REAL-TIME ASSESSMENT OF THE UNICEF SOUTH ASIA RESPONSE TO COVID-19

UNICEF Regional Office for South Asia Evaluation Section

Real-Time Assessment of the UNICEF South Asia Response to COVID-19

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"The entire world was not prepared. Neither were we – this is a rural and poor area. After the outbreak, we made new plans" - Frontline Worker in Bangladesh

Figure 1 Health services continue despite COVID, Bangladesh 2020 © UNICEF

Title	Real-Time Assessment of the UNICEF South Asia Response to COVID-19
Country	Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka
Timeline of the evaluation	September 2020 – January 2021
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EXECUTIVE SUMMARY

CONTEXT

During the first quarter of 2020, South Asia reported low numbers of confirmed COVID-19 cases, but by May, India had exceeded China in the total number of cases. By mid-June, Pakistan and Bangladesh also reached levels that exceeded that of China. Overall, the pandemic gained momentum in Afghanistan, Nepal, Sri Lanka, Bhutan and the Maldives by mid-March and lockdowns in almost every country of the region curtailed economic and development activity and brought the South Asia region to a near standstill. According to November 2020 WHO data, the total number of deaths in South Asia (excluding India) was 16,597 and 1,089,005 confirmed cases. India alone accounted for a further 132,162 deaths and more than 9 million confirmed cases.

PURPOSE AND METHODOLOGY

The objective of this RTA is to inform a forward-looking reflection on the effectiveness of implementation of the UNICEF country office response to COVID-19. It includes an assessment of the effect of COVID-19 pandemic on basic services, particularly for the most vulnerable populations. Findings are consolidated across countries and regions at RO level, with a view to identify trends and generate cross-country learning and timely actions to strengthen the ongoing response. Key stakeholders and primary users of this evaluative assessment include therefore the UNICEF Regional Office for South Asia, the eight UNICEF Country Offices in the region as well as the respective Governments and implementing partners in the same. The stakeholders also include the frontline health workers as well as communities as soliciting feedback from these groups was considered necessary to construct a better overall picture over how the response was meeting the needs and how the response could be further improved.

This UNICEF South Asia RTA assessment includes country reports or briefs for all countries (as separate reports), excluding India. The mainly qualitative assessment was conducted between September 2020 and December 2020 . The main assessment tools included an extensive desk review, online surveys covering each of the 8 Country Offices, Government and Implementing Partners and Regional Advisers. Key Informant Interviews (KIIs) were carried out with Deputy Representatives of all COs, except with that of India CO. KIIs were also carried out with frontline workers and representatives of affected communities. The total number of key informants through the KIIs and surveys was 126.

FINDINGS

UNICEF response: All 7 UNICEF Country Offices covered by this assessment have adapted their programming and operations to respond to the pandemic. The most commonly used modes of adaptation were:(1) enhancing coordination with external partners; (2) strengthening cross-sectoral programming; (3) scaling up the use of digital platforms and programmes; (4) increasing international procurement of supplies; and (5) the use of local solutions.

There was consensus among Country Offices, frontline workers and affected community representatives alike, that previous emergency preparedness and contingency planning (geared towards natural disasters like tsunamis and earthquakes, and political upheavals) were not of major relevance to cope with the complex, multi-dimensional challenges of COVID-19. Nevertheless, the Pakistan and Afghanistan Country Offices indicated that capacity in place for the polio campaigns did prove useful in adapting to meet the needs of COVID-19. In many cases, UNICEF helped frontline partners by facilitating digital access, including by paying for zoom accounts during the initial phase.

Adaptation: Overall, UNICEF Country Offices adapted their programming through the use of detailed situation reports and other surveys. From March onwards, except for Afghanistan, all the Country offices were working remotely. They deployed their 'Business Continuity Plans" and the transition to online work was generally swift but not without constraints. This transition helped UNICEF engage in supporting national governments in developing their national COVID-19 response through planning and re-purposing ongoing programming to emphasize training of frontline workers and health messaging. Risk Communication and Community Engagement (RCCE) efforts became a key component of all country programmes covered by this RTA.

Attention was paid to ensuring that priorities of child protection were upgraded to 'essential service' status. UNICEF also facilitated the speedy setting up of 'virtual courts'. These efforts are particularly important to help address the increases reported in terms of child abuse and childhood marriage.

Distance Learning programmes were developed within tight time frames and attention was paid to introduce efforts for safe re-opening of schools. Attention was also paid to ramping up mental health support services through the increased use of hot-lines, which were particularly required in those countries that went through lockdown periods that stretched for three months and beyond.

In many countries, UNICEF was also involved, often for the first time, in setting up new programming arrangements. These involved large-scale procurement arrangements of PPE, test kits and related support (hospital beds, ventilators) with funds provided to national governments by external partners such as the World Bank and Asian Development Bank. This became a prominent feature and considered by many Country Offices as an important win.

Implementation: In terms of implementation, attention was placed on reaching the most vulnerable segments of the population through risk communication and community engagement that covered, health, hand-washing and mask wearing messages through various media. Training of frontline workers in the health sector and development of on-line, and distance learning materials for use by teachers, was prioritized. The promotion of cash assistance was also seen, though in most instances the distribution of medical kits and food supplies was more common. In terms of the types of support received, both Government and implementing partners indicated that funding and supplies were the most prevalent, followed by technical and training support. The overall assessment from Government and implementing partners, as well as frontline workers interviewed through the RTA was that UNICEF had succeeded to a large extent in meeting the needs of the most vulnerable.

The timely delivery of supplies posed a significant problem for Country Offices due to world-wide shortages. There was widespread understanding that UNICEF was working in a very difficult situation and wanted to ensure fair distribution of scarce supplies. However, delays in the provision of supplies also resulted in concerns in some countries about 'reputational risk' in terms of meeting the expectations of partners like the World Bank and Asian Development Bank. Some COs reported that given delays, donors turned to UNDP and UNOPS who had quicker systems to source supplies directly from countries and charter flights for their delivery.

Quality: All Country Offices covered by this RTA indicated that processes and verification systems for monitoring and distribution of supplies were used. UNCEF's response quality was generally considered good – the timeliness of the support was corroborated positively by the interviews with frontline workers. The frontline workers often stated that while the response might have been activated with a delay in some cases, UNICEF would often be the first one reaching out to the communities. But it was also noted that lack of access due to lockdown and the late delivery of supplies were bottlenecks in terms for timeliness.

There was also concern expressed by some frontline workers that UNICEF could have facilitated the integration of responses at the local level. Education, WASH and Protection programmes were seen as having their local partners and therefore there was less integration or sharing of information and achievement. There was also concern expressed that

government departments were not coordinated in their COVID response. There were a number of interviewees who referenced the need for food assistance and called for UNICEF to coordinate more with partners like WFP to address the issue of food security.

PRELIMINARY RECOMMENDATIONS

Shift from emergency phase and focus more on secondary impacts of the pandemic: COVID-19 is a uniquely complex challenge and future planning must take into account the multi-dimensional nature of this emergency. Given the prolonged and uncertain nature of the pandemic, UNICEF should shift to seeing this challenge as part of its routine programming. The initial impetus was to see COVID-19 as a health sector issue but now it is critical to focus on addressing food scarcity and the secondary economic and social impacts brought by the loss of income and remittances, particularly in light of second and third waves and the onset of winter in some parts of the region.

Building on recent experience with external partners: COVID-19 presented an opportunity for UNICEF to leverage its neutral, trusted partner status with national governments and external partners like the World Bank and the Asian Development Bank which led to increases in the resources available for procurement of PPE, other COVID-19 oriented supplies and technical support. However, in some cases the urgency to prepare these proposals came at the expense of consultations with Governments and other stakeholders. While the agency builds on these 'wins,' there is a need to document, take stock of the burdens such commitments place on administrative and operational budgets, and also on country office staff.

Strengthening and coordinating the frontlines particularly in the area of food and cash assistance and COVID-19 supplies: While UNICEF was recognized as doing a lot at policy level, there is a role for it to be more visible partner 'on the ground' supporting governments that are crippled by the economic and social costs of the pandemic. This could ensure greater focus on strengthening and coordinating frontline capacity of government for improved service delivery. It should also review and come up with a regional strategy on how it can support the provision of cash assistance. Critical medical services (laboratory capacity for testing, for example) should also get more on-the-ground support as second and third waves roll in.

Review the procurement, supply and logistics experience from a country office perspective: Supplies of critical PPE items were globally unavailable and offices often described other UN agencies that had more latitude, agility and creativity to meet this situation through direct procurement from countries. There were calls for UNICEF to take steps to review its arrangements for ensuring effective supplies and logistics arrangements so that a more flexible, responsive and less centralized approach can be adopted in the future.

In a related issue, there may be merit to review the criteria used for decision-making on which one country gets priority over another. The country classification criteria by income is apparently a key criterion and led to some countries in the region being placed at the "back of the of the queue" for supplies (and other support such as surge capacity). The pandemic has had a devastating impact globally and it was felt that this approach requires re-consideration in terms of future planning, keeping in mind the principle of the universality of human and child rights.

Duty of care: The **"**Duty of Care" dimension was seen as an issue that requires further guidance from headquarters given the challenges of taking informed risks, for UNICEF staff as well as consultants and other support personnel contracted to provide services particularly in quarantine sites.

Digital technology and analytics: There was a call to build on the COVID-19 lessons and invest in the development of a repertoire of innovative digital and non-digital strategies to ensure accurate data analytics were available to help address gender, economic and social inequity in health, education and protection. Providing technical assistance would build

capacity within UNICEF, as well as it partners which would help with monitoring and real time assessment of future emergencies of this type. Initial studies undertaken by ROSA to study and analyze digital penetration, would also help COs define country-specific digital penetration strategy for education, and other sectors. The opportunity to invest in the use of AI to review documents and make lesson learning agile and simple, should also be explored in more depth.

Lesson exchanges/learning to be made simpler: Deputy representative interviews referenced the need for a less formal and light modes for exchanging experiences. ROSA's organization of fortnightly sessions on specific topics (such as COVID-19 and high density urban areas) were cited as providing an opportunity for COs to pause, and reflect in the middle of dealing with the pandemic, and participate in fortnightly sessions chaired by the Regional Director, where the participants learned from others and ploughed the knowledge back into CO programming.

Streamline demand for situation reporting and budget processes: UNICEF staff and as government and implementing partners consulted during the course of the RTA requested that the volume of reporting and zoom meetings should be lessened/streamlined. Many implementing partners also suggested that that the quarterly budgetary allocation process be reviewed and reporting streamlined as this was often time consuming. In order to lessen the burden of COVID-19 reporting at regional and global levels, it was suggested that UNICEF should support harmonize the indicators that had to be reported on to various UN entities.

Ensure more effective and diverse monitoring: Several countries mentioned using zoom, asking partners to take picture to monitor and verify services. As the COVID-19 pandemic continues, it is imperative that UNICEF develops more appropriate guidelines for more rigid monitoring in times such as those faced during the COVID pandemic.

Ensure more effective coordination and guidance with other UN agencies in country: Country Offices mentioned lack of coordination with UN agencies in some countries. In some cases, negotiations and agreements reached at the headquarter levels were not effectively communicated with other UN agencies in country creating confusion and delays. UNICEF must work with other agencies to ensure that agreements at HQ are effectively communicated across the system.

Work with country partners to develop more diverse continency plans: In many countries, existing contingency plans focused on natural disasters. Many countries therefore were not prepared for a health emergency that COVID presented. It is imperative that UNICEF and countries in SAR enhance their contingency planning/ preparedness to include all types of emergencies. The lessons learned during COVID will be critical in this effort.

Contents

ACRONYMS

AI	Artificial Intelligence
BCP	Business Continuity Plan
BGD	Bangladesh
BTN	Bhutan
CMT	Country Management Teams
CO	Country Office
CPWG	Child Protection Working Group
CPWG	Child Protection Working Group
ECD	Early Childhood Development
EO	Evaluation Office
GBV	Gender-based Violence
GoSL	Government of Sri Lanka
GOV	Government
HAC	Humanitarian Action for Children
HQ	Headquarters
IN	India
IP	Implementing Partner
IPC	Infection prevention and control
IYCF	Infant and young child feeding
KII	Key Informant Interviews
LK	Sri Lanka
MDV	Maldives
MHPSS	Maternal Health and Psychosocial Support
MNCH	Maternal, newborn and child health
MOH	Ministry of Health
MPHSS	Mental Health and Psychosocial Support
MUAC	Mid upper arm circumference
NCPA	National Child Protection Authority
NEP	Nepal
NFI	Non-food item
PAK	Pakistan
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
RO	Regional Office
ROSA	Regional Office for South Asia
RTA	Real-Time Assessment

SA	South Asia
SAARC	South Asian Association for Regional Cooperation
SAM	Severe Acute Malnutrition
SIM	Self-Instructional Material
SOP	Standard Operating Procedure
U-report	
UNDP	United Nations Development Programme
UNOPS	United Nations Office for Project Services
VAS	Vitamin A supplementation
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme

INTRODUCTION

Background and purpose of the RTA

Since the start of the outbreak in December 2019, the coronavirus disease (COVID-19) has spread to over 215 countries and territories. As noted by the UNICEF Executive Director, children are "the hidden victims of the COVID-19 pandemic." Lockdowns and school closures are affecting their education, mental health and access to basic health services and raising the risks of exploitation and abuse.

In an operating environment that is rapidly changing and amidst calls for continuous adaptation, the UNICEF GMT determined that there was an urgent need for an in-depth understanding of the ways in which countries are responding to this crisis through means which go beyond current reporting efforts. Therefore, in July 2020 the Evaluation Office (EO) launched a Real-Time Assessment (RTA) of the UNICEF ongoing response to COVID-19 at the country level. The RTA was intended to support Regional Offices in their oversight role vis-a'-vis the implementation of the CO response to COVID-19. The RTA has been managed by Regional Offices (ROs), with coordination support from EO, and in collaboration with the COVID-19 Secretariat. The Regional Office for South Asia customized and contextualised the approach for the region and where possible, efforts to minimize duplicating other data gathering underway in the region were put in place. Most notably this relates to the Real Time Evaluation of the India Country Office, which was conceptualised prior to the EO decision to roll out the global RTA. However, India Country Office has participated in selected data collection efforts, in particular those that would inform the RTA results on the overall effectiveness of the response in South Asia and those that were focusing on areas which the India RTE did not have an in-depth focus – i.e. the mental health and psychosocial support(MHPSS) component. The MHPSS component is not covered in these findings but is summarized under a separate report.

RTA Objectives

The objective of the global RTA is to inform a forward-looking reflection on the implementation of the country office response to COVID-19. It includes an assessment of the effect of COVID-19 pandemic on basic services, particularly for the most vulnerable populations. Also, the RTA will gauge the implications of COVID-19 response on UNICEF's regular / pre-Covid programme delivery (the eventual extent of their repurposing for responding to COVID-19), the quality of the related delivery, while also providing early insights on the outcomes achieved. Findings are consolidated across countries and regions at RO level, with a view to identify trends and generate cross-country learning and timely actions to strengthen the ongoing response. Key stakeholders to this evaluative assessment include therefore the UNICEF Regional Office for South Asia, the eight UNICEF Country Offices in the region as well as the respective Governments and implementing partners in the same. The stakeholders also include the frontline health workers as well as communities since soliciting feedback from these groups was considered necessary to construct a better overall picture over how the response was meeting the needs and how the response could be further improved.

The intended primary user of the assessment include the stakeholders at UNICEF Country Office level (Country Management Teams, programme sections), the Regional Office level (management and Regional Advisers) as well as the HQ level, who will utilise the assessment results from the regions for a consolidated global assessment report on UNICEF's COVID-response programming. The ROSA RTA assessment includes country reports or briefs for all countries, excluding India. ROSA is planning a mini-retreat with the Country Offices to discuss and disseminate the country-level findings in January 2021. The idea of these dissemination sessions is to further improve the COVID programming in 2021 by ensuring an uptake of the findings, lessons and recommendations from the assessment.

The overall evaluation framework for the RTA in South Asia was guided by the following 4 overarching questions:

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

In addition to overall questions and tools used for the South Asia assessment the mental health and psychosocial support component sought to answer to the following specific questions which are also aligned with the above-mentioned overarching evaluation questions:

- *How effectively is the CO implementing the MHPSS aspects of the response to COVID-19 so far? What modalities are being used for the different populations?*
- *How well is the CO adapting to the MHPSS needs of the population? How have these needs been determined in each country?*
- *What are the early lessons (for CO/RO/HQ) that are emerging from the implementation of the MHPSS response? What are the emerging positives from the response as related to MHPSS wellbeing? What have been the greatest challenges in responding to the MHPSS aspects of COVID-19 so far? Are there discernable trends that are applicable to different settings (i.e. urban/rural; low-resource/high-resource settings)?*
- *What more should be done in the area of MHPSS programming? What should be done differently to enhance COVID-19 response programming for children and their communities in this area?*
- *How have existing guidance, tools and standards on MHPSS been used to support CO MHPSS strategy and programmes?*

The Real Time Evaluation of the gender integration and effectiveness of the UNICEF COVID-19 response in South-Asia, has the following objectives:

- *To establish the operational preparedness for gender effective COVID-19 response programming in SA by reviewing the enablers, normative and accountability frameworks set up at the onset of the response period;*
- *To assess the extent to which gender has been integrated to the response measures;*
- *To evaluate the gender effectiveness of the of the response measures by using the gender scale/diagnostic tool1 and against organizational/regional priority actions, for further improving UNICEF and host government's policy and programmatic responses;*
- *To document lessons, good practices and successful initiatives and partnerships for improving UNICEF and host government's gender integration and outcomes in policy and programmatic responses and develop a set of recommendations for each phase, for improving UNICEF SA and key partners' capacity to deliver gender transformative results;, with particular focus on gender in emergency programming*

[1] Please see figure 1: UNICEF Gender Diagnostic Tool at the end of the Concept Note

RTA scope, approach and methods

After the initial launch of the RTA by the EO in July 2020 and the subsequent tool development by EO, ROSA recruited two consultants to support the ROSA evaluation function in the implementation of the RTA in September 2020. The data collection was also initiated in September while the main data collection took place in October and early November and was finalised by the second week December 2020.

As mentioned in the previous section, the RTA in South Asia covers all the eight countries – Afghanistan, Bangladesh, Bhutan, India (with limited data collection), Maldives, Nepal, Pakistan and Sri Lanka. The desk review covers the UNICEF programming period from the onset of the COVID crisis in early March 2020 to November 2020.

The RTA covers India with limited data collection as India had developed earlier its own RTE on the India response to COVID. The current RTA report reflects the results from the CO survey tool, which was the only tool administered in India under the ROSA led RTA.

The general approach to the RTA was to carry out a light-touch assessment of the response elements, which would inform the UNICEF South Asia on the improvements required in order to make the response more effective – this assessment was not intended as a full-fletched evaluation. Therefore, the data collected is analysed to form general evaluative conclusions and recommendations on the way forward. The Assessment does not attempt to construct any level of attribution or contribution of UNICEF's programming to the national COVID responses in the host countries. While many of the assessment enquiry areas relate to the effectiveness and efficiency of the UNICEF response, **the RTA did not follow the OECD/DAC evaluation criteria.**

Regional customization of the assessment. As part of the ROSA efforts to improve the COVID-19 response in real-time, the regional customization of the assessment efforts also includes an in-depth component on mental health and psychosocial support and a separate yet synchronised Real-Time Evaluation of the gender integration and effectiveness of the UNICEF COVID-19 response in SA. Both of these efforts will be documented as separate stand-alone evaluation. In this report, only the key evaluation questions and objectives are provided for the sake of stressing the interconnectedness of these learning efforts.

METHODOLOGY

Data collection Methods.

a. Desk review: The RTA conducted a comprehensive desk review that includes documents prepared and/or published on the response between March and November,2020. The role of the desk reviews for the RTA was to review and synthesize the information and evidence that has been collected in the region regarding the COVID-19 response. A tracker was developed by the ROSA Planning section, listing all planned data generation activities in the region. This was used as a starting point by the ROSA Evaluation unit to develop an online repository of reports. Documents reviewed included study reports from each country, U-reports, regional and country level situation reports (Sitreps). The contents of the online repository were reviewed and summarized for each country and the region as a whole. In addition, UNICEF country office websites were reviewed for additional literature regarding the response. Further, information from other agencies working on COVID-19 in South Asia was reviewed to understand patterns and trends. Unpublished material, including various programme updates and reports from UNICEF country offices also was used to understand the planning and implementation of the response in each country. Each country desk review consisted of a programme overview, data generation activities, and an analysis of this material vis-a-vis the evaluation questions (adaptation,

implementation, quality). The desk reviews were later in the process merged with the country RTA reports.

b. Online survey for UNICEF Country Offices: An online survey was administered to all eight (8) country offices in the region. This survey was conducted via survey monkey using a global tool designed by the EO. The survey solicited information on the following key areas of the country office's response to COVID- 19: a) Needs assessment; b) programme adaption to address COVID-19; c) quality of the COVID-19 response; d) challenges and lessons learned. ROSA added questions to solicit feedback on the support provided by the regional office.

c. Online survey for Government and implementing partner representatives; An online survey also using survey monkey was administered to selected government and implementing partner representatives. The survey solicited feedback on the UNICEF supported response from these respondents. The survey also covered the core areas addressed in the UNICEF country office survey but solicited information from a government and implementing partner perspective.

d. Online survey for ROSA section chiefs: In addition to the surveys from EO, ROSA developed and administered a survey to ROSA chiefs of section. The survey solicited feedback on the country's response(from the ROSA perspective) and also provided information on the support extended to the country offices during the COVID-19 pandemic.

e. Key Informant Interviews. Key informant interviews were conducted for the respondents below. Given the Covid-19 restrictions, these interviews were carried out via phone calls/WhatsApp/Zoom/Skype. The KIIs were carried out in 7 countries, India excluded. KIIs protocols were structured around the KIIs tools EO developed.

1. UNICEF staff interviews (KIIs): Staff interviews were conducted for six (6) Deputy Representatives and 1 Representative at CO level. These interviews were conducted by the lead consultant hired by ROSA and sought to provide a deeper understanding of the country's response. Moreover,the interviews with the deputy representative and/or representative answered questions the evaluators had after reviewing the country's CMT survey.
2. Frontline workers (remote KIIs) – The RTA also conducted interviews with front line workers in the 7 UNICEF country offices. Frontline workers were defined as service delivery category of persons that are in direct contact with the beneficiaries of UNICEF supported programming. This category included teachers or health workers, as well as community staff and volunteers from NGOs and other community-based organizations. The interviews for this category of respondent used a EO provided KI guide and sought feedback on a) **most critical changes** required to **basic services** to meet new and emerging COVID-19 needs; b) reach, quality and timeliness of UNICEF supported programming; c) extent to which UNICEF had solicited input in its programming from the community. Interviews were conducted either in English or in a local language for respondents who did not speak English. The interviews were conducted via telephone, or Whatsapp by the evaluation consultants with assistance of a local translator or UNICEF evaluation staff who spoke the local language. In cases where telephone or Whatsapp was not available to the respondent, the respondent was facilitated to take the interview at a local UNICEF office that had access to a phone or internet.

3. Representatives of communities and beneficiaries; To capture the beneficiary voice, the RTA also solicited feedback from representatives of communities and beneficiaries. Representatives of beneficiaries included those from women's organizations, parent's organizations, religious organizations, or other beneficiary representatives from the community level. In addition, some individual beneficiaries were interviewed in some countries. The decision to solicit feedback from representatives of beneficiaries was based on the understanding that these would provide broader feedback on the services the people they represented received.

Translation for the KIIs.

UNICEF outsourced translation services for the conduct of the KIIs with frontline workers and affected communities' representatives in Bangladesh and Afghanistan. In practise this meant that the call with the respondents were three-way calls, with the interviewee, interviewer and the translator on the call. For Afghanistan, the translator also reviewed the final transcript to ensure that all essential information was captured in the transcript. Using a translator for the interviews meant that the initial time allocation was not adequate, sometimes having disruption of communication due to bad network quality (especially with respondents in remote locations).

Combined with the often-limited time available from the frontline workers, this resulted in the need to skip some questions. In Nepa,l the translations were done by a native Nepali speaker ROSA evaluation office staff and all other interviews were held in English without translation support. Key informant interviews for front line workers and affected community members were conducted in the following languages: Bhutan –English; Pakistan-English; Nepal-Nepalese; Afghanistan-Dari and Pashtu; Bangladesh-Bangladeshi /Bengoli; Sri Lanka-English.

Sampling and Recruitment of Respondents:

The data collected was not intended to be representative at any level, (except that of the Country Office survey tool). The goal was to select a sample that would provide a good picture of the response along the major questions of exploration. Therefore, ensuring diversity of respondents was critical. While representation was not the goal, ROSA made attempts to randomly select external respondents. The sections below describe how the different respondents were selected

a. Government and Implementing Partners: Country Offices were asked to provide a 'master list' of government counterparts and Implementing Partners by type of partner and sector proposing the partner. The extent (number of initial contacts) of these lists varied across the countries from a core set of key partners in the smaller countries but reaching over 150 contacts in the bigger countries such as Bangladesh. The evaluators and evaluation office staff (for some countries) randomly selected a list of government and implementing partners to administer the survey. The number of persons selected ranged from 10 to 25 per country. For countries providing less than 10 partners on their list, all persons on the list were selected. After selection country offices were asked to send the survey monkey link to the selected individuals. The message was accompanied by a letter describing the purpose of the survey. Respondents submitted responses directly to ROSA via survey monkey. Selected persons who did not respond were contacted several times by the country office to remind them to respond.
b. Frontline workers: A similar approach was used for selection of front-line workers to interview. In some countries, ROSA received lists by sections and often by regions in

the bigger countries. A front-line worker would not be selected from sections that did not submit a list.

c. Representatives of communities & beneficiaries: A similar mechanism was used to select representatives of communities and beneficiaries. Unfortunately, the number of people on the lists country offices submitted in this category was small (except for Nepal, which gave an extensive beneficiary contact list). Moreover, 3 (3) out of the seven (7) countries targeted for this component did not provide lists of community representatives and beneficiaries. In some cases, countries reported that their COVID-19 support was at a higher (government level), limiting their access to community representatives and beneficiaries.

d. UNICEF Country offices and staff: The CMT survey targeted all 8 country offices. In addition, key informant interviews were conducted for all Deputy Representatives for the 7 countries (all SAR countries except India) participating in the full scope of the ROSA led RTA. In Maldives, the representative was interviewed instead of the deputy representative because that position was still vacant at the time of the interviews. Similarly, all section chiefs in ROSA were selected and emailed a separate survey link soliciting their feedback on the country response and the support provided by ROSA.

Data Collection Responses by Type

A total of 123 responses were received. All eight (8) SAR offices completed and submitted a CMT survey. Fifty percent (61) of the responses were from government and implementing partners while 24% (31) of the responses were from people who were classified as front line workers. Only 10 (8%) representatives of community and beneficiaries were interviewed. Afghanistan provided the largest number of respondents (26%), followed by Bangladesh (20%) and Pakistan (15%). This is also more or less following the country budgets. While data on the gender break out was not collected for government and implementing partners, 61% of front-line workers participating in the survey were male and the remaining 39% were female. Fifty percent (5 out of 10) of the community representatives and beneficiaries were male.

Country/ Unit	Government/ Implementing Partner Survey	Front Line Workers KIIs	Affected Community Reps KIIs	CMT Surveys	Dep Rep KIIs	ROSA Regional Advisors urvey	
Afghanistan	22	4	4	1	1		**32**
Bangladesh	11	5	2	1	1		**24**
Bhutan	6	7		1	1		**13**
India	NA	NA	NA	1	NA	NA	**1**
Maldives	3			1	1		**5**
Nepal	3	3	3	1	1		**11**
Pakistan	10	6		1	1		**18**
Sri Lanka	6	5	1	1	1		**13**
ROSA	NA					6	**6**
Total	61	31	10	8	7	6	123

A breakdown of responses in the government and implementing partner category reveals that a nearly equal number of government officials as implementing partners responded to the survey. See table below.

Country	Government Respondents	Implementing Partner/Other Respondents
Afghanistan	13	9
Bangladesh	2	9
Bhutan	2	4
Maldives	3	0
Nepal	0	3
Pakistan	6	4
Sri Lanka	4	2
	30	31

Ethical norms and considerations for the RTA.

Two evaluation consultants were hired to support the ROSA evaluation function to deliver an independent and impartial assessment to the extent possible. While the assessment was not intended as a full-fletched evaluation, throughout the data collection and analysis process a level of 'externality' was maintained. The assessment tools and approach received an ethical clearance from Health Media Lab (see annexure 4). Participation in the RTA was voluntary for all individual respondents. The CMTs were required to submit a survey on behalf of their Country Office. Given the COVID-19 context, where required and applicable, the UNICEF Standard Operating Procedures for face-to-face data collection during COVID were followed. This was only relevant in Pakistan, where the low internet coverage meant that a few respondents came to the UNICEF field facility to participate in the Key Informant Interviews. In all other instances, data collection was done remotely, and UNICEF used a selection for the respondents which ensured that the interviews could be conducted with minimum disturbance to the respondents.

The interviews were thus conducted at the respondents' locality (home or workplace) at a timing most convenient for the respondent. This was critically important especially as the majority of the interviewees were frontline workers with COVID-related additional workloads. No minors were included in the respondent categories. Further, the RTA assured and maintained confidentiality to external respondents. Names of all respondents are are not listed in the report.

Limitations of the RTA

- As framed by the Concept Note of the EO, the RTA was undertaken as a "modified version of "Operational Reviews". It was seen as an opportunity "to pause, take stock and reflect on how to adapt further as the crisis unfolds." Therefore, the report itself does not aim to cover all the standard sections of a typical UNICEF-supported evaluation.
- While the survey randomly selected respondents, the sampling frame was provided by the Country Offices. Although there is no indication that country offices purposely eliminated any government, implementing partners of front line workers, the lists provided do not represent the full list of potential respondents in each category.
- Increased workload at CO, RO, IP and government level and fatigue in answering interviews and surveys for COVID related assessments reduced the number of respondents in all categories except that of the CO survey tool.
- Lockdowns, travel restrictions and quarantine procedures did not allow for field observations and time constraints for the data collection phase placed limits on triangulation, (particularly with external partners (e.g. World Bank, Asian

Development Bank, UN Country team) working with UNICEF to deliver the COVID-19 responses).

- Self-assessment was a limiting component which introduced the possibility of bias particularly in terms of the Country Office survey, as well as the Government/Implementing Partner survey. All COs provided fairly detailed responses to the open-ended questions. However, response from external partners, notably Government and Implementing Partners were typically not detailed and provided less information.
- All KII interviews were done remotely and the evaluation team had to rely on UNICEF COs to identify interviewees from which a sample was picked. Moreover, availability of interviewees during a short time-frame for data collection was another limiting factor.
- A further complication was the need to use translators, which sometimes led to the possibility that the full import of the responses was not captured.
- The use of rating scales in the KII instruments, also proved problematic as there were instances where respondents appeared reluctant to provide a precise score.
- Possible limited generalization of findings is another constrain given the short time frame for the assessment, limited number of data points, and the large number of COVID interventions the generalization of findings is challenging.

The above limitations notwithstanding, efforts have been made to derive as many perspectives from 'external voices'. These voices provide views on the issues being confronted by people, particularly those who are most vulnerable.

FINDINGS

The findings of this RTA have been grouped according to six different evaluation dimensions:

- Context
- Adaptation
- Implementation
- Quality
- Challenges and Lessons learned
- Emerging Conclusions

General Regional Context

The South Asia region countries covered by this RTA, comprise one low-income country, five lower-middle income countries and only one upper-middle income country. Maldives and Sri Lanka have relatively high Human Development index rates and also have the highest hospital beds per 10,000 beds per population.

All countries are experiencing severe resource constraints consequent to the effects of COVID-19. Vulnerability to public debt is increasing in many countries, "especially in Sri Lanka and Maldives."[2] Many are reliant on foreign exchange remittances and the World Bank projects that remittances for the South Asia region are to decline "by 22 per cent to $109 billion

[2] https://openknowledge.worldbank.org/handle/10986/34517

in 2020, following the growth of 6.1 percent in 2019."[3] All seven countries will also be affected by the drop in tourism - "COVID-19 is affecting nearly 47.7 million tourism jobs across South Asia, many held by women and vulnerable communities working in the informal sectors. Losses of US $50 billion in gross domestic product in the region are expected on the travel and tourism sector alone as a result of the crisis." [4]

Criteria	Afghanistan	Bangladesh	Bhutan	Maldives	Nepal	Pakistan	Sri Lanka
Population (thousands) 2019 data.worldbank.org	38,041.75	163,046.16	763.09	530.95	28,608.71	216,565.32	21,803.00
Income group data.worldbank.org	Low	Lower middle	Lower middle	Upper middle	Lower middle	Lower middle	Lower middle
2019 GDP per capita (USD) Data.worldbank.org	507	1,855.7	3,316.2	10,625.5	1,071.1	1,284.7	3,853.1
Real GDP growth 2020 (estimates) Worldbank.org	-5.5	2.0	1.5	-19.5	0.2	1.5	-6.7
HDI rank (out of 189 countries) UNDP 2020	169	133	129	95	142	154	72
Hospital beds per 10,000 population who.int	3.7	7.95	17.4	43	3	6.3	41.5
Health spend (% of GDP) 2028 data.worldbank.org	9.40	2.34	3.06	9.41	5.84	3.20	3.76

Regional context in relation to the COVID-19 epidemic

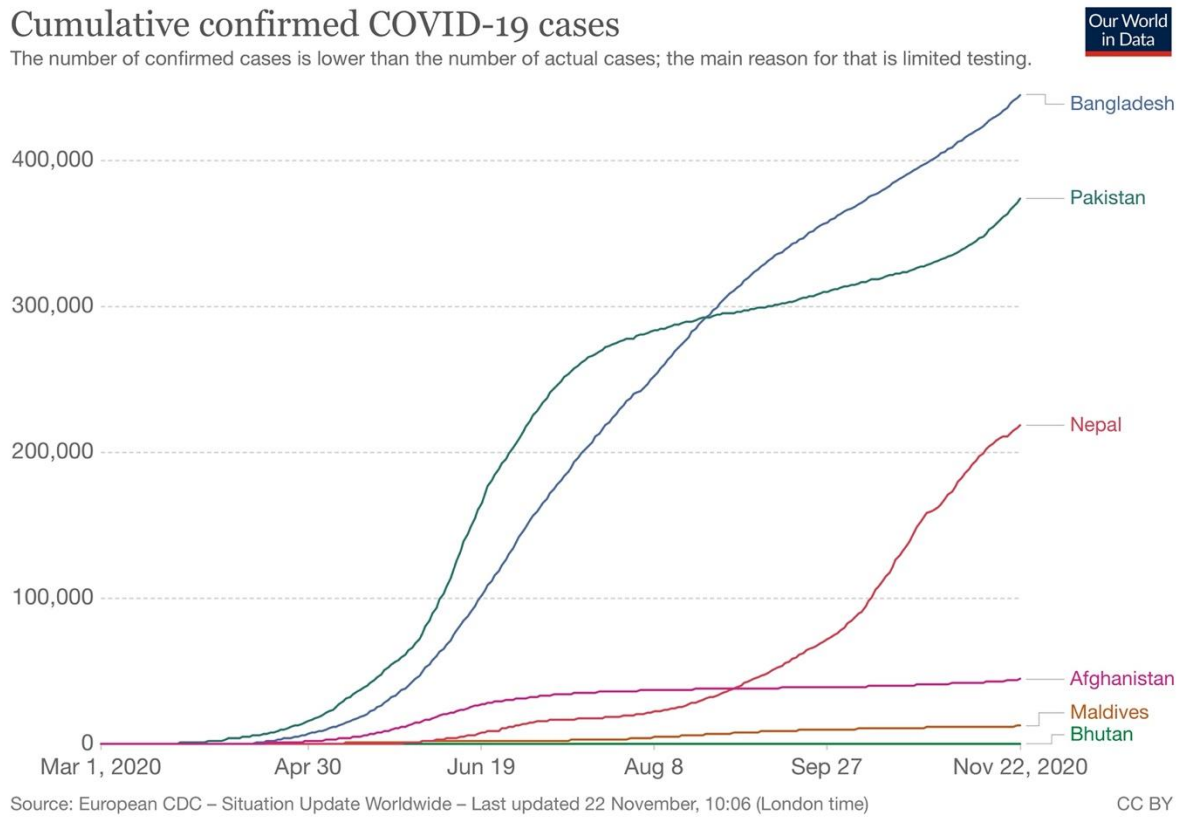
After the COVID-19 epidemic was first detected in China in December 2019 and infections soared in Europe in the first quarter of 2020, the South Asian region was reporting very low numbers of confirmed cases. Nepal was the first South Asian country to report a confirmed case on 23 January 2020, followed by India which confirmed its first case on 30 January. However, by the middle of May 2020, India had exceeded China in the total number of cases and by mid-June Pakistan and Bangladesh also exceeded that of China's.

While many countries began to talk of a "drop" in infections by end of July, rates of infections began to spike again in the fall as many countries relaxed restrictions on mobility and a "second wave" was soon being reported across the region in November (see Figure 1 below). According to WHO data, by 20 November, the total number of deaths in South Asia (excluding India) was 16,597 and 1,098,005 confirmed cases. India alone accounted for 132,162 deaths and more than 9 million confirmed cases. COVID-19 cases in the region excluding India, November 2020.[5]

[3] https://www.worldbank.org/en/news/press-release/2020/04/22/world-bank-predicts-sharpest-decline-of-remittances-in-recent-histor

[4] http://documents1.worldbank.org/curated/en/198651593536242978/pdf/COVID-19-and-Tourism-in-South-Asia-Opportunities-for-Sustainable-Regional-Outcomes.pdf

[5] BBC, ourworldindata.org.



Initially, South Asian countries were overwhelmed in their response especially regarding testing capacity. Although India accelerated its testing capacity and achieved almost 1 million tests per day since 21 August[6], other countries had very low testing capacity, especially in the early times of the pandemic. In terms of tests per 1 million population, the lowest in the region are Afghanistan (3,500), Bangladesh (16,000), and Pakistan (23,000).[7]

Bangladesh was testing over 18,000 a day in June when it witnessed a spike in cases. Since then, daily testing has hovered at between ten and fifteen thousand.[8] Bangladesh's testing numbers fell after the government introduced a high testing fee in July. Pakistan has increased its testing since September, and its positivity rate rose to 6%, the highest since July.

In the early days of the pandemic, beginning in March, almost all South Asian countries began implementing strict restrictions on mobility for people and goods to curtail infections; including India which imposed a complete lockdown for its 1.3 billion people from 24 March until mid-May. Many countries also instituted various levels of restrictions on international travel, completely sealing off their land borders and grounding most international flights.

However, by the middle of summer there was growing dissent about the restrictions on mobility which overwhelming affected the urban poor and daily wage labourers and small businesses. Many governments cautiously resumed domestic travel and began allowing businesses to operate, while still banning large gatherings and urging the use of masks and social distancing protocols.

Summary of the impact of COVID-19 upon focus countries

[6] BBC, ourworldindata.org.
[7] Worldometers.info
[8] BBC, ourworldindata.org

At the onset of the crisis, all governments immediately took a precautionary approach and imposed strict restrictions on mobility and rallied around a SAARC emergency fund. By 10 April 2020, the emergency fund had US$21.8 million with contributions from the eight countries. UN agencies, including UNICEF through its regional and country offices coordinated with government and INGO and civil society partners, immediately promoting approaches that prioritized sanitation and hygiene, including key messages focusing on handwashing and social distancing measures

COVID Impact on the Economy: Home to almost 2 billion people, South Asia economies have been hit hard by the COVID-19 pandemic according to a recent report by the World Bank.[9] The report suggests that South Asia is set to plunge into its worst-ever recession in 2020 due to the impacts of COVID-19 on the region's economies. As a result, informal workers are at risk and millions of South Asians may fall into extreme poverty. In the region **three-quarters of all workers depend on informal employment**, particularly in hospitality, retail and transport, sectors that have been severely affected by containment measures. Informal workers generally have less access to social insurance, savings or finance to buffer the impact.

The lockdowns across the region in almost every country starting in March 2020 curtailed economic and development activity and the crisis has brought South Asia to a near standstill. While economic activity dropped by 40% in Pakistan in April, other countries saw a two-thirds drop. Although activity has recovered subsequently across the region, it remained below pre-COVID levels by August 2020.

The Asian Development Bank's outlook for August 2020 estimates that remittances to South Asia could fall by a record 28.6 billion for 2020; with millions of households depending on international remittances. Thus a sudden stop in remittance flow to these regions could push people into poverty.[10] According to a recent UNICEF report, in Afghanistan, an estimated 11.9 million people could be pushed to food security deprivation which could cause the incidence of multidimensional poverty to rise from 51.7% to 61.4%.

COVID Impact on Education: Since the outbreak of the COVID-19 pandemic, school closures have affected approximately 434 million children and youth in the region, in addition to 22 million children who missed out on early education in the critical pre-school year due to COVID-19.[11] In most countries, some or all schools are still closed. Only two countries have fully reopened their schools; Pakistan in September and Afghanistan in October. Bhutan and

[9] Beaten or Broken? Informality and Covid-19 in South Asia. https://openknowledge.worldbank.org/bitstream/handle/10986/34517/9781464816406.pdf
[10] COVID-19 Impact on International Migration, Remittances, and Recipient Households in Developing Asia https://www.adb.org/sites/default/files/publication/622796/covid-19-impact-migration-remittances-asia.pdf
[11] UNICEF SAR Education COVID-19 response, Update # 12, October 2020.

Nepal have started to open in a phased manner. Sri Lanka had reopened its schools in August but closed them down in October after a spike in cases.

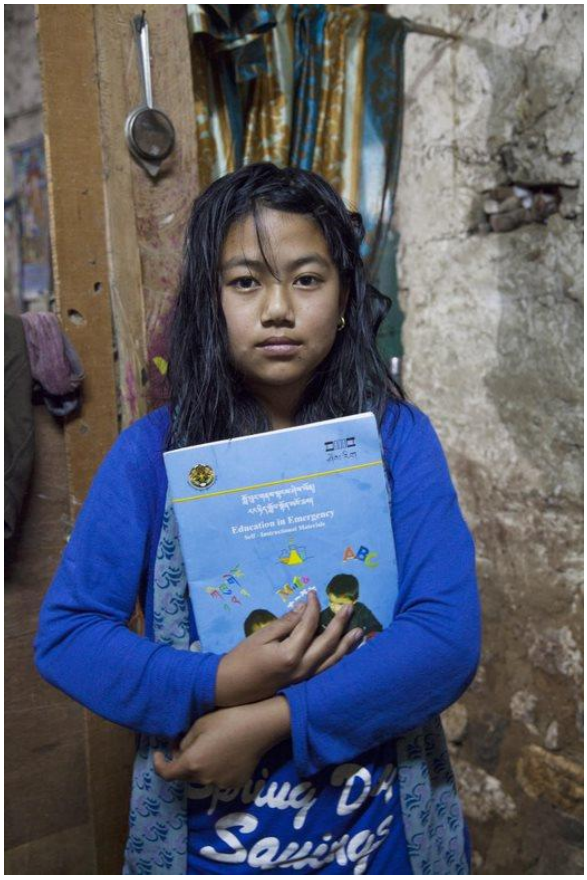


Figure 2: Case illustration from Bhutan, a student with Self Instructional Material

While most countries in the global north were continuing education at home through online learning, South Asia faced additional challenges due to limited connectivity.[12] Only 33 per cent of the people in the region have access to the internet. Access to both radio and television is limited in some parts of the region.

A UNICEF U-report on how youth in the region are coping (16,527 youth from the 8 South Asian countries responded) revealed that 79% reported difficulties in studying, 59% reported feeling stressed, sad or angry, and 21% felt there was a need to focus on psychosocial care of young people.

Impact on health Services: As lockdowns were extended, the negative impacts on health service delivery became evident in April. Assessments and monitoring findings showed that there was a significant decrease in access and provision of essential health and nutrition services across the region.[13] There were sporadic outbreaks of vaccine-preventable diseases in several countries. By May, there were concerns that infant mortality could increase for the first time in decades in South Asia due to the impact of Covid-19. For example, data from Bangladesh show that 41% fewer women sought facility care for deliveries in March 2020 compared with March 2019. During April, there was also a 90% reduction in severe acute malnutrition (SAM) admissions compared to January 2020. In Afghanistan, there was a 38% decrease in in-patient admissions of children with SAM in March 2020 compared with March 2019. Maldives reported that routine immunization was halted.

According to a joint statement by WHO/UNICEF in July, the reasons for disrupted services varied. Even when services were offered, people were either unable to access them because of reluctance to leave home, transport interruptions, economic hardships, restrictions on movement, or fear of being exposed to people with COVID-19. Many health workers are also unavailable because of restrictions on travel or redeployment to COVID response duties as well as a lack of protective equipment.

In a UNICEF survey of disruptions to violence against children-related services, among all regions South Asia had the highest proportion of countries reporting such disruptions due to COVID-19. At 63%, the most commonly reported disrupted service was that of case management or referrals to prevent and respond to violence against children. Several countries have seen a large increase in callers to helplines for victims of domestic violence.

In July 2020, South Asia was again pounded by widespread flooding and landslides during the monsoons, which wreaked havoc and over 8.5 million people were displaced in Bangladesh, India, and Nepal.

[12] https://www.unicef.org/press-releases/urgent-need-secure-learning-children-across-south-asia
[13] UNICEF ROSA Regional SitReps.

Across the region, millions of children are affected by the ongoing restrictions on mobility which have affected their parent's wage-earning abilities for the poorest households. Additionally, in countries where schools have not reopened, it could exacerbate the rates of out-of-school children, compelling children to drop out of school to help support the family or to reduce the economic burden on their families.

1. Adaptation

This section presents findings in terms of the need identification and determination, modes of adaptation chosen by country offices, the external factors that drove these adaptations, the types of local solutions chosen, the key internal barriers experienced by offices and the levels of flexibility in terms of meeting the new challenges to support the community.

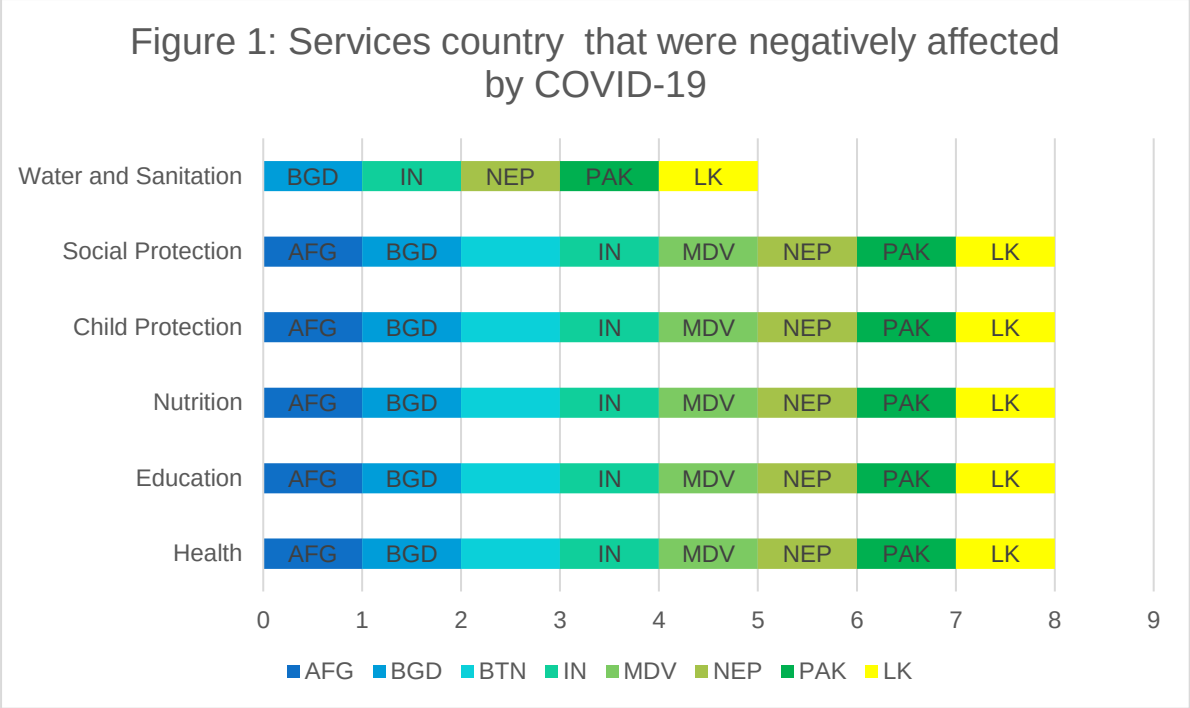
1.1 Need Identification and Determination

In terms of Covid-19 response planning, UNICEF country office staff indicated that they supported needs evolving from consultations with governments on their National COVID-19 response plans. As one staff indicated, "the overarching hypothesis we entered into was that given our role in basic service provision and child rights and protection, there isn't a massive change in the content but a change in operation and priorities set with the government."

As a first step, country offices re-purposed ongoing UNICEF programmes to support the national effort, with RCCE and WASH sector messages on handwashing and masking as key priorities. Staff interviewed also noted that given the multi-dimensional challenges posed by COVID-19, plans were constantly changing and evolving – "By end of March we had a plan and then in April a second plan that covered education, nutrition and vulnerability analysis… but then there were gaps covering refugees."

By March/April, large-scale World Bank and Asian Development Bank resources were being made available to countries and UNICEF worked together with governments particularly in the area of procurement of PPE supplies and other COVID-response items. While this development was seen as a positive showcasing UNICEF's "neutral partner" role, the global scarcity of PPE supplies proved problematic in terms of the speed with which UNICEF could respond to the needs. Staff who were in charge of UNICEF programmes in smaller countries also indicated that the UNICEF responses was not proportionate to national needs because of the lack of funding- "We could have done more with more money. There always were more requests coming from government, more than UNICEF can act on with current funding."

As indicated above, needs were based on understanding of sectors that were affected by the pandemic. During the RAT, Country teams were asked to specify what services were negatively affected by COVID-19. All countries responded that services in all sectors were affected, except for Afghanistan, Bhutan and Maldives who indicated that WASH was not negatively affected(Figure 1)



Tools Used in Determining Needs

Several of the country offices have made use of innovative and rapid assessment tools to determine need and assess impact (see appendix 7) for examples of studies and assessments conducted in country). In Bangladesh, the most widely used method is U-reports. In Bhutan, WeChat has been used as a tool for information sharing on needs and showcasing solutions among ECCD facilitators following up on children while ECCD centres are closed. In Sri Lanka and Nepal, a key needs assessment tool is the multisectoral household impact telephone survey, implemented in three rounds so far. For awareness programming, repeated rounds of surveys among the general public as well as particular groups have been made to ascertain levels of knowledge and practice related to COVID-19.

While there are many needs assessments, the direct link to interventions is generally not explicit, nor is the impact on interventions and their design evident in subsequent reporting (in for example SitReps). This is not the case for assessments particularly in WASH and IPC, where there is often a very clear link to interventions, showing that the assessment is used as a tool for identifying needs and planning UNICEF support to government-led response plans. These are often in a simpler format, for example a mapping exercise in MS Excel, allowing a fast turn-around and use of the results. Other assessments that have a more traditional, narrative and analytical presentation, have a much longer period between data gathering and presentation, likely delaying the use of data and risking losing the precarious link to constantly evolving interventions that have to “roll with the punches” rather than wait for a final report.

How well UNICEF targeted the needs of the population

Door-to-door nutrition campaign in Cox's Bazaar, Bangladesh.

In the Rohingya refugee camps in Bangladesh, access was restricted to essential staff early on in the pandemic, severely impacting service delivery across all sectors. Utilization of health and nutrition services dropped by half in April and May due to decreased staffing and fear of infection. As an operational tool to counter the lack of access, the solution was in some cases to train and rely on volunteers who were inside the camps, to carry out activities or monitoring in different sectors.

As children with vitamin A deficiency seem to be at greater risk of illness, the decision was made to organize, with partners, a door-to-door Vitamin A supplementation (VAS) and nutrition screening campaign combined with messaging on infant and young child feeding. The campaign was carried out in all 34 camps with the support of 822 Rohingya volunteers in summer 2020. The volunteers were managed from 45 integrated nutrition facilities. The aim of this month-long campaign was to provide VAS to all 160,026 children aged 6-59 months in the Rohingya camp while identifying children with acute malnutrition and targeting caregivers with messages on feeding and caring practices.

Despite working remotely through volunteers, the potential issues in relying on newly trained hands to carry out the campaign, concerns and need for strict COVID-19 preventive measures, this initiative succeeded in reaching 97 per cent of the children in the target age group with vitamin A and screening for acute malnutrition. A total of 2,576 children (62 per cent girls) were identified with severe acute malnutrition, of these 691 (61 per cent girls) were new cases who were not in the treatment programme. They were subsequently referred to the Integrated Nutrition Facilities for treatment. Mother/caregivers were oriented on how to measure their children for acute malnutrition using mid upper arm circumference (MUAC) tapes and given MUAC tapes to identify and self-refer acutely malnourished children.

During VAS activities, the average monthly admission rate of acute malnutrition children more than doubled. Children who were not reached with routine household screening were reached through this mass screening.

Figure 3 Case Illustration from Cox's Bazaar, Bangladesh

In terms of **targeting**, attention was placed on reaching the most vulnerable segments of the population through the RCCE efforts that covered hand-washing and mask wearing messages through various media. Training of frontline workers in the health sector and development of on-line, and distance learning materials for use by teachers, was prioritized. However, support to vulnerable mothers and children in Cox's Bazaar, for instance, proved problematic.

The promotion of cash assistance with UNICEF support was seen as very important by stakeholders, though in most instances the distribution of medical kits and food supplies was more common as the national government was largely responsible for this aspect of support. In terms of the types of support received, both government and implementing partners indicated that funding and supplies were the most prevalent, followed by technical and training support. The overall assessment from Government and implementing partners, as well as frontline workers surveyed through the RTA was that UNICEF had succeeded in meeting the needs of the most vulnerable. Similar support can be found from Regional Adviser's responses, whereby most Advisers stated they were somewhat confident that targeting the most vulnerable was successful, with one Adviser stating being very confident of targeting being successful. Some examples of enhanced targeting efforts mentioned included targeted, innovative interventions in Herat Afghanistan; Child Marriage in Bangladesh and Child Protection influencing real time family assessments and support to helplines/hotlines that stand out)

However, the timely **delivery of supplies posed a significant problem** for Country Offices due to world-wide shortages. There was widespread understanding that UNICEF was working in a very difficult situation and wanted to ensure fair distribution of scarce supplies. However, delays in the provision of supplies also resulted in concerns in some countries about 'reputational risk' in terms of meeting the expectations of the World Bank and Asian Development Bank. Some COs reported that given delays, donors turned to UNDP and

UNOPS who had quicker systems to source supplies directly from countries and to charter flights for their delivery.

Proportionality of the UNICEF Response versus the Need

Most country offices reported that they could have used more money to meet the needs, i.e the needs were larger than the available resources. Securing of additional resources remained a key focus as needs increased and evolved. The gaps however remained

In the Maldives, while UNICEF had the largest monetary resources compared to other agencies, the country office felt that there were missed opportunities. Being considered a middle-income country limited the resources available to the country office. Further, given the small population in the country, use of total number of COVID cases instead of a ratio that looked at number of cases per 1,000,000 meant that Maldives did not feature on the list of priority countries even if the cases per population in the country was considerable.

In several countries, the primary focus was on primary impacts, getting more PPE in, strengthening IPC facilities, Risk Communication. By the time of the RTA, the focus on secondary impact in some countries was in its earlier stages and yet to be fully understood.

In some countries, the UNICEF CO working with partners focused on larger issues of resource mobilization not UNICEF specifically. In Bangladesh, the office focused on leveraging resources from ADB, World Bank and EU funds. Although UNICEF was a major player, resources specifically coming to the office focused on specific sectors.

1.2.The most significant ways in which the UNICEF Country Offices adapted work during the COVID-19 crisis?

The overall picture emerging from this real-time assessment in South Asia in terms of adapting CO work to meet the needs of the COVID-19 pandemic is presented in figure 1 below.

The most common modes of adaptation chosen by the majority of countries (from the 11 choices stipulated in the survey), were the following six :

- enhancing of coordination with external partners
- scaling up the use of digital programming for remote programming and monitoring;
- strengthening cross-sectoral programming;
- increase of international procurement of supplies not readily available locally (e.g. oxygen concentrators, diagnostic tests);
- scaling up of programmes, and/or supplies to reach larger numbers of affected people including the most vulnerable; and
- increasing the use of local solutions (e.g. procurement, supplies, consultants, local partners).

Six of the eight (8) countries selected **adopting/altering delivery models** to respond to increasing needs and **scaling down pre COVID-19 delivery**/pausing (pre-existing 2020) objectives, as important modes of adaptation. Both Pakistan and Afghanistan noted that the existing programme for polio eradication was successfully adapted for the COVID response.

Door-to-door nutrition campaign in Cox's Bazaar, Bangladesh.

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During VAS activities, the average monthly admission rate of acute malnutrition children more than doubled. Children who were not reached with routine household screening were reached through this mass screening.

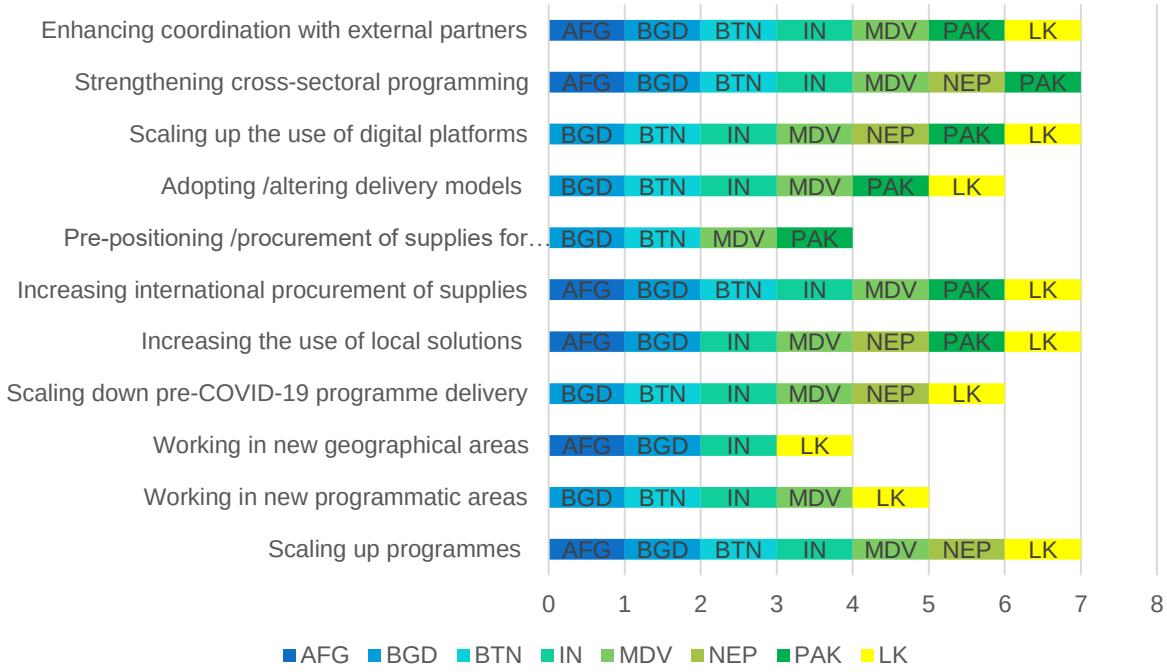
Figure 4 Case Illustration from Cox's Bazaar, Bangladesh

Pre-positioning/procurement of supplies (for either COVID-19 response or predictable seasonal disasters and/or for regular programme) and **working in new geographical areas** were chosen as adaptation modes by half of the county offices in the region. In Bangladesh, working with the Ministry, UNICEF pre-positioned supplies by using its own funding to ensure that handpumps and parts were available, increasing water supply at the local level.

Examples of effective adaption were reported in all countries. Countries across the region coordinated with government, other UN agencies including WHO and other stakeholders. Adaption was varied and diverse. As an example, in Bangladesh, UNICEF worked with Ministry of Women and Children's Affairs to ensure virtual courts training, as well as training for training of supreme court staff, probation officers and official in the department of social services. The training and advocacy allowed children who had been pushed crowded detention centres with limited facilities to access justice and freedom. With the support of probation officers, the Bangladesh UNICEF Country office arranged cash grants for the children who were not able to go home.

In Afghanistan, continuous response to vulnerabilities and challenges made the office more resilient, fastening overall adaption and response to COVID-19. Herat province where UNICEF was working prior was a few weeks ahead of the rest of the country, providing good lessons for the rest of the country. While the usual Education programme started slowing down, WASH, Nutrition and Health, C4D got busier. The usual programme was not necessarily stalled, but it slowed down, including vaccinations and polio campaigns. Nevertheless, an internal review of ACO showed that despite COVID between 60 to 70% of the country office's work plan was implemented

Figure 2: Most significant ways in which the UNICEF Country Offices adapted their work during the COVID-19 crisis



In Pakistan, an existing Polio programme as well as procurement for the immunization programme had prepared the country for conducting massive procurement. Existing relationships and arrangements in procurement were optimised and adapted quickly for COVID related procurement. While the volume of procurement increased within a short time, the PCO was able to manage the procurement given their experience and existing relationships. Beyond procurement, the PCO adapted its programming to address the public health aspects of COVID-19 in a number of ways: RCCE increased substantially with a strong basis on social data analytics to understand behavior; 2) Infection prevention and control linked to the existing WASH programme which focused more on hand hygiene in the COVID programme became the top area of work; 3) Expansion of the MHPSS programme. PCO had a small programme developed in the Northern Pakistan in Peshawar 2016 bomb blast. This was expanded rapidly to target a wider population (including health workers) with WhatsApp messages.

Use of digital platforms for education was conducted in several countries. In Bangladesh, UNICEF worked with government and teacher to create teaching sessions on Television. The office later supported internet sessions. The UNICEF Maldives Country Office (MCO) also worked with the government to ensure continuity of education - through distance learning, an approach that was relatively new to the country. Moreover, unlike other agencies in the country, UNICEF went beyond the health sector, providing food rations for families that could not access food.

Adaptations around Mental Health and Psycho Social Support

Most countries have adapted to include a significant focus on mental health, both in awareness campaigns as well as in service delivery, and finding innovative ways of remotely providing psychosocial counselling. ROSA conducted a separate assessment focusing on MHPSS. A separate report on that component is being finalized. However, the table below summarizes the modalities adopted by country.

While there was diversity in MHPSS modalities across countries, the main weakness was in the failure to integrate MHPSS in routine health and other sectors. Interventions tended to be siloed, limiting their potential to reach more people. Another limitation arose based on how MHPSS in UNICEF is organized. While MHPSS has relevance for different UNICEF sections, such as Health, Nutrition, Protection and Education it is currently situated under Child Protection. UNICEF should consider organising MHPSS in a way that better reflects its cross-cutting nature.

Lockdown and movement restrictions also hampered the MHPSS response to COVID-19, but alternative ways to address mental health and psychosocial needs, such as through on-line activities were soon supported by several Country Offices. However, despite the efforts, it remains difficult to reach those who are most vulnerable, also because the online services available for those with access to the needed technology. Further possibilities to reach those in need should be explored through discussions with community- and frontline workers, families, young people and people with lived experience. Despite these challenges, the RA survey pointed out to UNICEF's increased focus on MHPSS in SAR as having increased the interest and awareness of governments towards mental health issues and reducing stigma.

MHPSS Modalities adopted by Country		
Category	Activity/intervention	Countries
MHPSS awareness raising and messaging	Awareness raising efforts and messaging on MHPSS, including on suicide prevention (Nepal)	Bangladesh (Cox's Bazar) Bhutan, India, Maldives, Nepal, Pakistan
	Training of adolescents and youth ambassadors to provide their peers with (Bangladesh: face to face; Pakistan online) messages and support;	Bangladesh, Pakistan
	A package for a wider audience has been developed on: how to deal with COVID-19 related stress. Field tested and multiplied (training of trainers) across the country, more than 2500 sessions so far	Nepal
	Awareness raising on the dangers of social media	India, Nepal
Technical support and capacity development	Technical support to authorities and other partners; development of materials for authorities;	Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka
	Designing training programmes and support to capacity development and of teachers, social	Bangladesh, Bhutan, India; Nepal, Maldives, Pakistan, Sri Lanka

	workers and frontline workers on how to provide psychosocial support during COVID-19	
	Psychological First Aid (PFA) training to different groups, including on community level	Pakistan, Bhutan, Bangladesh
	Training on mhGap; adapted for local circumstances and needs of children and adolescents	Nepal
	Support to community health workers, and or frontline workers	Bangladesh, Nepal
	Training to teachers and caregivers on how to deal with COVID-19 related stress. Field tested and multiplied across the country	Nepal
	Training police officers how to deal with women and children	Nepal
	Training of journalists	Nepal
Community supports	Support to youth groups	Maldives, Nepal
	Provision of recreational kits	Sri Lanka, Bangladesh
	Child friendly spaces after cyclone Amphan	India, West Bengal
Community mobilisation	Community based child protection mechanism	Bangladesh, India
Support to virtual platforms	Virtual platform for adolescents	Nepal, Sri Lanka
	Virtual support to village level Social Workers	Sri Lanka
	Teacher support through WhatsApp groups	India
Psycho-education and guidance	Parent guidance and support	Bhutan, Sri Lanka
	Psychoeducation for adolescents	India
Life skills training	Life skills training for adolescents	Bangladesh
Promotion of child participation	Participation of children and adolescents as agents of change	Bangladesh, Bhutan, India, Nepal
Support to counselling services and referrals	Support to online counselling services / virtual support	India, Maldives, Sri Lanka
	Support to counselling services through Ministry of Education system, both online as well as face-to-face	Bhutan
	Support to counselling services for children with special needs	Nepal
	Support to counselling services for migrant/seasonal labourers and others in quarantine	Nepal
	Support by social workers to provide door-to-door counselling services (according to UNICEF Guidelines adapted to circumstances) to age groups 10-14 and 15-19 years-old. After screening. In refugee as well as host population	Bangladesh
	Support to families directly affected by COVID-19 (one or more members tested positive).	

	Referral through partners	India
	Child help lines/ call centre	Afghanistan, Bhutan, India, Nepal
Case Management	Limited case identification and management possible in Rohingya camps. Done by volunteers and social case workers	Bangladesh, India
Child care institutions	Child protection, including MHPSS	India
	Capacity building	India
Staff support	Staff support materials and training	Bangladesh, Bhutan, India, Nepal
MHPSS tools and materials	Specific tools for MHPSS to children	Bangladesh
	A MHPSS package	Bhutan
	A community-based psychosocial support manual	India
	Information, education and communication materials for NGOs and authorities	India
	Story books for children	India
Practical support	Mobile data packages	Bhutan, Nepal
	PPE and hand sanitizer supplies	Bangladesh, India

1.3 Gender integration in the SAR COVID response.

As mentioned before, parallel to the RTA for UNICEF SAR COVID response, in September 2020 ROSA launched a deep-dive to assess the gender integration and effectiveness of the response. The first deliverable of this Real-Time Evaluation (RTE) was a portfolio review, which focused on the response measures initiated at the onset of the pandemic in SA and during the lockdown looking at the normative & accountability structures and preparedness to deliver a gender effective response.

While the RTE is still ongoing throughout 2021, the main findings (also presented at the Regional Management Team meeting and RIGOR meeting in November 2020) from the portfolio review indicated the following:

From March 2020 to November 2020, about 20+ guidance documents and tools were shared by HQ, ROSA and COs, including 8 cross-cutting ones and 12 related to 5 Priority Actions On gender. The SAR gender network in general found the guidance, capacity building and technical support for ensuring a gender effective response adequate and timely. Similar feedback was also confirmed by the RTA CO survey, which assessed the CO's satisfaction on relevance and timeliness of ROSA support on gender (score 8, on the 1-10 scale).

According to the survey among the SAR CO gender focal points, of the 5 Priority Actions on Gender Equality maintaining core health and education services was perceived to be the area were the COs were being able to best deliver, followed by prevention and response to GBV, with data and care for caregivers somewhat lagging. The global expenditure analysis on gender also correlates positively with this finding.

By global comparison, SAR is one of the top performers for inclusion of gender-disaggregation of data when looking at for instance the SitRep COVID-19 indicators. Many larger data collection exercises in SAR, including the Community Rapid Assessment and

Socio-Economic Impact assessment surveys also include gender as a socio-economic variable thus enabling a gender analysis. However, the region also reports challenges in collecting and meaningfully analyzing and using gender, age and disability disaggregated data, such as: (i) quick rollout of data collection; (ii) remote data collection modalities making it difficult for controlling gender balance of the respondents especially in contexts where a steep digital divide exists and (iii) capacity issues (internal and external) with respect to data analysis, coupled with the requirements of rapid delivery of results. Overall, use of gendered data is inconsistent and has gaps that needs to be bridged as the response efforts continue.

In addition to the above, the SAR also reports challenges vis-à-vis the structural demands and office bandwidth. Human resources and financial resources are required to efficiently respond to the needs and proactively drive gender integration. Balancing guidance and implementations is key as well as strengthening understanding of linkages between other issues such as GBV and VAC so that response programming can address both issues comprehensively and more effectively. Lastly but not least, capacity of partners including gender machinery and line ministries remains limited. There are some ad-hoc efforts to build their capacity (e.g. GBViE learning series), however, more structured approach may be required.[14] Further, programming should focus on linking informal structures and women and girl-led community service organizations to the formal social service workforce. Some examples of the recommended way forward include;

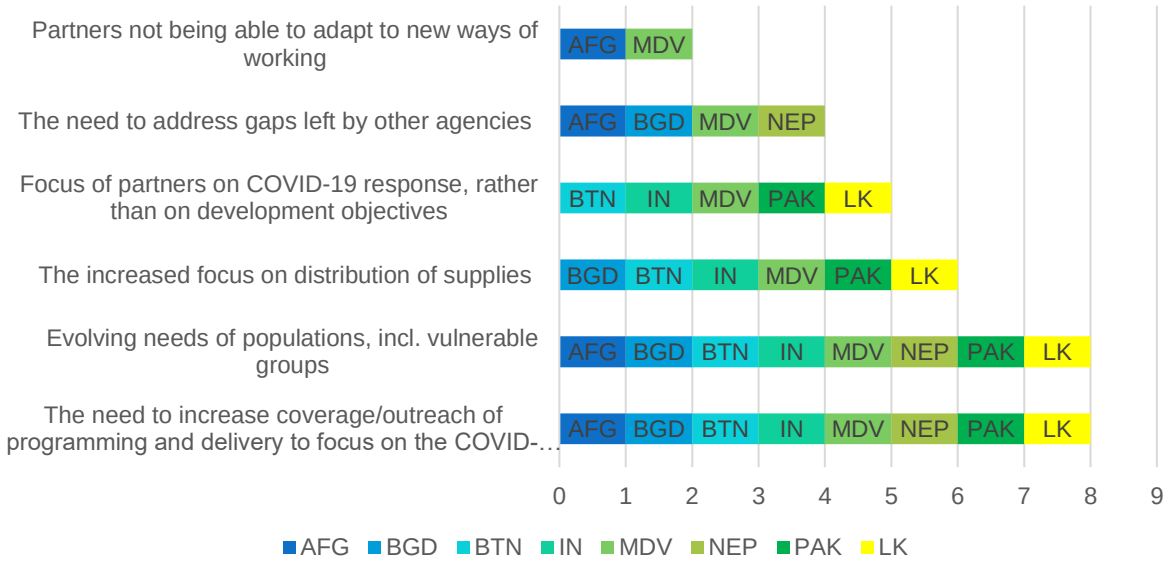
- Train first responders on how to handle disclosures of GBV and provide support to the first responders.
- Update GBV referral pathways to reflect new healthcare facilities where services are available. Psychosocial support should be available for women, girls and boys who may be affected by the outbreak and are also GBV survivors.
- Ensure that women and girls can get information about how to prevent and respond to the epidemic.

1.4. The external factors that drove these Country Office adaptations?

In terms of **external factors** that drove these country office adaptations, as noted in figure 2 below, the most significant factor across the board in all countries was the **need to increase coverage and outreach of programming and delivery** to focus on the COVID-19. Similarly, evolving needs of populations, including the most vulnerable, was a driving factor for all 8 countries. The shift away from development objectives to meet the needs of the COVID response was another factor in 5 of the 8 countries. The need for UNICEF to adapt their programmes to address the fact that partners were not able to adapt to new ways of working was the least reported factor, reported by two countries - Afghanistan and Maldives. Clearly despite, partner limitations, UNICEF was able to make the necessary adaptations

[14] Update Regional Office for South Asia: Gender Equality in COVID-19 Response, October 2020.

Figure 3: External factors that drove these Country Office adaptations



1.5. Key internal barriers to the country office's ability to adapt to the changing context?

Country offices cited the following issues as barriers constraining their response and efforts to address them:

- Country-wide lockdowns, risk averse attitudes of partners and fear factor of COVID-19 transmission among staff and non-availability of PPE in the early stages of the pandemic posed considerable challenges. Afghanistan was the one country in the region that did not close the office with some staff travelling cross-country to relieve other staff who got sick in one their 15 offices countrywide. But after three months, there was a sense of exhaustion and the staff started getting COVID-19 themselves (including the UNICEF representative); In other countries that locked down, adapting to remote working varied, with some countries adjusting faster than others. See details on section regarding impact of lock down on the response.
- Lack of staff familiarity about how to work in emergency response mode and overall **limited experience in remote monitoring of partners**, was also noted. Teleworking and virtual meetings created some barriers but overall these constraints were short-lived

- In Pakistan, initiatives were taken to test the **Business Continuity Plans** (BCP) before the country lockdown and address gaps so that all staff had required equipment to work online. In Sri Lanka, it was noted that having had to activate the Business Continuity Plan (BCP) for earlier emergencies, helped that CO to adapt swiftly to COVID-19 lockdown conditions. Nepal indicated that the UN Country Team took a conservative approach and personnel began working from home in March. This was combined with limited programme-oriented trips efforts which were all aimed at trying to find the right balance between risk and reward. Bhutan noted that limited funding

and the absence of key staff (the supply focal point post has been abolished) was a constraint, as were setbacks with local consultants;

- The **mobilization of external resources** from the World Bank and Asian Development Bank and other donors also created a **marked stress in already stretched resources of a small country office**. For example, Maldives normally delivers a programme of $1 million annually with 14 staff and during the past few months has been called on to deliver a resource envelope that has grown to $6 million with the same number of staff. This was coupled with multiple reporting requirements and limited flexibility of donors in adapting their funds to COVID-19 relief purposes. There were fears of staff burn-out, particularly since surge support has been slow to arrive. Pakistan noted that there indicated that delays in government procedures for approval of procurement of COVID-19 supplies were a constraint. However, in Sri Lanka, taking on **large scale programming** and delivering $30 million dollars of World Bank resources for PPE supplies in an efficient and timely manner, was seen country office staff as having helped sustain staff morale and faith that their work mattered.

- **Delays in the provision of supplies** resulted in concerns about 'reputation loss' in terms of meeting the expectation of the World Bank and Asian Development Bank. Delays in provision of supplies was reported as one of the main challenges in responding. In some cases, it was reported that given delays, donors turned to UNDP and UNOPS who had quick, nimble systems to source supplies directly from countries and to charter flights for their delivery. Country offices provided different explanations for these delays. In some cases, country offices pointed that there was no creativity and coordination in solving supply problems. In some cases the supply division did not adequately update and brain storm with country offices. The feeling that the supply challenges would have been solved sooner had the global UNICEF supply division consulted the country offices who knew the region better was cited. Front-line workers and affected community representatives, while appreciative of the assistance they received complained that the quality of the masks received was poor but were sometimes unable to pinpoint the precise source of supply. Another frontline worker noted that UNICEF could have facilitated the integration of responses at the local level. It was observed that all the components like Education, WASH and Protection have their local partners and this leads to siloed programme delivery or sharing of information and achievement.

- **"Duty of care**" was uniformly seen as an issue that required attention from the start. In Pakistan, the Representative held weekly zoom meetings for all staff: these meetings were focused not on work issues but on "COVID and how to care for ourselves". Additionally, a COVID Task Force was set up by PCO to keep track of evolving information and other issues and met three times a week to share information. The emphasis was placed on promoting a culture shift and new ways of working: these emphasized 'management by result, not presence'
  In the Maldives, the duty of care dimension was a critical concern as the office staff themselves were involved in delivering food to residents of Male who were hard hit by the effects of pandemic. Nepal introduced a tracking system on Sharepoint which covered around 210 people including UNVS and JPOs and consultants as a measure to address internal concerns about how much risk was acceptable.

- Lack of clear guidance in terms of **treatment of consultants and others** (e.g. Youth Scouts) being hired by the Country Office was also cited by Nepal as a duty of care issue involving partners who are expected to take risks that UNICEF staff themselves are not being asked to expose themselves to. Efforts are ongoing to reach out to local insurance companies to try and address this issue. Pakistan addressed this issue by

providing detailed guidance to consultants and contracted personnel to enable them to take “informed risks”. In addition, it was noted there was a lack of clarity around about ‘evacuation guidelines’ and how they applied to various cadres of staff.

Perceived Challenges of the UNICEF Response by Government and Implementing Partners

To further understand the challenges faced, information on the perceived challenges on the UNICEF response was solicited from government and implementing partners. Respondents indicated that at the beginning of the response, UNICEF faced the following challenges: 1)Due to excess caseload, response-related works in Health Care Facilities could not be conducted ; 2) Challenges in Monitoring, Supervision, and Field Verification ;3)constraints of working under a lot of predictions; (4) need to make short-term decisions in situations of uncertainty ; (5) lack of funding; (6) severe constraints in terms of PPE supplies (with logistics consuming over half the budget for supplies); (7) lack of coordination at the field level;(8) lack of skilled human resources and capacity development issues in terms of COVID-19, e.g UNICEF could not mobilize human resources for mass awareness and capacity building; (9) school closures; (10) late delivery of non-food items (NFIs); (11) challenges of maintaining quality education through online solutions; and (10) bureaucratic delays in contract signing and release of funds.

In at least one country, partners noted that UNICEF was not part of the Government's response and preparedness need assessment causing challenges in their response. Also noted were the difficulties of outreach to remote areas and to the most vulnerable and marginalized children. Security concerns as well as cultural barriers with people not taking the COVID pandemic seriously and that new information on the second wave not being effectively disseminated were commented on as other challenges in the beginning. The ever-increasing vulnerabilities of the families who have lost employment and the need to protect children in distress were also seen mounting challenges for UNICEF as the pandemic progresses.

When probed about challenges the UNICEF response faced later in the pandemic, government and implementing partners noted a few of the same challenges. Notably, challenges in reaching remote areas in some countries stayed. Budget restrains relative to the needs was one of the commonly reported ongoing challenges. Additionally, challenges in mobilising government to see the threats identified during the 1st wave of COVID 19 and planning to address them during the new wave; challenges in maintaining COVID-19 Prevention standards as the government is relaxing the rules were added. The above seems to suggest that UNICEF solved or begun addressing initial challenges, adjusting delivery as problems were addressed.

1.6. Types of local solutions adopted by the COs in response to COVID-19

All 8 country offices in South Asia used local solutions, including procuring supplies locally to address COVID-19. Sri Lanka reported that UNICEF actively facilitated the use of World Bank resources for the production of masks by local garment factories and that 3 of the big factories in Sri Lanka have been approved by UNICEF's Supply Division to produce PPE for procurement by other countries. Maldives CO reported reaching out to the country office in Sri Lanka to facilitate the procurement of needed PPEs. In addition, as a measure to accelerate procurement of intensive care items, Maldives also reached out directly to China with the help of the UNICEF country office. Nepal CO is also exploring the production of face masks by small-scale entrepreneurs among youth, women and cottage industries in what has been termed "socially conscious procurement".

In Bhutan, using WeChat to support Early Childhood Care and Development (ECCD)

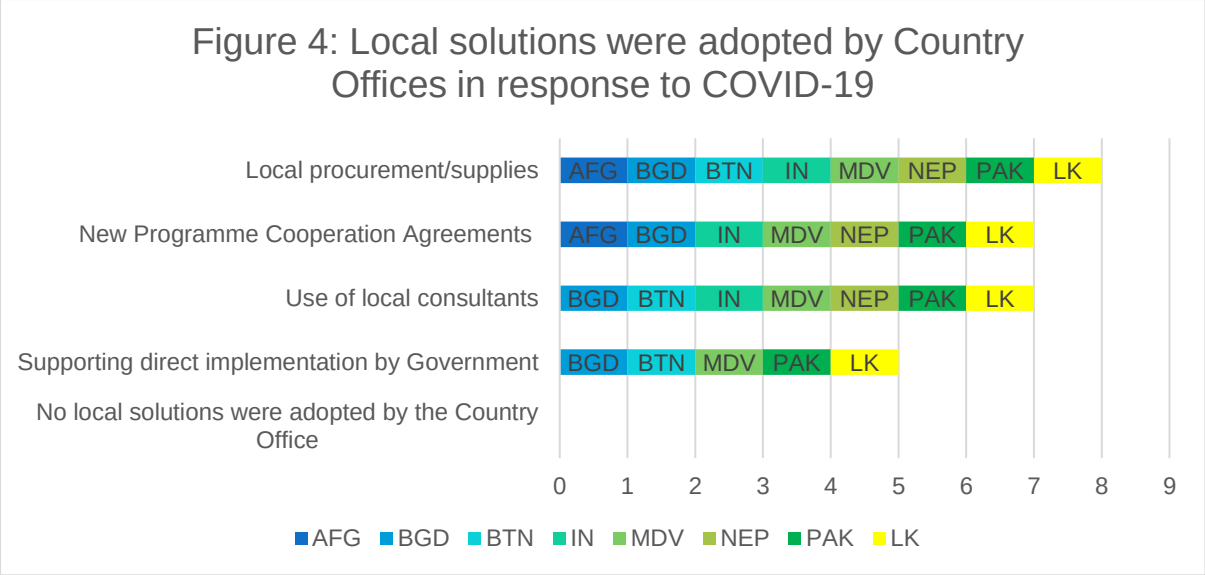
With the onset of the COVID-19 crisis, Bhutan shut down its educational institutions, including the Early Childhood Care and Development (ECCD) centres attended by pre-schoolers. As a result, 9,400 children aged 3-5 years (from 495 ECCD facilities) experienced a profound disruption to their daily routine, finding themselves at home all day with little access to play and stimulation outside the home.

To continue providing support to the children, ECD facilitators with the support of the MoE switched to remote learning platforms. The primary vehicle was WeChat, and for parents without smartphones the facilitators would make regular phone calls and also home visits. By sharing weekly activities by recorded audio or video on various themes, the facilitators kept the children engaged in their social group despite the physical distance and isolation.

UNICEF Bhutan found that the parents were generally happy with the efforts the facilitators were making to keep their children engaged. Parents requested the facilitators to share the lessons and activities through videos instead of voice messages, as they found that the children respond and learn better when they see their teachers on the video. To accompany these efforts, UNICEF printed 10,000 parenting education packages that were distributed to parents and caregivers.

The use of WeChat by ECCD facilitators is not just a great example of reach and offsetting the negative effects of the pandemic. It is also an example of the power of tools such as WeChat to create a virtual community, between facilitators and parents/children, but also among facilitators as well. Carrying out their work in physical isolation, the platform aided in creating a sense of community among frontline workers at a critical time. This is evidenced in the response to UNICEFs call for sharing their messages on the website of UNICEF Bhutan, which resulted in a publication entirely devoted to their pictures and updates on their work (Early learning from home, The life of an early Childhood Care and Development Facilitator during the COVID-19 pandemic 2020).

Figure 5 Case Illustration from Bhutan

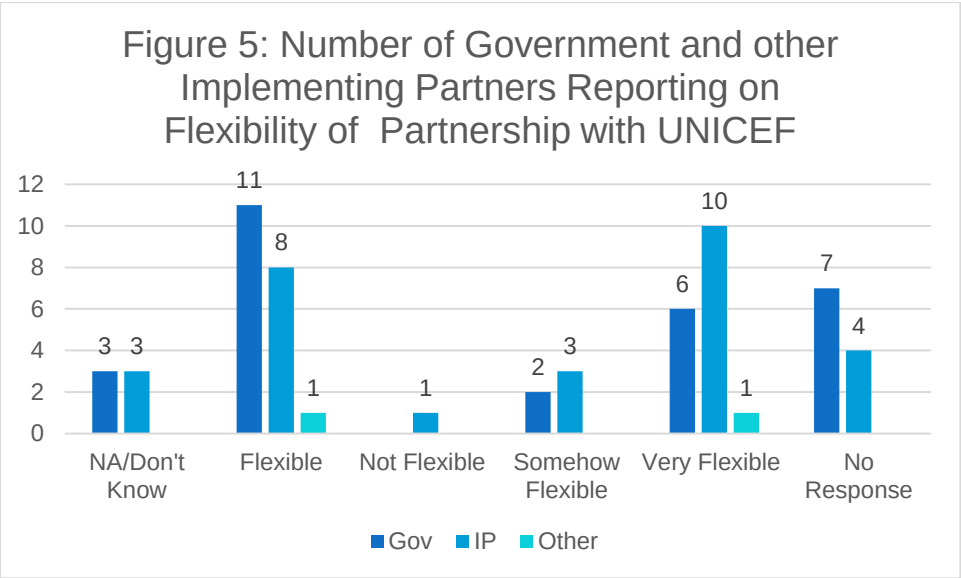


[15]

In addition to procurement, other local solutions applied by country offices included: having new programme cooperation agreements(PCAs) and small scale funding agreements(applied by 7 countries); use of local consults(also applied by seven Cos) and supporting direct implementation by government which was reported by five(5) country offices.

Perceived quality of partnerships with UNICEF by Government and Other partners

A question was asked of both Government and IP informants through the survey about the flexibility their partnership with UNICEF was as they implemented activities to meet community needs during COVID. Using key informant interviews, front line workers also were asked how easy it was to reach UNICEF if they needed to. The response from those who responded was broadly positive(Figure 5). Out of the 49 government and implementing partners providing a response on this question, 76% (37) indicated the partnership was either very flexible or flexible.



[16]

[15] Source: Country Office Survey, Question 4
[16] Source: Government and Implementing Partners Survey, Question 6

Frontline workers who were asked about how easy it was to contact UNICEF or its partner, often replied that it was 'very easy to easy'. In some cases, frontline workers also reported that UNICEF itself had initiated contact to find out what the needs were. Another frontline worker noted - "Sometimes it was difficult to buy PPE, hand sanitizers due to shortage in the market. Whenever we informed UNICEF that we could not obtain it, UNICEF would never mention budgets but just say "we are getting this for you. Please send someone to collect it."

When asked about whether UNICEF asked for frontline worker opinions on the UNICEF approach or operations and whether UNICEF would change approach or programmes in line with advice, a WASH facilitator in Bangladesh noted that UNICEF staff would come to the Upazila level and they could convey their concerns on costing (in pre-COVID times). Another frontline worker noted "Our opinions are accepted. UNICEF knows we are working in the field and have knowledge of the situation. We frequently correspond with the WASH officer in the UNICEF office. He takes our feedback and considerations. Sometimes it takes time, but we feel well considered."

2. Implementation

This section covers the following aspects of implementation; role of pre-COVID planning, the kinds of UNICEF support, success in addressing the needs of vulnerable community needs, implementation challenges faced by UNICF and services negatively affected by the demands of the COVID response.

Overall, all Country Offices indicated that while there were pre-existing plans in place prior to the pandemic, they were not adequate to tackle the complex, multi-dimensional aspects of COVID-19. In countries, where humanitarian programming was ongoing and a polio campaign was in place, adapting to take on COVID oriented support was relatively smooth.

Furthermore, country-level responses were affected by the pace at which national governments themselves responded to reports of first cases of the virus. While some governments had more centralized planning approaches, others were more decentralized. In all cases, UNICEF was understood to have taken a central role and also recognized for its efforts particularly in the area of Risk Communication and Community Engagement and WASH guidance tailored to the health and education sectors and community at large.

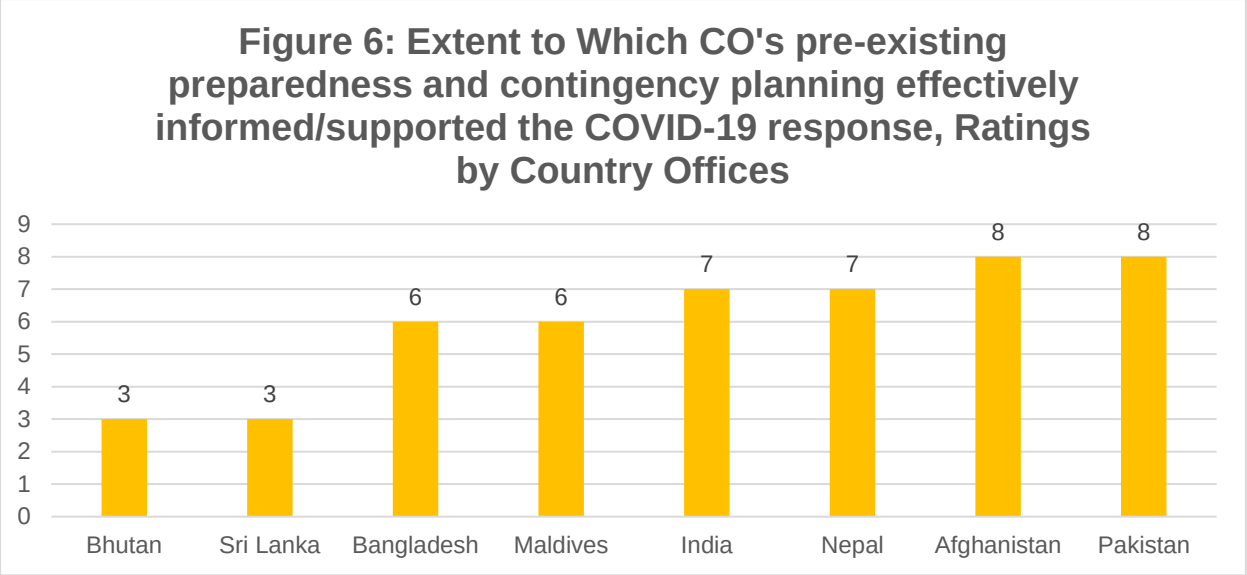
UNICEF was also quick to provide its support for government arrangements of loans from the multilateral banks for PPE and other COVID-19 essentials. Advising governments on the need to make child and social protection, and mental health support 'essential services' was another key feature of UNICEF interventions.

As mentioned in the adaptions section above, the pandemic also led to innovations, *inter alia*, in the development of Distance Learning for schools, the setting up of Virtual Courts and the government endorsement of SOPs for Gender Based Violence which laid the groundwork for future programming. ROSA's support in terms of technical advice and providing fund mobilization support was favourably acknowledged by Country Offices, as was the usefulness of the first Global HAC. The overriding constraint, however, was the global shortage of emergency affecting supplies like PPE, test kits and other critical equipment, which had an effect at all levels of support at the country level.

The following figures provide more detailed information on these aspects of UNICEF's implementation of programmes as assessed through the RTA,

2.1. Extent to which country pre-existing preparedness and contingency planning effectively informed and supported the response to COVID-19

Using a scale of one to ten, country offices were asked to rate the extent to which pre-exiting preparedness and contingency planning informed the response. Ratings on the utility of existing contingency planning ranged from three (3) to eight (8)- Figure 5



The higher ratings provided by the Afghanistan and Pakistan offices can be explained by the fact that the COVID response was integrated into the ongoing polio campaign activities. Nepal and Bangladesh have both had natural disaster mitigation planning in place. However, the general feedback was that nothing had prepared most Country Offices for an emergency such as COVID- 19. In the Maldives, the office noted that the only relevant part of pre-planning was how to mobilise our staff all working from home. All other scenarios of existing preparedness were planned on natural disasters. However, the banking system was working smoothly without any one in the office. The Regional Advisor responses for the same question confirm *the difficulty of assessing* whether pre-existing preparedness and contingency planning was sufficient given the fundamental changes but at the same time RAs confirmed that those countries with experience in responding to humanitarian situations or who already had HACs were able to mobilize faster with partnerships, funding and with clearer priorities to e.g. targeting.

Afghanistan and Pakistan country offices indicated that preparedness planning effectively informed their COVID-19 responses. In Afghanistan, contingency planning was informative since the country office conducts all the preparedness through the emergency section: the Chief of Field Planning is also head of Emergency.

In Pakistan, the established presence of polio prevention campaigns, with medical specialists and a medical anthropologist were cited as important aspects. The polio campaign and other immunization was halted in Pakistan until July. Issues such as whether health workers should use gloves (which had the drawback of increased waste) and the decision to use hand sanitizers were some of new problems that to be solved while tackling COVID.

In Nepal, the existing contingency planning worked partially. The country had to re-purpose capacity that was there for floods and earthquakes. Nepal's response in terms of adapting the use of emergency Hygiene Kits for the quarantine and isolation dimensions of COVID-19 is instructive. The initial expectation was that the health systems would be overwhelmed and that large numbers of people would therefore be isolating at home. To support these people, the kits were transformed into 'Health and Hygiene kits' and included basic medical supplies. The first wave of quarantine, however, was of young men returning from India and it was decided to provide them with soap instead of kits. As infections increased, it became apparent that the highest areas of transmission were among day laborers in crowded urban conditions who did not want to be tested given the implications of a positive result in terms of their employment. Currently, the kits are being distributed to families approved for home isolation (who are generally wealthier) and to health centres.

At the other end of the scale were smaller countries like Sri Lanka and Bhutan. While the latter had contingency plans for floods and earth slides, Bhutan had never experienced an emergency of this multi-dimensional type. In terms of Sri Lanka, while the country is vulnerable to climate change and regular emergency situations, traditional emergency response measures, prepositioning supplies did not come into play. A regional director of health services noted that while in Sri Lanka there was some preparation for public health awareness among medical staff, COVID-19 was a different experience of quarantine and isolation, patient management and preventive measures, which was all new.

Amidst the COVID Crisis Pakistan immunizes 39 million children against polio: Pakistan is one of three remaining polio-endemic countries in the world. Following the launch of the Polio Eradication Programme in 1994, there has been a decline in cases from approximately 20,000 every year in the early 1990s to only eight cases in 2018. Due to COVID-19, polio campaign activities were put on hold for six months, and regular immunization services were also disrupted. As a result, polio outbreaks were not contained effectively, and the virus was spreading to new regions. As of 30 September 2020, Pakistan reported 74 polio cases. The Pakistan Government, with support from UNICEF, WHO and GPEI partners, resumed polio activities in July and conducted two sub-national campaigns in July and August 2020, when COVID-19 cases started declining in the country. In order to contain the virus, Pakistan utilized its vast army of more than 260,000 trained frontline workers who went door to door, equipped with personal protective gear to ensure the safety of children, caregivers and polio workers. Despite heavy rain and flooding in several provinces due to the monsoon, Pakistan's national polio immunization campaign reached over 39 million under-five children with the polio vaccine. In order to reach so many children, the campaign mobilized and engaged religious and political leaders, media, pediatricians and local influencers to reach caregivers and children in all corners of the country. Following the successful resumption of vaccination campaign activities, the Pakistan Polio Eradication programme seeks to interrupt polio virus circulation in the country, and end polio for good.

Figure 6: Case illustration Pakistan

Even PPE items for Sri Lanka CO staff became available only in April given the global supply situation. The speed with which L3 status was declared, however provided the country with flexibility in terms of human resources required to prioritize the response. Quick support from ROSA in terms of resource mobilization was also seen as a "game changer" for Country offices like Sri Lanka and Maldives, which have smaller progammes (given their middle-income status) than the larger programmes in India, Pakistan, Afghanistan and Bangladesh.

Government and implementing partners also had mixed views regarding the utility of existing preparedness and contingency planning. As one government official from Bhutan noted

"the entire plan of preparedness and contingency planning required new thinking and approach. The pandemic called on for a new plan and contingency adaptability which included availability of expertise and resources to reach the schools and institutions". Another NGO Implementing partner from Sri Lanka noted the following in regards to existing contingency planning

"Its not played a great role, as this type of emergency was unprecedented. However, there have been learnings from the previous waves and particular initiatives have been continued (e.g. online education, online reporting of VAC) to prepare for the new normal"

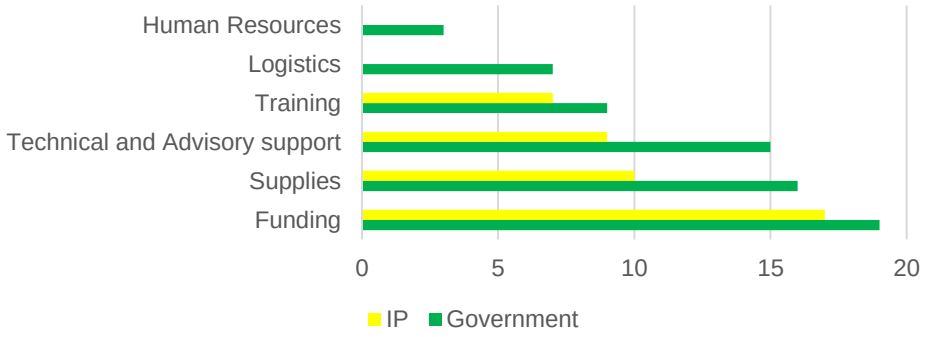
Yet others felt that having contingency plans enabled quick adaptation in terms of putting in place emergency and response measures

2.2. Support Governments and Implementing Partners received from UNICEF

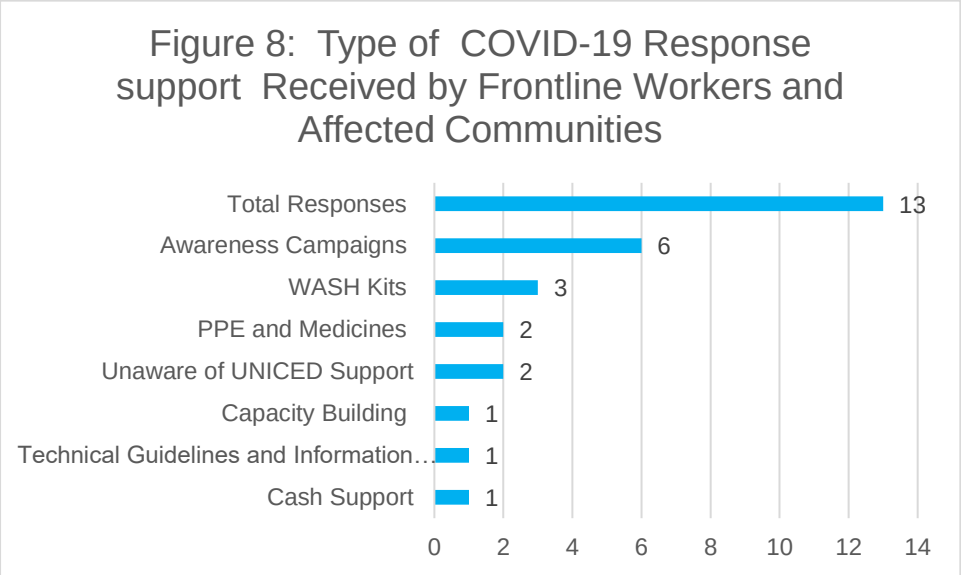
Figure 7 below indicates that **'funding'** was the most common support modality received by both categories of stakeholder, followed by supplies and technical, advisory support. Governments indicated they received all 6 types of support stipulated the survey, while unsurprisingly, partners did not indicate they had received human resource or logistics support from UNICEF.

The provision of funding as the most prevalent support points to the increased resources from the multilateral banks which were funnelled through UNICEF. In terms of overall support, it is of relevance to note that the quick action to cover Zoom account costs in various key government ministries and entities was a win that facilitated the resumption of government services after the lockdowns were set in place.

Figure 7: Type of COVID Response support Received by Government and Other Implementing Partners from UNICEF in the past 6 months



In terms of types of support, a small sample of frontline workers providing a response on this question in the key informant interviews indicated that RCCE, WASH Kits, PPE and medicines were the top three. Figure 8 captures this information. The sample size remains small -- but helps validate other findings on UNICEF support--because some frontline workers did not answer the question while others were not able to fully articulate UNICEF's contribution.



2.3. UNICEF Added Value

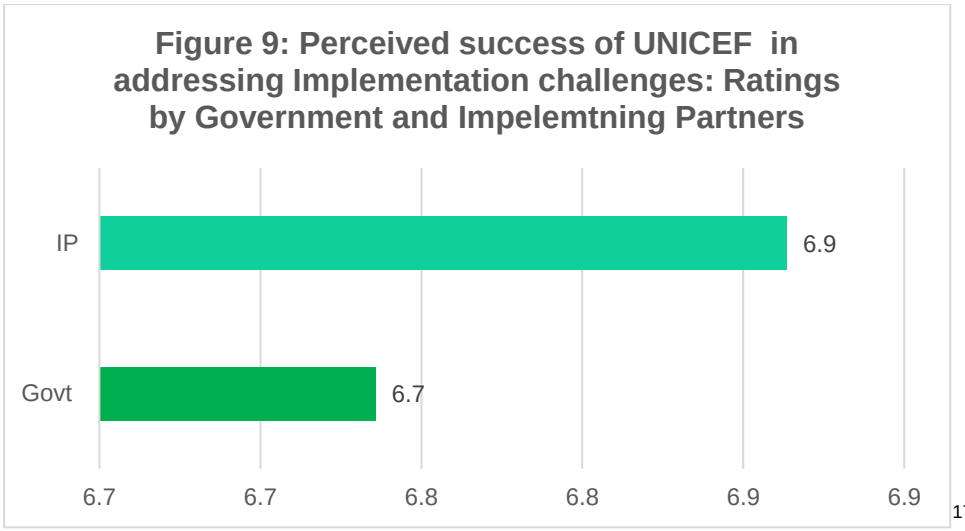
The RTA solicited feedback from government and implementing partners on the UNICEF added value. A wide variety of responses was received in this area.

Respondents reported that UNICEF was critical in providing technical support and preparing for the response, which would not have been possible in some countries without UNICEF. In other countries, respondents pointed to the limited capacity and resources government had and the role that UNICEF played in bridging this gap. UNICEF's role in supplies, and training was noted by several respondents. Also noted as a value add was the role the organization played in ensuring continuity of learning in some countries.
Moreover, the speed and timeliness of UNICEF's response was viewed as a key in ensuring an effective country response particularly in the earlier stages of the pandemic. The agency's coordination role with government and other partners also was pointed out as a strong value add.

Other partners pointed out the technical expertise, strong global networking, global data and ability to influence government partners as a value added by the agency during the response. UNICEF's role in maintaining vaccination services also was highlighted.

Extent to which Partners perceived UNICEF was able to address challenges

Government and implementing partners were asked to assess UNICEF's performance in addressing implementation challenges. As seen in figure 8 below, while the implementing partners gave UNICEF a slightly higher average rating of 6.9 and the government partners gave UNICEF an average score of 6.7.



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

Figure 10 provides a view of how the stakeholders surveyed (country office, governments and implementing partners) rated UNICEF success in reaching vulnerable populations through different interventions. The data shows that a larger proportion of respondents believed that basic services, RCCE and supplies had reached intended beneficiaries

Cash assistance was on the lower side and this may reflect differences in government policies. In Nepal, it was reported that the government favoured food distribution over cash assistance. In Pakistan, the National Plan includes the use of 'e-money' transfers. In Afghanistan, frontline workers spoke of receiving cash transfers.

In Bhutan, one frontline worker indicated that UNICEF's support was critical to increase testing while another noted that "With the help of UNICEF we can reach most monastic institutions and nunneries for soap, hygiene and toile construction." Similarly, frontline workers in Pakistan and Afghanistan emphasised the importance of UNICEF working with religious leaders, imams and mullahs to increase the COVID prevention awareness in the remote rural communities.

The figure 10. below indicates the percentage of respondents who indicated that basic services, training, cash assistance, RCCE and supplies had reached intended beneficiaries. (NB. Govt and Implementing partners were not asked about whether 'Basic Services' has reached beneficiaries.)

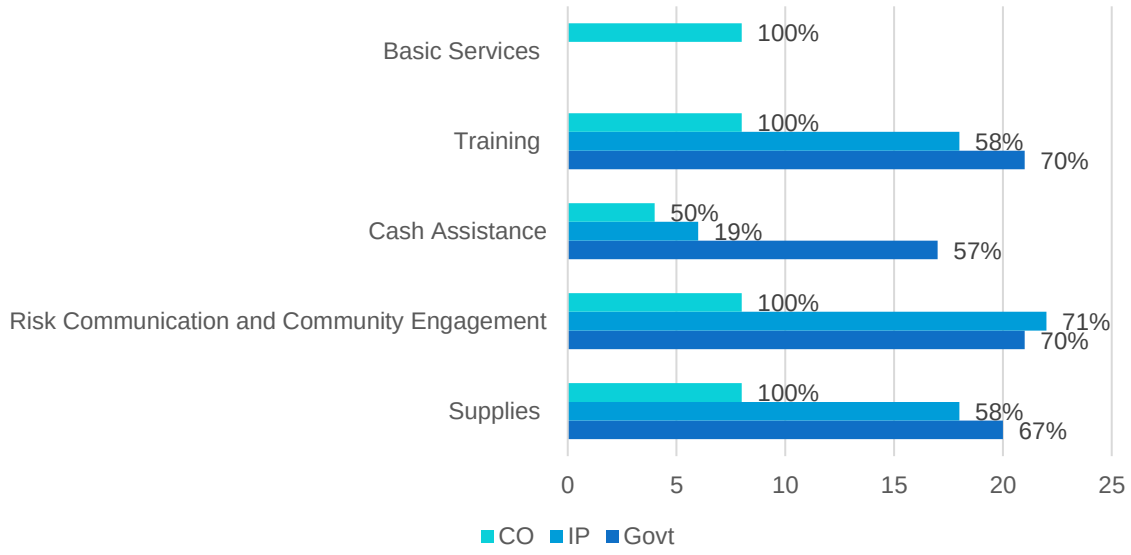
Cash Transfer programme in Afghanistan helps adolescent girls attend school

In Afghanistan, more than 52% of people live in multidimensional poverty. COVID-19 has further exacerbated the situation, pushing more families into deep poverty. This adversely affects families' ability to buy even basic educational supplies to enable their children to attend school in a country where 3.7 million children are out-of-school, and more than 60 per cent of them are girls.

In order to offset this and enable girls to attend school, UNICEF along with partners, implemented the cash transfer programme to support adolescent girls' education and to reduce the impact of the COVID-19 pandemic on vulnerable families, and improve their access basic services, especially girls' education. The cash transfer programme involves a one-time unconditional cash transfer of 19,500 AFN (USD 255) and there are no restrictions on how the families spend the stipend, although they are encouraged to use the money to enable their adolescent girls to attend school. Additionally, in the last quarter of 2020, UNICEF and partners also targeted 400-500 families with children for cash-based winter assistance, so that they can meet their basic needs during the harsh winter. Prior to cash distribution, UNICEF's implementing partners carried out awareness raising and consultation sessions with the communities, including local government representatives. During these sessions, the criteria of the cash transfers were clearly explained to ensure community acceptance and understanding.
In Herat province, UNICEF and partners completed cash distribution to 2010 households, including 472 families in need, who have adolescent girls aged between 10 and 15 years of age. There is no available data yet on whether these transfers had an impact on enrolment.

Figure 7 Case illustration from Afghanistan

Figure 10: Percentge of Respondents Indicating that Specific Services had Reached Beneficiaries



Impact of Lockdown on the COVID- 19 Response

Working remotely can cause isolation and lack of coherence in the midst of a pandemic. The RTA therefore explored the effect of the lockdowns on the Country office's responses. Countries that had worked remotely before tended to adjust better than those who had not as a result of the lockdown. As an example, in Sri Lanka, office staff had worked remotely for about 3 weeks after a bombing last year. This experience helped staff switch to work from home, having the right internet connectivity. As a result, frequent meetings were held routinely to help staff feel connected.

There was a feeling in some UNICEF offices that the Global Guidance did not understand the field, and was developed with the New York experience in mind. As an example, there was a feeling that the guidance did not deal with the duty of Care anxieties of field staff if they fell ill. Some offices were concerned that consultants were being asked to hire cars while UNICEF Country Offices had cars that had more IPC measures. In countries like Pakistan, successful working remotely was embedded in a strategy that emphasized 'managing by result, and not by presence'. The Pakistan CO also purchased zoom licenses for government offices, helping the coordination.

The lockdown also impacted physical monitoring of services. While some monitoring was done via zoom (see section below), accountability processes including checking partner book of accounts could not be done. The lock down also further hindered access to data, making determination of needs more difficult. In Sri Lanka, the Department responsible for surveys was closed and could not conduct any assessments. The UNICEF Sri Lanka office therefore, conducted a telephone survey to assess whether most vulnerable populations were being reached with social protection, education and health services. While there were challenges the SLCO noted that training remotely, in some ways made services more equitable since those outside Colombo could also attend online trainings

Government access to the internet varied. In some countries, government was not able to operate online due to limited access to internet and zoom.

The survey also asked Country Office Management Teams to reflect on one successful and one unsuccessful intervention during the implantation of the COVID-19 response.

The responses are presented in the table below.

SUCCESFUL & UNSUCCESSFUL INTERVENTIONS INDICATED BY COUNTRY OFFICES

Successful Intervention	Unsuccessful Intervention
AFGHANISTAN: • PPE for health workers & Education *"Provided the frontline health workers with PPEs for continued service delivery during Covid."* • *"Quickly developed online teaching materials for education to continue"*	• Immunization bottlenecks *"Due to lockdown restriction, immunization/polio vaccination faced severe bottlenecks "*
MALDIVES • Remote learning *"Continuity of learning: when school closed down during lockdown, UNICEF successfully advocated for remote learning and ensured through provision of supplies and training of teachers. Further UNICEF successfully advocated phase reopening of schools across the country specially in COVID free islands*."	• Universal Child Grant for Under 5s *"UNICEF advocated for initiation of a universal child grant for children under 5 years. However, it was dropped by the Government after much deliberation and effort due to the required amendments to the legislation and due to the budget limitation during this insecure financial situation."*
BHUTAN • Support to Heath, Edu and CP, GBV *"UNICEF provided Technical support to get Health, Education and CP sectors to develop SOP 1) Immunization, 2) Online learning tools, 3) GBV that were endorsed and currently being implemented and monitored*."	• Breastfeeding by COVID positive mothers *"Promotion of breastfeeding by COVID positive mothers despite undertaking several consultations and being sensitized on WHO guidance on safety of breastfeeding"*
INDIA • MNCHA & Nutrition *"Advocacy and technical assistance focused on policy and programmatic shifts aimed at protecting continuity of routine essential MNCHA & nutrition services. Together, health and nutrition teams coordinated first policy actions at central and states level (contributions to development of guidance notes, issuance*	• School re-opening *"Promotion and support for continued education and planning for school reopening has been one of the more challenging areas initially as the government was slow to see this as a priority. There is still a lack of recognition for the need of special remedial or review programme once schools reopening*

of directives at states level, follow up with districts etc.), and then initiated actions to support the implementation at scale of new policies for RMNCH+A and nutrition (adapt/adopt new protocols for service delivery; training of cadres; supportive supervision; e-mentoring; data analysis; program reviews; etc)"

SRI LANKA

- Child Protection

"UNICEF immediately activated the Child Protection Working Group (CPWG) comprised of the senior management of the National Child Protection Authority (NCPA), Department of Probation and Child Care Services (DPCCS) and Child Protection organizations operational in Sri Lanka. The CPWG advocated with the Executive President and the COVID-19 Task Force to declare Child Protection services as an essential service during lockdown situation and government provided an approval to continue Child Protection services during lockdown. This enabled the continuation of child protection services during strict curfew.

UNICEF lead the development of the strategic response plan for child protection through the CPWG and endorsed by the GoSL. It standardizes the response and effectively coordinates among agencies.

In addition, UNICEF provided capacity building support on providing virtual psychosocial support to the National child Protection Authority (NCPA) officers and continuation of 1929 child helpline line service seven during lockdown and curfew. Mental health and Psychosocial (MHPS) guidelines were developed and around 268 NCPA officers were trained on psychosocial first aid module. Overall, UNICEF reached over 5,000 children and caretaker through psychosocial supports to date through above interventions."

BANGLADESH

- Vitamin A and Screening campaign in Rohingya camps

"In the early part of the pandemic we noted that service delivery across all sectors was impacted. In the COVID-19pandemic,

- Malnutrition

"Even before COVID-19 became a global pandemic, an estimated 277,716 (15,1%) of children under 5 years of age suffered from wasting in Sri Lanka at any point in time. Therefore, as a country with high burden of child undernutrition, it is critical that measures are in place to continue provision of quality nutrition services at community and hospital level. UNICEF continuously advocated and requested for resources to provide micronutrient powder for identified malnourished children in the country. However, the resource mobilizing efforts were not successful and therefore, UNICEF could not support the Government of Sri Lanka to reach the malnourished children with nutrition supplements.

This was compounded by the lack of required raw supplies (maize) to produce locally manufactured nutrient supplement powder (Thriposha) in the country due to COVID-19 lockdown. Nevertheless, UNICEF developed a program brief on urgency to address the wasting in SL and had several advocacy meetings with high level decision makers at the Ministry of Health (MOH) to discuss the issue. As a result, the MOH decided to have a special topic to discuss the challenges and gaps to address acute malnutrition during the Nutrition month. It is expected that technical experts will come up with the concrete action plans and recommendation to address high level of wasting in the country."

- Learning opportunities for Rohingya refugee children

"One unsuccessful intervention was regarding education. UNICEF and partners were unable to continue to provide focused on key knowledge and skill areas in the curriculum."

children with vitamin A deficiency seem to be at greater risk of illness, so the Nutrition Sector (NS) tried a new approach in all the 34 Rohingya camps. UNICEF and NS partners organized a door-to-door Vitamin A supplementation (VAS) and nutrition screening campaign from 21 June to 20 July 2020. This involved the deployment of 822 Rohingya volunteers by the 07 NS partners, managed from 45 Integrated Nutrition Facilities. The aim of this month-long campaign was to provide VAS to all 160,026 children aged 6-59 months in the Rohingya camp while identifying children with acute malnutrition and targeting caregivers with messages on key infant and young child feeding (IYCF) and caring practices. The supplementation campaign reached 155,080 children (97 per cent of the total children in target age group, among them 49 per cent girls) with vitamin A and 155,217 (97 per cent total, 49 percent girls) were screened for acute malnutrition. A total of 2,576 children (62 per cent girls) were identified with severe acute malnutrition (SAM) including 691 new cases (61 per cent girls) who were not in the treatment programme and were referred to the Integrated Nutrition Facilities for treatment. Due to the COVID-19 containment measures put in place by the authorities from March 2020 onwards, the coverage of nutrition programmes was adversely affected with fewer children being screened, identified and admitted for treatment for acute malnutrition and IYCF counselling. To help counter the negative impact of the containment measures, a number of steps were initiated, including bundling the VAS with community-based screening for acute malnutrition and messaging on IYCF. During VAS activities, the average monthly admission rate of acute malnutrition children more than doubled. Children who were not reached with routine household screening were reached through this mass screening. Moreover 109,165 mothers/caregivers (86 per cent of the target) received IYCF messaging to ensure optimal feeding of children in the household. Mother/caregivers were oriented on how to measure their children for acute malnutrition using mid upper arm circumference (MUAC) tapes and given meaningful learning opportunities to the Rohingya refugee children during the pandemic. Due to the sudden closure of schools and all learning facilities by the Government, no preparations were made for the continuation of learning. While at national level remote learning was introduced using television, radio and the Internet, the situation in the Rohingya refugee camps was different. Education was not included among the essential services which meant complete closure of all learning facilities and restrictions on access for education personnel. Initial advocacy for continuation of education through the provision of support for home-based learning packages was not successful; the camp authorities prohibited all education services. Through the creative partnership with some of the other services – CP Sub-Sector, Food Security Sector, Nutrition, WASH, Health Sectors - which were allowed in the camps - learning materials were distributed and a programme of caregiver-led home-based learning education was introduced. While it contributed to continued engagement of some children, it was an inadequate response to the needs of the children and is a high risk to the refugee children returning to learning when the centers reopen."

MUAC tapes to identify and self-refer acutely malnourished children."

PAKISTAN

- RCCE, WASH /IPC

"Effective implementation of RCCE; WASH/IPC, Continuation of essential health services including routine immunization and polio campaign; management of severe acute malnutrition; Psychosocial support; preparation of safe reopening of schools & procurement and supplies of PPEs and other medical equipment including Lab items and oxygen concentrators."

- Supply of basic PPE

"The major bottleneck was supply of basic PPE in the initial period; severe disruption of RMNCH & routine immunization services including planned polio campaign"

NEPAL

- Vaccine delivery & Vit A

"Orientation / training / supplies HW on vaccine delivery as well as vit A led to drop/delay and emerging catch of these services. (vit A, MR campaigns, RV launch, resumption of EPI services.)"

- Acute Malnutrition, Protection & Education

"A severe drop in operation of acute malnutrition services has not been met, yet with solutions to detect and enroll these cases systematically. Protection (both child/social) has low scale of coverage. Education did not find alternative learning in the short-term, working on medium term."

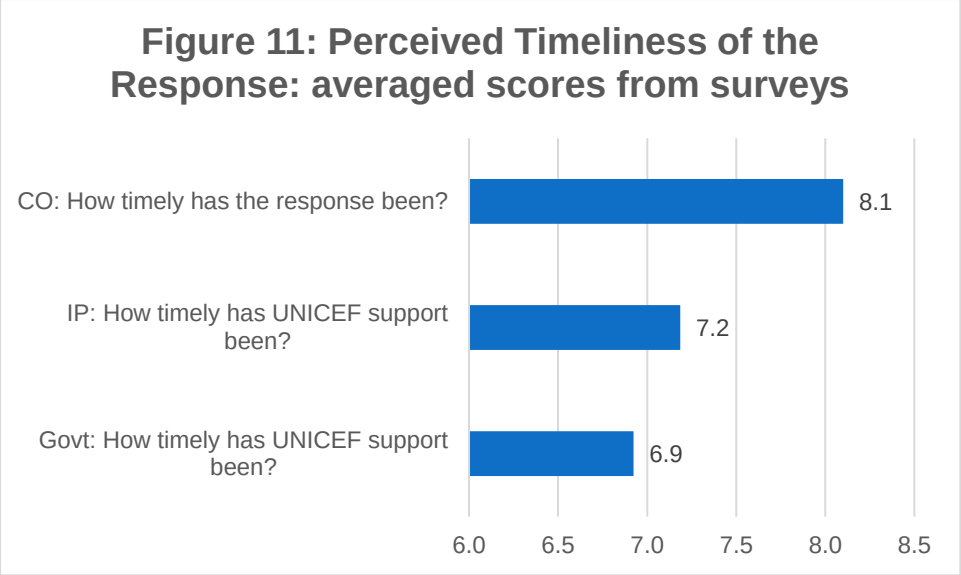
3. Quality

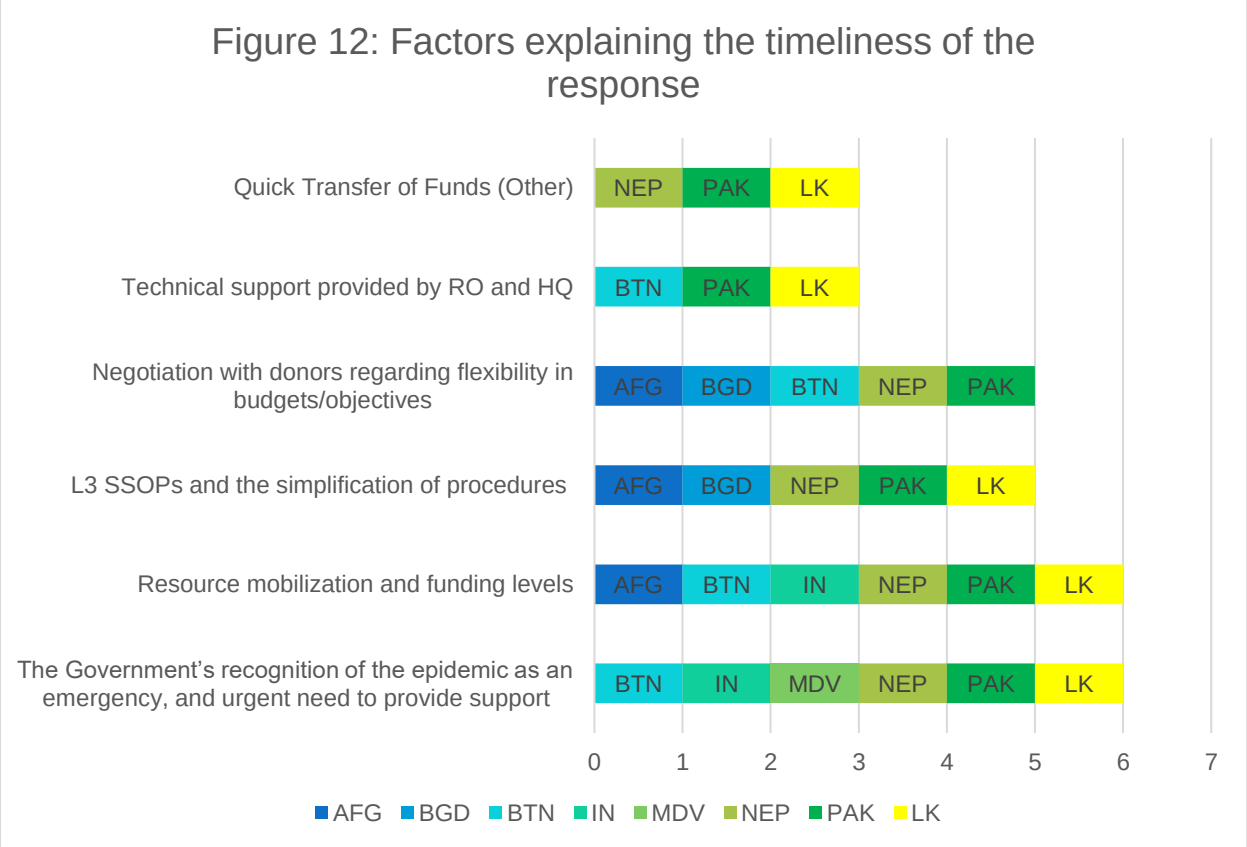
This section provides information on how the quality of UNICEF's response was gauged by data on timeliness and the use of standard UNICEF mechanisms for monitoring and distribution of supplies. These are viewed as preliminary measures to monitor the quality of assistance during the past 8 months. Quality has also been assessed in terms of responses to questions on UNICEF success with reaching the most vulnerable populations and this issue has a more mixed response from frontline workers and those informants from affected communities.

3.1. How timely was the overall COVID response?

Figures 11, 12 and 13 below deal with the timeliness of UNICEF' response and the factors that explain the timeliness and hindered it.

Overall, UNICEF got generally positive responses on timeliness from Governments while the Government had slightly lower ratings than Implementing Partners. The Country Office scored themselves higher than both governments and implementing partners. While the frontline worker's view on the timeliness was varied, almost unanimously the interviewees in the region commended UNICEF for being the first agency and/or partner on the ground and activating the response.

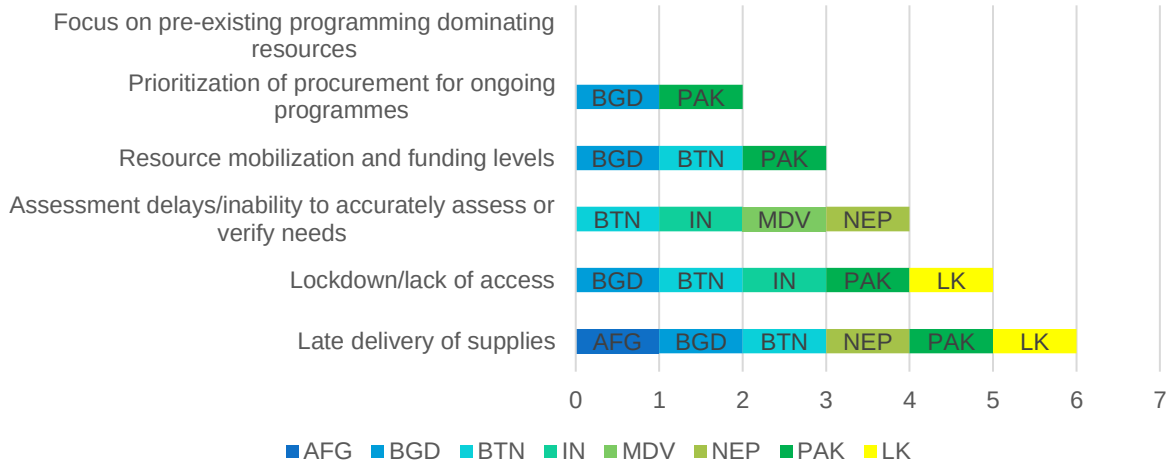




In most countries, the country offices reported that the most salient factor that explained a timely response rested on the government's own recognition of the urgency posed by the pandemic. This was facilitated by the resources mobilization efforts and increase in funding levels, which was also chosen as one of the key factors resulting in a timely response. This was also confirmed by the Regional Adviser survey, where the timeliness was seen with strong correlation to 1) when there was a clear direction and result to achieve, 2) when financial support was provided upfront with some flexibility of its use.

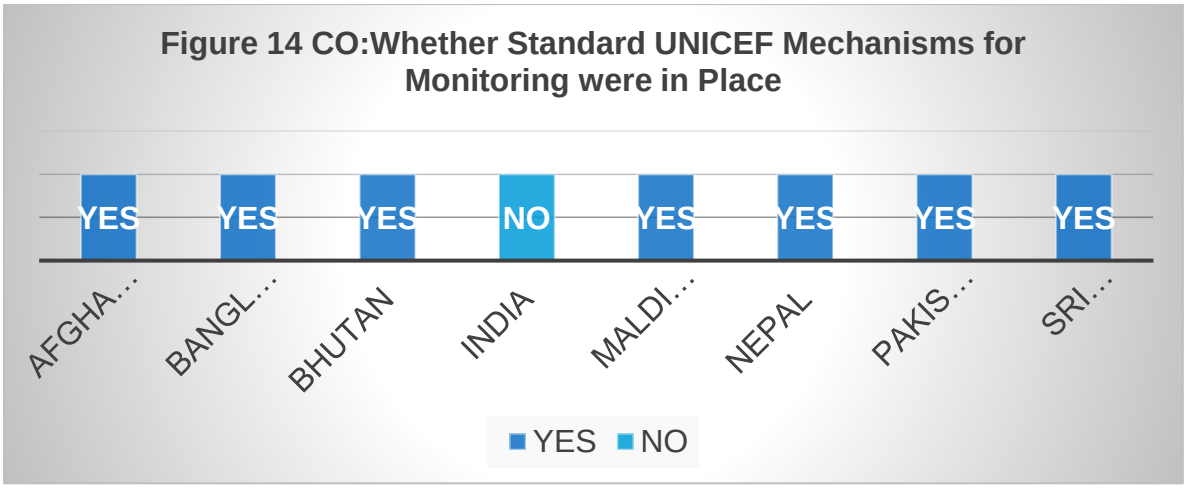
But in terms of factors that hindered timeliness, figure 13 below indicates that late delivery of supplies and lockdown affecting access were the two key reasons All the country office representatives interviewed acknowledged the global shortages and commented on the effects of delays which ranged from being unable to provide for UNICEF staff to reputational risks of being unable to follow-through on commitments for large scale supply for partners like the World Bank and the Asian Development Bank. The agility and nimbleness of sister agencies being able to deliver by proactively and contracting directly with source countries was referenced . The need for those in charge of logistics to have been more proactive and creative (for e.g. in terms of using road transport when cargo flights were cancelled), was also commented on. Afghanistan indicated that to address these concerns, as most of their supplies come through Karachi, they deployed staff to that location to expedite the supply chain.

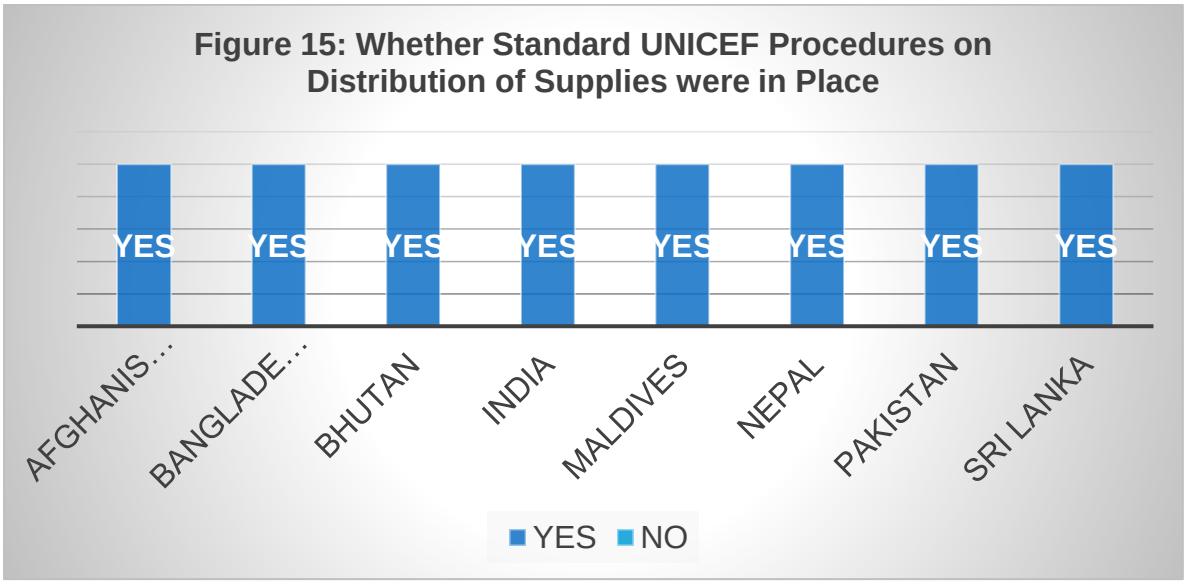
Figure 13: Factors most Commonly Cited for Hindering timeliness of the response?



3.2. How did UNICEF COs ensured quality of the response, and processes and verification systems used to ensure quality?

In response to the questions on standard UNICEF mechanisms for monitoring, only India indicated that there were no standard mechanisms in place. In terms of mechanisms for distribution of supplies, all country offices responded in the affirmative (See figures 14 and 15 below)





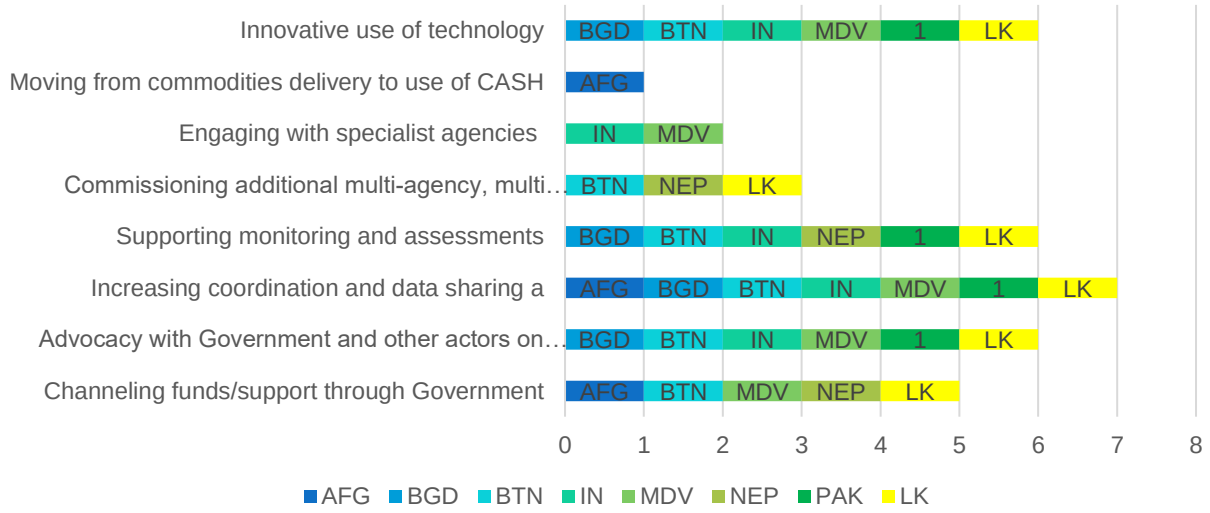
Frontline workers were asked if the COVID 19 response was taking place as intended and was of good quality. Overall, respondents provided favourable replies. In Afghanistan, the respondent indicated "the quality of the support has been good -the products distributed with UNICEF support have been of good quality, the soap, towels etc were of good quality." In Bangladesh, a partner in a Child Rights organization, indicated that "We used to report monthly and quarterly to UNICEF. Since COVID, we have reported weekly. The format was revised and includes information on guardian/parents, the disabled, both locally and in the wider community. UNICEF provides feedback on our reports, and our organization will take that into account in our work." Another worker in the WASH sector reported "We have been reporting continuously, and have photos of WASH installations in the reports." A teacher in Bhutan reported that "UNICEF worked with the Ministry of Education and through them Self Instructional materials (SIM) came in a full package including tools and clear instructions. The quality was really good." Some comments were received on the quality of the masks being inadequate – "the strings keep breaking." However, there was acknowledgement that this was not UNICEF's fault as it does not manufacture the masks.

3.3. To what extent has UNICEF been successful in reaching the most vulnerable?

In terms of success in reaching the most vulnerable, averaged scores on a scale of 1-10 indicated that Government, Implementing Partners and Country Offices scored the response as between 7 and 8. A small sample of frontline workers indicated that there was adequate provision of training and provision of WASH infrastructure. They also noted there was inadequate provision of PPE.

Figure 16 below provides further information on means used to target the most vulnerable: (1) Increased coordination and data sharing and use across sectors and partners, (2) innovative use of technology, (3) supporting monitoring and assessments and (4) advocacy with Governments and other actors on addressing gaps in provision for particular populations, were the commonly selected modes of targeting the vulnerable and excluded populations.

Figure 16: Means the Country Office used to ensure that it is targeting and reaching the most vulnerable and excluded populations

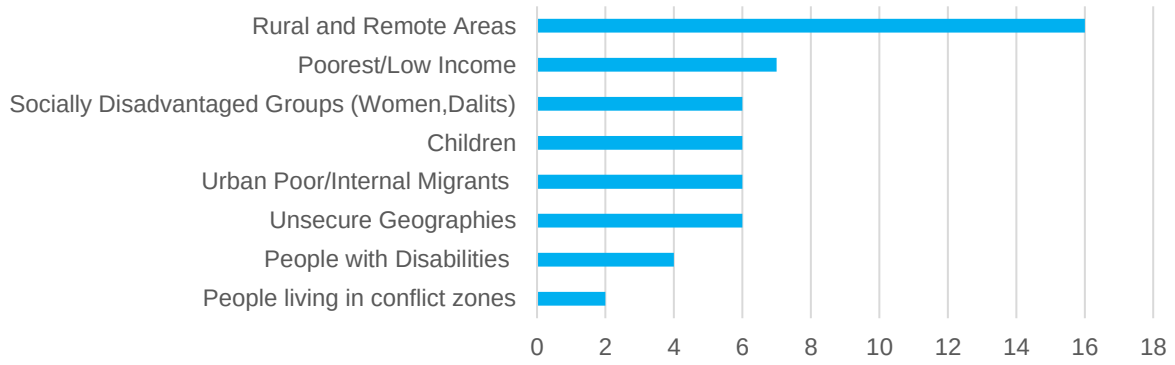


3.4. Groups that were in most danger of being left behind

Government and Implementing partners, including the frontline workers were asked a question on who is in danger of being left behind? Many of the KIIs with the frontline workers pointed to the fact that the households depending on daily wages were hardest hit by the lockdown and closing down business of all sizes. In Afghanistan frontline workers also noted that many previously relatively well-off families were falling into destitute situations as cash was suddenly cut off thus creating new segments of ultra-poor in the communities. Many frontline workers also noted that as employment possibilities became non-existent the regular flows of remittances stopped, and this for instance in Pakistan was noted to have a devastating impact on education, as school fees are often covered by remittances. Children-out-of-school were most commonly noted as 'new emerging vulnerable groups' by frontline workers and community representatives.

New emerging vulnerable groups identified by frontline workers were: (1) children out of school; (2) children with Special Needs; (3) the urban poor; (4) pregnant women; (5) individuals suffering from mental distress; (6) migrant workers; (7) people with disabilities; and (8) Covid patients and their families. The view of government and implementing partners is presented in Figure 17.

Figure 17. Populations in most danger of being left behind: Government and IP views(no. of mentions)



EMERGING CONCLUSIONS

3.5. How Effective was UNICEF's COVID-19 response in terms of adaptation and implementation?

All UNICEF Country Offices covered through this RTA **adapted their programming, overcame initial constraints and deployed Business Continuity Plans** to ensure a robust response to the COVID-19 pandemic in South Asia. From March onwards, except for Afghanistan, all the Country Offices were working remotely. Through quick transitions to working remotely, UNICEF was able to engage and support national governments in developing their national COVID-19 response through planning and re-purposing ongoing programming. In many instances, UNICEF facilitated Government efforts to move to an online working environment which helped to jumpstart crucial aspects of the COVID-19 response.

In many countries, UNICEF was also involved, often for the first time, in setting up **new programme arrangements.** These involved large-scale procurement arrangements of PPE, test kits and related support (hospital beds, ventilators) with funds provided to national governments by external partners such as the World Bank and Asian Development Bank. This became a prominent feature and considered by many Country Offices as an important win.

Stakeholders who were interviewed or surveyed through this exercise, generally **lauded UNICEF's response at both the policy and the community levels.** There was little negative commentary on the timeliness, quality of the supplies and support, only calls for UNICEF to be more active at the local level in terms of supplies, support and the use of its field network to help coordinate vital aid such as food assistance.

RCCE efforts became a key component of all country programmes. Common modes of adaptation for most countries were scaling up the **use of digital programming** and increasing international procurement. The use of **local solutions** for procurement was also common mode of adaptation that helped address socio-economic impacts sub as unemployment (e.g. of up opening up garment factories that had been closed due to COVID-19).

Attention was paid to ensuring that priorities such as **child protection** support and social workers were upgraded to '**essential service' status**. UNICEF also facilitated the speedy setting up of **'virtual courts'** which helped at-risk children. After initial slow-downs, vitamin A, polio and other immunization programmes supplies were secured and support resumed,

In many cases, UNICEF helped frontline ministries by facilitating digital access and by paying for zoom accounts during the initial phase. **Distance Learning programmes** were developed

within tight time frames and attention was paid to introduce efforts for safe re-opening of schools. Increasing attention was also paid to ramping up **mental health** support services through the increased use of hot-lines, which were particularly required in those countries that went through lockdown periods that stretched for three months. Gender started with five gender priority areas, but as the strategy developed and pandemic evolved in the region, new elements were integrated into programming strategies such as high density/low capacity; humanitarian/development nexus; focus on girls.

How did UNICEF assure the quality of support?

All country offices covered by this RTA indicated the **processes and verification systems for monitoring and distribution of supplies**, were used. But it was also noted that lack of access due to lock down and the late delivery of supplies were bottlenecks in terms for timeliness. Frontline workers attested to the quality of UNICEF COVID messaging and Self-Instructional Materials, for example, as being clear and of good quality. In some cases, however, frontline workers found that masks were of poor quality.

Frontline workers were near unanimous in noting that UNICEF was attentive to requests for support and ensured that **monitoring was carried out effectively**. Even though field visits had to be curtailed, UNICEF field offices requested partners to provide photographs of WASH installation, for example. Concern was however expressed by some frontline workers that UNICEF could have facilitated the integration of responses at the local level. It was noted that components like Education, WASH and Protection have their local partners and tend to work in a siloed manner with little integration or sharing of information and achievement. There was also concern expressed that government departments were not coordinated in their COVID response and also a call for UNICEF to work more directly with WFP in terms of addressing key issues such as food security.

V. GENERAL RECOMMENDATIONS

Shift from emergency phase and also address secondary impacts of the pandemic: COVID-19 is a uniquely complex challenge and future planning must take into account the multi-dimensional nature of this emergency. Given the prolonged and uncertain nature of the pandemic, UNICEF should shift to seeing this challenge as part of its routine programming. The initial impetus was to see COVID-19 as a health sector issue but now it is critical to focus on addressing food scarcity and the secondary economic and social impacts brought by the loss of income and remittances, particularly in light of second and third waves and the onset of winter in some parts of the region

Building on recent experience with external partners : COVID-19 presented an opportunity for UNICEF to leverage its neutral, trusted partner status with national governments and external partners like the World Bank and the Asian Development Bank which led to increases in the resources available for procurement of PPE, other COVID-19 oriented supplies and technical support. However, in some cases the urgency to prepare these proposals came at the expense of consultations with Governments and other stakeholders. While the agency builds on these 'wins,' there is a need to document, take stock of the burdens such commitments place on administrative and operational budgets, and also on country office staff.

Strengthening and coordinating the frontlines particularly in the area of food and cash assistance and COVID-19 supplies: While UNICEF was recognized as doing a lot at policy level, there is a role for it to be more visible partner 'on the ground' supporting governments that are crippled by the economic and social costs of the pandemic. This could involve ensure greater focus on strengthening and coordinating frontline capacity of government for improved

delivery. Most immediately, UNICEF should engage more in coordinating food assistance for the poor, drawing on its field experience and expertise in targeting the poorest of the poor. It should also review and come up with a regional strategy on how it can support the provision of cash assistance. Critical medical services (laboratory capacity for testing, for example) should also get more on-the-ground support as second and third waves roll in.

Review the procurement, supply and logistics experience from a country office perspective: Supplies of critical PPE items were globally unavailable and offices often described other UN agencies that had more latitude, agility and creativity to meet this situation through direct procurement from countries. There were calls for UNICEF to take steps to review its arrangements for ensuring effective supplies and logistics arrangements so that a more flexible, responsive and less centralized approach can be adopted in the future.

In a related issue, there may be merit to review the criteria used for decision-making on which one country gets priority over another. The UN country classification criteria by income is apparently a key criterion and led to some countries in the region being placed at the "back of the of the queue" for supplies (and other support such as surge capacity). The pandemic has had a devastating impact globally and it was felt that this approach requires re-consideration in terms of future planning, keeping in mind the principle of the universality of human and child rights.

Duty of care: The **"**Duty of Care" dimension was seen as an issue that requires further guidance from headquarters given the challenges of taking informed risks, for UNICEF staff as well as consultants and other support personnel contracted to provide services particularly in quarantine sites.

Digital technology and analytics: There was a call to build on the COVID-19 lessons and invest in the development of a repertoire of innovative digital and non-digital strategies to ensure accurate data analytics were available to help address gender, economic and social inequity in health, education and protection. Providing technical assistance would build capacity within UNICEF, as well as it partners which would help with monitoring and real time assessment of future emergencies of this type. Initial studies undertaken by ROSA to study and analyze digital penetration, would also help COs define country-specific digital penetration strategy for education, and other sectors. The opportunity to invest in the use of AI to review documents and make lesson learning agile and simple, should also be explored in more depth.

Lesson exchanges/learning to be made simpler: Deputy Representative interviews' referenced the need for a less formal and lighter modes for exchanging experiences. ROSA's organization of fortnightly sessions on specific topics (such as COVID-19 and high density urban areas) were cited as providing an opportunity for COs to pause, and reflect in the middle of dealing with the pandemic, and participate in fortnightly sessions chaired by the Regional Director, where the participants learned from others and ploughed the knowledge back into CO programming. As one interviewee put it *"ROSA took away some back-end headaches so we could focus on implementation."*

Streamline demand for situation reporting and budget processes: UNICEF staff and Government and implementing partners consulted during the course of the RTA requested that the volume of reporting and zoom meetings should be lessened/streamlined. Many implementing partners also suggested that that the quarterly budgetary allocation process be reviewed and reporting streamlined as this was often time consuming. In order to lessen the burden of COVID-19 reporting at regional and global levels, it was suggested that UNICEF should support harmonize the indicators that had to be reported on to various UN entities.

The data collection surveys for the RTA requested input from the Country Offices, Government and implementing partners and affected community representatives on these

aspects of UNICEF's Covid-19 response. (These suggestions are reproduced verbatim, save for minor language editing to help clarify the message.)

IV. WHAT UNICEF SHOULD DO MORE OF, LESS OF AND DIFFERENTLY?

The surveys requested input from the country offices, Regional Advisors, government and implementing partners and affected community representatives on these aspects of UNICEF's Covid-19 response. Responses are summarised and put in context. These statements should be viewed as supplementing/reinforcing the preliminary recommendations contained in the section above.

What should UNICEF Do More of?

PROGRAMME ISSUES

Increase UNICEF presence at the front line. Service delivery should explicitly target vulnerable and disadvantaged groups. The focus should be on children out on the street, with or without parental care. Some partners suggested that UNICEF should do this by supporting NGO organizations working at the frontline (rather than working through government). All partners surveyed and interviewed indicated that UNICEF's staff were quick, responsive and dedicated and this is a strength on which UNICEF country offices could build while planning the next phases of COVID-19 outreach support.

Set up more Rapid Response Teams and also consider SURGE capacity needs. This was particularly required in circumstances where the focus of the health services had been on the 'preventive' and a swift switch was required to providing 'curative' support because of COVID-19. Furthermore, in the initial stages, frontline workers noted there was a reluctance among some medical workers to be involved in the COVID-19 response, given fears of getting infected themselves. Now that there is more known about COVID-19, this information should be incorporated into training so that health workers are better prepared.

Support cash distribution as the unemployment rate is high because of COVID-19. Some national policies favoured providing supplies over cash (Nepal), while others provided cash support (Afghanistan, Pakistan, Sri Lanka, Maldives, Bangladesh). The role of UNICEF itself in terms of providing cash assistance was not clear as in some cases it was part of the overall National COVID response, (where Pakistan provided e-money for instance), while in others UNICEF seemed to be the vehicle to provide cash assistance. This is an area that merits deeper attention for UNICEF programming in the future as part of its overall strategy at the country level.

Pay more attention to hygiene kits. This recommendation suggests that attention should be paid by UNICEF to ensuring that supplies that are provided to quarantine camps and sites, for example, should be upgraded to ensure specific COVID-19 relief supply. (In Nepal, for example, hygiene kits were supplemented with medical items such as Paracetamol, and labelled 'health and hygiene kits').

Support the pre-positioning of supplies through better coordination and develop a clear plan including pre-positioning of necessary supplies in the event another type of crisis emerges. This issue should be integrated as part of the review of the procurement, supply and logistics experience from a country office perspective noted in the 'preliminary recommendations' section of this RTA.

Promote food security: unemployment rates are high during COVID and this situation will become more dire as the colder weather moves in. The need for secure food supply was

highlighted by frontline workers and affected community representatives alike. There was also a view that UNICEF should work more closely with agencies like WFP and assess the possibility of coordinating its own sector programmes more closely at the local level.

Focus of developing Accelerated Learning Programmes, promote 'back to school' campaigns, initiate remedial programmes to adjust the learning loss due to school closures. The issue of school closures was raised repeatedly, especially by UNICEF partners working in child-care centres, as a need from parents who had to go back to work (in garment factories, for instance). The option of teachers providing in-home learning support, was seen as not addressing the needs of parents who had left young children unsupervised at home.

Focus on strengthening Child Protection mechanisms and Child Mental health. Data in all South Asian countries has shown that children are much more vulnerable to violence because of lockdowns and suffering from mental health issues from isolation during the time of pandemic. In some countries, psycho-social efforts are being pursued with partners who provide hotline support. But this type of assistance requires deeper and broader application because there is limited supply of skilled support as well as resistance to accepting mental health support in some traditional communities;

Youth engagement – early indications of the power of tools such as WeChat, Whats-app videos to create community among frontline workers as well as for messaging to students, should be built on. The U-report data should be used to provide further information on what works and what does not in terms of outreach. Furthemore, UNICEF should target partners in a school settings who are already using smart phone applications and could be effective facilitators who have insights on how to reach high-school and other at-risk populations.

More training of religious leaders. There is a need to use religious leaders for spreading the COVID-19 prevention messages. UNICEF staff and partners indicated that early in the response, religious leaders had training on COVID-19 prevention at Madrassa schools, churches and monasteries with in some institutions denoting 'hand washing days', which had proven effective.

MANAGEMENT ISSUES

Maximize equity in access and utilization as UNICEF moves towards increased digitization. There is a need to ensure equity of access to all UNICEF services. Partners indicated that "the mandate to ensure equality is always looked after" but that indicator to measure effectiveness have yet to be produced. Inequity was most starkly a problem in access to on-online schooling. This issue should be prioritised, with both innovative digital and non-digital strategies to address gender, economic and social inequity.

Develop a repertoire of innovative digital and non-digital strategies to address gender, economic and social inequity in health, education and protection. Data analytics and the ability feed key information to inform national RCCE messaging, for example, was an area that UNICEF proved adept at for the COVID-19 response. Mobile phone-based surveying communities had proved particularly useful. These experiences should be assessed and lessons learned and used.

Undertake assessment and research and data analysis which will help COs understand the dynamic situation of COVID-19 was highlighted as an area where evidence could be gathered for programme design at the country level. The ROSA studies on digital penetration, handling COVID-19 responses in urban settings, as well as the Evaluation Offices 'Community Rapid Appraisal System' were examples that were noted as useful. To follow up, COs should detail the data and research needs they require at this juncture to help with new programming.

What should UNICEF Do Less Of?

PROGRAMME ISSUES

Avoid taking on more small-scale new initiatives. Some partners indicated that small-scale initiatives created a heavy administrative and recommended that UNICEF focus on coverage and impact instead. Partners also noted that UNICEF should avoid sporadic support to agencies to do one-off work.

MANAGEMENT ISSUES

Decrease number of reporting requests and online surveys coming from different sectors and organizational layers. There was to demonstrate that the reports sent to HQ/RO are being used to guide programmatic and resource allocation decisions. The number of indicators to which COs had to report to was also flagged as an area that needs streamlining. Further on evidence generation, avoid studies and research without a clear utilisation and dissemination plan. There needs to be a better strategy on knowledge management and how to use evidence for better COVID response, as well as strengthened coordination on data and evidence generation between sectors within RO and between RO and HQ.

Funding of quarterly based reporting and provision of budget. Some partners noted that there was difficulty in spending budget allocations when the allocation themselves had been received late**.**

Less of hiring of not very competent consultants: one partners noted that some consultants were not effective in terms of the job. Effective assessment of consultant partners was an area requiring more attention.

What should UNICEF Do Differently?

PROGRAMME ISSUES

Cross Sectoral work: Partners suggested that UNICEF should seize the opportunity to enhance cross-sectoral work within UNICEF to do more targeted programming. It was noted that partnering with WHO and WFP would help, in particular.

Prioritize during emergencies: Partners requested that UNICEF should be cognizant of the fact that during crises, it may not be feasible to address the full range of complex issues and that UNICEF had an important as an organization to guide the focus on the most critical issues.

Adopt more participatory approaches: Design programmes in a participatory manner, engaging with the grassroots and civil society organizations and more directly with children and young people, was suggested as a “different” approach to be adopted by UNICEF.

Reaching those without phones has been a challenge for Early Childhood development facilitators and teachers during closure of schools and ECCD centres. This should be a specific area of attention in the future.

MANAGEMENT ISSUES

Organize monthly cluster meetings with implementing partners. This was noted as a possible way of supporting coordination among the sectors at the local level

Streamline communication with implementing partners: Consider setting up an on-line portal as a better way to communicate once a project or an activity begins. This was seen as particularly relevant when there were multiple projects and activities ongoing simultaneously and constant email traffic was cumbersome.

Establish rosters and LTAs for pre-vetted consultants who can be quickly deployed to support the response efforts.

Additional case illustrations from SAR

Remote psychosocial counselling in Sri Lanka.

The COVID-19 pandemic has caused, both directly and indirectly, a burden on children's mental wellbeing. Children suffer from fear of the virus itself, fear for the safety of their family, being deprived of school, staying at home with parents who are under stress and might have lost their income. In Sri Lanka, the national hotline on domestic violence recorded 463 cases in March and April 2020 compared to 123 cases in February and March 2020.

The country office worked with partners such as Save the Children, LEADS and World Vision to support the National Child Protection Authority (NCPA) to establish a virtual psychosocial support (PSS) mechanism to offset some of the loss in reach to vulnerable children due to the severe lockdown. At the national level, UNICEF provided technical support to establish a PSS network, and local MHPSS networks were set up in Eastern and Northern Provinces for psychosocial first aid (PFA) counseling and referral. In the two provinces, UNICEF activated community level psychosocial support through district mental health forums.

Other input from UNICEF included support for development of a mental health and psychosocial support guideline, and training of 268 NCPA officers on psychosocial first aid. Initial small support such as a paid Zoom license, were stated to have had a large ripple effect with NCPA effectively making the shift to a remote working modality. Similarly, an NGO doing the same type of work emphasized the critical importance of UNICEF being in a position to quickly supply a couple of additional phones for staff to increase the capacity to respond.

The newly trained officers were active already in April, and enabled continuation of the 1929 child helpline line services even during lockdown and curfew. During the period, UNICEF reached over 5,000 children and caregivers through virtual psychosocial support.

Despite the positive effects of remote services, there are also several drawbacks that should be mapped out and accounted for as remote service delivery in protection and also education may become a norm in certain places, times or circumstances in the future. Some concerns noted by participants in the RTA exercise include equity (families without phones and/or living in remote areas are at a great disadvantage) and the limitations in providing counselling over the phone. These include lack of privacy for the caller and difficulties in building trust over the phone – both issues negatively affecting the progress that can be made.

"*The services we have been doing for 30 years, are direct services. This is face-to-face PSS, direct and regular contact is necessary. It is important to see facial expressions, reactions and so on. It is very challenging the way we were forced to move on after COVID-19.»*

Virtual courts and case management in Bangladesh.

With the outbreak of the COVID-19 pandemic, there were concerns for the health and safety of children living in crowded institutions, including children in detention. Across the region, children in conflict with the law often spend extended time in detention, the majority waiting to have their case heard. Most are held for minor alleged offenses, but even these can take months or years to resolve. Limited availability of juvenile courts creates a bottleneck in the system that leads to prolonged detention.

With lockdown being imposed in Bangladesh, children were not allowed to attend court hearings. Concerned at the prospect of these children remaining in detention over an extended period of time, UNICEF worked with the Ministry of Women and Children's Affairs to establish virtual courts to expedite decisions on cases involving children. Intense advocacy on the part of the country office led to an agreement to push forward, and on 9 May the President issued the ordinance introducing virtual courts - the first virtual children's court was launched just days later. UNICEF supported the Bangladesh Supreme Court in this task and trained

members of the courts, probation officers and others. All children's courts were suitably equipped for virtual court proceedings.

More than 500 children accessed justice through the virtual courts and were released. The majority could be reunited with their families, with UNICEF support for reintegration. A small number who could not return to their families were either given a cash grant for a transition period supported by probation officers, or placed in suitable alternative care.

There are 23,000 child-related cases pending in the justice system in Bangladesh alone. Through this innovative approach, and related innovations in remote case management, children were ensured some degree of continuation of services during the lockdown period. The approach bears merit for future prolonged emergencies. However, the potential seems even larger, that COVID-19 could have paved the way for a partial solution to a chronic problem. By omitting the need for a physical space, and for court members to be able to be present there at the same time, virtual courts may help in expediting the backlog of cases waiting to be heard by a juvenile court. This would naturally require adequate child protection measures installed to ensure that the virtual approach does not put children at any disadvantage in comparison to non-virtual juvenile case proceedings, and that any recordings are properly handled.

Release of children in detention was done in several countries in the region, including Afghanistan, India, Nepal, Pakistan, and Sri Lanka.

Tracking the socio-economic impact of COVID-19 on families.

It soon became evident as lockdowns were imposed in many countries, that such preventive measures to stop the spread of COVID-19 would cause adverse economic and social effects at the household level. Data collection during lockdown is an obvious challenge, and for most offices in the region the alternative has been various online or phone-based means of getting information.

Both Nepal and Sri Lanka country offices embarked on an ambitious plan to collect, at regular intervals, data from families across a wide range of indicators. The purpose was to monitor the socio-eco impact of the pandemic on families with children, assess their situation and needs, and identify the most vulnerable and marginalized groups affected by the pandemic. Results were to be used for evidence-based advocacy, resource mobilization and response.

The Nepal country office implemented a longitudinal telephone survey with a very large sampling size of about 7,500 households with at least one child, covering 85% of municipalities in the country. Results are representative at the national and provincial level. The "child and family tracker" returns to the same respondents each round to get an assessment of any change in the situation. In addition to the families, telephone interviews were also held with female health workers in selected districts, and IVR messages were sent to randomly selected households within the sampled population, to be used in triangulation of the telephone data. While the aim was to implement the tracker once a month for six months, by the end of October three rounds had been completed (May, July, August 2020) and all results were not finalized and published.

In Sri Lanka, the "household impact telephone survey" used telephone interviews in sentinel sites, with a smaller sample of about 2,000 households in each round. Three rounds were completed by end October (May, June and July).

The RTA exercise does not provide sufficient detail to exercise any judgement on the extent to which these were actually translated into action, in adapted or new programming, for advocacy or better targeting of vulnerable groups. However, there were reports of results being fed directly back to government for quick decision making. The family tracker does provide information on vulnerable groups, including children with disabilities, however it is not clear if and how this information has been used in programming.

These tools, if found to be cost effective, can be powerful experiences as and when future emergencies arise, also in smaller, subnational geographic areas. The lessons learned in both countries should be documented for region-wide learning and preparing for future scenarios. Another data collection effort in Nepal, gathering real-time data on health services through ONA, has been well documented including very informative lessons for future efforts using ONA. Something similar could be done for the family tracker in Nepal and Sri Lanka. It would appear from the above that the exercise at least in Nepal was more time-consuming to implement and analyze than planned. In both countries it appears that it was challenging to keep up the expected pace of regularly releasing new findings.

Although a telephone-based survey carries numerous drawbacks in comparison to the standard, in-person data collection, it does cost a lot less to implement, in both direct and indirect (for example planning and preparation) costs. It could be that a spillover from this experience can and will be used in non-emergency situations, moving more towards a hybrid data collection using some of the benefits of U-report and other simple tools, while staying closer to traditional survey methodology and scope.

APPENDIX (See separate file)