information requests**, which were felt to be overwhelming at times. COs have reported considerable pressure because of the **multiplicity of data-gathering mechanisms** and undergoing a **learning and rationalization process** is considered a matter of priority.

Annex 1
RTA Concept Note

CONCEPT NOTE – Draft 22 July 2020

A real-time assessment of the UNICEF response to COVID-19 at country level

1. Background

Since the start of the outbreak in December 2019, the new coronavirus disease (COVID-19) has spread to over 215 countries and territories. As of 8 July 2020, there have been an estimated **11,669,259 confirmed cases** of COVID-19, including children, and with nearly **640,000 deaths** reported.[51] As noted by the UNICEF Executive Director, children are "the hidden victims of the COVID-19 pandemic". Lockdowns and school closures are affecting their education, mental health and access to basic health services and raising the risks of exploitation and abuse. UNICEF has recently revised its Humanitarian Action for Children (HAC) appeal to **US$1,620,132,267**[52] to meet the needs of children, communities, health systems and health structures, protect against the disease and address its immediate health and socio-economic impacts.

The UNICEF evaluation function issued two technical notes in March and April 2020 to guide evaluative initiatives aimed at responding to the organization's evidence-generation needs as the response evolves. The Evaluation Office (EO) and the COVID-19 Secretariat have since launched the continuous learning evaluation of the global response (including the *Fly of the Wall*), and some regional and country offices have embarked on other initiatives to inform their response.

Almost four months into the pandemic, **overseeing the quality of the UNICEF response** on the ground is being consistently recognized by the emergency management team as a challenge that country offices (COs) face due especially to the unusual remote working modalities. In an operating environment that is further **rapidly changing** and calls for continuous adaptation, there is an urgent need for an in-depth understanding of the ways in which countries are actually responding to this crisis through means that go beyond current reporting efforts.

In this context, **the EO is proposing a real-time assessment (RTA) of the UNICEF response to COVID-19 at the country level**.

At a time where countries across the world are further grappling with the socio-economic consequences and secondary costs of what started as a public health crisis, the opportunity to pause, take stock and reflect on how to adapt further as the crisis unfolds, while preparing for both the **next round of HAC and next generation of workplans**, is particularly timely and relevant for UNICEF.

The RTA should be seen as a means to support regional offices (ROs) in their oversight role vis-a-vis the implementation of the CO response to COVID-19. The RTA will therefore be managed by ROs, with coordination support from EO, and in collaboration with the COVID-19 Secretariat.

[51] World Health Organization, 'Situation Report 08 July 2020', WHO, Geneva. https://covid19.who.int/
[52] United Nations Children's Fund, 'UNICEF Coronavirus (COVID-19) Global Response', UNICEF, New York, 2019. https://www.unicef.org/appeals/covid-2019.html

2. COVID-19 RTA: objectives and proposed methods/approach

The objective of the RTA is to inform a **forward-looking** reflection on the **implementation** of the country office response to COVID-19. It will include an assessment of the effect of COVID-19 pandemic on basic services, particularly for the most vulnerable populations. Also, the RTA will gauge the implications of COVID-19 response on UNICEF regular/pre-COVID programme delivery (the eventual extent of their repurposing for responding to COVID-19), the **quality of the related delivery**, while also providing **early insights on the outcomes achieved**. Findings will be further **consolidated across countries and regions, with a view to identifying trends** and generating **cross-country learning** and **timely actions** to strengthen the ongoing response.

The RTA will be guided by the following **four overarching questions**:

1. How effectively is the CO implementing the response to COVID-19 so far?[53] How is the **quality** of the response to COVID-19 being affected by remote working modalities and the generally constrained operating environment?
2. How well is the CO adapting to the needs of the population, including the **socio-economic impact** of the pandemic?[54] How have these **needs been determined** in each country? (Will include gauging: target-setting, required capacity, early insights on results achieved so far and where most value is added);
3. What are the **early lessons** (for CO/RO/HQ) that are emerging from the implementation of the response? What are the emerging positives from the response, and what have been the greatest challenges in responding to COVID-19 so far? Are there discernible trends that are applicable to **different setting**s (e.g. urban/rural; low-resource/high-resource settings etc.)?
4. What more should be done? What should be done **differently** to enhance COVID-19 response programming for children and their communities?

The proposed exercise is a **modified version of operational reviews**. These are typically 'live learning processes' that help teams and leaders understand 'for themselves' important events by reviewing and identifying, through fruitful discussions and exchange of ideas, 'what happened', 'why it happened', and ways to sustain strengths and improve on weaknesses.[55]

While adopting a similar '**shared learning**' approach, the proposed RTA will gather information (**remotely**) **from UNICEF staff as well as from partners and the target population**, to the extent possible. In this sense, the RTA will not only be informed by internal/UNICEF sources but external ones as well. To help build the **external stream of evidence**, pre-existing 'infrastructure' and information available at the

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53 Due to the fluid operating context, the use of COVID-19 response country plans as the 'unit of analysis'/reference point in the RTA was not deemed appropriate. Following discussions, the focus of the question therefore shifted from the implementation of COVID-19 **plans** to the implementation of the **response** to COVID-19. This question will entail gauging the adaptation of the response over time, including vis-a-vis pre-COVID programme delivery.

54 This question will include an assessment of the effects of COVID-19 on access to basic services, including for the most vulnerable segments, to the extent possible.

55 https://www.alnap.org/help-library/after-action-review-technical-guidance

country level (e.g. U-reporters, phone banks at community level, third-party monitoring data, knowledge, attitudes and practices studies/ other assessments, etc.) will be explored and support the final choice of methods and data collection tools. The presence of other ongoing/ planned initiatives, at regional and country level, to generate information on the UNICEF response to COVID-19 will be carefully mapped out to ensure alignment and minimize overlap with the RTA. Examples of instruments that can be used include:

- Short survey monkey questionnaire for **UNICEF COs**: to ensure a widely consultative process at the level of each CO, the instrument will be sent to UNICEF CO representatives for the COs to respond;
- Insights into what is happening with **implementing partners**: short survey monkey questionnaire for implementing partners at country level (e.g. partners involved in programme delivery);
- A glimpse of what is happening on **AAP** - short survey with **U-reporters** in districts where UNICEF operates plus other innovative methods to capture, from an equity perspective, the 'voice of the community';
- **Phone surveys and phone calls** with implementing partners; end-user satisfaction surveys for beneficiaries in sampled countries (e.g. countries receiving largest amounts of supplies);
- Remote interviews with UNICEF staff, implementing partners and **government representatives** at CO levels, etc.

To ensure the soundness of findings generated, attention will be given to the **validation** of information gathered to reduce **potential biases**.

To enrich learning, EO is proposing to conduct **two rounds** of assessments, with the first round (R1) planned to yield findings in early **Q4 2020**, and the second round (R2) in 2021.

3. Scope

With a view to support **cross-country learning** and **cross-region learning**, the EO is suggesting a **sampling approach** whereby a number of UNICEF-supported countries are selected based on their ability to illustrate a diversity of profiles against a range of criteria. While these will be determined **in consultation with ROs and the COVID-19 Secretariat**, possible criteria include: i) geography (region); ii) CO size; ii) government capacity and systems to respond to outbreak; iv) outbreak size/level of disruption of basic services; v) focus of UNICEF programmatic response (e.g. social protection; child protection; education etc.), or a **combination of any of these criteria**.

Thematically, the assessment will focus on the **public health response** and the **early stages of the socio-economic response** of UNICEF. The sampling approach adopted in each region may ultimately further determine the thematic focus of the assessment.

The focus and approach for the **second round** of the RTA (R2) including the countries to select in R2, will be determined on the basis of the first round (R1).

4. Use and audience

This exercise has the potential to offer timely insights on different levels. Primary users will be the **UNICEF management at the country level** who would harness the RTA findings to improve **ongoing implementation** of the response to COVID-19. Findings from the RTA will, more specifically, inform potential adjustments to the **2021 appeals** and the **next round of CO planning**.

The wealth of information generated from an extensive sample of countries can also represent a valuable asset for the **oversight role of regional offices**, and to **HQ**, with a view to informing **broader forward-looking strategic decision-making** across typologies of countries and responses. If completed as planned, the evidence generated will inform RMT discussions on the response in the fall of 2020.

The findings of the assessment are also expected to plug into the **global** continuous learning initiative around the COVID-19 response that EO is currently implementing with the COVID-19 Secretariat, and importantly, will be used as one of several information/evidence streams which will feed into the eventual **L3 summative evaluation** of the response to COVID-19 (that EO plans to conduct in 2021).

Information gathered will be analysed and trends identified and presented in a **digital interactive report**. Each RO is encouraged to produce a regional report on the RTA. The findings will be presented and discussed as appropriate, with findings from Round 1 expected to inform the fall RMT.

5. Roles and resources

The RTA is intended to support the **oversight** role of **regional directors**. It will therefore be managed **by ROs**, through the **regional evaluation advisors (REvAs)**, who will work closely with the regional emergency advisors and the deputy regional directors. To expedite the delivery of the RTA, **multi-country evaluation specialists (MCESs)** will have crucial roles as 'team leaders' in the implementation of the assessment (on average each region has two MCEs). The **humanitarian evaluation portfolio (HEP) in EO and the COVID-19 Secretariat** will support the RTA and ensure a coordinated approach. Specifically, the following are envisioned as the key roles and responsibilities:

- REvAs, in collaboration with the EO, will **determine the sampling approach** which will inform the **selection of countries** that will be involved in the RTA in each round.
- A small taskforce, comprising REvAs, MCESs and HEP, will **co-develop the tools** that will drive the exercise. This group will be responsible for developing a note/paper which finalizes the conceptualization of the design of the RTA and includes the tools and templates which will be used. While this 'toolkit' with templates will be available to collect, analyse and use data from COs, each region will plan for the execution of the assessment, with the understanding that **specific regional adaptations** in such tools and approaches may take place, as needed.
- While REvAs and MCESs will be responsible for **consolidating findings** at the level of *their respective regions*, EO will, in turn, be responsible for consolidating findings, identifying trends and generating learning *across* regions.

- A **consultant/methodologist** will be recruited to support the roll-out of the RTA, including the design and development of tools, the logistics of data collection and analysis/ consolidation of findings thereafter.
- EO will keep all informed, provide cross-region insights and advice, when needed, with a view to ensure the continuous relevance and utility of the RTA.

USD $150,000 are being allocated to each RO to support this assessment.

6. Timeline

A **tentative timeline** for Round 1 of the RTA is presented below:

July 2020	HQ planning, including initial consultations/discussions; funding arrangements; technical support instruments
August 2020	Sampling of countries; review/ adaptation of instruments; identification of potential respondents from governments, CSOs and communities
September 2020	Data collection
October-November 2020	Analysis and sharing of report to inform fall RMT, next iteration of HAC appeals and CO workplans

Annex 2
Links to available RTA Regional and Country Reports

1. EAPR

2. ECAR: finalized regional report coming soon

3. ESAR
    a. Kenya
    b. Madagascar
    c. Namibia
    d. Somalia
    e. South Africa
    f. Uganda

4. LACR
    a. Argentina
    b. Dominican Republic
    c. El Salvador
    d. Venezuela

5. MENAR

6. SAR

7. WCAR: finalized regional report coming soon

Annex 3
Approaches adopted by each region for implementing the RTA

EAPRO

Data gathering in EAPR was undertaken entirely by an Independent Assessment Team (IAT) made up of UNICEF evaluation staff and consultants working in the evaluation unit. Focus was placed on the surveys for COs, government and implementing partners, and key informant interviews used to capture perspectives of frontline workers and community members. Purposive sampling was used to select respondents in these processes. A desk review was undertaken for each focus country and an after-action review was undertaken for one country (Thailand).

The focus countries were selected to provide a varied sample of country contexts, considering: The feasibility for any given CO to commit to taking part in the assessment; representativeness of large and small country populations; the higher middle-income-countries (MIC) economies (Malaysia, Thailand), and lower MIC countries such as Mongolia; countries where the health impact of COVID-19 has been most keenly felt (Indonesia and Philippines) and where it has been successfully contained (Thailand, Viet Nam, and Mongolia).

ECARO

In ECAR the RTA was conceived as a continuous exercise with a series of rounds. These began in August 2020 with the consolidation of country office self-reported evidence by the evaluation unit, and a number of consultations and dialogues held with the country / regional office staff and government counterparts, civil society organizations and private sector actors involved in the response.[56] In January 2021, a consultancy firm was subsequently commissioned to undertake the next stage of the RTA. While building on the evidence collected until then, a process evaluation approach with contribution analysis components was undertaken to understand the extent to which the CO processes, procedures and activities contributed to achieving COVID-19 response results. A ToC was developed in the inception phase to help articulate the logic behind achieving the desired outputs, outcomes and impact. A range of qualitative and quantitative data sources was analysed using framework analysis technique and descriptive analysis. A 'natural language processing'[57] (NLP) approach was applied to support the analysis of large amounts of unstructured and qualitative data presented in text across various documents.

ESARO

Work was undertaken by both individual consultants and a consultancy firm, with a preliminary analysis produced, based on CO survey findings and a desk review of internal resources, followed by deep dives in six countries and a light touch regional analysis. Overall data collection focused on surveys for the 21 COs in the region, as well as other

[56] Surveys were undertaken in 6 focus countries with COs and key partners including civil society organizations and private sector partners.

[57] A technique for programming computers so they are capable of "understanding" and processing documents and analyse large amounts of natural language data, including contextual nuances within them.

stakeholders, with the latter group registering 46 responses from government counterparts, NGOs, United Nations agencies and private sector partners in the 15 countries that were not 'RTA deep-dives'. Forty interviews were conducted with UNICEF CO staff and partners in the six deep-dives/focus countries. The regional analysis drew on the findings of the RTA case studies.

A framework analysis technique was used to analyse data collected, with an assessment matrix to score CO performance against a red/amber/green rating system.

LACRO

The RTA was undertaken by individual consultants. The emphasis in the LACRO study was on key informant interviews, with perspectives captured across UNICEF staff, government and implementing partners. Purposive sampling was used to identify key informants among government officials, national partners and other stakeholders. Country office surveys were conducted in the four focus countries and desk reviews were undertaken to glean relevant information from key documentation and secondary data. Participatory exercises comprising a total of 11 workshops were conducted to convene participants to contribute to the data collection and analysis process and help validate the findings generated. Evidence gathered in LACRO was weighted as strong evidence (3), medium evidence (2), or weak evidence (1) and treated accordingly.

MENA

The RTA was undertaken by individual consultants. The primary data collection methods comprised of surveys, administered to 14 COs in the region, and key informant interviews, conducted with UNICEF staff, implementing partners, government contacts and frontline workers.

ROSA

The RTA was undertaken by individual consultants. In addition to the surveys for the eight COs in the region, surveys were administered with government and implementing partners. Survey responses were also sought from ROSA regional advisors, to solicit feedback on the country's response (from the ROSA perspective) and also provide information on the support extended to the country offices during the COVID-19 pandemic. Interviews were conducted with a total of 31 frontline workers, ten community representatives and seven UNICEF deputy representatives/representatives. In addition to the general RTA, ROSA conducted two deep-dives on mental health and psychosocial support (MHPSS) aspects and gender integration in the UNICEF response in South Asia.

WCARO

The RTA was undertaken by a team of national consultants in each of the countries participating in the RTA. A participatory mixed-method approach relying on multiple data sources was applied in all countries. In addition to the surveys administered to CO management teams, semi-structured interviews were held with key informants (including response managers, national partners and implementing partners and agencies) and frontline workers (local authorities, including health and education). These were complemented by focus groups and participatory child-centred data collection methods in sampled communities. RTA reports were then presented to COs and discussed before being finalized and shared with stakeholders.

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