ASSESSMENT REPORT

TITLE: REAL TIME ASSESSMENT NUMBER TWO OF UNICEF MENA COVID-19 RESPONSE

Final Report

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List of Acronyms

ACT-A	Access to COVID-19 Tools Accelerator
AMC	Advance Market Commitment
C4D	Communication for Development
CDS	Covid Vaccines Delivery Support
CEPI	Coalition for Epidemic Preparedness Innovations
CO	Country Office
COVAX AMC	COVID-19 Vaccines Advance Market Commitment (COVAX AMC)
EMRO	Eastern Mediterranean Regional Office
HAC	Humanitarian Appeal for Children
HR	Human Resources
IDMC	Internal Displacement Monitoring Centre
IDP	Internally Displaced Person
KAP	Knowledge Attitude and Perceptions
KII	Key Informant Interview
LTA	Long Term Agreements
M&E	Monitoring and Evaluation
MENA	Middle East and North Africa
MENAR	Middle East and North Africa Region
MENARO	Middle East and North Africa Regional Office
MoH	Ministry of Health
NDVP	National Deployment and Vaccination Plan
NGOs/CBOs	Non-Governmental Organizations / Community-Based Organizations
PPE	Personal Protective Equipment
Q&A	Questions and Answers
RCCE	Risk Communication and Community Engagement
RTA	Real Time Assessment
RTA R2	Real Time Assessment Round 2
RO	Regional Office
SBC	Social and Behavioural Change
SoP	State of Palestine
UAE	United Arab Emirates
UCC	Ultra Cold Chain
WHO	World Health Organization

Executive Summary

Background

a) UNICEF has provided multi-sector support to 20 countries in the Middle East and North Africa (MENA) region during the COVID-19 pandemic and assumed a significant role in the Access to COVID-19 Tools Accelerator (ACT-A) that the WHO and its partners launched in April 2020. The ACT-A aims to accelerate equitable access to and the development and production of COVID-19 tests, treatments, and vaccines to fight the pandemic. The ACT-A has three pillars: Vaccines/COVAX, Diagnostics and Therapeutics.

b) The ACT-A vaccines pillar, known as COVAX, was created to accelerate COVID-19 vaccine development and manufacturing, and to guarantee equitable access to COVID-19 vaccines globally. The COVAX pillar is co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi and WHO, and aimed to deliver two billion vaccine doses globally in 2021 to cover initial high-risk target groups. Due to its extensive experience supporting routine immunization, UNICEF was designated the key delivery partner for COVAX. In the MENA region, UNICEF is procuring and delivering COVID-19 vaccines and cold chain equipment, providing technical assistance to governments, and implementing RCCE activities. As of 12 December 2021, approximately 470 million COVID-19 vaccine doses had been delivered to MENA countries, including 115 million (25 percent) via the COVAX Facility.

c) UNICEF's response to COVID-19 occurred in an already complex context. Prior to COVID-19, countries in the MENA region were facing diverse and significant challenges such as conflict, forced displacement, recurrent disasters, inflation, collapsing oil prices, political upheaval and migration, amongst others. About 12.4 million people were living in internal displacement across the MENA region at the end of 2019, and more than 7.8 million people have sought refuge abroad (IDMC). Overarching regional trends related to COVID-19 vaccination, particularly in conflict-affected countries, include large populations located in areas outside of national government control, gender disparities in COVID-19 risk perceptions and vaccine demand, and constrained UN access to national health information.

d) The COVID-19 vaccination has proceeded at an uneven pace across the region and country-level responses varied, as did financial arrangements for sourcing COVID-19 vaccines. Health systems in the most fragile countries were at a disadvantage, having been already affected by years of conflict or crisis. The severity and magnitude of the crisis varied as well, and UNICEF support was crucial in these contexts to ensuring that populations had access to vaccines. In terms of COVID-19 vaccine financing, the region has both self-financing countries and countries that depend entirely on external support and donations. Several countries in the region participate in the Advance Market Commitment, which supports the participation of low- and middle-income economies in the COVAX Facility by providing payment facilities and enabling access to donor-funded doses for the poorest.

Purpose, objectives and scope

e) The purpose of the MENA Real Time Assessment Round 2 (RTA R2) is to leverage the experiences of selected COs and RO during the initial COVAX implementation to inform and improve future COVID-19 response activities. The RTA R2 covers UNICEF's engagement in the COVID-19 ACT-A from January 2021 to October 2021, with a focus on UNICEF's contributions to the COVAX facility, capacity building and RCCE efforts to increase vaccine uptake. The geographic scope of this assessment includes the RO and four COs representing a diversity of CO experiences: Djibouti, Iraq, State of Palestine, and Syria.

Methodology

f) The RTA R2 employed a mixed methods approach that included the collection and analysis of both primary and secondary data. Primary data were collected remotely via 51 Key Informant Interviews (KIIs) and online surveys. Secondary data was provided by the MENARO Evaluation team and additional documentation was provided by COs during RTA R2 process.

Limitations

g) Access to information and informants was a major challenge due to stakeholders' demanding pandemic response workloads and end of year obligations, as was the limited data and information in some contexts. The diversity of case study COs, and of COs in the region more generally, also made it difficult to extract regionally applicable conclusions and recommendations. Finally, COVID-19 vaccine deployment scaled up massively during the period covered by the RTA R2. The report tries to reflect this trend to the extent possible, but the situation is very dynamic, and data is evolving daily.

Findings

h) UNICEF has been responding to clearly identified population and government needs in a manner tailored to its comparative advantages as a major immunization provider. COs have been providing direct support to governments in terms of response planning, resource mobilization, supply management and procurement, and cold chain strengthening. COs played a central role in supporting and influencing government ability to deliver and the RO played a significant role in supporting COs. After an initial phase dedicated to setting up delivery systems, a massive delivery scale up occurred from September 2021 onwards. UNICEF's central role in the vaccination campaign put a considerable strain on its human resources.

i) UNICEF is playing an active role in coordinating the vaccination effort and RCCE efforts at a national and regional level. Coordination amongst ACT-A stakeholders, particularly UNICEF coordination with Gavi and the WHO, has been constrained at regional and country level by limited partner capacity and communication flows despite a clear division of labor under the COVAX structure. The ACT-A set-up, and the COVAX pillar division of responsibilities, led to UNICEF-Gavi coordination on supply and financing that was of variable frequency and content at the beginning of the vaccination effort. Despite multiple communication streams on supply and financing at the beginning of the ACT-A, communication has become much more efficient and

streamlined with time. Limited WHO capacity at the country-level often constrained WHO capacity to quickly quality assure the volume of RCCE messaging that COs referred to WHO.

j) UNICEF's overall contribution to the ACT-A COVAX pillar was timely and had a clear value-add. During the initial phase of the response, CO efforts focused on building capacities to procure and receive vaccines; later, COs also focused on expanding national vaccination capacity, thus contributing to more equitable access to vaccines and information.

k) UNICEF COs built on their strong comparative advantage in RCCE to support governments, plan and implement information campaigns, and generate vaccine demand. The nature of the pandemic requires very responsive RCCE systems. The first phase of the response focused on planning, capacity building and mass communication, leaving important gaps and areas for growth, particularly related to community engagement.

l) Supporting equitable access to vaccines through the MENA region poses new challenges for UNICEF despite its longstanding experience in delivering immunization support. The target population for COVID-19 vaccination is particularly large and diverse, requiring UNICEF to develop new tools and partnerships. Supply and the demand for COVID-19 vaccines have been very volatile, requiring daily CO and RO responsiveness. The government-led response is highly sensitive, and COs provided several forms of support to the government-led response that went above and beyond UNICEF's assigned COVAX delivery role.

m) ACT-A partners have been navigating a fragile balance between vaccine supply and demand since COVAX's inception. As a consequence of the COVAX setup, national vaccine portfolios are complex due to multiple sourcing arrangements. From January until July 2021, UNICEF focused primarily on getting the vaccines to countries, although country-level vaccination sites and demand generation activities were limited. From July 2021 onwards, vaccine deliveries scaled up and UNICEF provided important support to expand vaccination capacities, sites and demand.

n) UNICEF support to governments was crucial to plan the response and mobilize vaccines and financial resources. During the initial phase of the response, COs supported the governments to assess needs for COVID-19 vaccines, equipment and information and to plan the vaccination campaign deployment, including RCCE components. COs provided direct support on developing NDVPs and managing overall vaccine supplies. UNICEF support was particularly crucial to helping governments manage complex national vaccine portfolios, which were composed of several vaccine types from diverse sourcing arrangements with varying expiration dates. Governments widely recognized the relevance of this CO support despite important shortfalls in communication and coordination. UNICEF also supported government efforts to mobilize financing for the ACT-A activities and provided important pre-financing support to self-financing countries to accelerate vaccine procurement.

o) UNICEF's support as a key partner to governments to accelerate vaccination efforts has been highly relevant and filled important gaps. UNICEF support was crucial

to ensuring sufficient cold chain capacities for vaccination, often as the main and sole provider of cold chain support. COs also provided important training and ad hoc support to build government, health worker, and other partner capacities for the vaccination effort. COs helped in shipping the vaccines in countries and procuring essential equipment, including syringes, safety boxes, and technology equipment. Countries that conducted pre-pandemic and pre-vaccination campaign needs assessments were able to run more timely vaccination campaigns once sufficient vaccine supply was in place. CO support on strengthening the cold chain and increasing national vaccination capacity has been important to making vaccine access more equitable and will have durable impacts on overall country immunization capacities going forward.

p) The division of labor among COVAX partners is clear but hard to implement. Coordination benefitted from pre-existing arrangements, and the COVAX resulted in unprecedented levels of collaboration between UNICEF and WHO in the region. It has also led to close coordination with Gavi. However, communication between partners on vaccine supply and deliveries was often insufficient.

q) The understanding of the ACT-A framework and its specificities is limited. The division of roles and responsibilities was not always clearly communicated beyond the ACT-A partners, which generated partners' confusion about UNICEF's role and inappropriate demands and expectations.

r) Constantly evolving information needs and rumors regarding COVID-19 vaccination required very responsive RCCE strategies and activities. UNICEF's comparative advantage in RCCE is widely acknowledged, and COs have played a leadership role in national RCCE coordination and developing RCCE messages and campaigns. CO evidence generation on vaccination rates, vaccine demand and barriers to vaccination has been improving, but still relies heavily on RO support. UNICEF COs and field offices often lack sufficient human and financial resources to support the level of direct community engagement that the COVID-19 vaccination effort requires; direct community engagement has therefore been limited.

s) UNICEF contributed to an equitable response, although there is significant room for improvement. COs strived to ensure equitable access to vaccines and information about vaccination in various ways and often with insufficient resources. Pre-response partnerships, UNICEF's field offices, and COs' wide networks of implementing partners helped COs to accelerate these efforts. UNICEF's support to governments on scaling up vaccination has had a specific emphasis on vaccinating hard-to-reach and at-risk groups., particularly migrant, refugee, and minority populations, as well as people on the move. UNICEF engaged in sustained, successful engagement with governments for the inclusion of IDPs, refugees, and people on the move in national vaccination plans. Key stakeholders note gender disparities in vaccination rates, but this pattern varies across countries and data on this issue is not yet being uniformly collected, analyzed or systematically addressed. Disability considerations have not been systematically included in COs' COVAX and RCCE activities.

t) The COVID-19 response is providing an opportunity to mobilize resources to strengthen the health systems but has strained CO staff and financial resources. The

response is implemented with limited additional human resources, and existing personnel are overextended. Insufficient CO funding, planning, and utilization of streamlined contracting procedures have impeded COs from adequately responding to this need.

Recommendations

Recommendations	Responsibility	Timeframe
Recommendation 1: Continue supporting governments to decentralize vaccination sites and plan for the changes in vaccine supply, portfolio, and demand Continue 1-to-1 RO advising to countries not reaching WHO targets Provide additional in-country technical support to governments in low performing countries on vaccination decentralization, vaccine demand generation, portfolio management and cold chain strengthening	COs (Health, Communications, Supply, and C4D/SBC sections) RO Taskforce	Immediate
Recommendation 2: Provide additional human resources support to UNICEF COs Conduct an assessment on staffing for COVAX-related activities (number of personnel vs. workload) at RO and CO levels Provide additional outreach, support, and information to COs to assess risks and needs, and to provide information on how to leverage available financial resources Provide additional capacity building opportunities to UNICEF staff to build internal resources in areas of emerging need Increase SBC staffing at COs to focus on vaccine demand, particularly increase senior level staffing to enable UNICEF to engage at levels that reflect its leadership in RCCE	RO (Human Resources, Health and SBC) COs (Human Resources, Health and SBC)	Immediate
Recommendation 3: Mobilize/allocate financial and human resources to expand direct community engagement and technical support Support the expansion of direct communication engagement to ensure all population groups have access to information and feedback loops Continue to provide quality technical support to all RCCE activities	RO and COs COs (Communications and C4D/SBC), with the support of RO	Immediate
Recommendation 4: Continue supporting governments to generate, analyze, manage, and utilize data and evidence Continue to support governments to develop integrated data systems for managing vaccines supply, demand, and cold chain Continue to support governments to design and implement evidence generation strategies to manage vaccines demand and rumors, including clear plans for evidence utilization Commission a study/assessment to deeper understand the challenges met by specific COs in supporting COVAX activities and develop mitigation strategies Improve access to disaggregated data and evidence generation on vaccine supply and demand to support the	COs (Health, Communications, Supply, and C4D/SBC sections) RO	Medium Term (6-12 months)

development of specific strategies to reach groups with specific needs: gender, disability, remote locations. Embed staff in government to increase government capacity and reduce the impact of COVID-19-related work on routine immunization campaigns		
Recommendation 5: Improve communication flows with COVAX partners and address bottlenecks in coordination mechanisms Request regular, direct communications between UNICEF RO and Gavi and include the COs in the lines of communication Engage with COVAX partners for increased transparency on vaccine allocation processes, timeframe and sourcing on both vaccine and grant allocation	RO Supply, Representative, and Deputy Representative	Immediate
Recommendation 6: Continue supporting equitable and right-based approach programming Increase evidence generation activities focused on at-risk populations to inform efforts to support equitable programming Improve coordination on access to camps and conflict zones	COs (PM&E, Representatives and Deputy Representatives)	Medium Term (6-12 months)

1.0. Introduction

1.1. Overview of the ACT-Accelerator

1. The World Health Organization (WHO) and its partners launched the ACT-A partnership to accelerate the development production of, and equitable access to, COVID-19 tests, treatments, and vaccines. The ACT-A vaccines pillar, known as COVAX, was created to accelerate COVID-19 vaccine development and manufacturing, and to guarantee equitable access to COVID-19 vaccines globally. The COVAX pillar is co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi and WHO, and aimed to deliver two billion vaccine doses globally in 2021 to cover initial high-risk target groups.

2. Due to its longstanding experience in supporting routine immunization, UNICEF became the key delivery partner for COVAX, leading on the Procurement and Delivery at Scale workstream and serving as a member on the Health Systems Connector committee. As part of its collaboration on the ACT-A, UNICEF has been working to procure and deliver COVID-19 diagnostic equipment, therapeutics, and quality-assured vaccines, primarily for low- and middle-income countries.

3. The ACT-A partnership was launched by WHO and its partners in April 2020 to accelerate equitable access to and the development and production of COVID-19 tests, treatments, and vaccines to fight the pandemic. The ACT-A collaboration framework has three pillars: Vaccines/COVAX, Diagnostics and Therapeutics. There is also a Health System Connector and a Country Allocation and Access workstream.

Figure 1: ACT-Accelerator structure, with Pillar co-conveners and leads. Source: "What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?"

4. The COVAX pillar aims to accelerate COVID-19 vaccine development, manufacturing and to guarantee fair and equitable access for every country. The COVAX facility is a procurement platform accessible to all participating countries. To increase access to vaccines in low- and middle-income countries, Gavi, the Global Vaccine Alliance, launched the COVID-19 Vaccines Advance Market Commitment (COVAX AMC). COVAX AMC supports the participation of 92 low- and middle-income economies in the COVAX Facility by providing payment facilities and enabling access to donor-funded doses for the poorest. COVAX participating countries include donating, self-financing, and AMC countries. As of 4 January 2022, 934 million doses had been delivered globally by the COVAX facility as part of the 2 billion targets.
5. Each ACT-A pillar has several workstreams, with one to two organizations leading each workstream. Under this collaboration framework, UNICEF is a key delivery partner and

serves on the COVAX pillar committee co-convened by CEPI, Gavi, and the WHO. UNICEF is also on the committee of the Health Systems Connector, co-leading three workstreams: community-led responses, protecting front-line workers and supply chain.

1.2. MENA region crisis and response overview

6. COVID-19's impacts have varied by country. Pre-pandemic health sector capacity, national financial and human resource availability, and other country-specific circumstances have all influenced how COVID-19 has impacted individual countries. The COVID-19 pandemic and associated measures to control the pandemic also heavily impacted the economic, social, and mental health of individuals across the MENA region.

7. UNICEF's response to COVID-19 occurred in an already complex context. Prior to COVID-19, countries in the MENA region were facing diverse and significant challenges such as conflict, forced displacement, recurrent disasters, inflation, collapsing oil prices, political instability, and migration, amongst others. About 12.4 million people were living in internal displacement across the MENA region at the end of 2019, and more than 7.8 million people have sought refuge abroad (IDMC). Overarching regional trends related to COVID-19 vaccination, particularly in conflict-affected countries, include large populations located in areas outside of national government control, gender disparities in COVID-19 risk perceptions and vaccine demand, and constrained UN access to national health information.

8. UNICEF has been supporting national governments to strengthen their cold chain capacity for COVID-19 vaccination campaigns and is further supporting nine countries (Algeria, Djibouti, Egypt, Morocco, Palestine, Syria, Sudan, Tunisia and Yemen) with Ultra Cold Chain (UCC) services, which include assessments, UTL freezers, ancillary items such as generators, air conditioners, PPE and other UTL freezer deployment costs to prepare for Pfizer vaccine delivery.

9. COVAX planning started in August 2020 with an official, structured global working group that established a clear division of responsibilities amongst partners. The global working group's structure and division of labor mirrored in regional working groups formed shortly thereafter. UNICEF and WHO co-chair the Eastern Mediterranean/MENA Regional (EMRO) Working Group, with UNICEF leading the Supply and Logistics, Communications and Demand Generation (RCCE), and Cold Chain subgroups. WHO leads on regulatory matters and data compilation. UNICEF and WHO collaborate and co-lead in implementation in all other areas, and IFRC (International Federation of Red Cross) is the primary on-the-ground partner. The EMRO Working Group was formed in the initial stages of the response and continues to convene regularly. The EMRO Working Group's division of labor at the regional level is intended to be mirrored at the country level.

10. The contributory nature of the COVAX facility makes the response complex because it results in diverse sourcing and financing arrangements. The MENA region includes countries eligible and not eligible for Gavi support, self-financing countries, and countries benefitting from the AMC as well as other financing support. Meanwhile, most countries also receive bilateral donations. In addition, the COVAX facility's humanitarian buffer allows UNICEF to provide vaccines in areas outside government control. The various sourcing arrangements have resulted in diverse national vaccine portfolios because vaccine allocations from COVAX and bilateral donations often consist of different vaccine types. Unique vaccine administration protocols and cold chain requirements for different vaccines complicate supply, cold chain management, and RCCE for countries with diverse vaccine portfolios, as do population preferences for certain vaccine types.

11. Between September 2020 and January 2021, as part of a global exercise, UNICEF MENARO conducted a Real Time Assessment Round One (RTA R1) to examine the Regional Office (RO) and Country Offices' (COs) response to the COVID-19 pandemic. The RTA R1 included six country case studies: Egypt, Iran, Jordan, Oman, Tunisia and Yemen. The exercise assessed the quality of UNICEF's COVID-19 response, primarily focusing on the implications that the COVID-19 response had for UNICEF's regular program delivery, the quality of the COVID-19 response and early insights on achievements and lessons learned during the COVID-19 response.

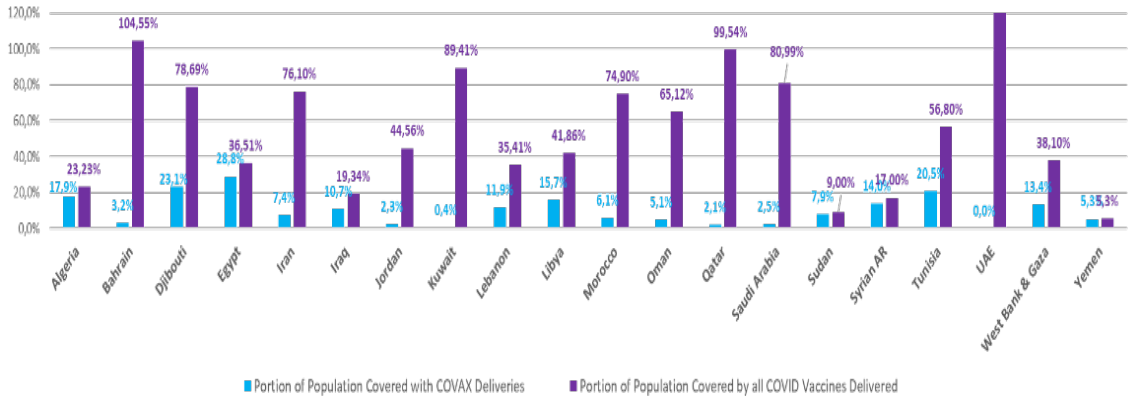
2.0. Background of the intervention

12. Over the course of the COVID-19 pandemic, UNICEF has provided support to 20 countries in the Middle East and North Africa (MENA) region in health, nutrition, remote learning, mental health and psychosocial support, research, and Risk Communication and Community Engagement (RCCE), and has taken a significant role in the development of the Access to COVID-19 Tools Accelerator (ACT-A) partnership launched in April 2020.

13. All MENA COs have been procuring vaccines, syringes, and safety boxes through UNICEF under the COVAX facility except for Kuwait, Saudi Arabia, and the United Arab Emirates (UAE). This support has been often accompanied by technical assistance to the governments to strengthen vaccination and communication systems and establish appropriate planning and coordination mechanisms. As of 12 December 2021, approximately 416 million doses of COVID-19 vaccines had been delivered to the MENA countries, including 945 million (23 percent) via the COVAX Facility. The degree to which individual countries have depended on COVAX for vaccine supply has varied, with some countries, like Sudan, Syria, and Yemen, receiving more than 60 percent of their COVID-19 vaccines from COVAX.

14. Vaccine supply increased in many countries towards the end of 2021. As of 12 December 2021, approximately 416 million doses of COVID-19 vaccines had been delivered to the MENA countries, including 94.5 million (23 percent) via the COVAX facility. More than 60 percent of the overall COVID-19 vaccines arrived in MENA countries between October and December 2021, as bilateral donations scaled up and COVAX deliveries arrived with more regularity. As of 12 December 2021, only 49 percent of the COVAX allocation had been delivered, and the vaccine availability and coverage were very uneven across the region, as demonstrated in Figure 2. Two MENA countries that depend primarily on COVAX for COVID-19 vaccine supply, Yemen and Sudan, had deliveries to cover less than 6 percent of their populations as of 13 December 2021.

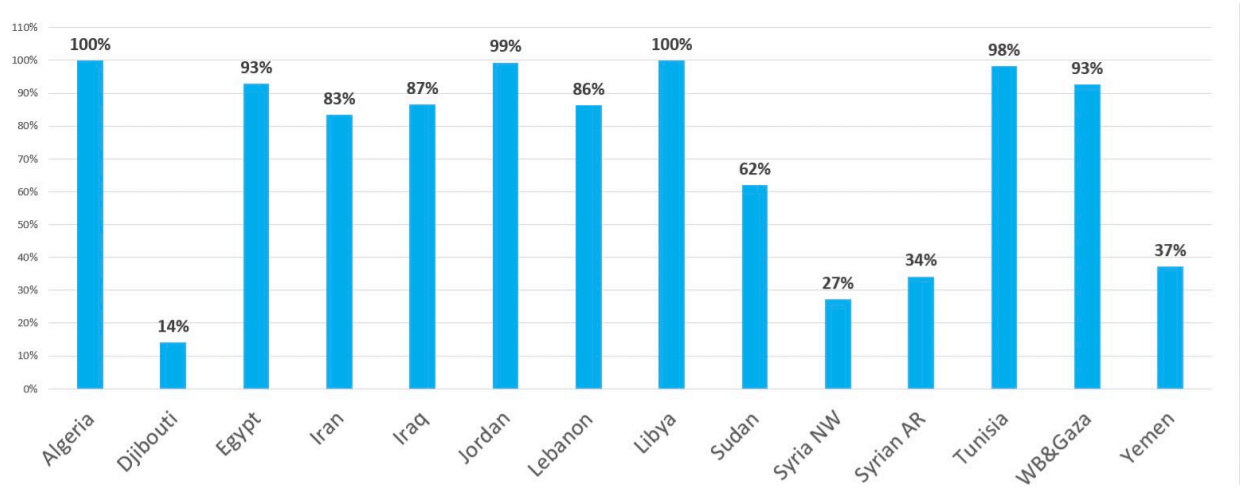
Figure 2: Covid Vaccine Availability by Country. Source: UNICEF COVAX Taskforce Internal meeting 10 January 2022



15. While the overall goal of the COVAX is to reach as many people as possible, initial deployment targets for COVAX were to prioritize 3 percent of each country's population for vaccination. Once this population was vaccinated, targets were progressively raised. The final 2021 target was to reach 20 percent of the population in every country, and progress towards this target is uneven. High-income self-financing countries in the Gulf have far exceeded targets while countries with the weakest systems, such as Yemen, Syria, and Sudan, are not on track to reach targets. Countries off-track to reach targets have faced challenges including political instability, insufficient or delayed vaccine supply, difficulties reaching substantial portions of their populations, and insufficient health infrastructure and workforce. Bilateral donations have played a significant role in boosting vaccine supply in countries struggling with delayed or insufficient supply.

16. Most countries' capacity to absorb vaccines exceeded their vaccine supply until October 2021, when supply deliveries scaled up dramatically, as shown by Figure 3, which shows high utilization rates. This was not the case, however, in countries facing severe operational constraints, such as Yemen, Sudan, and Djibouti. The rapid supply scale up and limited vaccine absorption capacity led some countries to opt out of the last allocation round in 2021 (Iran, Iraq, Jordan, Lebanon).

Figure 3: Utilization of delivered Covid-19 vaccine by country (4 October 2021). Source: UNICEF COVAX Taskforce Internal meeting 04 October 2021



Note: Larger portions of vaccines (over 60 percent) arrived in Syria NW and Yemen in September, hence below data does not fully represent the utilization pattern in these countries

17. UNICEF is providing vaccine procurement management, syringes, safety boxes, and cold chain equipment as part of COVAX implementation. UNICEF is also providing technical and operational assistance to the governments in managing their overall vaccine supply, demand generation, and RCCE needs, in close collaboration with other partners. While UNICEF has extensive experience with routine immunization campaigns targeting children, the COVID-19 vaccination response has required a drastic expansion of traditional target groups and operation scale for UNICEF and its partners. The country responses are also primarily Government-led, and COs were supporting national response plans and Ministries of Health (MoH)-led work to vaccinate the population. This arrangement has led UNICEF to work in close partnership with the national Ministries of Health.

3.0. Purpose, objectives, and scope of the assessment

3.1. Purpose

18. The purpose of the MENA Real Time Assessment Round 2 (RTA R2) is to leverage the experiences of selected COs and RO during the initial ACT-A implementation to generate lessons that will inform and improve the quality of future country and regional COVID-19 response activities. The RTA R2 provides insights on the lessons that have emerged during ACT-A implementation, outcomes achieved, and how cross-cutting issues such as human rights, gender, and equity have been integrated into UNICEF's ACT-A activities.

3.2. Objectives

19. The RTA R2 is an input into regional management reflections and the global real-time assessment process to improve ongoing response efforts and future pandemic responses. The RTA R2 aims to provide additional clarity on successes and areas for improvement

during the initial COVAX and RCCE implementation to inform CO and RO work going forward, including the RO internal COVAX group.

3.3. Scope

20. The MENA Real Time Assessment Round 2 (RTA R2) covers UNICEF's engagement in the COVID-19 ACT-A from January 2021 to October 2021, with a particular focus on UNICEF's contributions to the COVAX facility and capacity building. The RTA R2 also documents the quality of RCCE efforts to increase vaccine uptake and public health and social measures implementation. Importantly, the RTA R2 does not examine COVID-19 diagnostics or other pillars of the ACT-A with which UNICEF had less engagement during the initial phase of the ACT-A. After consultation with MENARO Evaluation staff, oxygen supply has been eliminated as a dimension of analysis for the RTA R2 because it was not a primary area of focus in most COs in the region during this period. The cross-cutting issues of gender, human rights-based programming, and equity provisions are incorporated into the analysis of UNICEF's engagement on COVAX, capacity building, and RCCE.

21. The analytical framework of the RTA R2 focuses on the United Nations Evaluation Group evaluation criteria of relevance, effectiveness, and efficiency. The RTA R2 analyzes these dimensions by focusing on specific questions about UNICEF's engagement in the ACT-A, with a particular emphasis on coordination. These questions are:

    - How relevant has UNICEF's response been with regards to COVAX in each of the target COs and Regional Office?
    - How efficiently has UNICEF been coordinating and engaging in system-wide efforts (e.g., with WHO, humanitarian country teams, United Nation Country Teams, Governments, and civil society partners) to achieve a swift, multidimensional, human rights-based response to COVID-19 at country level?
    - How effectively has UNICEF been supporting ACT-A in each of the selected COs?

22. The RTA R2 seeks to identify CO and RO challenges, determinants of success, and lessons learned during the implementation of the ACT-A over the selected period. A matrix detailing the assessment questions is presented in Annex 2.

23. The geographic scope of this assessment includes the RO and a group of four COs that did not participate in RTA Round 1. These COs were purposively selected by MENARO and represent a diversity of CO experiences in terms of CO size, country context, and COVID-19 caseload and mortality rates. The COs selected for case studies are Djibouti (a development context, small CO), Iraq (a large CO emergency and humanitarian context), State of Palestine (emergency and humanitarian context) and Syria (a large CO, emergency, and humanitarian context). The Algeria CO was first included in the RTA R2 scope, but the CO later opted to be included in the next phase due to workload constraints.

4.0 Methodology

24. The RTA R2 employed a mixed methods approach that included the collection and analysis of both primary and secondary data. Primary data was collected remotely via Key Informant Interviews (KIIs) and online surveys. Secondary data was provided by the MENARO Evaluation team and additional documentation was provided by COs during RTA R2 process. A list of the documents reviewed and analyzed as part of this assessment is provided in Annex 5.

25. The RTA R2 team conducted 51 key informant interviews (KIIs) with UNICEF RO and CO staff, government agency staff (Ministry of Health and others), implementing partners (private

sector and NGOs), ACT-A partner agencies (World Health Organization and others), and frontline workers in case study countries using a semi-structured interview protocol (see Annex 6). Table 1 describes the major categories of stakeholders consulted during KIIs. KII participants were selected using purposive sampling in consultation with the MENARO Evaluation team and CO focal points for the assessment. All KIIs were conducted remotely via videoconference or telephone.

Table 1: Key informants profile*: This table includes the eight interviews during the scoping phase in addition to the KIIs conducted during the data collection phase.*

Respondent Group	SoP	Syria	Iraq	Djibouti
CO Staff	6	8	6	4
Government		3	1	1
ACT-A partner agency staff	1	1	1	2
IPs	3			
Frontline workers	1	2		
Total	11	14	8	7
Regional	UNICEF: 10 ACT-A partner (WHO): 1			
TOTAL	51 KIIs			

26. The RTA R2 also included an online survey targeting frontline workers and the key stakeholders involved in the ACT-A response at country and regional levels. Surveys allowed those not able to participate in KIIs to share their views. There were 20 respondents to the stakeholder survey spread across four COs and the RO, and 137 respondents to the frontline worker surveys spread across three COs. Response rates varied significantly between countries and are presented in Table 2.

Table 2: Online surveys responses

Respondent Group	SoP	Syria	Iraq	Djibouti	Regional
Stakeholder survey					
Per locations	3	1	7	7	2
UNICEF staff	16				
National NGOs	4				
Total	20 Responses				
Frontline workers survey					
Frontline workers	95	39		1	
Total	137 Responses				

4.1. Limitations and mitigation measures

27. Access to information and informants was a challenge during the RTA R2 data collection process due to stakeholders' demanding pandemic response workloads and end of year obligations. These competing priorities led to uneven representation in KIIs and survey responses across COs. The MENARO Evaluation team helped to mitigate this limitation by mobilizing Deputy Country Representatives at case study COs and by extending response deadlines for both the KIIs and online surveys.

28. It was particularly challenging to secure frontline worker participation in the RTA R2 data collection process in some case study COs where UNICEF has less direct contact with frontline workers and where frontline workers connectivity is more limited. This challenge led to an uneven response rate to online surveys targeting frontline workers. Overall, 95 frontline workers participated from State of Palestine (SoP), 39 from Syria and one from Djibouti. Survey responses amongst other stakeholders also varied across COs. Extracting global statistics from these surveys given these differences in response rates across COs would not, therefore, accurately portray inter-CO trends. To mitigate the impact of this limitation, the RTA R2 analyzes survey responses on a per-country basis.

29. The diversity of case study COs, and of COs in the region more generally, also made it difficult to extract regionally applicable conclusions and recommendations. The RTA R2 case study COs comprised countries that procured their COVID-19 vaccines via self-financing as well as countries receiving financial support. The granularity of the data and information available in each country varies and it was not always possible to analyze trends and patterns comprehensively. The RTA R2 therefore highlights broad patterns, conclusions, and recommendations, while explicitly noting specific examples and exceptions to these patterns, as applicable.

30. Many national stakeholders had limited knowledge of the ACT-A process and setup, thus limiting their ability to provide insight into certain aspects of UNICEF's work on COVAX under the ACT-A structure. This limitation has been addressed throughout the text by highlighting areas in which stakeholders have limited knowledge. Finally, COVID-19 vaccine deployment scaled up massively during the period covered by the RTA R2. The report tries reflecting this trend to the extent possible, but the situation is very dynamic, and data is evolving daily. KII and survey responses were focused on the response until October 2021. The RTA R2 analysis therefore focuses on the period until October 2021 but notes the changing dynamics by including supply data up until early January 2022, as available.

5.0. Findings

5.1. Relevance: UNICEF support to COVAX and Capacity Building

31. UNICEF has been responding to clearly identified population and Government needs in a manner tailored to UNICEF's comparative advantage. Both UNICEF staff and partners consider the UNICEF response relevant to the needs of the population and their governments, particularly in terms of response planning, resource mobilization, supply management and procurement, and cold chain strengthening. Since national ACT-A activities are primarily Government-led, CO partnerships and capacity strengthening work have played a central role in supporting and influencing the Government ability to deliver. The RO played a significant role in supporting COs with information and hands-on technical support.

32. UNICEF's response thus far has had two phases that reflect the overall dynamics of Government and COVAX needs. During the first phase, which lasted from January until July 2021, UNICEF RO and COs were focused primarily on ensuring that vaccines arrived in countries. This effort was more complicated than expected due to unforeseen supply delays; vaccine supply, logistics, and contingency planning, therefore, consumed significant CO and RO staff time. During this initial phase, vaccination target groups, vaccination site number, and vaccination site location were limited. Populations eligible for vaccination during this period varied from country to country depending on the National Deployment and Vaccination Plan (NDVP), which, in most countries, initially limited vaccine eligibility to the elderly and specific groups of at-risk workers. Constrained vaccine supply and vaccination capacities limited national ability to scale up vaccination. Vaccination sites were primarily located in healthcare settings in urban centers, limiting access for populations residing outside cities. Self-financing countries, particularly Gulf countries, were not dependent on COVAX supply dynamics, and therefore their vaccination campaigns were not as constrained during this period, enabling them to vaccinate substantial portions of their populations during this period.

5.1.1. Supporting governments to assess needs and plan the response

33. UNICEF COs' support to the government on assessing vaccine, cold chain, and information needs were particularly relevant to the governments' need to plan the response. In many cases, COs had conducted joint needs and capacities assessments with government prior to the COVID-19 vaccination effort as part of their engagement in routine vaccination and other activities. This information allowed COs to quickly tailor their support to government based on demonstrated needs. In Iraq, previous knowledge of the national health system and cold chain capacities allowed the CO to rapidly focus COVAX related assessment and planning. In Djibouti, a review of the central purchasing agency for essential drugs conducted before the COVID-19 pandemic helped the CO and WHO rapidly determine the support that Government would require for the COVID-19 response and vaccination campaign.

34. During the initial planning phases of the ACT-A response, COs supported governments to conduct rapid needs assessments to determine national vaccine volume needs, cold chain capacity, and information needs. This support was particularly relevant for governments with limited human resources, technical expertise, or instruments to rapidly conduct these analyses. COs have also been conducting assessments with the government as part of the COVID-19 vaccination effort that is also helping improve national vaccine management protocols in the longer term. In Syria, for example, UNICEF coordinated an effective vaccine management assessment during 2020 with MoH and WHO, which led to the 2021-2023 Vaccine Management Improvement Plan.

35. The first requirement for countries participating in COVAX was the development and approval of a NDVP by January 2021. UNICEF COs provided direct support to the government to elaborate NDVPs. The plans covered vaccine eligibility criteria, targets, portfolio specifications, storage plans, deployment plans, and other technical considerations. UNICEF provided international consultants to support government efforts to meet the NDVP deadline, and governments across the region expressed that this support was extremely helpful. CO and WHO staff jointly supported the NDVP process, and NDVPs were then submitted to the regional WHO Partners Platform, comprised of regional UNICEF and WHO staff, for quality assurance and feedback. The regional working group has periodically indicated the need for NVDP updates when response dynamics have shifted.

36. As vaccines began to arrive, COs acted as both technical advisors and thought partners to governments analyzing their capacity to absorb incoming vaccine types and volumes. Due to the specificities of the COVAX facility, governments did not control the volume or brand of vaccine allocations, leading to national vaccine portfolios with a variety of vaccine types. In many cases, information on vaccine brands and shelf lives in each shipment was delayed, limiting government ability to engage in timely planning on cold chain, vaccination logistics, or RCCE. While in some cases, MENARO has been able to advocate for countries to receive allocations based on absorption data during the COVAX facility's weekly dose sharing discussions, UNICEF's primary method of providing support to government on vaccine supply management and planning was providing technical support and capacity building for government employees, helping them to cope with uncertainty.

37. To support vaccination planning and management, COs are also supporting the development of the health information systems and monitoring and evaluation (M&E). The crisis highlighted national health information systems' weaknesses but also provided an opportunity to strengthen these systems. COs and WHO have been supporting governments with the design, planning, equipment, training, and data analysis capacity required to implement more advanced health information systems. Health information system advances have been particularly notable in vaccination certificate production and registration. In many countries in the region, the COVID-19 vaccine was the first vaccine for which individuals received registered digital certificates, and COs provided crucial technical assistance to these efforts. UNICEF and WHO joint support on data systems, including equipment provision, training, and Internet connection strengthening, has been crucial for some government partners.

64. UNICEF has slowly been growing in its work on policy-level approaches, which is reflected in regional trends such as several COs advising Government to eliminate vaccination priority groups in favor of vaccinating as many people as possible once it became clear that this approach would raise national vaccination rates more quickly. Similarly, RO took on a policy advising role in many COs on how to manage and minimize vaccine expiry, vaccine hesitancy amongst teachers, and gender-based discrepancies in vaccination rates.

5.1.2. Supporting governments to mobilize resources

38. UNICEF COs supported government budgetary planning and financial resource mobilization for COVID-19 vaccination, including costing the vaccination effort and conducting financial resources needs assessments as part of the NDVP process. For self-financing countries unable to pay for their full vaccine request upfront, UNICEF provided pre-financing so that countries could submit Purchase Orders before all discussions and details regarding payment transfers were complete. Prefinancing functioned as a "hybrid" model of vaccine

sourcing arrangements in which self-financing countries would receive temporary financial support. Prefinancing was essential for many self-financing counties because it accelerated the procurement process and allowed these countries to receive vaccine shipments on a similar timeline to non-self-financing countries.

39. COs also supported governments with the technical aspects of COVAX applications and other funding applications. These applications required substantial data, analysis, and planning, and government capacity to engage in this work in a timely manner varied depending on MoH human resources capacity. UNICEF support on applications was highly relevant to country needs, as COs provided the technical expertise necessary to translate the needs governments expressed into technically sound grant applications. In countries where UNICEF provided such support, such as Syria, the MoH determined vaccination priorities and financial needs, communicated these needs to UNICEF and WHO colleagues, and UNICEF and WHO then supported the Government to develop the budgets, narratives, and tables required for funding applications.

40. Vaccine sourcing arrangements varied widely across the region, as did resource mobilization eligibility. The ACT-A's complex structure meant that governments were not always aware of the financial resources available or the protocols for securing them; CO support crucially filled such knowledge gaps and provided additional human resources that governments required to complete funding applications on time.

41. UNICEF's HAC (Humanitarian Appeals for Children) funding also enabled countries to administer doses in-country regardless of political developments that might otherwise endanger external funding. For example, in Sudan, UNICEF internal resources (HAC) were critical when other funding sources were suspended because of the political crisis. In some cases, COs leveraged organizational relationships to secure money and in-kind support for Government vaccination efforts. For example, in SoP, the CO successfully advocated with WHO and Gavi to include SoP in AMC arrangements to access COVAX vaccines.

5.1.3. Supporting governments to manage procurement and supply

42. UNICEF's strength in supply and procurement is widely recognized because of the organization's work on routine immunization. Many Governments were already accustomed to UNICEF procurement procedures prior to ACT-A for the same reason. Routine vaccination work also provided UNICEF with close pre-established relationships with industry in logistics, cold chain, and manufacturing at the beginning of the ACT-A. These partnerships positioned UNICEF well as the key delivery partner for COVAX. COs have been able to leverage UNICEF's strong brand identity as vaccine provider, even though previous UNICEF vaccination efforts had only targeted children, and governments appreciated CO technical advising that capitalized on UNICEF's experience delivering health services in emergency contexts.

43. As part of its role as the COVAX delivery partner, UNICEF is responding to government technical and operational assistance needs to facilitate vaccine portfolio procurement and supply management by building on the organization's experience with vaccines logistics, custom clearances, and delivery. UNICEF provides key logistics support to governments, covering shipping and transport costs in many countries. COs leverage established partnerships with governments across the region to get vaccines across borders in complex political contexts. In Iraq, the CO was able to leverage its international relationships to help the Government ship vaccines and vaccination equipment through different routes across Jordan, Turkey, and through Iraqi Kurdistan. Similarly, in the State of Palestine (SoP), UNICEF's strong coordination with both Israeli and Palestinian authorities from previous

vaccination campaigns and cross-border efforts uniquely positioned the CO to help facilitate the process of getting vaccines across border crossings into SoP. In Syria, the CO similarly supported Government to get vaccines into the country via Lebanon and Turkey.

44. COs have also been procuring the needed syringes for COVID-19 vaccines. UNICEF support on syringe procurement was particularly crucial because syringes did not come with vaccines and sufficient syringes were often not available in-country.

45. CO support to governments on vaccine supply management improved over time and was essential as governments responded to the rapid supply scale-up from September 2021 onwards. Overall, UNICEF COs have been filling a key gap in Government capacity by providing supply and procurement support at various stages of the ACT-A.

5.1.4. Strengthening the cold chain systems

46. UNICEF support on developing and strengthening the cold chain was crucial. Cold chain assessment and strengthening has been a primary way in which UNICEF has been assisting with vaccine delivery management and scaling up the vaccination capacities. MENARO has technical expertise in increasing cold chain storage capacity and secured dedicated funding in bilateral contributions for cold chain equipment purchase. UNICEF support in this area has been highly relevant and filled an important gap; in many countries, UNICEF is the only agency providing cold chain support to the government because of a lack of other financial and technical resources. These cold chain gaps often existed and were acknowledged prior to the COVID-19 pandemic, so the additional resources secured for COVID-19 vaccination are also benefiting overall national vaccinations capacity, including for routine vaccination.

47. UNICEF's pre-pandemic work on cold chain strengthening helped COs tailor their support to local needs and scale up national cold chain capacity rapidly. In Iraq, UNICEF had already engaged in cold chain support prior to the pandemic and was able to use pre-pandemic cold chain assessments to quickly compile early national cold chain needs assessments. In Syria, meanwhile, prior CO healthcare center solarization efforts played a significant role in facilitating CO efforts to strengthen the national cold chain despite an unreliable electric grid.

48. The UNICEF technical and financial cold chain support has included cold chain gap identification, maintenance, information management, training, and equipment provision. This support has helped governments store vaccine doses, safely use COVID-19 vaccines, decentralize vaccination efforts and, thus, run more equitable vaccination campaigns. In Iraq, Syria and Djibouti, for example, COs supported efforts to scale-up and decentralize cold chain capacity, which allowed the countries to then scale up and decentralize vaccination efforts by using techniques such as remote temperature monitoring. The strengthened national cold chain capacities were particularly crucial as the deliveries scaled up. In Syria, UNICEF helped the Government ensure that national cold chain capacity was sufficient for a rapidly increasing vaccine supply during September and October 2021.

49. COs played an important role in facilitating Government requests for cold chain management support. During the initial stages of the response, some Governments were concerned that highlighting national gaps in cold chain capacity and requesting cold chain support would adversely affect their COVAX allocation. As some COVID-19 vaccines required ultra-cold chain capacity, the broad UNICEF strategy was to procure a minimum ultra-cold chain capacity in most COs so that all countries would be able to receive any vaccine brand while also working to rapidly scale traditional cold chain capacity. UNICEF COs were instrumental in clarifying for Governments that identifying cold chain capacity gaps would not adversely affect their dose allocation. COs' direct outreach to Government to offer support on cold chain gap identification and cold chain strengthening helped build rapport

between COs and MoH in many countries. In SoP, for example, UNICEF's work on cold chain support strengthened the CO relationship with MoH considerably and led to increasing ad hoc cold chain support requests over the course of the COVID-19 vaccination campaign.

50. COs played a specific role in advocating for and supporting the development of national ultra-cold chain capacities in eight countries in the region: Algeria, Djibouti, Egypt, Morocco, Palestine, Sudan, Tunisia, and Yemen. The COs advocated strongly with governments to develop national ultra-cold chain capacity as a preparedness measure despite not receiving Pfizer doses in early allocation rounds; this advice proved useful in subsequent allocation rounds and enabled countries to absorb more of the vaccine types offered.

5.1.5. RO support to country offices

51. RO coordination mechanisms to identify and respond to emerging CO needs have helped RO tailor its support to COs. CO needs have largely been in the areas of supply information and technical assistance, both of which RO has worked diligently to address despite limited information availability and human resources. RO followed WHO vaccine deployment guidance and provided additional guidance to COs based on RO vaccine uptake data. For high-income countries, this advising was focused on analyzing which portions of the population had not yet received vaccine and were vulnerable. In most other countries, RO focused on increasing uptake via demand generation and process-orientated targets.

52. At the beginning of the COVID-19 vaccination effort, RO established a MENARO COVAX Internal Taskforce led by the RO Health Section to discuss and strategize on emerging issues, identify countries of concern, conduct deep dive sessions to analyze the countries of concern on a case-by-case basis, and follow up with 1-to-1 advising. As of October 2021, the countries of concern were Djibouti, Sudan, Syria, and Yemen. COs found the Taskforce's 1-to-1 advising and dissemination of lessons learned across the region to be particularly relevant to CO needs. Under the leadership of the Regional Director, Regional Senior Management also organized regular meetings with CO senior management to receive progress updates; HQ and the Supply Division were also invited to regularly provide the latest updates. A significant challenge for RO has been that the COVID-19 crisis affected all COs at once, yet the magnitude of these effects varied by country, so RO needed to develop a way of responding to these shared and country-specific needs.

53. In addition to the taskforce-coordinated support, individual RO sections also provided hands-on technical assistance to COs and acted as regional conveners. In January and February 2021, several RO sections provided technical assistance to COs on NDVPs. Other types of section-led technical support developed with time. RO staff visited COs to meet with CO staff, partners, and government stakeholders, and COs mentioned in KIIs that these visits often accelerated existing work. RO sections provided enhanced technical support to COs based on demonstrated needs.

54. RO support on Supply was strong and relevant to CO needs, despite RO receiving limited information from the Supply Division in Copenhagen and Gavi early in ACT-A implementation. Information gaps on supply limited RO support's relevance at the beginning of ACT-A, which caused considerable CO frustration and led some COs to communicate with the Copenhagen Supply Division, surpassing RO Supply altogether. Despite these challenges, RO worked to provide COs with the clearest information possible by calling regular meetings and supporting COs with resource mobilization, logistics, technical information, and guidance on supply. As the response continued, information availability bottlenecks have resolved, and the RO has been increasingly able to respond to CO queries

on supply delivery dates. RO began to provide hands-on supply information support that enabled the CO to follow up on vaccine deliveries daily.

55. To address low vaccine utilization rates in the region, in July 2021 RO refocused its support strategy on equitable vaccine utilization. This work examined and targeted the specific geographical, cultural, gender, age, and other factors influencing utilization, inter-sectoral links to increase vaccine utilization before expiry, and vaccine hesitancy in healthcare workers, teachers, and the public. The focus on vaccine utilization has been highly relevant to CO needs, however recent WHO and UNICEF joint research has highlighted that vaccine hesitancy, although initially considered the main driver low vaccine utilization, may not have as much influence on vaccine utilization as issues of vaccine access.

5.2. Efficiency: Engagement in coordination and system-wide efforts

56. UNICEF contributed efficiently to efforts to improve vaccination operations. UNICEF COs are playing an active role in coordinating the vaccination efforts and ensuring smooth delivery. These efforts have been limited by partner capacity and communication flows, placing considerable strain on the COs resources and capacities.

5.2.1. The ACT-A coordination efforts

57. While the division of labor among the stakeholders was clear, the understanding of the ACT-A structure and function is limited at the country level, even amongst CO staff. COVAX planning started in August 2020, and there was an official, clear structure of global working groups and regional stakeholder responsibilities. However, UNICEF staff and partner responses during KIIs and in surveys reveal a limited understanding of how the ACT-A is structured and UNICEF's role beyond vaccine delivery. Government and implementing partners are aware that UNICEF leads on vaccine delivery and RCCE but are not aware of the specific roles that other stakeholders, like Gavi and CEPI, play. Familiarity with ACT-A terminology and pillars is particularly limited, with partners more likely to think of the response in terms of the "COVID-19 vaccination effort" rather than as part of the ACT-A.

58. UNICEF and WHO collaborated closely on planning and capacity building for ACT-A. The ACT-A effort was the first time UNICEF and WHO had collaborated so closely on a cross-regional effort, with UNICEF leading on supply, logistics, information and cold chain, and WHO leading on regulatory affairs, authorizations, and data. The two organizations co-led and collaborated in all other areas, including support to Government to elaborate the NDVP, releasing joint communications and supporting the Government jointly. The WHO Partners Platform, the regional working group that quality assured and provided feedback on NDVPs, was comprised of both WHO and UNICEF members. The specific dynamics of UNICEF-WHO coordination varied from country to country, but the unprecedented level of collaboration between UNICEF and WHO was a commonality across country contexts. At the CO level, two organizations communicate daily through formal and informal channels.

59. Each partner's role was clearly delineated as part of UN joint response planning at the regional and country levels. When COVAX planning began in August 2020, the official global and regional working groups developed a clear division of labor. UNICEF co-chairs the EMRO working group composed of six subgroups headed by different stakeholders. UNICEF leads the supply chain and vaccine management subgroups but has representation in every subgroup. This regional structure was intended to be mirrored at the country level, with the WHO responsible for helping Government secure vaccine authorizations and providing technical and epidemiological information. UNICEF, meanwhile, led on vaccine procurement, supply and cold chain. Capacity-building and other support to Government was then a shared responsibility between stakeholders, with the specific arrangements

varying from country to country. Overall, the division of labor between UNICEF and WHO did avoid duplication of efforts. In cases where Governments made identical equipment requests of UNICEF and WHO, for example, frequent and open communication between the organizations helped the organizations quickly identify the duplicate requests and formulate a joint response.

60. Country-level coordination took many forms with varying results. In Iraq, several coordination mechanisms were developed, including a national COVID-19 Task Force and an MoH Technical Advisory group composed of UNICEF, WHO, and other ACT-A committee members. There is also Health Cluster coordination at the national and field levels. These several layers of coordination were helpful, however, they required significant time investments to facilitate coordination and information sharing. In SoP, for example, UNICEF serves on the MoH's Vaccine Transparency Committee and its Epidemiological Committee, leading coordination on the multiple streams of vaccine supply, giving MoH technical advice on how to harmonize the approach and monitor vaccine utilization. In Djibouti, UNICEF, Gavi, and WHO developed a capacity strengthening plan with the Government that included a clear division of labor between stakeholders, including the establishment of a logistics group to support vaccine and equipment receipt and customs clearance. There have been regular stakeholder meetings throughout the ACT-A efforts in Djibouti that include MoH, Gavi, WHO, and UNICEF, even in the absence of a formal coordination mechanism because of the limited number of partners and representatives in the country. In Syria, WHO, UNICEF, and MoH have daily calls, and Gavi copies all of these partners on all communications. The CO has been receiving supply information from RO and HQ Supply Division but has still been facing significant gaps in knowledge about when vaccine shipments will arrive.

5.2.2. Communication among ACT-A partners

61. The ACT-A's complex structure generated multiple lines of communication on supply during the initial stages of the response that compromised UNICEF's ability to provide timely information on supply status, which frustrated partners. At the beginning of the vaccination effort, RO Supply section received periodic Supply updates from the Supply Division in Copenhagen, but updates were not always timely and complete. In some cases, only non-UNICEF stakeholders, such as manufacturers, had the information that COs and partners required on delays and shipments. RO Supply was therefore not always able to provide COs with the supply information they needed to plan for vaccine transport, deliveries, and information.

62. The ACT-A set-up, and the COVAX pillar division of responsibilities, led to UNICEF-Gavi coordination that was of variable frequency and content. Gavi agreements were made directly with national Governments, and Gavi-Government communications about delays and deliveries did not always include COs, despite CO responsibility for shipment coordination. Governments were therefore informing COs of the latest information coming from Gavi, and the reliability and format of this process differed across countries. In some cases, like Syria, copying COs on Gavi-Government communications worked kept the UNICEF CO informed of supply status. In others, like SoP, this chain of communication required strengthening.

63. COs did not always have access to the information needed to effectively coordinate with national-level partners despite significant efforts to develop effective coordination mechanisms, given that there was a direct Gavi-UNICEF notification link. COs therefore took a multi-pronged approach to collecting supply information, sourcing this information from RO, Government, and other partners. Issues emerging from Gavi-Government discussions

were frequently escalated to UNICEF, regardless of whether COs had participated in initial discussions about the topic at hand.

64. Despite clear published documentation about UN joint response planning and coordination, several partners were confused about the scope of UNICEF's role in COVAX, particularly with regards to UNICEF's role in tracking and responding to supply delays. A widespread misperception about UNICEF's access to supply information led Government and partners to request information for UNICEF. In Syria, this misperception created a reputation management challenge for the CO, and other COs also noted that UNICEF's limited information on when and which vaccines were arriving frustrated WHO and Government partners alike.

65. Both RO and COs had to strike a difficult balance when significant supply delays occurred to avoid accepting the blame for dynamics over which UNICEF had no control without appearing to blame other organizations and stakeholders for these delays. Overall, UNICEF was in a difficult position because it was responsible for providing support on supply and shipping, but did not have a reliable, single source of supply information.

66. Supply procedures for self-financing countries had similar communication inefficiencies. The procurement process was confusing for self-financing countries because it differed from the typical UNICEF immunization procurement process. Countries were required to send funds to Gavi (the COVAX facility), and Gavi would then transfer the funds to UNICEF, the procurer. Countries engaging in this process did not fully understand this division of roles and were not prepared for the supply delays that occurred; many self-financing countries were under the impression that their payment to Gavi was synonymous with having procured the ordered doses and were therefore upset and confused when supply delays occurred. Since UNICEF was not always involved in the conversations between countries and Gavi but was the part of the procurement agreement, UNICEF sometimes bore the brunt of Government frustration without having much influence over the supply delays or the information needed to properly respond to Government inquiries about delays.

67. Despite these multiple communication streams on supply and financing at the beginning of the ACT-A, communication has become much more efficient and streamlined with time. In July 2021, Gavi established periodic country-facing meetings with country staff from Gavi, UNICEF, and WHO, which have helped stakeholders understand the issues over which UNICEF do and do not have influence. In September 2021, RO began to be systematically copied on all major Supply Division updates, which has eased RO access to supply information. Feedback from frontline worker surveys also support the idea that supply communication has improved; 53 percent of frontline workers in Syria and 53 percent in SoP said that the CO communicated the vaccine supply situation very clearly while 39 percent in Syria and 41 percent in SoP said the CO communicated the supply situation clearly.

5.2.3. UNICEF financial and human resources mobilization

68. As of 6 December 2021, 95.69 percent of MENARO's financial needs to support UNICEF's contribution to the ACT-A was funded through a range of bilateral and multilateral funding. The largest contributor is the Global Thematic and US Fund for UNICEF, a multi-donor fund that supports UNICEF's ACT-A activities including Covid Vaccines Delivery Support (CDS). The second largest donor is Gavi (21.6 percent of funds), which provides CDS to Gavi-eligible countries (Syria, Yemen, Sudan and Djibouti), amongst other forms of support.

69. The overall utilization rate in MENARO was 66.16 percent as of 6 December 2021, with important discrepancies across grants and countries. For example, as of December 2021, the Gavi-provided CDS fund utilization rate amongst Gavi-eligible countries was below 50

percent whereas UNICEF-supported CDS funding had slightly higher utilization rates, ranging from 43 to 68 percent. The driver of this trend is not clear, however. Utilization rates are certainly influenced by each CO's capacity to implement activities, but it is difficult to draw specific conclusions based on the available information because the response is supported by multiple grants with various starting dates, duration and conditions.

70. The ACT-A vaccine pillar funding comes from various sources and financial resources are mobilized based on needs-based plans that are updated quarterly. Analyzing the funding status of specific activities and sectors is therefore difficult; while some grants are clearly earmarked, like the Japan grant in support to the cold chain, some funds are blended within the HAC and some activities are supported via multiple funding streams, such as SBCC and RCCE. CO capacity to plan, navigate the various funding streams and requirements, and make comprehensive requests greatly influence the extent to which they have access to sufficient and timely resources.

71. The ACT-A response has placed considerable stress on UNICEF RO and CO personnel. Both RO and COs have tried to increase human resources dedicated to the COVID-19 response and the ACT-A, but despite these attempts, many ACT-A activities have been implemented with only limited, if any, additional human resources. CO Human Resources personnel experienced a significant increase in workload due to COVID-19 response and safety measures, and therefore were not well positioned to think strategically about additional personnel contracting for COVAX activities. RO Human Resources has not been closely engaged in regional response strategy or planning from the beginning; there was therefore no strategic approach disseminated to COs to attract and contract additional HR for ACT-A. Regional HR has been providing ad hoc support to COs rather than supporting COs to strategize solutions to their HR needs. Quarterly CO staffing updates have highlighted these HR gaps to RO and revealed the need for increased collaboration between the RO Operations and Support teams and the Programs team on ACT-A planning and implementation. A regional HR mapping exercise was therefore conducted toward the end of 2021.

72. There have been several barriers preventing COs from scaling up human resources for ACT-A. Firstly, regional surge mechanisms have not been sufficient because all COs needed similar HR profiles at the same time; the RO rosters for consultants and emergency staff were therefore insufficient to respond to all CO needs. There was a particular shortage of Arabic-speaking consultants. Travel and visa restrictions posed an additional challenge for COs. It has also been challenging to find qualified candidates for profiles and country contexts; Djibouti and Syria COs, for example, struggled to find qualified candidates for advertised positions. In other COs where relationships with MoH rely heavily on interpersonal relationships, such as SoP, COs have been hesitant to add new human resources because of the situation within the MoH and their heavy workload.

73. At RO, additional capacity was added for immunization, cold chain, supply, SBCC, and other areas; a COVAX Coordinator was also hired. RO strongly encouraged COs to hire additional technical assistance to handle the additional ACT-A workload and, in most countries, COs added some staff. However, COs often did not add enough people to meaningfully decrease permanent staff workloads. One reason for this pattern was insufficient information at COs about streamlined HR contracting procedures and opportunities. UNICEF has simplified many contracting procedures by declaring a global L3 emergency for COVID-19, thereby allowing single source contracting and shortening the time required between Temporary Appointment contracts to avoid staffing gaps. Despite these simplified procedures, many COs are still wary because they expect a long and labor-intensive contracting process.

74. Funds are available under several grants to hire additional human resources; however, they are often short-term grants, and COs are reluctant to engage in a recruiting process under these conditions. When COs recruited additional personnel, they often opted for consultancies over TA contracts because of a simpler contracting process, but this contracting modality did not enable them to secure enhanced support in the medium term because of limitations on consultancy lengths. Countries in conflict zones sometimes mix emergency and routine contracting procedures, making it difficult to process appointments, thus delaying contracting further.

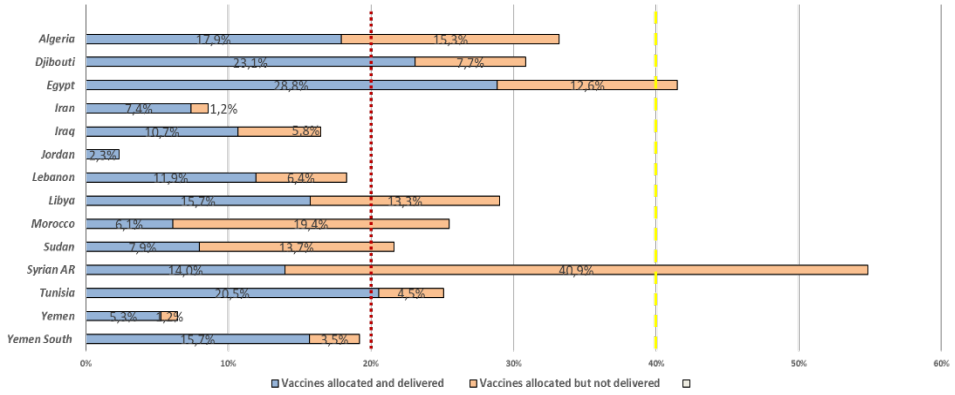
75. The assessment was not able to determine how has UNICEF's engagement in COVAX has changed UNICEF's access to certain ACT-A resources, due to the complexity and the lack of visibility of the ACT-A as a joint initiative at regional and country levels.

5.3. Effectiveness: UNICEF contributions to the ACT-A

76. The UNICEF contribution to the ACT-A was timely and had a clear value-add. Pre-established information, capacities and relationships played a crucial role in helping COs reach targets in a timely manner. However, insufficient supplies and national capacity often made it difficult for COs to meet targets despite UNICEF's clear contribution to capacity building. During the initial phase of the response, CO efforts focused on building national capacity to procure and receive vaccines; later, CO efforts also included a focus on expanding vaccination capacities.

77. Governments, with UNICEF and WHO support, have had to strike a difficult balance between vaccine supply, vaccination capacity and vaccine demand throughout the response. The progress to date towards reaching the vaccine delivery and administration targets is uneven across countries in the region, as shown in figure 4.

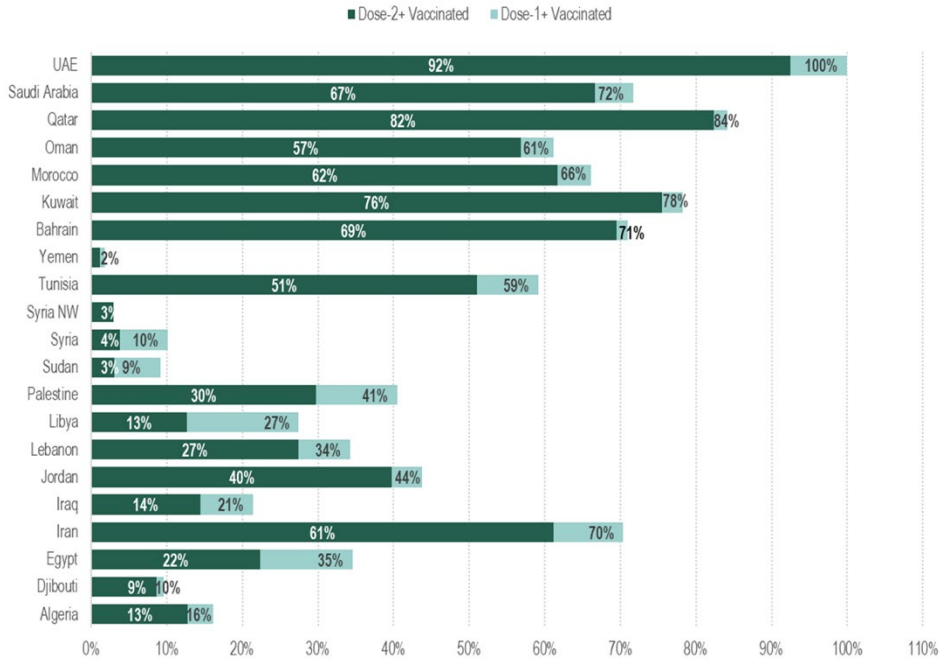
Figure 4: Ratio of the population covered with existing COVAX allocations and deliveries against the 20 percent target. Source: Internal MENARO COVAX Taskforce meeting update 10 January 2022



78. Limited data and information generation has been a challenge to planning and monitoring the effectiveness of the COs' ACT-A efforts, however, the statistics available highlight that vaccination rates are widely divergent between high-income and low-income countries, many of which have not been able to reach the WHO or COVAX-established targets for 2021, as shown in Figure 6. By early January 2022, Djibouti had fully vaccinated 9 percent of its population, they were only 3 percent in early October 2021 when the acceleration campaign was launched. In Iraq 14 percent are fully vaccinated (from 8 percent in October 2021). State of Palestine had fully vaccinated 30 percent, from 23 percent in October 2021. In Syria, according to the MOH data, in January 2022, 3,7percent are fully vaccinated. The vaccination rate in Syria grew during the first two weeks of October alone to 3 percent due to increased

vaccine supply. The vaccination rate in SoP rose dramatically in early September after SoP received a 500,000 dose Moderna bilateral donation from the United States.

Figure 5: Vaccination status of MENA countries, 9 January 2022. Source: Internal MENARO COVAX Taskforce meeting update 10 January 2022



79. The mismatch between vaccine delivery volume and national vaccine absorption capacity severely impacted the effectiveness of the vaccination campaigns that COs strived to support. For example, in Djibouti, supply exceeded demand when the country received massive quantities of vaccine during summer 2021 before the country had sufficient decentralized cold chain and RCCE capacity to absorb the vaccines. As a result,10,000 vaccines expired. Conversely, in Syria, the health system was prepared to lead a large-scale vaccination campaign by spring 2021. Low vaccine allocations were compounded by vaccine shipment delays and resulted in low vaccination rates until fall 2021. The MoH was then not keen to increase vaccine demand generation until it had enough doses to run a full vaccination campaign.

80. Delays in early COVAX vaccine shipments, caused by global supply chain issues and the reconfiguration of AstraZeneca sourcing arrangements after the July 2021 India vaccine export embargo, caused a slow initial phase of COVID-19 vaccination in countries relying upon COVAX for vaccine supply. From January until September 2021, most countries relying on COVAX did not have enough vaccine in-country to reach pre-established vaccination targets, making them hesitant to begin vaccine demand generation activities that could create a political liability. As of October 2021, there were six countries in the region where COVAX and bilateral deals/donations did not even cover 10 percent of the population (Yemen, Sudan, Syria, Egypt, Iraq, Libya), and all these countries depend primarily on COVAX for vaccine supplies.

81. When countries began receiving large vaccine shipments from COVAX again in September 2021, governments and COs faced the challenge of rapidly scaling up vaccine distribution

and demand to avoid vaccine expiry. Vaccines often arrived near their expiration dates, requiring Government and COs to rapidly scale up all aspects of the vaccination effort, from cold chain to RCCE, which was not always possible in these short timeframes. Under these circumstances, equity was sometimes compromised because of the need to vaccinate any willing vaccine recipients before doses expired. CO ability to provide government vaccine supply management support has been impacted by difficulty coordinating with government data providers and difficulty accessing accurate vaccine sourcing data that covers all sourcing arrangements, including bilateral donations; even the MENARO COVAX dashboard has limited country-level data. Many governments did not have a digitalized system for daily data sharing in place, making access to real-time data a recurring issue (ex. Djibouti, Syria, SoP). In Iraq, the CO provided crucial support to Government on remote vaccine monitoring, including support with information systems and stock management.

82. As governments had little political influence over the allocation processes, national preferences for vaccine brands were not considered as a factor during the allocation process, creating government concerns about political implications of providing vaccine brands that the population would not accept, and impacting vaccine utilization and expiration rates. For example, Syria received Chinese and Russian vaccines from COVAX in the first allocation rounds, which the population was hesitant to take because of a perception of low efficacy and these vaccines' repercussions on mobility in the Gulf region (see Equity section).

5.3.1. UNICEF support to vaccination capacity

83. Pre-pandemic and pre-ACT-A preparedness measures for national vaccination campaigns influenced the effectiveness of CO support to the Government. It was difficult for COs to scale up their vaccination support work when they had not done extensive vaccination or health work with the government previously. Countries that had extensive experience conducting routine immunization campaigns and emergency responses were better positioned to repurpose existing arrangements and datasets to scale up their vaccination campaign capacity. For example, in Iraq, the CO had a pre-pandemic Memorandum of Understanding in place with the Government for vaccine and syringe supply, which eased administrative procedures for the ACT-A contribution. At the Gaziantep Outpost covering northwest Syria, UNICEF was already coordinating a large group of partners working on health, and it was able to repurpose existing coordination mechanisms for the ACT-A work. Pre-COVID-19 assessments and evidence generation activities in countries where COs were already actively engaged in immunization campaigns gave those COs a head start on data at the beginning of the ACT-A and these COs were also more likely to have prior experience training health workers to build upon during ACT-A.

84. Prior CO experience in rapid response and emergencies also resulted in an enhanced understanding of how to rapidly set up vaccination capacities. For example, in SoP, the CO established a wide variety of Long-Term Agreements (LTAs) at the very beginning of the ACT-A effort to ensure that contracting for health, supply, and RCCE would not be delayed during the vaccination campaign. In Iraq, the CO is rapidly positioned to support the Government to train health staff to offer vaccination in health centers increasing the population reach.

85. CO expertise in coordinating multisectoral work at scale, developed as part of pre-pandemic work, helped governments progress towards vaccination targets despite logistical challenges. For example, in Syria, the CO was already working across sectors and governing groups on supporting governing bodies with health and other services, which enabled the CO to quickly adapt to a surge in vaccine supply in September and October 2021 when simultaneous scale-up of vaccine transport, distribution, information provision, and

community outreach was required. UNICEF's positioning as an organization with a purely humanitarian mission also allowed COs to manage stakeholders in complex political situations. In Iraq, the CO's pre-pandemic work on maternal and child health and routine immunization helped strengthen the government's COVID-19 vaccination capacity.

86. COs' expertise in stakeholder management, expansive field presence, and diversity of on-the-ground partners translated into a strength in bottom-up planning and helped COs adapt to dynamic field conditions while progressing towards vaccination goals. UNICEF COs had a much larger field presence than most other COVAX partners like WHO, Gavi, and CEPI, which enabled UNICEF to work dynamically on both the supply and demand sides of response. UNICEF's reputation as a leader in community presence and COs' warm rapport with local partners helped COs rapidly scale up RCCE activities in countries like Syria and SoP, and training activities in Iraq. Field offices and field presence also facilitated COs' ability to monitor and provide direct support to MoH in several cases, including in Iraq and Syria.

87. The limited health systems capacities, further affected by the pandemic, and the limited vaccination capacity posed a challenge to COVID-19 vaccination in several countries, and COs worked diligently to address this bottleneck. In many countries, MoH staff are the only individuals authorized to vaccinate the population and already had difficult working conditions prior to COVID-19. Particularly in countries experiencing conflict or economic trouble, MoH staff often received low and irregular salaries prior to the COVID-19 vaccination campaign, resulting in low motivation to commit significant additional time and energy to the COVID-19 vaccination effort. Staffing capacities at different levels have also been decimated by the pandemic. COs' worked with governments to address healthcare worker shortages and incentivize COVAX related activities, whilst abiding by UNICEF regulations about incentives provision.

88. UNICEF contributed to vaccination scale-up by training healthcare workers and providing solutions to expand the vaccination coverage. In Syria, the CO divided this work with WHO; WHO took the lead on technical training for MoH staff but did not have the capacity to do this at scale, so WHO and UNICEF developed a model in which WHO trained UNICEF staff who, in turn, trained NGO staff and other partners. In Iraq, the Government had limited resources to supervise and organize training, so UNICEF supported staff training to the extent that funding constraints allowed, which resulted in scaled up capacity to vaccinate people, particularly in hard-to-reach areas and to improve the registration and certificates edition. COs also supported national efforts to decentralize healthcare access; in SoP, a national hotline for individuals to report difficulties getting to a healthcare centre fed into a joint MoH, UNICEF, and UNRWA effort to reach these populations with mobile information centers and vaccine centers. Similarly, the Syrian MoH worked closely with the CO to identify areas not covered by health facilities, and to either quickly establish a health facility with UNICEF financial support or deploy a mobile team to the area. CO support for governments to diversify the locations of their vaccination sites was particularly important to increasing national vaccination rates and equitable vaccine access. CO support on cold chain also helped governments to address geographic reach limitations. For example, in Djibouti, where rural populations had more difficulty accessing health centers, the CO support on cold chain increased the number of fully equipped health centers accessible to rural populations.

89. Conflict and political dynamics affected CO ability to support government-led vaccination campaigns. In Iraq, uneven access to healthcare centers posed a major challenge to the COVID-19 vaccination campaign due to the geographic distribution of healthcare centers, security issues, and infrastructure destroyed in the conflict. Some population groups also had limited trust in the Government healthcare systems, considering recurrent weaknesses,

low coverage, and recent conflict. Humanitarian actors have been working to address these challenges during COVID-19 response, by supporting the creation of mobile vaccination units and increasing the capacities of health teams in hard-to-reach areas. In SoP, a special authorization was required for COVID-19 vaccines to enter Gaza; it was often not possible to secure these authorizations in a timely manner, which severely complicated logistical considerations, cold chain planning, and required the CO to advocate with COVAX so that doses awaiting Israeli approval were not reallocated to other areas.

90. The overall COVID-19 vaccination effort had the unintended result of affecting routine vaccination coverage. UNICEF's work strengthening cold chains for COVID-19 vaccination will have a positive impact on routine immunization at the medium term. In the short term, however, the COVID-19 vaccination effort placed additional stress on health care workers and health facilities without sufficiently scaling up their capacity, burning out staff and negatively impacting routine immunization efforts. Population concerns about COVID-19 vaccination have also negatively impacted routine immunization rates and health-seeking behaviors. In Djibouti, routine immunization rates decreased because of a health staffing shortage and the overburdening of existent healthcare workers during COVID-19 vaccination. In Iraq, routine immunization has decreased by 50 percent during the COVID-19 vaccination effort, with measles vaccination coverage hovering around 85 percent and putting the country at risk for an outbreak. These routine immunization rates in Iraq are related to limited healthcare personnel with low salaries that lead them to prioritize activities with additional incentives, such as COVID-19 vaccination, over routine activities to complement their salaries.

5.3.2. Data and information management

91. CO access to information management systems and data was also a major determinant of UNICEF's COVAX efforts' effectiveness. At the beginning of the implementation of COVAX activities, many countries had insufficient information systems to support planning and resource deployment. COs also commonly faced challenges securing timely data from governments due to burdensome administrative processes. Challenges with government data sharing were often due to government data collection and storage systems that were insufficient for the scale and nature of the COVID-19 vaccination effort. For example, in SoP, the Government registers where individuals are vaccinated, not where they are from, making geographic targeting data more complex to analyze. Furthermore, the extent of vaccination data sharing between the Palestinian Authority and the Israeli authorities has fluctuated with the political climate. In cases where COs have not had regular access to national datasets, they have worked to generate their own evidence and build closer relationships with governments to facilitate access to national data. In Iraq, the CO played a crucial role in improving the vaccination registration. While at the beginning of the campaign many recipients were left without certificates, the CO support in training and equipment led to clear progress.

92. Limited CO and RO access to country-level data has also limited UNICEF's ability to coordinate and engage in system-wide efforts to increase response effectiveness. Trust-building between COs and Government over the course of the response has mitigated this challenge in some COs, like Syria, but there is still much room for improvement. RO collects vaccine uptake data monthly and uses this data to analyze bottlenecks. RO also tracks and monitors CO data, providing feedback to COs. COs, in turn, pass this feedback on to governments. In Iraq, the CO is supporting digitalization and GIS mapping. In Djibouti, the CO is providing technical, equipment and training to improve the overall health information

system as part of the COVID-19 response. Constrained access to data also impacts RO and CO ability to support governments on supplemental funding applications in a timely manner.

5.4. Risk Communication and Community Engagement (RCCE)

93. UNICEF COs built on their strong comparative advantage in RCCE to support government planning and implementation of information campaigns to address the population information needs, generate vaccine demand and support public health policies. The nature of the pandemic requires very responsive RCCE systems to fight misinformation and rumors and support sufficient vaccine demand. The first phase of the response focused in most countries on appropriate planning, capacity building and mass communication, however, more was needed in community engagement and other areas.

5.4.1. Vaccine demand generation, awareness-raising, and rumor management

94. RO and COs played essential roles in providing RCCE planning, technical support, and communication materials. UNICEF's strong comparative advantage in RCCE and behavioral science is universally recognized. UNICEF's prior experience in these areas and its pre-pandemic establishment of dedicated C4D/SBC staff positions allowed COs to rapidly design and roll out RCCE efforts. In SoP, the CO quickly leveraged its large network of community partners at the start of the COVAX and formed a diverse RCCE taskforce to lead RCCE efforts while also printing and distributing materials for other stakeholders like WHO and UNRWA. The RO C4D/SBC section also regularly provided COs with guidelines and materials, technical packages, regular data/information updates, and hosted monthly technical meetings for COs across the region. In some countries, like Djibouti, these RO updates were the CO's main source of information on RCCE.

95. The C4D/SBC sections at RO and COs have been generating evidence that is crucial to designing vaccine demand generation efforts across the region. RCCE data has been collected routinely at the RO and CO levels, but there is significant variation in the depth of evidence generated and limitations on CO ability to collect data. For this reason, RO has led several initiatives to generate region-wide evidence on vaccine demand. Many of these efforts have been in collaboration with WHO, including the rollout of quarterly rapid assessments that are sent to all WHO and UNICEF COs. These surveys are a stocktaking exercise that asks COs to report on which aspects of a complete RCCE system are in place and which require further development, thus aiding both COs and RO to identify where additional work or support is required. A joint UNICEF/WHO 23-country KAP phone survey on vaccine demand conducted in June 2021, November 2021, and with a third round in 2022, has also provided crucial data to inform vaccine demand generation strategy. The RO has also been providing social listening reports and data utilization strategies to COs to increase data-informed decision-making on vaccine demand generation.

96. When trends are detected in these RO-led evidence generation efforts, responses have been rapidly designed and operationalized with communications circulated to all COs and issues escalated during CO Representative calls on vaccine demand generation. For example, when data collected during summer 2021 highlighted high vaccine hesitancy amongst teachers, RO created a consultancy position to create technical packages to help COs respond. Similarly, RO leveraged the detailed national data it had collected throughout the region to identify that vaccine uptake was lower amongst women in several countries and created specific job aids and tools to address this issue. After conducting a detailed analysis of vaccine hesitancy factors in October 2021, RO facilitated data utilization discussions with all COs. The process through which data is used to adapt messages and platforms to increase vaccine demand and manage misinformation is not uniform across COs. RO-led evidence

generation efforts have filled a gap for COs facing data generation challenges. RO has supported CO on misinformation response by releasing social listening reports every fortnight. The COs submit their study results to RO, which then supports the CO to design initiatives to respond to the vaccine demand findings.

97. Many COs have also conducted significant evidence generation activities to facilitate vaccine demand generation and have used existing data to support the overall ACT-A strategy. However, evidence generation at the country level is uneven, due to resources constraints and limitations related to national contexts. The April 2021 WHO/UNICEF RCCE Rapid Assessment found that 27 percent of countries had done national KAP studies on vaccine hesitancy and demand and 46 percent countries had social listening fully operating. By the end of October 2021, 67 percent of COs responding to the Rapid Assessment either had conducted or were in the process of conducting a national KAP study on vaccine hesitancy, demand, and acceptance during Q3 of 2021; 58 percent had social listening fully operating. In SoP, a 2020 KAP exercise and feedback from the COs' more than 46 local partners' feedback on UNICEF messaging effectiveness helped determine which channels and framing to discuss vaccination would be best. The CO has also supported a MoH study on vaccine hesitancy to be published in 2022 and conducted door-to-door surveying in the Gaza strip to understand community perceptions of COVID-19 vaccines. In Iraq, the CO has conducted needs assessments, KAP studies, and leveraged U-Report and youth advisory groups to understand the population's attitudes about vaccination. The CO also used innovative approaches like a rumor digital tracker, updating materials regularly to correspond to the population evolving perceptions and the diversifying vaccine portfolio. In Syria, the CO has been collecting data monthly, receives regular media reports, and has built a robust network of partners on data and social listening who produce regular reports for the CO. The CO also supported a local NGO to launch an interactive COVID-19 website that is also being used as a rapid assessment tool to gauge COVID-19 behaviors. In Djibouti, evidence has been collected and updated through focus-group discussions and interviews. COs have also been addressing misinformation by responding to comments on UNICEF's sites, establishing WhatsApp-based Q&A mechanisms, and training frontline workers on misinformation response.

98. It has been challenging for COs to access vaccination, vaccine demand and utilization data and secure evidence generation permissions but increasing trust between UNICEF and governments over the course of the response has eased these challenges. In Syria, for example, the CO's close relationship with MoH has the CO to expand the scope of data generation efforts over time from largely localized data samples in May 2021 to representative samples of more than 10,000 people in health centers across the country in September 2021. In Iraq, the training of the vaccination frontline workers provided an opportunity to engage them more in RCCE as well. The expansion of data generation activities and data access permissions has been a learning process for all stakeholders; as governments have recognized the utility of viewing UNICEF as a partner on data generation and analysis, data generation efforts have expanded and multiplied.

99. Evidence generated directly impacted government and partner strategies to respond to volatile vaccine demand. In areas with strong internet and cellular connectivity, COs have leveraged digital footprint tools to increase vaccine demand generation. In SoP, the CO paid for targeted social media advertising and set up a geographically targeted SMS system able to target population subsets in areas with outbreaks or low vaccination rates. The Iraq CO similarly diversified its communication so that there would be accessible information for all

population groups, releasing vaccine information in traditional media, on social media, and via influencers.

100. One strategy used across the region to increase vaccine demand has been engaging local leaders. In Syria, the CO has partnered with local religious, tribal, and cultural leaders so that all members of the population will receive information on vaccines and vaccination from leaders and in a framing that they trust. For example, the UNICEF field office work with religious leaders in camps that emphasizes the religious imperative to protect one's community. In SoP, the CO also mobilized public figures to increase vaccine demand and worked particularly closely with religious leaders, advocating for them to actively engage in the vaccine demand generation effort. As a result, many of these leaders released influential statements about vaccination during the initial stages of the COVAX implementation: The Grand Mufti released a video encouraging vaccination, an influential imam in Gaza discussed the religious duty to vaccinate oneself during weekly sermons, and Christian priests distributed vaccination information at church services. The CO in Djibouti also involved community and religious leaders in vaccine demand generation activities.

101. COs have made a significant effort to localize the vaccine demand generation efforts, particularly for vulnerable groups and in hard-to-reach areas. The Syria CO worked with radio announcers to broadcast vaccine information in different languages and shared paper materials at public places in areas without access to Internet. The CO also partnered with the private sector to include vaccination information on different supports.

102. Data collected during the first six months of the COVAX implementation highlighted the need for increased focus on vaccine demand generation. More recent data suggests that vaccine demand improved during summer and fall 2021, so the current challenge is to facilitate easy access to vaccines for more of the population. By October 2021, an analysis conducted by RO on vaccine uptake trends found that 20 percent of the region's population had been vaccinated with at least one dose while 60 percent intended to get vaccinated but had not yet done so; only approximately 5 percent remained undecided and unvaccinated, and 15 percent were unvaccinated and not intending to get vaccinated.

5.4.2. Community engagement and feedback mechanisms

103. Direct community engagement and feedback mechanisms are a key component of CO demand generation efforts; however, this component has not yet been implemented at scale in all countries. The need to go beyond mass media and communication are widely acknowledged. Efforts have been impacted by operational constraints, such as access and security, and by the lack of financial resources and capacity. Many COs spent the first phase focusing on national trends and did sub-national trend segmentation later. Initially, most COs were doing segmentation digitally, but this excluded large portions of the population without a digital presence. There is now an effort in most COs to conduct local mapping of problems and partners that can be addressed by extremely localized and person-to-person approaches.

104. Direct, field-based community engagement initiatives have been initiated but need to be scaled up. In Syria, UNICEF has hired C4D facilitators across the country to hold in-person sessions, particularly in rural and hard-to-reach areas; these facilitators coordinate closely with mobile vaccination teams so that increased demand can be quickly followed by easily accessible vaccination. In SoP, the CO trained pharmacy and medical students to do home and area visits to correct vaccine misinformation, collect data, and increase vaccine demand. In Djibouti, the CO has financially supported the training and incentives of community mobilisers in the vaccination sites, however their capacity to go beyond information

dissemination and to influence vaccination demand in hard-to-reach groups is still limited. In Iraq, a new project has been launched including direct community engagement activities and feedback mechanisms for specific hard-to-reach population groups. These efforts are promising but require significant scaling up to reach vaccination targets.

105. Feedback loops are limited and rely primarily on implementing partner feedback, resulting in mostly one-way communication. Community engagement efforts have seldom included formal feedback loops specifically geared toward COVAX; COVAX-related feedback has therefore been relayed using existing systems used to provide general feedback to COs. COs have continued monitoring their traditional feedback mechanisms and relied heavily on implementing partners and MoH for feedback on the vaccination effort. There are, however, exceptions to this trend. The Syria CO has a two-pronged feedback process, for instance. In this system, local C4D and MoH teams report to governorate-level teams that provide feedback to MoH, which shares the information with the CO for joint follow-up. The second prong is regular WHO and UNICEF meetings with NGOs operating in the field to gather feedback. The CO then considers both streams of feedback as it adjusts its vaccine demand generation strategy.

106. Efforts to expand RCCE activities beyond traditional media depend on government capacity, and COs' human resources are already stretched thin, limiting the capacity-building support COs can provide. An April 2021 rapid assessment of RCCE capacity found that 24 percent of COs had not yet staffed RCCE, and 53 percent were partially staffed. By the end of October 2021, 16 percent of COs responding to the rapid assessment reported not having the necessary staff in place and 58 percent were partially staffed. In Djibouti, RCCE has been a collaboration between the C4D and the Communication Officers, faced with major national capacities limitations. In SoP, the Communications and C4D teams work together on community engagement and have a huge field presence, but feedback from their extensive network of partners has revealed that SoP is saturated in mass communications and person-to-person community engagement is essential to increasing the vaccination rate. The scale of this work requires additional human resources to coordinate the vast network of implementing partners. In Iraq, the RCCE efforts benefitted from the arrival of a C4D team leader in the initial phase of the response. In all cases, additional human resources are required to provide RCCE support at the scale required for UNICEF's contribution to the ACT-A.

107. Insufficient financial resources have also been limiting community engagement activities in some contexts. In Iraq, the CO does not have the required financing to contract NGO/CBOs to undertake community engagement and is therefore exploring the possibility of mobilizing community volunteers to complement existing work by partners like UNHCR. These constraints have limited CO community engagement. The April 2021 WHO/UNICEF RCCE Rapid Assessment found that there was a 60 percent funding gap in RCCE for the vaccine rollout.

5.4.3. RCCE Coordination with partners

108. While WHO was already well-versed in risk communication, UNICEF was a key support in many of the systems-change aspects of RCCE planning, including advocating for RCCE to be included in response coordination structures and budgeting. During the initial phase of the ACT-A rollout, the WHO started the EMRO working group, which UNICEF co-chairs, including six subgroups headed by different stakeholders. The regional division of labor on RCCE stipulates that UNICEF coordinates RCCE for communities, partners, and NGOs while the WHO provides technical assistance on medical messaging and coordinates RCCE for health workers and national Ministries of Health. UNICEF leads the EMRO Working Group

Communications and Demand Generation committee and co-chairs the regional COVAX demand planning sub-group with WHO. UNICEF also worked closely with EMRO RCCE partners to develop the regional RCCE strategy, which has four pillars: response localization, capacity building, evidence generation, and improved coordination. In addition, UNICEF and WHO have jointly released packages on training healthcare workers, social listening, and data collection to increase CO behavioral science capacity.

109. In terms of RCCE coordination within UNICEF, the internal RO COVAX Team was supply-driven at the beginning of COVAX implementation, with only two Taskforce members working on RCCE. Over time, however, these members have integrated social, and behavior change items into the agenda of the meetings as the importance of behavioral barriers to vaccination became clear.

110. UNICEF is playing a significant role in RCCE coordination with MoH and WHO at the national level. UNICEF has been successful in its efforts to include RCCE in ACT-A planning and in coordination mechanism plans with partners by adopting the role of convener, and UNICEF's partnership with other UN agencies has deepened because of joint work on RCCE coordination mechanisms. In Syria, the Humanitarian Country Team tasked UNICEF to lead the interagency RCCE working group, and UNICEF also chaired the subnational working group. Syria CO, in close coordination with the Regional Director, Resident and Humanitarian Coordinator, other UN agencies, continued to advocate with the government on various issues, including greater access to data. The CO also developed a COVID-19 social, and behavior change strategy for other UN organizations to use and led monthly coordination meetings with RCCE partners. In Iraq, UNICEF co-leads the RCCE technical working group with WHO, which reviewed the group's terms of reference and workplan as part of the COVID-19 response. In SoP, UNICEF co-chairs the national task force of private and public sector organizations with WHO and has been recognized so broadly as the lead convener of RCCE that UN-OCHA approached the CO to ask for technical advice on forming a RCCE working group for the Gaza emergency appeal.

111. ACT-A coordination mechanisms provided a clear framework and division of responsibilities on RCCE, but limited capacity at the country level strained these arrangements and sometimes created bottlenecks and tensions. UNICEF coordinated large-scale RCCE campaigns with implementing partners but required technical messages approval from WHO counterparts. COs also required the technical expertise of WHO counterparts to respond to vaccine rumors COs were monitoring daily. In many countries, the WHO did not have sufficient RCCE or Communications capacity to quickly process the volume of quality assurance and rumor response requests received from UNICEF, creating a delay in UNICEF-led publication of RCCE messages. Some COs were able to publish messages by quality assuring content with other stakeholders, like MoH. There is a need to involve partners specialized in outreach to vulnerable groups, such as UNRWA, in strategic planning. Viewing such organizations exclusively as implementing partners rather than as thought partners does not allow UNICEF to fully benefit from their in-depth knowledge of at-risk populations. These mismatches between organizational capacity and predetermined response responsibilities sometimes strained relationships between stakeholders, however pre-COVID-19 arrangements and relationships played a significant role in reducing the strain on these relationships and on human resources.

112. While coordination between UNICEF and other stakeholders on RCCE has been close, COs expressed a need to communicate the limits of RCCE's ability to improve vaccination rates to other stakeholders. Vaccination demand and scale-up is not solely dependent on RCCE. Other factors play a significant role, such as access to vaccination centers, and more

comprehensive coordination on and accountability for the linkages between these factors and RCCE would be helpful.

5.4.4. Policy-level influence

113. UNICEF played a key role in developing national communication plans and materials, which were often, but not always, integrated into NDVPs. NDVPs, in turn, were translated into national policy on vaccination procedures. By April 2021, 78 percent of countries had integrated RCCE into their NDVPs. In some cases, Governments were not able to integrate RCCE into NDVP plans as UNICEF advocated because national planning was not organized along ACT-A pillars or in a centralized manner, such as in Djibouti. Governments appreciated ACT-A partners' support and no major restrictions were imposed by governments on the deployment of the proposed RCCE strategies.

114. UNICEF's regional and national social listening data sentiment analysis highlights that willingness to get vaccinated exceeds vaccination rates across the region. UNICEF has therefore been advising governments to pursue policy-level interventions to make vaccination more accessible rather than focusing exclusively on vaccine demand promotion. While it is challenging to systematically track whether this advice has been followed, KIIs and survey results revealed that governments view UNICEF as a valued thought partner and adviser on RCCE. There are some clear illustrations of UNICEF's successes in this regard. For example, in Syria, Field Office staff successfully advocated for the mayor of Deir Ezzor to send a letter to all governorate employees inviting them to get vaccinated. In Iraq, the CO successfully advocated for the Government to decentralize vaccination, expand outreach to the most vulnerable, and mobilize additional funds for community engagement and vaccination efforts.

115. UNICEF CO support was crucial to improve the overall RCCE quality and responsiveness to the specificities of the pandemic. In SoP, the CO played a significant role in the Gaza MoH's decision to make vaccination mandatory for MoH workers and successfully advocated for MoH to extend its vaccination hours to enhance population access to vaccination. The scheduling expansion was so successful that demand has sometimes exceeded supply in SoP. In Djibouti, the CO supported the development of the national acceleration campaign strategy launched in October 2021.

116. The COVID-19 immunization response is likely to have a lasting impact on national RCCE capacities. The response has necessitated a massive scale-up of CO RCCE and SBCC activities, which has included opportunities for COs and implementing partners to develop new skills, use new tools, and pursue new behavioral science approaches to increase vaccination rates. As logistical barriers to vaccination have become fewer, both UNICEF and partners have increasingly acknowledged that pursuing behavioral approaches to increasing vaccination rates is essential. UNICEF is, therefore, well-positioned to make the case for massive strategic investments into regional and national RCCE capacity. This process is underway; for example, UNICEF is developing a new partnership with New York University and the American University of Beirut to offer behavioral science courses to UNICEF and WHO staff, which will help increase local technical expertise in region. The next phase of the response will require additional strategic investments to expand technical expertise on RCCE.

117. UNICEF contribution to gender equality, promoting equity and a rights-based approach to programming

118. UNICEF COs contributed to equitable access to COVID-19 vaccines and information and RO developed materials to address gender-specific concerns about vaccination. COs have

been working hard to ensure equitable access to vaccines and information but have encountered resource and capacity limitations.

119. The MENA context is particularly challenging due to social, political, and cultural norms that complicate equitable access to services generally, and to COVID-19 vaccination. Specific constraints include security conditions and unequal access to the population, particularly in hard-to-reach areas. There is also unequal health system coverage across the region and general government capacity constraints with which COs must contend. In this context, COVID-19 is not always seen as a high priority in communities with several competing, urgent priorities. UNICEF COs have developed strategies to cope with these challenges, and governments appreciated UNICEF's focus on equitable access to vaccines. CO efforts to increase equity have, however, been limited by resource availability and by social, cultural and political sensitivities.

120. UNICEF's financial and technical contributions on vaccination planning, cold chain, health staff training, expanding the vaccination coverage and RCCE has improved population access to vaccination and helped facilitate more equitable access for vulnerable groups. UNICEF's financial support on vaccine transport and cold chain strengthening was particularly important because it increased access to vaccination in rural and hard-to-reach communities.

121. UNICEF provides crucial COVID-19 vaccination support to areas that have been impacted by armed conflict. For example, the RO Gaziantep Outpost is the only vaccine provider in the areas outside of Government control that the Outpost serves. UNICEF's pre-pandemic field presence and partnerships in such areas played a key role in providing access to vaccines in conflict zones. In Iraq, the CO developed training and equipment provision strategies to increase vaccination coverage in hard-to-reach areas with limited health services, including partnering with UNHCR and IOM to provide access for the people living in camps. A similar strategy was developed in Djibouti, to expand the vaccination coverage in rural areas and to reach refugees and migrants.

122. Financial support and training to increase health worker numbers and geographic reach was also one of UNICEF's key contributions to increasing response equity. In Syria, UNICEF funded additional field workers to reach hard-to-reach populations with vaccine and vaccine information. CO technical support on vaccination campaign planning and monitoring was similarly critical; in SoP, the CO supported MoH and WHO to plan for and monitor equitable vaccine distribution, including providing observers at health facilities to monitor equity, while in Djibouti supported the Government to improve health information systems and monitoring to improve the deployment of the vaccine.

123. Despite these efforts, there is much work to be done to increase equity in the ACT-A. Inter-country allocation and supply were not equitable during the first phase of ACT-A due to supply delays that wealthier and more influential countries navigated around via bilateral deals. UNICEF was a strong advocate for basing vaccine allocation on countries' absorptive capacity, and this will continue to be an important activity in the next phase of the response. Supply delays also impacted equity because delayed doses arriving with short expiration dates shifted national priorities from an equity focus to a focus on administering doses prior to expiration. UNICEF provided technical assistance to governments trying to balance these competing imperatives. Several COs and Government officials also acknowledged the role that UNICEF plays in advocating for increased transparency in the Gavi allocation process. There is widespread concern in countries like Syria about the implications of particular

vaccine brands on population ability to travel as migrant workers in the Gulf region, which has limited entry to recipients of particular vaccine brands.

124. CO strategies have been supported by a right-based approach. While results are still piecemeal, there have been notable efforts to ensure the protection of the health professionals by providing PPE and to ensure appropriate access to information for all.

5.5.1. Inclusion of IDPs, refugees, and people on the move

125. UNICEF was a key advocate for the inclusion of IDPs, refugees, and people on the move in national vaccination plans. This became a key CO advocacy point with national governments; regionally, RO ensured that NDVPs included these populations early in the vaccination campaign planning. UNICEF also provided funding to this effect. In Iraq, UNICEF advocated the MoH for the deployment of mobile teams in camps and hard-to-reach areas. supplied all vaccines to IDPs and refugees while also providing funding for training and equipment needed to decentralize the vaccination effort, thereby increasing access to vaccines for these populations. In Djibouti, UNICEF provided technical support to UNHCR and IOM for the vaccination to reach refugees and migrants, while the Government is vaccinating all individuals eligible according to the age restrictions.

126. One challenge that COs advocating for the inclusion of these populations in national vaccination plans have faced is difficulty calculating vaccination rates amongst refugees and at-risk groups because data on these populations is often decentralized or disjointed, if collected at all. For example, in SoP, the CO faced difficulties calculating the total vaccination rate and the refugee vaccination rate because some people were vaccinated by MoH, others by UNRWA, and others across the border in Israel. These disparate data sources were sometimes successfully merged to construct refugee vaccination rates; however, data merging ability has often depended upon the state of political relations at a given time.

127. Despite efforts to advocate for IDPs, refugees, and people on the move, there is still room for improvement; only 55 percent of frontline workers surveyed in Syria and 54 percent of frontline workers surveyed in SoP rated UNICEF-supported interventions as "very equitable" in terms of reaching these populations.

5.5.2. Gender considerations

128. As vaccination targets and coverage increased across the region and began to include priority groups that were mostly female such as health workers and teachers, gender discrepancies in vaccination rates became clear. For example, in the area covered by the Gaziantep Outpost, 63 percent of the vaccinated population is male. In Iraq, it is estimated that no more than 30 percent of the vaccinated are women. This issue is specific to COVID-19 vaccination, and not all COs have been able to access gender disaggregated data. Most COs have been making concerted efforts to make vaccination campaigns and vaccine information available to both genders and across all age groups. Additional data is required to tailor these efforts to local needs, perceptions and barriers. in Iraq, UNICEF and WHO are advocating for coverage evaluation to understand barriers. Frontline workers surveyed in Syria and SoP did not report discrepancies in equitable access based on gender and it appears that this trend may not be uniform across countries in the region; 100 percent of frontline workers surveyed in Syria and 99 percent in SoP said that UNICEF-supported interventions were either very or somewhat equitable across genders.

129. RO commissioned a study on gender-based barriers to vaccination that revealed that primary barriers include work in the informal sector that excluded them from national priority groups for vaccination, restricted decision-making over household resources, interruption of women's health services during the pandemic, limited mobility and time, a

perception that risk of severe COVID-19 is lower amongst women, and fear of side effects. Based on these findings, RO developed specific materials to address gender-specific barriers to vaccination, including the Little Jab Aid tools that leverage behavioural science insights to provide practical guidance on vaccine hesitancy. Few COs have similarly detailed barrier mapping at the national or sub-national level. COs have been trying to increase outreach and vaccination conditions favorable to women to counter these barriers. For example, in Syria, the CO has been supporting mother groups led by female doctors to increase the female vaccination rate, while in Iraq, vaccination centers provide separate areas for female vaccination. These efforts to increase female vaccination rates have resulted in new partnerships between COs and women's groups.

5.5.3. Disability considerations

130. Access to vaccine and vaccine information for people with disabilities has not been a focus of CO or RO COVAX efforts thus far. Governments do not systematically collect disability information in all cases, making it hard to track vaccination equity amongst this population. COs have made a concerted effort to make RCCE materials accessible to the blind and deaf populations, however, additional evidence generation activities are required to determine whether disabled populations have equitable access to vaccine centers and vaccine information. Frontline workers surveyed noted that there is room to improve equity for these populations in UNICEF-supported COVAX and RCCE activities; 32 percent in SoP and 46 percent in Syria rated UNICEF-supported COVAX and RCCE activities as "somewhat equitable" for individuals with disabilities, while 6 percent in SoP and 11 percent in Syria rated them as "not at all equitable."

6.0. Lessons Learned

131. UNICEF is a recognized leader in RCCE and behavioral science across the region. UNICEF took on a leadership role in RCCE coordination and implementation regionally and in almost all COs. There is a need for COs to increase RCCE staffing generally, but particularly at CO senior levels, given UNICEF's leadership role on RCCE. Activities focused on increasing vaccine demand require an increase in both number, level of staff and capacities at COs. Even so, COs had considerably more capacity to respond to government requests for RCCE support than other COVAX partners.

132. Evidence generation has been a challenge because of the rapidly evolving vaccine supply and demand situation. Particularly innovative methods and projects have been developed to address these needs, including social listening, U-report adaptation, and digital data tracking and geographical targeting. The COs and their government partners have relied heavily on joint regional WHO-UNICEF evidence generation efforts. Constant CO coordination with governments during the COVAX effort has, in some cases, increased data-sharing and streamlined evidence generation permissions processes. However, disaggregated data reflecting the need to engage with specific groups are still insufficient, especially regarding gender and disability. For RCCE in particular, there have been three main data challenges: obtaining data that is standardized and comparable across countries, receiving regular data updates, and responding quickly enough to the rapidly changing dynamics.

133. UNICEF's robust preparedness approach for crisis response did not sufficiently contemplate a public health crisis that affected all countries simultaneously and limited international travel. It was therefore challenging for ROs to respond to overlapping CO needs for HR, technical support, and other support. RO Human Resources was not strategically engaged in the COVAX response planning initially, resulting in ad hoc support to COs rather than a comprehensive strategy to address the regional crisis. The nature of the response also highlighted the need for COs to create local surge rosters to respond to public health emergencies that limit international travel, particularly in countries where visas are more difficult to obtain. Rapidly establishing LTAs, roasters, public and private sector partnerships early in the response was a crucial determinant in CO ability to quickly scale up their COVAX activities.

134. Digital health systems building work is an essential component of the capacity-building support that COs are providing to governments; this work has built trust between COs and government, fast tracking joint data generation activities and CO access to government datasets. Integrated digital data systems that include both vaccine supply and demand data are needed for all levels of the ACT-A response. Governments greatly appreciate COs' provision of urgently needed technical assistance developing and deploying such systems. Particularly in countries where COs have struggled to secure continued access to government datasets, this digital health system support has helped build trust between COs and governments that have facilitated easier access to national datasets. Systems tracking vaccines were new for many countries; once these systems were developed, the central challenge became data utilization rather than data collection.

135. RO and CO Supply staff felt simultaneously overwhelmed by the volume of communications for COVAX coordination and were excluded from key decision-making discussions with partners. Limited circulation of meeting notes from regional and global strategy discussions and limited direct feedback mechanisms to COVAX allocation partners perpetuated a sense that CO voices were not being heard.

136. The negative effects that COVID-19 vaccination efforts are having on routine immunization and health services were recognized after the implementation of the COVAX was well underway. COs are working diligently to minimize these effects, but these efforts are constrained by limited resources since these issues were not sufficiently considered during response planning or budgeting.

7.0 Recommendations

Recommendation	Responsibility	Timeframe
Recommendation 1: Continue supporting governments to decentralize vaccination sites and plan for the changes in vaccine supply, portfolio, and demand Continue 1-to-1 RO advising to countries not reaching WHO targets Provide additional in-country technical support to governments in low performing countries on vaccination decentralization, vaccine demand generation, portfolio management and cold chain strengthening	COs (Health, Communications, Supply, and C4D/SBC sections) RO Taskforce	Immediate
Recommendation 2: Provide additional human resources support to UNICEF COs Conduct an assessment on staffing for COVAX-related activities (number of personnel vs. workload) at RO and CO levels Provide additional outreach, support, and information to COs to assess risks and needs, and to provide information on how to leverage available financial resources Provide additional capacity building opportunities to UNICEF staff to build internal resources in areas of emerging need Increase SBC staffing at COs to focus on vaccine demand, particularly increase senior level staffing to enable UNICEF to engage at levels that reflect its leadership in RCCE	RO (Human Resources, Health and SBC) COs (Human Resources, Health and SBC)	Immediate
Recommendation 3: Mobilize/allocate financial and human resources to expand direct community engagement and technical support Support the expansion of direct communication engagement to ensure all population groups have access to information and feedback loops Continue to provide quality technical support to all RCCE activities	RO and COs COs (Communications and C4D/SBC), with the support of RO	Immediate
Recommendation 4: Continue supporting governments to generate, analyze, manage, and utilize data and evidence Continue to support governments to develop integrated data systems for managing vaccines supply, demand, and cold chain Continue to support governments to design and implement evidence generation strategies to manage vaccines demand and rumors, including clear plans for evidence utilization Commission a study/assessment to deeper understand the challenges met by specific COs in supporting COVAX activities and develop mitigation strategies Improve access to disaggregated data and evidence generation on vaccine supply and demand to support the development of specific strategies to reach groups with specific needs: gender, disability, remote locations. Embed staff in government to increase government capacity and reduce impact of COVID-19-related work on routine immunization campaigns	COs (Health, Communications, Supply, and C4D/SBC sections) RO	Medium Term (6-12 months)

Recommendation 5: Improve communication flows with COVAX partners and address bottlenecks in coordination mechanisms Request regular, direct communications between UNICEF RO and Gavi and include the COs in the lines of communication Engage with COVAX partners for increased transparency on vaccine allocation processes, timeframe and sourcing on both vaccine and grant allocation	RO Supply, Representative, and Deputy Representative	Immediate
Recommendation 6: Continue supporting equitable and right-based approach programming Increase evidence generation activities focused on at-risk populations to inform efforts to support equitable programming Improve coordination on access to camps and conflict zones	COs (PM&E, Representatives and Deputy Representatives)	Medium Term (6-12 months)