Real Time Evaluation of UNICEF'S Response to the COVID-19 Outbreak Crisis in Malawi

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Final Evaluation Report

27 January 2021

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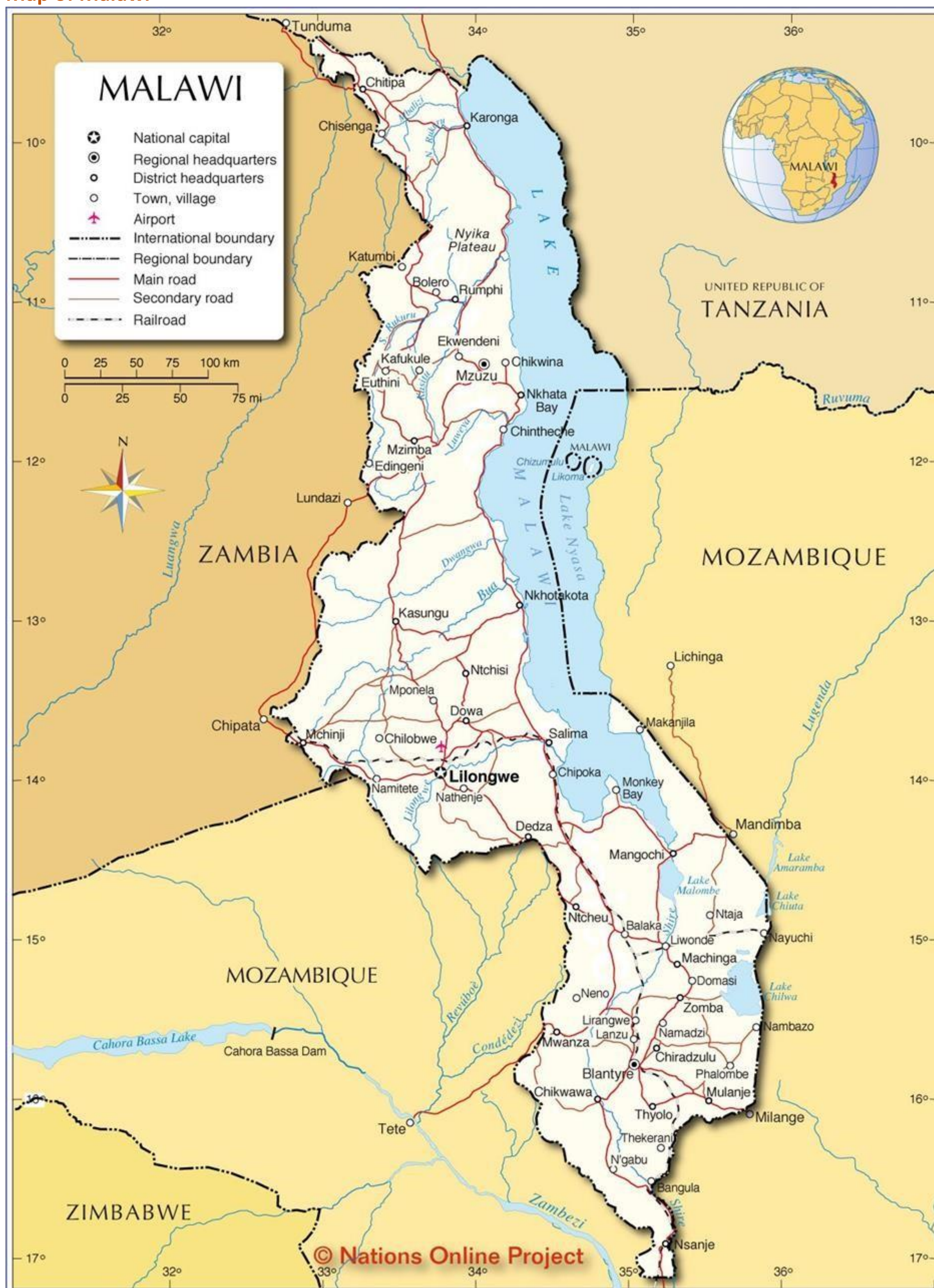
Map of Malawi



Source: *Map of Malawi showing districts, downloaded from nationsonline.org*

Disclaimer

The views presented in this report are those of the authors and do not necessarily represent the views of UNICEF.

Foreword

The DARA Evaluation Team would like to thank the wide range of people and organizations who have generously participated in this evaluation exercise. We are grateful that we were able to (e)-meet a large number of UNICEF partners, donors, Government of Malawi, United Nations Resident Coordinator Office, and UN agencies that support UNICEF's work in Malawi. The Evaluation Team is grateful to the Malawian people who agreed to participate in this study and had the generosity to share their opinions and experiences.

We want to especially thank the UNICEF Malawi Country Office staff who were involved in the evaluation, whose support was fundamental, particularly in this remote process, as well as the UNICEF Regional Office focal points. Their contributions guided the evaluation team and enhanced the quality of the work completed. In particular, the Evaluation Team would like to thank the Evaluation and Knowledge Management team, Mussarrat Youssuf, Abiba Lincy Phegamengo Longwe-Ngwira and Benson Kazembe for their management, support and contributions throughout the evaluation.

The team would like to thank our local partner, the Centre for Social Research (CSR) from the University of Malawi. Their support and work was essential in ensuring the participation of the Malawian people.

Abbreviations & Acronyms

AAP	Accountability to Affected Populations
BCP	Business continuity plans
CCC	Core Commitments for Children
CHS	Core Humanitarian Standards
CO	Country Office
COVID	Coronavirus Disease
CP	Child Protection
CPD	Country Programme Document
CSO	Civil Society Organizations
CSR	Centre for Social Research
C4D	Communication for Development
CUCI	COVID-19 Urban Cash Initiative
CWC	Communication with Communities
CwD	Children with Disabilities
DAC	OECD Development Assistance Committee
DALY	Disease Adjusted Life Years
DEHO	District Environmental Health Officer
eDHIS	District Health Information Software
DHMIS	District Health Management Information System
DoDMA	Directorate of Disaster Management Affairs
DFID	United Kingdom's Department for International Development
DHIS2	District Health Information Software2
DHWO	District Health and Social Services
DSWO	District Social Welfare Offices (merged with DHWO during 2020)
ECW	Education Cannot Wait
EiE	Education in Emergencies
EPI	Enlarged Programme of Immunization
EQ	Evaluation Questions
ERB	Ethical Review Board
ERIC	Ethical Research Involving Children
ET	Evaluation Team
ETU	Emergency Treatment Units
EVD	Ebola Virus Disease
FCDO	Foreign, Commonwealth & Development Office
FER	First Emergency Response
FGD	Focus Group Discussion
GoM	Government of Malawi
GBV	Gender-based Violence
GEROS	Global Evaluation Reports Oversight System
GPE	Global Partnership for Education
HDU	High Dependency Unit
HPM	Humanitarian Performance Monitoring
HSA	Health Surveillance Assistant
HSJF	Health Sector Joint Fund
IASC	Inter-Agency Standing Committee
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated management of childhood illness
IP	Implementing Partner
IPC	Infection prevention and control
IR	Inception Report
KAP	Knowledge, Attitude and Practices
KII	Key Informant Interviews
KPI	Key Performance Indicators
LEG	Local Education Group
LIMS	Laboratory Information Management System

M&E	Monitoring & Evaluation
MNCH	Maternal, Newborn and Child Health
MCO	UNICEF Malawi Country Office
MHPSS	Mental Health and PsychoSocial Support
MIPH	Malawi Institute of Public Health
MoAIWD	Ministry of Agriculture Irrigation and Water Development
MoCECCD	Ministry of Civic Education Culture and Community Development
MoEST	Ministry of Education Science and Technology
MoGCDSW	Ministry of Gender, Community Development and Social Welfare
MoHP	Ministry of Health and Population
MoICT	Ministry of Information, Communications Technology
MoLGRD	Ministry of Local Government and Rural Development
MRCS	Malawi Red Cross Society
MTR	Mid-Term Review
NGO	Non-Governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Co-operation and Development
PCA	Programme Cooperation Agreement
PCMT	Prevention of Mother-Child Transmission
PoE	Points of Entry
PFA	Psychological First Aid
PHEIC	Public Health Emergency of International Concern
PHIM	Public Health Institute of Malawi
PPE	Personal Protective Equipment
PSEA	Prevention from Sexual Exploitation and Abuse
RCCE	Risk Communication and Community Engagement
RCO	Resident Coordinator Office
REKM	Research, Evaluation and Knowledge Management Section
RFP	Request for Proposal
RP	Response Plan
RTE	Real Time Evaluation
RTA	Real Time Assessment
SAM	Severe Acute Malnutrition
SCF	Save the Children Fund
SitRep	Situation Report
ToR	Terms of Reference
UN	United Nations
UNCT	United Nations Country Team
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Hygiene and Sanitation
WHO	World Health Organization

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1. Executive Summary

Context

The pandemic caused by the new coronavirus pathogen was declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organization (WHO) on 30 January 2020. As of January 10, 2021, 8,302 cases and 220 deaths have been recorded.[1] Ranking 174 out of 189 on the Human Development Index, Malawi is one of the poorest counties in the world. With a population of more than 19 million, the country faces structural challenges which adversely affect children, their caregivers and other vulnerable populations. As the COVID19 pandemic hit Malawi, stringent measures were initiated including screening of travellers from other countries and closing of schools in March 2020. A Presidential Task Force was activated and the Directorate of Disaster Management Affairs (DoDMA) established the thematic cluster structure, providing a mechanism to coordinate with organizations involved in the outbreak response.

Object of the evaluation

This Real Time Evaluation (RTE) assesses UNICEF's response to the COVID-19 outbreak in Malawi. UNICEF's response plan included Infection and prevention control (IPC) and provision of critical medical and WASH supplies and services; Risk communication and community engagement (RCCE); Assessing and responding to the immediate secondary impacts of COVID-19; and continuity of health, WASH, education, nutrition and protection services. The MCO was able to respond rapidly by redirecting funds from the Country Programme (CP) and by mobilizing contingency supplies. UNICEF funding needs for its COVID-19 response amount to more than US$55 million. So far US$21 million has been received.[2] Programme Cooperation Agreements (PCAs) have been established with 11 civil society organizations (CSOs) to aid the response. Private contractors have been engaged for construction works in Emergency Treatment Units (ETU) while local manufacturers have been hired for community mask production. UNICEF co-leads the Nutrition, Education, WASH and Protection clusters and is a key partner in the Health cluster. It participates in all other clusters and in the inter-cluster coordination. The MCO actively participates in the National Emergency Operations Committee (NEOC) and promotes action to ensure a coordinated response at the national, district and community level. UNICEF has also led the supply portal to facilitate procurement and distribution of critical supplies for all stakeholders.

The main stakeholders examined by this RTE include the UNICEF MCO programmatic staff and operation unit, relevant Government of Malawi (GoM) line ministries included in clusters co-led by UNICEF (Nutrition, Protection, Education and WASH) and partners of the Health Cluster, UNICEF's implementing partners (IPs), CSOs, and primarily, COVID-19-affected populations, children and vulnerable groups. Key stakeholders within the UN system include the Resident Coordinator's Office (RCO) and partner UN agencies (WHO and UNFPA) in addition to Malawi's donor community, international NGOs and other agencies involved in the response.

Evaluation Purpose and Scope

This RTE has a dual purpose: to provide real time analysis to help make informed decisions when adjusting the MCO COVID-19 response, and to provide a forward-looking reflection on the current implementation of the country office response to COVID-19 in order to inform future programming. The evaluation covers the entire span of the COVID-19 emergency response in Malawi, starting with the declaration by WHO of COVID-19 outbreak as a PHEIC on 30 January 2020 and extending until the end of the data collection phase, i.e. 27 November 2020. The geographical scope covers the whole country, although most analysis is concentrated in the 12 priority districts as defined by UNICEF Response Plan.

[1] PHIM dashboard, January 2021. A significant increase of cases is reported from end of December 2020
[2] UNICEF SitRep, December 4, 2020

Evaluation Criteria and Methods

To generate robust evidence, the evaluation employed a mixed methods approach and triangulated different sources of data. The analytical framework was constructed combining the DAC criteria with the Core Commitments for Children (CCC) framework. The evaluation criteria are built from the DAC criteria, with a specific focus on applicability to humanitarian response: Appropriateness, Coverage, Efficiency, Effectiveness, Coordination, Connectedness and Sustainability. The ET retroactively constructed a Theory of Change (ToC) an evaluation matrix (see Annex 1) including the relevant judgment criteria, indicators, sources, and analytical approach for each EQ. Ethical consideration have been respected in all cases during the evaluation. The inception report was approved by the Ethical Review Board (ERB, annex 13). The ET has identified and addressed limitations related to the availability of GoM officials, the challenges in accessing internal UNICEF IMS, and COVID-19 travel restrictions.

Findings

Appropriateness

Initial uncertainty about the pandemic's evolution justified UNICEF's swift engagement in response efforts, and a focus on support to the health system and RCCE. The UNICEF Response Plan was prepared in line with the GoM plan. UNICEF has also supported the formulation of guidelines and standard operating procedures (SOP) to support institutional leadership in the response. The focus of Malawi's public health and WASH response efforts eventually focused on points of entry (PoE), where multiple imported COVID-19 cases needed to be identified, in a context of challenging infection prevention control (IPC) and testing capacity. WASH interventions have targeted as well needs at health facilities and in public places and to ensure adequate WASH preparedness in schools. The MCO has established an internal mechanism to integrate accountability to affected populations (AAP) and attempts to monitor constraints to critical services have been established. However, the applicability of AAP has been constrained by challenges regarding community engagement and limited feedback from vulnerable populations and rural areas. The education sector quickly mobilized to provide technical assistances, guidelines and tools for the MoEST to establish distance learning after schools closed down. UNICEF's Child Protection section provided psychosocial support and addressed specific challenges of children lacking parental care, as well as GBV-awareness and referral.

Despite being comprehensive, and containing an adequate integration of a variety of components, the UNICEF Response Plan is short-term in nature and reactive to the circumstances. It does not address the likelihood that the pandemic will endure in the long-term. Given the reported moderate COVID-19-related mortality in Malawi, the appropriateness of prioritizing the IPC response, which will have a limited impact on children, is debatable in the face of other significant challenges caused by HIV/AIDS, tuberculosis, malaria, water-borne diseases, maternal mortality and others. Other issues triggered by COVID 19, which have affected adolescent girls and young women, vulnerable and disabled, have been secondary to the outbreak itself.

Coverage

The UNICEF Response Plan prioritizes affected districts, initially targeting 12 districts, and then extending to a total of 28 with FCDO-funded interventions. C4D messaging was relayed through mass media and reached the entire country, as did lab testing and personal protective equipment (PPE) supplies provided by the UNICEF-led supply portal. The UNICEF Response Plan explicitly covers vulnerable groups, is mindful of gender equity and human rights and pays attention to children with disabilities (CwD). The option of systemic coverage (the health system, including districts and PoE) versus targeted interventions based on vulnerabilities is not always well balanced and raises issues such as lack of access to basic essential services dedicated to maternal, newborn and child health (MCNH), immunization and nutrition. The situation in rural areas, with limited connectivity, lack of power supply and poor access to radio networks[3] has affected coverage of RCCE and distance education support. In addition, monitoring gaps affect coverage of

[3] In Malawi, around 13% of the population has access to electricity, and 33% possess radio appliances: from Government of Malawi: 2018 Malawi population and housing census, main report

vulnerable populations, including addressing specific needs of people with disabilities (PwD), as highlighted by informants and FGD participants.[4]

Efficiency

The MCO has been able to develop its response through its experience with previous emergencies. An interdisciplinary core emergency team was activated, led by the Health section and integrated by all MCO sections under the supervision of the Deputy Representative. The MCO Health section was reorganized to align existing resources with different areas of activity to respond to the challenges. The MCO COVID-19 Response Plan was formulated in a timely manner, even before the first cases of the virus were confirmed in Malawi. UNICEF initially managed to redirect funds to aid the response while additional funding was being mobilized. Out of the US$55 million requested a funding gap of more than US$41 million remains.[5] WASH and RCCE have complemented funding for their activities with funds raised for the public health response, creating synergies that have promoted cost-effectiveness. Innovation is part of the CP's integrated approach and has been a key aspect of the COVID-19 response effort. The communication section of MCO was able to capture and generate compelling stories that play a crucial role in public advocacy for UNICEF.

One of UNICEF's main contributions to the response effort has been in supply provision, hosting the supply portal and facilitating real time information on the availability, procurement and delivery of supplies. The balance between international supplies and local procurement is identified as an innovative response by the MCO to addressing limited availability of some items on the global market.

With regard to monitoring, obtaining reliable data from the field became one of the main challenges due to mobility restrictions. This situation led UNICEF to strengthen innovative solutions: The m-quarantine, SMS messaging, Laboratory Information Management Systems (LIMS), District Health Information System 2 (DHIS2), and different e-surveillance modalities, are all examples of dynamic approaches taken. However, e-surveillance and e-reporting are still uneven and show significant gaps in some districts. Essential aspects of monitoring at the district level have been affected by mobility restrictions, including nutrition status and protection-related monitoring activities, including capturing data on CwD and on disabilities at large. On staff wellbeing measures, given the situation created by COVID-19, the MCO implemented efficient and adequate measures to protect staff while distance working was established. Furthermore, committees followed up on staff wellbeing and psychosocial support.

Effectiveness

Challenging the assessment of effectiveness, the Response Plan is largely input oriented and lacks a comprehensive result framework. Targets defined based o HPM indicators provide an approximation of the effectiveness. UNICEF has contributed to providing health system staff with adequate training, test capacity and adequate protective equipment to deal with COVID-19 cases. UNICEF has also supported the development of guidelines, SOPs and case management tools. The WASH intervention has directly supported management of returnees at and delivery of WASH resources at points of entry and in targeted health facilities and selected areas. The support provided has been short-term in nature, and while some elements contribute to a permanent strengthening of the health system capacity (training, laboratory capacity, oxygen plant, ETU refurbishment), challenges remain to consolidate what has been achieved. RCCE activities have reached more than 12 million people with distant messaging, mostly, but also through on-site activities with vans, theatre and community awareness. The establishment of platforms to capture feedback, such as U-Report, SMS which provided inputs to the humanitarian monitoring dashboard, are good examples of integrating information in real time.

UNICEF strongly advocated for, and supported the design of, the Covid-19 Urban Cash Intervention (CUCI) aimed at cushioning the socio-economic impact of the pandemic on Malawi's most vulnerable population. COVID-19 has impacted the implementation of basic service programming in Malawi. Some consequences have already been detected such as coverage of the Enlarged Programme of Immunization (EPI) and

[4] The Evaluation notes that UNICEF MCO is reporting addressing CWD, providing braille materials, in the sitrep of December 4
[5] UNICEF sitrep December 4, 2020

access to MNCH. UNICEF's WASH section supported all five water boards to make water accessible for vulnerable populations. The Education section engaged well with the MoEST and cluster partners to reinforce capacity for distance learning and home-based schoolwork during school closures and is supporting the back-to-school campaign. On Child Protection, the response struggled with funding and initially focused on psychosocial and mental health support (PSMHS) activities, and support for children without parental care. Additionally, the CP section has been engaged in supporting the Child Helpline and GBV Helpline, and provided specific support to priority district social welfare offices and Malawi police. The surge of gender-based violence (GBV) cases, child marriages and teenage pregnancies has been linked to school closures and weak CP mechanisms at the community level.

Coordination

UNICEF plays a critical coordination role as a lead UN agency in Malawi, providing the capacity to convene stakeholders for the COVID-19 response, and was able to support initial efforts around a coordinated public health response. The GoM triggered the activation of a so-called cluster system under the leadership of DoDMA with the integration of the RC and the HCT. Within these arrangements, UNICEF led the clusters of Protection and Social Support, RCCE, WASH, Nutrition and co-led Education with Save the Children Fund, as well as playing a key role in the Health cluster.[6] UNICEF also engaged in active coordination with UN partner agencies, UNCT and RCO, channelling funds to WHO and UNFPA. Internal coordination at MCO is judged by informants as optimal. UNICEF swiftly reorganized the Health section to conform to challenges presented by the pandemic and immediately convened partners to activate coordination mechanisms for a MoHP led public health response.

Connectedness

The UNICEF COVID-19 Response Plan aligns with the Malawi Government's National COVID-19 Preparedness and Response Plan and the UNCT Emergency Appeal. It also conforms to the 2020 WHO Global Strategic Response Plan (SRP) and UNICEF Global COVID-19 Humanitarian Action for Children appeal. It is noted that at a time of uncertainty at the beginning of the outbreak, ESARO's guidance was critical to aligning the MCO response. The MCO linked all PCAs and IP formulations for the COVID-19 response to an outcome of the CP, adding new outputs related with the COVID-19 emergency response, providing the basis for an adequate connectedness and coherence to UNICEF interventions.

Sustainability

UNICEF has been building capacity and implementing activities aimed at system strengthening that should eventually lead to a resilient health system and empowered communities. UNICEF's WASH section supported the development of business continuity plans (BCP) for all five water boards in the country, an example of how UNICEF has used a critical situation to appropriately address existing structural challenges. However, challenges remain due to the weak health system which has structural limitations and limited capacity for absorption of external support. Poor infrastructure, limited human resources and weak quality of care have chronically affected delivery of services.

Conclusions

Amid uncertainty at local and regional levels the MCO managed to maintain focus and deliver results, contributing critical outcomes within the response to the COVID-19 outbreak in Malawi.

The MCO reacted swiftly by preparing Response Plan in line with plans formulated by the UN and the GoM, addressing the reinforcement of the health system, supporting the supply of PPE and other medical materials, enhancing RCCE to promote behavioural change and promoting mechanisms to ensure continuity of health care, education and protection of the most vulnerable.

The initial input-oriented approach of the response is acceptable, focused on reinforcing IPC through supplies, which was the main challenge at the time, given the high degree of uncertainty as to how the

[6] Changes have occurred in the last weeks, when the Presidential Task Force has been charged to lead the COVID19 related coordination while DoDMA has returned to its mandate of natural disasters'' prevention and response

pandemic would evolve. However, the need to establish a new log frame or ToC for an intermediate period between the emergency response and the CPD has emerged from the RTE.

It has become clear that access limitations in the field have affected the normal roll out of critical activities for the benefit of children in Malawi. It is to be expected that the disruption of access to education, as referred to in the report, will eventually be addressed if schools remain open.

While the incidence and impact of COVID-19 has been limited in Malawi, the secondary impact on socio economic conditions, on children and on young girls, is of concern. This will affect mainly already deprived populations, particularly in urban centers and especially among CwD. As such, there is the opportunity to align UNICEF programming to these new priorities and contribute to permanent change.

Recommendations

Detailed recommendations are provided in the main report, including suggested actions for the concerned sections and related stakeholders. Here a summary of overarching recommendations is proposed:

- **Build into an adapted Preparedness and Contingency Planning for different scenarios of COVID-19 in Malawi for 2021** including the need to foresee the eventuality of a second wave and the likelihood of a vaccine becoming available in the medium term: ensure supplies, support to PoE, rapid reaction teams, e-surveillance tools, national strategy for vaccination and adapted monitoring.
- **Design a "Bridge programme**" to link ongoing emergency response to the CPD: Refocus on the needs of women, children and other vulnerable groups of interest for UNICEF. Define an integrated log frame with a Theory of Change and an adapted timeframe in order to ensure continuity of health services, access to education, reinforcing child protection at district level, addressing shortcomings in AAP and support district response plans.
- **Establish an advocacy strategy** promoting the need to address priorities for children and vulnerable people in a context of limited funding. This will require engaging main stakeholders (donors, UNCT, GoM), involving the Regional Office and should include defining specific approaches for health challenges and social support for children based on ethical considerations and equity-based decisions in low-income countries (LIC.).

2. Introduction

The COVID-19 pandemic has impacted the entire globe since it broke-out in China at the end of 2019. The WHO declared a PHEIC on 30 January 2020. Caused by a new pathogen, the pandemic created a high degree of concern uncertainty among government leaders and health professional. "*The coronavirus disease pandemic (COVID-19) has triggered an unprecedented global health, humanitarian, socioeconomic and human rights crisis, which has spread to over 215 countries and territories".*[7]

With more than 71 million cases and 1,608,648 reported deaths as of 4 December 2020,[8] the virus4,[9] continues to overstretch health systems and medical supplies chains, and has negatively impacted the socioeconomic circumstance of many of the world's vulnerable people.

After UNICEF launched the "Global COVID-19 Humanitarian Action for Children appeal", the UNICEF Evaluation Office (EO) and the COVID-19 Secretariat at HQ launched the "continuous learning evaluation of the global response" and a number of UNICEF regional and country offices have embarked on other own initiatives to inform their efforts. A Real Time Assessment (RTA) of the UNICEF ongoing response to COVID-19 began in September 2020 in various countries across all UNICEF regions. This RTE is a unique initiative by MCO and is integrated within the corporate learning process.

This RTE has a dual purpose: to provide real time analysis to support decisions in adjusting the Country Office COVID-19 response, and to provide a **forward-looking** assessment on the current **implementation** efforts, informing future programming. The RTE implies a learning exercise shared by all involved, mainly the MCO, IPs and the regional office.

This report is the result of a process that started on 16 September 2020, including an inception phase, a data collection phase and a validation and reporting phase, finally leading to the evidence-based conclusions and recommendations included in this report. This RTE has been conceived as a participatory exercise and has involved the regional office, the MCO and the Evaluation Reference Group (ERG) in the progress of the different phases.

3. Object of the evaluation

The object of this RTE is to assess the critical elements of UNICEF's role and mandate and the response and preventive actions carried out. The UNICEF RP, formulated in March 2020, and subsequent revisions constitute the reference basis for the evaluation.

The COVID-19 pandemic reached Malawi in April 2020 with the first imported cases reported on 2 April. Since then, it extended into community transmission, challenging health system capacity and triggering socioeconomic consequences in an already deprived context (see Context section).

The ET has compiled some of the main dates of interest related to the global, regional and national milestones of the COVID-19 outbreak in Malawi, which is summarized in the graphic below to illustrate the pandemic's evolution over time.

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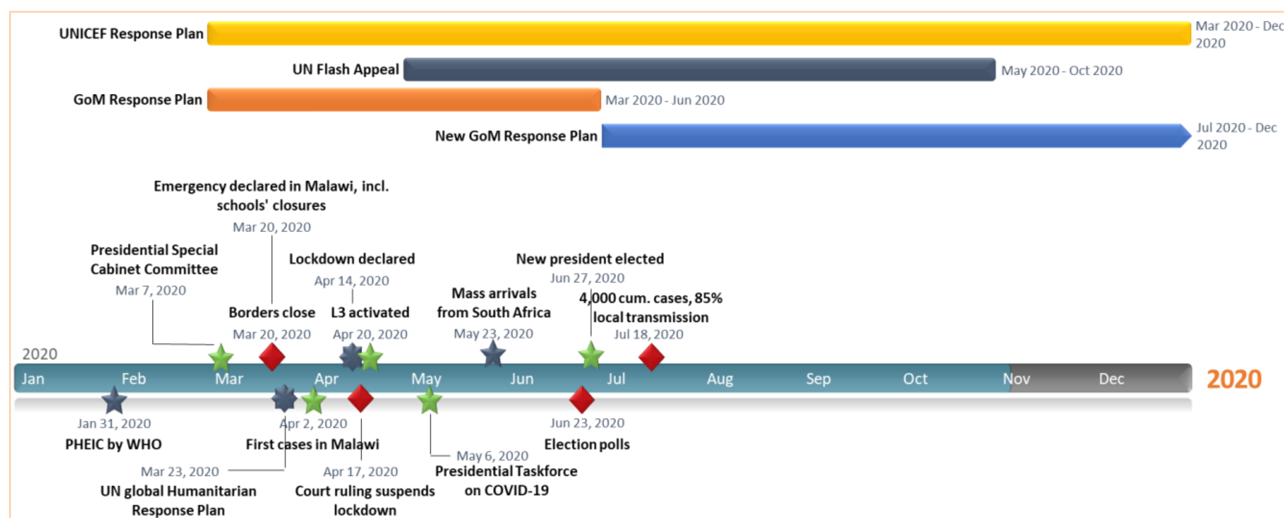
[7] UNICEF Global Covid 19 HAC appeal, July 2020
[8] https://covid19.who.int/table, 4 December 2020
[9] https://covid19.who.int/table, 4 December 2020

Figure 1. Timeline



UNICEF Response Plan

UNICEF's response is articulated through the specific COVID-19 RP, extending from March to December 2020, and aligns with the Government's National COVID-19 Preparedness and Response plan.

Ultimately, the MCO's goal is to strengthen capacity to prevent and reduce morbidity and mortality associated with COVID-19 and to address the socioeconomic consequences for the population of the containment and mitigation measures, especially for vulnerable and disadvantaged children in Malawi. The UNICEF response provides technical assistance and guidance to the GoM, and mobilizes partners to implement activities in the field. Continuity of services and adaptation of the CPD are essential elements that have been taken into consideration.

The sectors of intervention supported by UNICEF include: Health, WASH, C4D, Nutrition, Child Protection (CP), Education and Social Protection, in addition to support to the Ministry of Local Governance and Rural Development. Targets for each sector have been established and progress reported through internal M&E mechanisms with weekly SitReps published, where cumulative Humanitarian Performance Monitoring (HPM) are reported (see annex 14). The main areas of intervention are:

- Public health response to reduce coronavirus transmission and mortality.
- Continuity of health, education, nutrition, and protection services.
- Assessing and responding to the immediate secondary impacts of COVID-19.
- Strengthening risk communication and community engagement (RCCE)

The evaluation also examines the contribution of the different actors and the support provided by UNICEF to the COVID-19 supply chain system in Malawi.

The MCO already included preparedness and response activities in its annual response plan in January 2020, alongside its regular Ebola viral disease (EVD) and cholera contingency plans. Initial supplies were mobilized quickly because of these preparedness arrangements.

Prevention and response activities were scaled up across the country beginning in March. The coverage of some interventions was targeted initially to some at risk districts, expanding later to 12 priority districts. Other activities covered the nation. UNICEF established contractual arrangements with CSO and provided operational and financial support to government services across key areas.

UNICEF provided health workers training, distribution of PPE supplies, nationwide C4D/ RCCE awareness and messaging activities and technical support to national and sub-national COVID-19 coordination efforts.

UNICEF also supported the MoEST on distance learning and promoted innovative solutions to create an enabling environment in communities, with special attention and consideration to preparation of schools for reopening and administering remedial interventions to minimize loss of learning. UNICEF is also providing technical and financial support to the MoE ST to develop data collection tools for monitoring.

On CP, the MCO aimed at supporting the provision of psychological first aid (PFA) and strengthening of reporting and referral mechanisms to ensure children are protected, including where there have been cases of violence. This included sexual exploitation and abuse and negative coping mechanisms, such as child marriage, which are increasing during the COVID-19 pandemic. UNICEF is also supporting the Ministry of Gender, Community development and Social welfare in coordinating protection stakeholders through the protection cluster.

On Social Protection, more than 641,590 children were benefiting from the Social Cash Transfer Programme before the pandemic and an effort has been made to expand the coverage and a specific cash transfer programme for urban contexts has been designed (Urban Cash Initiative, CUCI). As noted, the impact of the pandemic will affect the socio-economic status of the more vulnerable, and social protection schemes are becoming are needed more than ever to avoid negative coping mechanisms and the risk of falling into ultra-poverty.[10]

The diversity of areas covered by UNICEF shows a determination to address the main issues that could contribute to the improvement of the situation of children and their caregivers. The RP includes an extensive number of activities dependent on the scenarios of extension of the outbreak.

Gender and HR in the response plan: UNICEF incorporates a significant gender and HR dimension in its humanitarian response. The COVID-19 response strategy builds on and expands the significant investments which have been made over the past years in supporting national health systems, previous outbreaks or health response, and draws on strong risk communication networks, especially for the most vulnerable children, women and communities or those in hard-to-reach and refugee settings (Dowa district). As such, the MCO developed key intervention areas, such as special mechanisms for reporting on human rights abuses including prevention from sexual exploitation and abuse (PSEA), collecting and analysing data of COVID-19 secondary impacts on children and women, and technical support for inclusion of specific rights, needs and vulnerabilities of women and children.

Funds mobilization

UNICEF funding requirements for the COVID-19 response amount to more than US$ 55 million, and UNICEF reports having so far received US$ 21 million.[11] Initially, the MCO was able to reprogram some existing funds, and additional key funding was obtained from FCDO and Government of Ireland. Germany, GAVI and Norway have also provided funds for the UNICEF response (see table 9). The education section was able to mobilize significant funding from the GPE that should cover activities from May 2020 until November 2021 (in the funding table below only part of the funding has been reflected, as the rest will be allocated in 2021). In addition, the MCO Education section has received funds from ECW and reprogrammed the ongoing ECW project that was meant to end in May 2020.

The RP establishes funding requirements by section of intervention and, while initial funding was made available quickly, mainly for health and education, no increase has taken place since. Some sections, such as CP, Nutrition and Social Protection, are reported as receiving no funding (CP section informed of a funding gap of 73 per cent, with only US$2,016.998 available out of the US$ 7,551,005 requested; this information is not provided in the overall funding status as per SitRep and not included in table 1), while WASH is clearly underfunded.

[10] As stated in the UNICEF Response Plan narrative, page 4*: The poor, especially the urban poor and ultra-poor, will be the most affected.*

[11] UNICEF SitRep, December 4, 2020

Table 1. Malawi COVID-19 funding status by sectors as of 2 December 2020

Appeal Sector	Funding Requirements	Funds received against the appeal	Funding gap $	Funding gap %
Health	$30,600,000	$9,337,367	$21,262,633	69%
WASH	$8,600,000	$736,793	$7,863,207	91%
C4D	$1,000,000	$632,054	$367,946	37%
Education	$3,200,000	$ 6,484,529	$0	0%
Social Protection	$7,200,000	$0	$7,200,000	100%
Nutrition	$4,000,000	$0	$4,000,000	100%
Child Protection	$1,000,000	$0	$1,000,000	100%
TOTAL US$	$55,600,000	$ 17,190,743	$41,693,786	75%

Source: UNICEF sitrep December 4, 2020, from https://www.unicef.org/appeals/malawi/situation-reports

PCAs have been established with 11 CSOs for COVID-19 response, mainly for health system support, case management and surveillance, WASH related interventions, RCCE and social protection, as well as support for innovative solutions engaging LIKA University and the Drone and Data Academy. Private contractors have been engaged for construction works in Emergency Treatment Units (ETUs) and local manufacturers for community mask production. Noted are the bilateral arrangements that were established to channel funds to UNFPA and WHO, in the framework of the One UN approach.

3.1. Logical model and ToC

UNICEF established four intervention areas as its strategy for the response:

1- Infection and Prevention Control (IPC) and provision of critical medical and WASH supplies and services

2- Risk communication & community engagement (RCCE) including digital engagement and rumours monitoring

3- Assessing and responding to the immediate secondary impacts of the COVID-19

4- Continuity of health, WASH, education, nutrition, and protection services

Several activities are formulated for each intervention area, and targets and indicators established already in the initial plan and adapted over time. The HPM system is mainly applied to monitor the progress toward targets. This constitutes the basis for measuring response progress, and as such, is reported in the weekly SitReps.

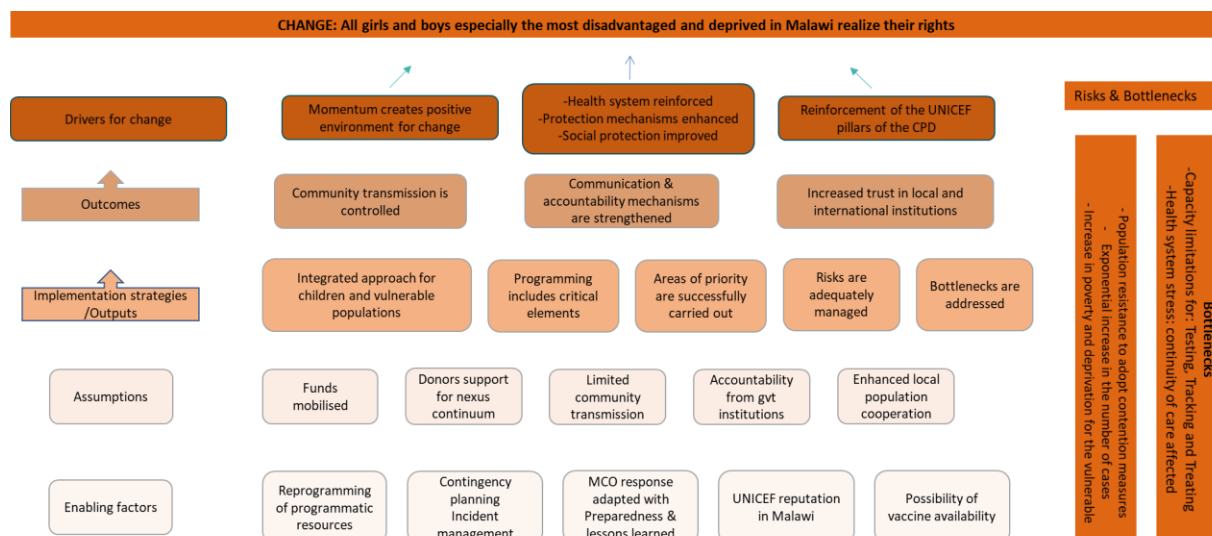
The RP is not articulated through a logical framework, rather an activities matrix is annexed to the RP: *"Annex 1- Activity breakdown including targets and indicators"*.

In the absence of an articulated UNICEF COVID-19 response logframe, the ET proposed at inception stage a ToC to frame the intervention. In this way, UNICEF's response has a wider aim for a comprehensive change, as in the CPD: "***All girls and boys especially the most disadvantaged and deprived in Malawi realize their rights and grow up in resilient, inclusive and child-friendly communities that are supported by an enabling environment and systems that provide an equitable chance in life."*** To contribute to that aim through the COVID-19 response, UNICEF should promote a positive environment for change (momentum for community participation and community-based accountability), while reinforcing the UNICEF integrated pillars described in the CPD through COVID-19 response activities.

Assuming that funds are mobilized or reprogrammed, and donors maintain support, essential supplies are available at local and global level, COVID-19 community transmission does not become massive, Government of Malawi institutions improve their capacity at central and district level, enhance their accountability to the rights holders and local communities maintain cooperation with UNICEF programmes, while MCO establishes an adaptive programming based on lessons learned, through critical programming, integrated approach and prioritization, *then* while community transmission will be controlled, communication and accountability mechanisms will be reinforced and local communities will have increased trust and collaboration with local and international actors, *conditions will lead* to the drivers for change (see Figure 2 below). The likelihood of a vaccine that could be available in the future to ensure control of transmission is also included in the ToC.

The ET factors in this theory-based approach throughout the evaluation exercise and elaborates on its validity in the conclusions section of this report.

Figure 2. Theory of Change



3.2. Context

Malawi ranks 174 out of 189 on the Human Development Index and remains one of the poorest countries in the world, despite making significant economic and structural reforms to promote economic growth. Over 70 per cent of the population lives below the income poverty line and approximately 63 per cent of children live in poverty.[12] The economy is heavily dependent on agriculture, employing nearly 80 per cent of the population. Malawi's development challenges are multi-pronged, including vulnerability to external shocks such as weather and health crises. Other challenges include rapid population growth and environmental degradation.

With a total population of 19,842,560, and a population growth rate of 3.31 per cent, Malawi has a young population with half of all people below 18 years old. Only around 5.7 per cent of the population is above 55 years old.[13]

Significant health challenges are relevant in Malawi, even if progress on basic indicators has been achieved in the past years, such as the under 5 mortality rate, which has halved since 2010 to the current 41.6 deaths per 1000 live births.[14] The main causes of death retained for 2019[15] are related to HIV, neonatal disorders, lower respiratory tract infections, tuberculosis, diarrheal disease and malaria, being the same conditions as 10 years earlier.

The prevalence of HIV in 15-49 years old is still 9 per cent (2019),[16] and the number of children (0-14 years) living with HIV is estimated to be 110,000.[17] One million people are estimated to be living with AIDS and 13,000 HIV/AIDS related deaths are estimated per year (2018).[18]

The death rate is 7,7/1000 in 2018; diarrhoeal disease is the cause of death in a rate of 70/100.000 people in Malawi,[19] showing a decline of one third since the introduction of the rotavirus vaccine in 2012.[20] Other major causes of child mortality are malaria and respiratory infections.

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[12] World Bank, 2013 and UNICEF: https://www.unicef.org/malawi/situation-children-and-women-malawi; Child Poverty in Malawi, Ministry of Finance and Economic Planning, UNICEF Malawi: https://www.unicef.org/malawi/MLW_resources_childpoverty.pdf
[13] https://www.indexmundi.com/malawi/demographics_profile.html, based on CIA World Factbook
[14] https://data.unicef.org/country/mwi/
[15] Institute for health metrics and evaluation, healthdata.org, country profile, Malawi
[16] (UNAIDS estimates in: https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?locations=MW)
[17] https://www.unicef.org/malawi
[18] https://www.indexmundi.com/malawi/demographics_profile.html, based on CIA World Factbook
[19] https://ourworldindata.org/diarrheal-diseases

Regarding disabilities, about 10 per cent of the population over 5 years suffer some form of disability (701,000 male, 855,000 female), in addition to 134,636 persons with albinism.[21]

The health system struggles to address the challenges and structural limitations affecting health sector performance, with two physicians per 100,000 population, 1.3 hospital beds per 1,000 population.[22] The MoHP, with the support of UNICEF, develops the community health programme to provide basic health services to communities through health surveillance assistants (HSA)[23]. A decentralization process has been ongoing since 2017 and operational and budgetary responsibilities have been transferred to districts from the MoHP to the Ministry of Local Governance (MoLG). These transitions become problematic in many cases, as management capacity is not always present at district level, and decentralization processes, especially financial, have not been smooth.

Adequate water, sanitation and hygiene (WASH) services are essential for infection prevention and control (IPC). In Malawi, inadequate access to sanitation (42 per cent) and clean water (67 per cent)[24] contributes to child mortality and morbidity. The poor and vulnerable are disproportionately affected.

Regarding Child Protection, in addition to the prevalence of child poverty in Malawi, which affects equity of access to opportunities,[25] social norms hamper the realization of rights for women and children, in particular for girls. Challenges to implement new legal and policy norms have been raised in the process of modernization of Malawi's society. Gender discrimination, child marriages, early and unplanned pregnancies remain prevalent.[26] Malawi has one of the highest child marriage rates in the world: almost half of all females marry before reaching the age of 18 years and nearly 10 per cent before reaching the age of 15 years.[27]

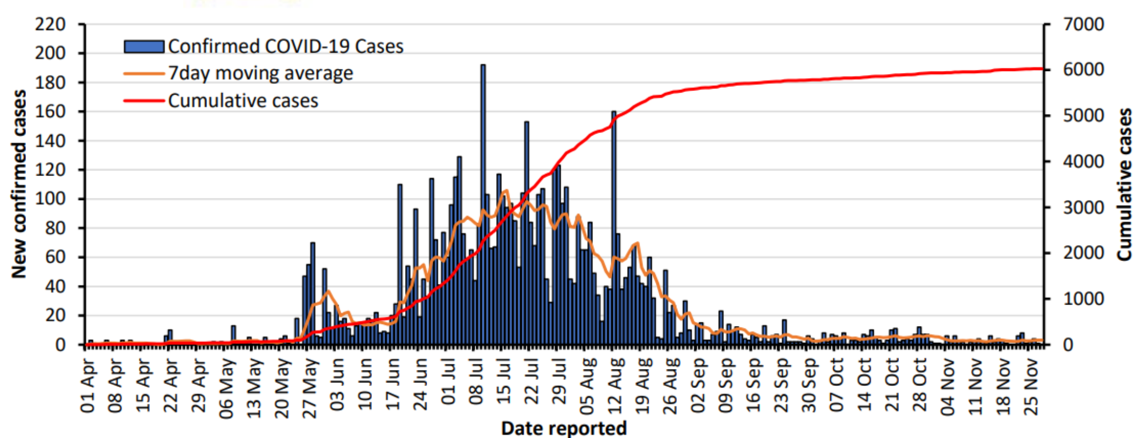
Education challenges are significant in Malawi. While most children access primary schools, only 35 per cent of them transition from primary to secondary school, among them are only four per cent from the lowest wealth quintile. These, joined with challenges when it comes to health care, HIV treatment, nutrition service, protection from violence and WASH constraints, poor educational opportunities, especially among girls, prevent children from reaching their full potential (UNICEF SOWC, 2015).[28]

The COVID-19 pandemic in Malawi

Malawi declared a national alarm on 20 March and the first cases were reported on 2 April. As of December 14, 6.070 cases were reported and 187 people died.[29] As of January 10, 2021, 8,302 cases and 220 deaths were reported in the PHIM dashboard, suggesting a new wave of transmission.

[20] https://www.genengnews.com/topics/drug-discovery/infant-diarrhea-deaths-drop-sharply-in-malawi-due-to-rotavirus-vaccine/
[21] Government of Malawi: 2108 Malawi population and housing census, main report
[22] https://www.indexmundi.com/malawi/demographics_profile.html, based on CIA World Factbook
[23] https://www.unicef.org/malawi/media/561/file/Health%20Narrative%20Factsheet%202018.pdf
[24] World Health Organization/UNICEF Joint Monitoring Programme, 2017
[25] Child Poverty in Malawi, Ministry of Finance and Economic Planning, UNICEF Malawi, https://www.unicef.org/malawi/MLW_resources_childpoverty.pdf
[26] The *Life Cycle (Situation) Analysis of Children and Women in Malawi. (UNICEF 2017, UNICEF study, 2017/004*
[27] https://www.unicef.org/malawi/media/526/file/Child%20Marriage%20Factsheet%202018.pdf
[28] UNICEF Malawi CPD 2019-2023, School age pillar strategy note
[29] PHIM dashboard, 14 December 2010. Figure 3 is maintained as the last available, but the new data suggest a new wave of transmission

Figure 3. COVID-19 cases in Malawi (up to 29 November 2020)



Source: PHIM, COVID-19 daily situation report, 29 November 2020, 6:00 am CAT

Even with issues of testing and actual case detection and follow up capacity, the situation in neighbouring countries, except South Africa, share the relatively low incidence and moderate number of cumulative deaths since the beginning of the pandemic,[30] as is shown in the following table:

Table 2. Number of cases and deaths of COVID-19 in the region (29 November 2020)

Country	Cumulative case	New cases	Cumulative deaths	New deaths	Days since last reported case
South Africa	785,139	3,198	21.439	61	0
Zambia	17,589	20	357	0	0
Zimbabwe	9,822	108	275	0	0
Mozambique	15,386	80	129	1	0
Tanzania	509	0	21	0	199
Malawi	**6,025**	**0**	**185**	**0**	**0**

Source: PHIM, data for 29 November, Available at https://covid19.who.int/

In mid-February, a National Preparedness and Response Plan was finalized and screening of travellers entering the country was initiated in March. On 20 March, schools-closing and other measures were declared by the GoM. A presidential task force was established and the Directorate of Disaster Management Affairs (DoDMA) activated the thematic clusters structure, providing a platform for integration.[31] UNICEF co-leads the Nutrition, Education, WASH and Protection clusters, is a key partner in the Health cluster, and participates in all other clusters and in the inter-cluster coordination. The MCO's actively participated in the National Emergency Operations Committee (NEOC) and promoted action to ensure coordinated response at the national, district and community levels.

The COVID-19 outbreak in Malawi has, as in many other countries, forced health services to adapt, protect the safe continuity of some services and discontinue others as the caseload has overwhelmed system capacities. As a consequence, mitigation measures designed to reduce virus transmission have had the adverse effect of reducing access to basic health services. The risk of interruption of services such as institutional deliveries and caesareans, antenatal and postnatal care, immunization and treatment of HIV, severe diarrheal disease, acute malnutrition and pneumonia may lead to increased child morbidity and mortality in the medium to long term.

Loss of household income for the poor and vulnerable, including migrant workers, is affecting the financial ability of parents and caregivers to access nutritious, safe and affordable food. Basic social services essential to fulfilling children's rights, growth and development needs, are also out of reach for many.

[30] This statement is based on the data available until December 2020, the situation is evolving as of January 2021. The reported increase of cases suggests a new wave. This is not reflected in the figure 3 (see footnote above).
[31] Since the end of the RTE data collection a new dedicated coordination secretariat has been set up, in order to allow DoDMA to focus on weather related shocks (UNICEF sitrep December 4, 2020)

The education system has been also affected by the COVID-19 containment measures. Schools providing primary and secondary education have been closed since March due to the lockdown caused by COVID-19, and challenges in continuity of learning and potential increases in dropout rates are significant. Schools have been reopening progressively since 7 September, but challenges remain to allow for a safe environment, mainly related to inadequate WASH facilities, classroom space and capacity for arranging shifts.[32]

CP risks have increased due to school closures and weak community-based protection and accountability systems. The disruption of institutional referral pathways due to the limitation of movements for GoM officials has also been a CP issue. This is also heightening protection risks and vulnerabilities for already at-risk groups, including children, young girls, women and crisis-affected families.

Funding for the response has been challenging considering the global nature of the pandemic and competing requirements of donors. A few traditional donors reprogrammed some of the development funding to support the response; others moved resources from contingency funds. Initial pledges to the Malawi Response Plan are detailed in the table below.

Table 3. Summary initial pledges for the National Response[33]

Partner	Pledge	Pillar
Gov of Malawi	$ 3.4 million	*Logistics, incentives, supervision*
GAVI	$ 4,897,012	*Labs, PPE, procurement, training*
Global Fund	$ 300,000	*C4D*
World Bank	$ 8 million	*Lab PCR, Supplies, training, equipment*
CDC	$ 700,000	*Lab PCR at central hospitals*
Gov. Of Ireland	€ 500,000	*PoE, ETUS, training and C4D in Karonga and Mangochi*
USAID	$ 1,390,773	*Surveillance in 16 ONSE districts*
HSJF	$ 2,470,035.51	*Supplies (PPEs), equipment*
UK Aid	£ 1,823,230.40	*Labs PCR, Surveillance, supplies, ETUs, C4D Coordination, UNICEF districts*
Gov China	$ 47,295	*PPEs*

**GIZ not reflected as other contributions from HSJF, IMF and WB*

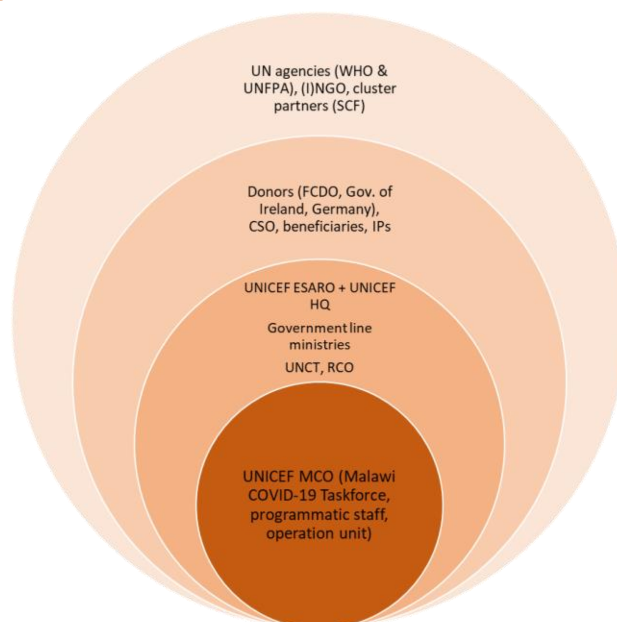
In April, the UN Humanitarian Country Team (UNHCT/ HCT) launched an emergency appeal for the period May to October, aligning UN agencies with the National Response Plan and into a joint and coordinated response. The appeal requested US$140 million to address emergency needs, and so far, the appeal has received 75 per cent of its funding requirements.[34]

3.3. Key stakeholders

The main stakeholders of the response, and primary users of this RTE, are the MCO's programmatic staff and operations unit, the relevant line ministries engaged in UNICEF cluster's co-leadership (Nutrition, Protection, Education and WASH) as well as partners of the Health cluster, UNICEF's IPs and CSOs. The UNCT, the RCO, the donor community, international non-governmental organizations and national CSOs and agencies involved in the response are the secondary stakeholders and users. This includes donors present in the country, as FCDO, Government of Ireland and Germany, cluster partners (SCF), and WHO and UNFPA who have received funds thorough UNICEF.

[32] UNICEF SitRep September 2, 2020
[33] From table 1 in UNICEF CONCEPT NOTE TO DFID for the Grant Extension for COVID 19 response, dated 20 May 2020.
[34] From the "emergency Appeal Financing Tracking", not refreshed since August 2020, which reckons a funding request of $345 Million USD:
https://app.powerbi.com/view?r=eyJrIjoiOGYwNmY2NDktNDM3Yi00NWU3LTlmYTItN2U2NjNiOTg4ZmM5IiwidCI6ImIzZTVkYjVlLTI5NDQtNDgzNy05OWY1LTc0ODhhY2U1NDMxOSIsImMiOjh9

Figure 4. Users and Stakeholders



This RTE takes primarily affected population and vulnerable groups while government counterparts (both at national and sub-national/district level) are considered mainly as duty bearers.

4. Evaluation purpose, objectives, and scope

4.1. Purpose

The main purpose of the RTE is to establish a shared learning framework to inform UNICEF management and support decisions in adjusting the MCO COVID-19 response. It should also provide a forward-looking assessment on the current implementation efforts being conducted by the MCO.

It is noted that this RTE is occurring at the same time as RTAs, looking COVID-19 responses, in different countries in the region where UNICEF is present. This RTE inevitably encompasses the RTA purpose and will intend to provide answers for the case of Malawi to the questions to be addressed through both exercises. This RTE will undoubtedly contribute to the RO effort to address the learning challenges envisaged, providing additional elements of judgment to the RO RTA through this specific case study.

In particular, as stated above and in coherence with the RTA purpose, the RTE provides, in a timely way, a reflection "*on how to adapt further as the crisis unfolds, while preparing for both the next round of HAC and next generation of work plans*".[35]

4.2. Objectives

The objectives of this RTE, as per the ToR, are summarized in four key points below:

a) Evaluate in real time the effectiveness, efficiency and relevance of UNICEF Malawi's COVID-19 emergency response.

b) Provide real time feedback to the UNICEF Malawi COVID-19 Taskforce and UNICEF MCO head of sections to allow timely operational adjustments on UNICEF's COVID-19 response.

c) Evaluate the effectiveness, efficiency, and relevance of UNICEF Malawi COVID-19 Accountability to Affected Populations, including the engagement of UNICEF's implementing partners, government, UN and CSO partners and beneficiaries in shaping UNICEF's crisis response.

d) Identify challenges and bottlenecks and act as a real time lessons learning exercise on what works and what does not work for girls, boys, men and women to help improve planning and performance and allow for ongoing correction of the crisis response.

[35] TOR: A Real-Time Assessment (RTA) of the UNICEF ongoing response to COVID-19 at country level, draft version

4.3. Scope

The ET can identify some relevant dimensions for the scope of this RTE:

Institutional: This RTE is meant to evaluate the work of UNICEF Malawi and its down-stream partners in responding to the COVID-19 pandemic outbreak. However, the evaluation takes into account the wider framework of the COVID-19 response, including that of the government counterparts (both at national and sub-national/district level). Particular emphasis will be placed on assessing the role of UNICEF as a key actor in the cluster system and co-lead in four of the clusters (Nutrition, WASH, Education – with SCF – and Protection.

Programmatic: The RTE focuses on the criteria applicable to the programmatic response. A set of EQs have been adopted (see below in the Evaluation Matrix section) and relevant evaluation criteria framed in the evaluation matrix. As this is an RTE and the response is ongoing, the impact criteria is not included. Sustainability as an evaluation criterion in such an emergency operation will only be gauged so as to capture the likelihood to contribute to the drivers of change in the proposed theory approach and to the extent of the eventual integration of current activities and lessons learned in the long-term programme.

Geographic: The response has been rolled out countrywide, but some geographical prioritization has taken place and has been considered in the evaluation planning. The situation in Malawi has allowed for a local consultant to travel to several locations to observe and assess the actual roll-out of response activities in the field, focusing on beneficiaries' feedback. The ET focused on ensuring geographical coverage of the field visits, aiming at targeting districts from the north, central and southern parts of the country through a balanced approach.

Timeframe: The evaluation covers the entire span of the COVID-19 emergency response in Malawi, starting with the declaration by WHO of the COVID-19 outbreak as a PHEIC on 30 January 2020 and extending until the time of the data collection phase, 27 November 2020.[36] In this report, the ET has incorporated report data provided in early December from Round 12 of the HPM monitoring, included for informative reasons but not affecting the analysis.

5. Evaluation methodology

5.1. Evaluation criteria

As per the Terms of Reference (ToR), evaluation criteria are built from the DAC ones with specific focus on its applicability to humanitarian response as per ALNAP reference[37]: Appropriateness, Coverage, Efficiency, Effectiveness, Coordination, Connectedness and Sustainability.

These criteria have to be balanced with the necessary focus of an RTE, which takes place while the action is still ongoing and intends to provide guidance on how the design and the processes in place are likely to reach intended results. The ToR reasonably rules out assessing impact, but even effectiveness can be gauged only partially, and from the perspective of judging if the ongoing processes and what has been achieved so far allow for an assumption of the level of effectiveness.

Consequently, this RTE pays special attention to processes and outputs, assessing, when possible, the achievement of outcomes or their likelihood. As per the ToR, special attention will also be paid to lessons learned.

Evaluation matrix

The ET has prepared an evaluation matrix based on the evaluation questions (EQ) provided in the ToR. They have been grouped as EQ and sub questions, so as to provide a framework of reference. The evaluation matrix includes the relevant judgment criteria, indicators, sources, and analytical approaches for each EQ (see evaluation matrix in annex 1). The overarching EQ retained are:

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[36] The ET has incorporated in this report data provided early December from the round 12 of the monitoring of HPM. While this is included for informative reasons and actually confirms conclusions reached, it is beyond the time scope.
[37] Evaluation of Humanitarian Action Guide, ALNAP 2016, Margie Buchanan-Smith, John Cosgrave, Alexandra Warner

Table 4. Evaluation Questions

Criteria	Evaluation Questions
Appropriateness	EQ1. To what extent are the activities undertaken as part of UNICEF's Malawi COVID-19 crisis response in line with national sectoral COVID-19 Response Plans and with UNICEF Regional and global COVID-19 response plans and related guidance?
	EQ2. Was UNICEF Malawi COVID-19 response agile and timely and commensurate to the needs?
Coverage	EQ3. Were the target populations adequately identified, targeted, and reached under respective sector approach and in a cross-sectoral manner?
Efficiency	EQ4. Is UNICEF's response allocating timely the adequate resources (including financial and human resources) to achieve its objectives given the COVID-19 operational environment?
	EQ5. Were supplies procured and distributed timely to meet the needs of affected populations?
	EQ6. How efficiently UNICEF Malawi was able to organise its work in view of implementation constraints, such as movement restriction, elections impact and other external events?
	EQ7. How efficient were the data collection mechanisms established and was the use of data to inform programmatic approaches utilized efficiently?
	EQ 8. To what extent has UNICEF Malawi innovated in the Malawi COVID-19 response context, and continued to sustain efforts that are seen to be working?
Effectiveness	EQ9. To what extent was UNICEF Malawi able to adapt as the situation unfolded on the ground and contribute to reducing the COVID-19 impact on children and their families?
	EQ10. To what extent the intended UNICEF Malawi COVID-19 response immediate, intermediate, and longer-term outputs and outcomes are being achieved? (disaggregated by sector of activity. *Health, Wash, education, nutrition, Child Protection, social protection, RCCE, Innovation, communication supply)*
	EQ11. To what extent did UNICEF Malawi's emergency response engagement with youth and communities apply a "do no harm" principle, while also ensuring safety from sexual exploitation and abuse of the young girls and boys as well as its staff and counterparts?
	EQ12. Did the COVID-19 response jeopardize UNICEF Malawi support to continuity of service provision?
Coordination	EQ13. Are existing coordination mechanisms (both internal and external) functioning effectively and efficiently to facilitate effective emergency response?
	EQ14. What was the value added of UNICEF's coordination role in the national COVID-19 response in Malawi?
Connectedness	EQ15. To what extent UNICEF COVID-19 Response plan takes into account the long term CPD and builds on the integrated service provision envisaged?
	EQ16. Was UNICEF Malawi response able to quickly learn from and apply best practices used by other organizations, neighbouring UNICEF country offices and/or ESARO offices in responding to the COVID-19 crisis?
Sustainability	EQ17. To what extent and in which ways UNICEF supported COVID-19 interventions are likely to promote community resilience, GBV and PSEA integration?
	EQ18. How is the learning from the current response being integrated into UNICEF programming to ensure long-term, sustainable response for an expected protracted pandemic situation?

5.2. Evaluation framework

The analytical framework has been constructed combining the OECD DAC criteria adapted for Humanitarian Action with the CCC framework which will play a key role in assessing the timeliness and the overall performance of the response. The evaluation gives special attention to the programmatic side of the CCCs with a focus on immediate results of the interventions and trying to look at how they were produced. The CCCs also have important strategic commitments: human rights-based approach, coordination leadership and participation, impartiality and neutrality, the "do no harm" approach, managing for results, emphasis on preparedness and early recovery, advocacy, and disaster risk reduction.

The CCCs articulate how UNICEF supports the UN Convention on the Rights of the Child (CRC) and protects the rights of the child in all humanitarian crises, both sudden, acute and prolonged crises. The Core Humanitarian Standards (CHS) will be used as an additional layer of reference.

The evaluation is anchored in the relevant gender and HR frameworks. Throughout the evaluation, the ET used a gender-sensitive approach. It also entails examining how protection strategies against sexual and gender-based violence, prevention of child marriages and adolescent pregnancies, have been incorporated into the interventions. The ET also strives to ensure that all data is disaggregated by age and gender, to allow gender-sensitive analysis and identification of gaps and recommendations specific to women, men, boys, or girls.

Overall, the approach includes a strong utilization focus. This ensures that all relevant stakeholders are involved in each step of the process and in ways that support their learning. This can be in response to compelling evidence and clear recommendations, as well as prompting new ways to address common issues.

5.3. Design and methods

The evaluation uses a mixed methods approach and relies on the qualitative comparative analysis, and on the quantitative and qualitative data based on documentary reviews and existing monitoring systems, including Humanitarian Performance Monitoring (HPM) indicators, consultations with key stakeholders using survey and key informant interviews (KII), and focus group discussions (FGD) with rights holders.

A theory-based approach was constructed through the formulation of a number of hypotheses and assumptions as per the ToC proposed. A counterfactual analysis is not applicable in this case as under a Real Time approach the arrangement of a control group is not possible.

The field phase was done mainly remotely. This entailed adapting data collection protocols for semi-structured questionnaires and a survey. The team used a variety of tools to collect data remotely in the field. (See annexes 2 to 8 for guides and consent forms.) The ET also relied on data from tools and mechanisms developed by UNICEF in the framework of Communicating with Communities (CwC) and Accountability to Affected Populations (AAP) that are in place and provide access to groups of beneficiaries, such as U-Report data. In addition, the following evaluation tools were used:

- Desk review of analysis planning and programming documents, UNICEF's SitReps, partner's progress reports, PCAs, U-Report data, as well as other reports and relevant sources identified by the team and UNICEF. The team developed a stakeholder map to highlight intersections where collaboration and partnership enables a connected and adapted response, and where synergies were explored through UNICEF initiatives.
- Self-assessment questionnaire: a survey was distributed to UNICEF MCO staff. The survey provides some quantitative elements, although they are limited due to the response rate, with the possibility to capture qualitative judgments. (See annex 9 for survey analysis.)
- KII: the evaluation was mainly based on interviews amongst distinct groups using semi-structured interview protocols to ensure that collected data was consistent and could be easily validated. The team developed protocols with different question sets for different types of interviewees. The team focused on five main groups of interest: (i) UNICEF staff at country and regional levels, (ii) partners and implementing partners, (iii) Malawi government representatives, (iv) development and humanitarian partners and other UN agencies, and (v) donors.

- Telephone interviews: the team also relied on telephone interviews with COVID-19 district focal points in 11 intervention districts. This allowed the local team led by the national consultant to gather district, decentralized information on the COVID-19 response, what worked and what didn't. The field team called local district officials, with contact information provided by UNICEF MCO, allowing for language and culturally sensitive data collection.
- FGD: the situation in Malawi allowed for the local evaluation team to conduct in-person FGD in November. The team focused on 12 UNICEF intervention districts. The purpose of the FGD is to enhance understanding of the views and experiences of rights holders. See table 6 in Phases of the evaluation for a summary of FGD carried out and annex 10 for a complete list and FGD composition.

Analysis and synthesis:

- Contribution analysis: this was used to determine the extent to which the response contributed to the objectives (to prevent and control infections, ensure continuity of education, promote positive behaviours preventing transmission and ensuring protection of children rights, especially of the most vulnerable) and what course corrections need to be made.
- Information management analysis: the ET carried out an analysis of UNICEF processes and protocols regarding management and use of information related to the COVID-19 response, particularly in the areas of health, education, CP and social protection, WASH, nutrition, C4D and RCCE.
- Data synthesis: from the analysis of collected data a body of evidence was constructed and validated to reach solid conclusions. The ET coded all data obtained in the form of findings related to the EQ in an 'evidence matrix' to identify response categories, emergent themes, and contextual factors. All data has been disaggregated by location and activity sector to capture differing perspectives or experiences among the groups and compare stakeholder perceptions.
- Triangulation: the team triangulated the data to ensure a reasonable level of convergence across different data sets to fully demonstrate a conclusion. Information was shared with the MCO during the process, in the form of a progress report, to ensure a real time participatory approach and to further triangulate. The following approach has been put into practice:
  - Source triangulation: the team compared information from different sources, for example, perspectives from different stakeholder groups and documentation.
  - Methods triangulation: the team compared the information collected by different methods, for example, interviews, document review and focus groups.
  - Researcher triangulation: the team compared the information collected by the different researchers.
  - Geographic triangulation: the team compared information gathered from different parts of the country to ensure differentiation between results that can be generalized and results that are limited to a particular context.

Sampling and data sources

The main target groups which were used to capture information were UNICEF MCO staff, UNICEF RO focal points for the RTA, IP staff, rights holders from selected districts (men, women and youth above 18 years old), GoM officials, including district authorities related to the response, UN agencies, the RCO's office and donor representatives.

Gender sensitivity has been applied when selecting data sources with due consideration to the local context and in consultation with implementing organizations with first-hand knowledge about local conditions. For an adequate gender perspective, the evaluation ensured that the analysis used sex and age disaggregated data whenever possible.

The ET, with the support of the MCO, has jointly defined the most appropriate approach for each case: a purposive sampling method has been used for all data collection. Purposive sampling was also used when setting up discussion groups of targeted rights holders, where the team relied on community committees and youth clubs in the selected districts.

As most of the data collection was done remotely, location sites were only selected for FGD. For the sampling, from the initial 28 districts that were stated in UNICEF planning documents, the ET retained the 12 districts that were prioritized in the second phase of the response financed by FCDO. The team selected two sites in every region (South, Central and North), to have a total of six districts where FDG was carried out. The field team selected participants amongst the village committees and youth clubs to obtain a homogenous group in age, gender, and socio-economic levels. The team established several FGDs per district visited. Inclusion criteria were established in two age group levels: 18 to 25 as "young" and 25 to 70 as "adults." Information on ethnicity and religious beliefs was also captured but no segmentation was adopted based on those criteria.

Stakeholder participation

The evaluation sought to exchange with a variety of stakeholders to ensure different perspectives were gathered. Specifically, the ET engaged with the following stakeholders:

- UNICEF MCO: all UNICEF operational and programmatic staff were contacted through KII and/or the survey.
- UNICEF RO: the regional office was contacted through KII to gather their perspective and understand how the RTA and the RTE could complement each other.
- Implementing Partners: IPs were contacted through KII. Their insights were critical to gather a field perspective and to assess how the work of UNICEF Malawi and its partners are contributing to address the challenges of the pandemic.
- UN agencies: the ET selected two UN agencies that worked directly with UNICEF-channelled funds on the COVID-19 response. The ET spoke with WHO and UNFPA to better understand how potential partnerships worked during the response.
- Duty bearers: (GoM): the two main counterparts were contacted to request KII: MoHP and DoDMA, and a meeting was arranged with DoDMA and with UNICEF supported staff at MoHP. (District authorities): local authorities were contacted through telephone interviews by the ET national team member.
- Rights holders: FGDs were organized in 12 districts with different groups, such as men, women, young adults 18-25. The ET selected these groups and districts to promote participation.

UNICEF MCO put together an Evaluation Reference Group to participate in the feedback mechanism and comments loop to validate the deliverables. The findings, conclusions and recommendations included in this report have been developed with the participation and contribution of the above-mentioned stakeholders.

6. Phases of the evaluation

While most of the data collection has been remote due to COVID-19 travel restrictions, the ET attempted continuous engagement with stakeholders to capture feedback throughout different phases. These include the inception data collection and analysis, reporting and dissemination phases.

The inception phase, which started 2 September, included a desk review of relevant documents shared by UNICEF MCO and documents found by the ET (see annex 11 for bibliography.) The team also conducted 21 KII with key MCO staff to better develop a stakeholder consultation strategy. This phase was completed by 28 September with the validation of the inception report. The report was also submitted and validated by the Ethical Review Board (ERB) (see annex 13 for certificate of approval.)

The data collection phase was split into four iterations, commencing 1 October and ending 27 November: (i) desk review and secondary data analysis, (ii) remote key informant interviews with key stakeholders (UNICEF MCO and RO staff, IP, donors, Malawi government officials- see annex 12), (iii) survey sent out to operational and programmatic MCO staff (see annex 9 for survey analysis), and (iv) field data collection through FGD and telephone interviews with local district authorities (see annex 10 on the FGD report). In tables 5 and 6 below we offer a summary of people met and districts visited.

Table 5. Summary of People met

Organization	Gender	Total
UNICEF MCO	15 F, 18 M	33
UNICEF RO	2, F, 1 M	3
UNHCT	2 M	2
UNFPA	2 F	2
WHO	1 F	1
Government (MoHP, DoDMA)	1 F, 1 M	2
District authorities (DEHO, DHO)	3 F, 10 M	13
FCDO (DFID)	1 M	1
CHAI	1 M	1
Luke International	1 M	1
DCT	1 F, 1 M	2
Malawi Red Cross	1 M	1
Save the Children	1 F	1
MIJ	2 M	2
United Purpose	1 F	1
Yoneco	2 M	2
Pachi	1 F, 1 M	2
Segal Family Foundation	1 F	1
Total	**29 F, 42 M**	**71**

Table 6. Summary of FGD disaggregation

District/ FGD	Participants by gender
Kasungu, 4FGD	16 F, 16M
Chitipa, 4 FGD	16 F, 16M
Chiradzulo, 4 FGD	16 F, 16M
Ntchisi, 4 FGD	16 F, 16M
Phalombe, 4 FGD	16 F, 16M
Rumphi, 4 FGD	16 F, 16M
TOTAL	**192 (96 F, 96 M)**

Continuous reporting and feedback as envisaged in the RTE has been addressed through a number of reports: the ET submitted a progress report on 6 November with some initial analysis and preliminary conclusions. This served as the basis for initial feedback from UNICEF to further develop the Evaluation Report. The Progress Report was also shared with the ERG and RO for a transparent and participatory process. A draft report was shared with the MCO and the RO on 27 November, and feedback received was incorporated into a revised version submitted on 22 December.

The final dissemination phase is expected to be completed by a presentation of the main findings and recommendations and further dissemination activities as judged pertinent by the MCO.

7. Ethical approach

The inception report, which included a detailed methodology, sampling, and data collection tools, were approved by the Ethical Review Board (ERB) (see document attached in annex 13). Ethical considerations related to the local context, health and sanitary precautions, confidentiality and anonymity, voluntary participation, and "do no harm" were respected in all phases of this evaluation. The team also committed to incorporate an inclusive approach, ensuring access and participation of women and hard-to-reach communities with a respect for cultural norms.

The evaluation follows and abides by the ethical code of conduct for research and evaluation in the UN system as postulated by UNEG.[38] This includes the independence of the consultants, the anonymity and confidentiality of individual participants in the evaluation, sensitivity to social and cultural contexts and monitoring integrity and honesty in relations with all stakeholders. Verbal consent for participation in the study has been obtained from all participants.

[38] UNEG. April 2005. *Standards for Evaluation in the UN System*; UNEG. April 2005. *Norms for Evaluation in the UN System*; UNEG. March 2008. *UNEG Code of Conduct for Evaluation in the UN System*

The members of the evaluation team have received the appropriate training on the responsibilities and obligations for PSEA and safeguarding of children.[39]

The evaluation team was diligent in maintaining their independence, not challenging or offering their opinion on any matter. In all interactions and tools developed, the ET maintained its independence and impartiality.

All team members declare not having conflicts of interest in this evaluation or with any actors involved. Lastly, all evaluators were requested to sign DARA's Code of Conduct (see annex 14), which details the key principles for all evaluations including independence, impartiality, conflict of interest, honesty and integrity, confidentiality, do no harm, etc.

8. Limitations

In addition to the limitations regarding access to information, availability of stakeholders, and attribution/contribution of UNICEF interventions, some additional risks worth noting include:

Table 7. Risks and Mitigations

Risk	Mitigation measure
Limited availability of GoM officials	It became challenging to arrange distant meetings with GoM officials from different ministries. This has been addressed through indirect information from other sources and through access to District health officials during the field phase. Triangulation from different sources allows the ET to ensure that eventual information gaps have been addressed.
Internal IMS not accessible for external consultants	During the evaluation period the ET experienced difficulties in accessing internal information systems of UNICEF related interventions. Thus, KPI of the activities and outputs foreseen in the RP do not seem easily available. This has been managed through access to partners and donor reports, where this information is partially consolidated, and also counting on the collaboration of MCO M&E and PPM sections to navigate the restricted access.
Survey fatigue	The team noted some evaluation fatigue due to multiple ongoing processes in the country, notably the MTR, RTE and RTA. The ET tried to be mindful when requesting information and interviews. The ET also adapted its survey after receiving the RTA survey, to not duplicate questions. All tools included an opt-out option for all stakeholders, to avoid over-burdening them.
Delayed timeline of the evaluation	The timeline of the RTE was delayed due to contractual challenges, but an open communication between the ET, DARA's EM and UNICEF EM allowed for quick adaptation and response. New dates and deadlines were established in accordance with UNICEF's request, and the final products will be provided according to the deadlines foreseen.
Ethical Risks	The evaluation team submitted its Inception Report to the Ethical Review Board to ensure all ethical considerations were followed in the methodology, sampling and data collection tools.
COVID-19 related travel restrictions	Due to the outbreak of COVID-19, which has implications to travel at the global level with increasing travel bans, the ET mostly used remote data collection measures, where possible. After assessing the situation in Malawi in November, the local team was able to collect data at district level through phone interviews and FGD.
Potential bias	To mitigate any potential bias, the team consulted various key stakeholders from different cohorts: UNICEF staff, Government officials, rights holders, IP. Furthermore, all findings were triangulated to ensure that these were not the result of bias from either the key stakeholders or the evaluators.

[39] Certificate of completion of the UNICEF course on PSEA (agora Platform)

9. Findings

The ET proposes to articulate findings as per criteria and follow the EQ as in the evaluation matrix.

9.1. Appropriateness

The evidence collected supports the belief that UNICEF's response was appropriate. Initial uncertainty about the evolution of the pandemic fully justifies UNICEF's swift engagement in the response, and the focus on specific aspects of health system support and RCCE. The MCO has a duty to respond to different types of natural and manmade disasters, and has established a strong preparedness culture, with contingency plans frequently updated to be ready to respond. While COVID-19 was unexpected, the preparedness and contingency established were key elements for facilitating a swift response.

UNICEF supports the GoM commitment to respect, protect and fulfil children's rights in line with international conventions and standards.[40] This is currently framed in the Country Programme Document (CPD) 2019-2023, focusing on the life cycle approach and sector integration through thematic pillars arrangements.[41] UNICEF also supports GoM mechanisms to respond to emergencies, providing capacity building services to DoDMA and supporting the contingency plans elaborated by the government for different scenarios.

The RP was defined clearly in line with the GoM plan. In fact, the evidence collected supports that view UNICEF was instrumental in facilitating the outline of the GoM RP through adequate technical and strategic support. The UNICEF Preparedness and Response Plan is also in complete alignment with the overarching UNICEF corporate global response to COVID-19, thanks to RO and HQ guidance.

Since the onset of the emergency, the MCO worked closely with the government and WHO (the designated UN agency leading COVID-19 preparedness and response) to support the government in developing and implementing its COVID-19 preparedness and response plan. Key UNICEF staff from programme sections were mobilized to provide appropriate support. UNICEF activated the internal incident management team through the leadership of the Health section and engaged in the National Emergency Operation Center (NEOC) created to align and coordinate public health response. DoDMA and the Presidential Task Force eventually activated the cluster system, where UNICEF is leading fours clusters: Education, Protection, WASH and Nutrition.

The above is an example of best practice which should be noted, as UNICEF avoided the creation of parallel systems in the response effort, establishing mechanisms for an integrated and coordinated response that would eventually allow for system strengthening and support. This supports the assumption in the TOC proposed.

The MCO quickly reprogrammed funding of the CP to address the initial COVID-19 response and prepositioned supplies, although limited, allowed for initial distribution of PPE and WASH-related supplies that largely supported the leadership of UNICEF.

Regarding adaptation to changing needs, the MCO has been able to adapt to the evolution of the situation. For instance, focusing on PoE by addressing WASH, Protection and Health system capacity in those areas and eventually ensuring extension to other priority districts. This is the result of a combination of adapting to the situation on the ground and to the funding availability (see later in Coverage).

Despite challenges in getting needs information from the field, the MCO managed to establish some valid feedback mechanisms, allowing for adaptation of the response and identification of gaps. Examples include U-Report, the RO quarterly tracker of CP issues, and the Humanitarian Monitoring tracking dashboard.

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[40] https://www.unicef.org/malawi/what-we-do

[41] The CPD establishes a life cycle approach form early childhood (pillar 1) through school age (pillar 2) and though child friendly and inclusive communities (pillar 3), with pillar 4 aiming at ensuring programme effectiveness

The MCO has established appropriate internal mechanisms to integrate AAP in all programmatic interventions related to COVID-19, a specific strategy linking accountability to affected populations (AAP) and C4D has been outlined, and attempts to monitor constraints to critical services has been established.

Further supporting the appropriateness of the response is the integrated pillar approach that UNICEF has consolidated in the CPD and formulates in the COVID-19 response. In this sense, establishing WASH in schools and health facilities, promoting CP and C4D in health and education contexts, including nutrition and CP, and also engaging in RCCE through all UNICEF areas of activity provides added value. Caveats on lack of funding for this integrated approach have been identified and may become a lesson learned.

The MCO has highlighted the importance of gender and human rights in the formulation of the COVID-19 response, quite explicitly in the funding proposals to FCDO and in all PCA with IP. Awareness of gender-related issues and PSEA is adequately integrated across the response and support has been provided to all clusters to ensure a gender-sensitive perspective in the COVID-19 response. This is captured in the survey and praised by informants as an example of good practice.

Appropriateness: Key Strengths
Culture of preparedness and contingency planning: early formulation of Response Plan for COVID-19
Focus to strengthen health system, capacity building
Principled formulation (public health, RCCE, continuity of care, vulnerability, gender, CwD)
Swift reprogramming to support initial response; Capacity to mobilize prepositioned supplies to initiate response
Integrated pillar approach; Gender and PSEA dimension in the response

Challenges

Malawi enjoyed the benefit of a very gradual growth of the pandemic in its territory which allowed for stakeholders to establish a response over time, but delays have affected UNICEF response. While the UNICEF RP was formulated by the end of March 2020,[42] the actual roll-out of the response was delayed by contextual factors (such as the bottlenecks in global supply chains of medical materials, limited capacity of available implementing partners) and by the shortage of available funding.

Despite its comprehensive nature and the adequate integration of the different components, the UNICEF RP is of a short-term nature, and essentially reactive. It does not entail the likelihood of a protracted situation, not foreseen in the scenarios: COVID is here to stay. The RP would have benefitted from more structured planning over time (the time dimension is not clearly formulated). In this sense it is becoming clear that key aspects of interest for UNICEF have been side-lined, to some extent, for the benefit of a public health focus that, while justified by the nature of the pandemic and the prevailing uncertainty on its evolution, has limited scope. The issue here may be, from the perspective of time given the evolution of incidence and mortality of COVID-19 in Malawi, to judge how appropriate it is to prioritize IPC response in a situation that eventually would have limited impact on children, while mortality causes for children in Malawi are prevalent for other conditions (see Context). As one respondent of the survey highlights: *"from a programmatic perspective, the response should have been centred towards children, or at least explicitly show why and how the response will benefit children"*.

Further to the above, a number of issues have been only partially addressed in the COVID-19 planning process and, while most informants have mentioned lack of resources as the main reason for this limited strategizing on them, structural limitations also play a substantial role:

- Issues of continuity of care on MNCH, immunization, nutrition monitoring and PMCT.
- Issues of access to distance learning.
- Issues of protection: GBV, domestic violence, early marriages, teen pregnancies.
- Issues of socio-economic impact (ultra-poor.)

On AAP, issues remain on the limited capacity to engage communities during the COVID-19 outbreak in Malawi, due to movement restrictions for UNICEF staff and IPs and the limited "closing the feedback loop"

[42] UNICEF proposed already the 2nd of March a Response Plan to DFIDFCDO.

achieved (see effectiveness). This affects one of the major determinants of appropriateness, that is, community engagement and participation over time.

Appropriateness: Key Challenges
UNICEF Response Plan is of a short-term nature, and essentially reactive;
Limited capacity of the health system to absorb external support
Challenges in the programming of continuity of care, distance education, protection, and socioeconomic impact
Delays in the operationalization of the response; Limited access to global supplies
AAP established, but constraints prevail due to COVID 19 limitations

9.2. Coverage

From the RP: "*UNICEF is targeting up to 4.6 million children with preparedness and response activities*". We assume this number is related to the number of learners in districts prioritized by UNICEF: "*In total, UNICEF will target 21 districts with all or some of the interventions in the four strategic areas of UNICEF response […] However, the C4D interventions will target all the 28 districts of the country through radio spots and jingles and other mass media approaches*".

Table 8. Priority districts for UNICEF

Region	District
South	Mangochi, Neno, Nsanje, Chiradzulu, Thyolo, Phalombe, Chikwawa, Machinga, and Zomba
Central	Lilongwe, Michinji, Dedza, Dowa, Ntchisi, and Kasungu
North	Karonga, Mzuzu, Rumphi, Likoma, Mzimba N, and Chitipa

Source: UNICEF Malawi revised response plan

The table above is from the RP document. Over the course of implementation, UNICEF adapted to different coverage patterns: from initial high-risk districts to additional ones to roll out the response. In this sense adaptations in coverage were adopted jointly with donors and clusters, and geographical targets changed accordingly. For instance, Blantyre, Lilongwe, Mzuzu, Michinji, Mwanza, Dedza, Dowa, Karonga and Zomba were retained initially as priority districts, while Rumphi, Ntchisi, Likoma, Neno, Nsanje, Mzimba N, Chiradzulu, Thyolo, Phalombe, Chitipa, Kasungu, and Chikwawa are prioritized in the second phase (funded by FCDO). Not all activities are implemented in the priority districts, and emphasis is made in those that have PoE to Malawi (Chitipa, Thyolo, Nsanje, and Chikwawa); Kanonga and Mangochi were also covered through Government of Ireland funding.

In terms of supporting the health system and public health capacities through supplies (lab testing, PPE), the MCO's response is essentially directed to benefit all populations, and this extends to RCCE (messages and community engagement). The Education response (support for remote learning, assistance to the MoEST) extends throughout the country. Moreover, the RP is very explicit in its intention to cover vulnerable groups, and the gender and human rights dimension and attention to CwD are mentioned in all programmatic documents, PCAs and even in the funding proposal to FCDO. Being aware, as stated in the RP narrative, that children, women, disadvantaged and CwD would be at higher risk due to COVID-19, some analysis and specific strategies for coverage on these issues are missing.[43]

In UNICEF's priority districts, CP issues are mainstreamed, as well as social accountability mechanisms at district level. The evolving situation advised to redirect the focus of public health and WASH response to the PoE, where returnees went through a fragile situation in terms of quality of existing facilities, IPC and testing capacity, and accommodation and transport.

To be noted that UNICEF supported the continuation of parliamentary works, providing logistical and analytical support to Malawi's Parliament during the passing of two budget proposals (June and September) to ensure safety, hygiene and distancing measures were respected and that budget clusters had all the necessary information on the tabled budget documents. This support can be considered as of

[43] UN: sg_policy_brief_on_persons_with_disabilities_final

national coverage. UNICEF also supports the COVID- 19 Cash Initiative, covering 4 cities: Lilongwe, Blantyre, Mzuzu and Zomba.

UNICEF has been supporting local governance instruments in all districts, including feedback mechanisms. An integrated local governance support, including financial and budgetary technical assistance, is being piloted in two districts (Chikwawa and Nsanje), in the context of a decentralization policy in place that has created some problems of capacity at district level. Expanding coverage of this support to other districts will contribute to consolidating the decentralization process.

Coverage: Key Strengths
Wide geographical coverage, prioritization of districts helps to focus on the context of a coordinated response
Coverage of PoE with support to refurbish facilities and testing capacity
Public Health Measures and RCCE aiming at extended coverage
Local Governance support in some districts, potentially a driver for change if expanded

Challenges

Documents and data gathered through KII show that UNICEF coverage in urban areas is not well established for the most vulnerable. There is limited coverage of street children by the UNICEF programme. Only a limited number of children have been targeted and the size of the problem is not well characterized in the COVID-19 context. It is noted that other partners focus on CP issues for this vulnerable group.

Different geographical coverage by different activities (health versus RCCE and WASH) may decrease the synergies that could be obtained by an integrated response.

Systemic coverage (health system, including borders and PoE) versus targeted (vulnerabilities) is not always well balanced and raises issues of lack of access to UNICEF supported services: MCNH, immunization, nutrition. The response has been generic and has not addressed specific vulnerabilities in the districts targeted (survey respondent: "*Not really adapted to specific contexts, as the response has been generic").* The coverage of the needs of refugees going to Dowa refugee camp has been limited, according to some informants.[44]

The situation in rural areas, with limited connectivity, lack of power supply and poor access to radio airing[45] has affected coverage of RCCE and of distance education support. This limitation of coverage applies as well to women, as gender determinants in Malawi can limit access on a gender basis.[46] This connectivity limitation has also widely affected feedback mechanisms, as most of these rely on SMS or internet feedback.

People with disabilities are challenging to address due the lack of available monitoring data. The dimension of disabilities in Malawi is well known (about 10 per cent of the population over 5 years old suffer some disability).[47] Addressing the specific needs of PwD in the COVID response is a gap across all the responses highlighted by informants and FGD participants (FGD participants highlight the situation of deaf and blind persons being unable to understand COVID-19 messages on awareness and prevention). IP reports show limited data on CwD. In some cases (programmatic documents, cluster response plans), CwD is mentioned as targets in the outcomes and is quite relevant in the narrative, but indicators capturing achievement of results related to CwD are absent, and IP reports rarely offer data on CwD.[48]

For some respondents there is a need to establish vulnerability identification mechanisms at the community level: "*Targeting can be further improved through in-depth consultation and coordination with*

[44] Refugees from DRC are mainly under the mandate of UNHCR. It is not yet clear for the RTE how the needs of women and children have been covered, as UNICEF in Dowa has focused on C4D for COVID-19.

[45] In Malawi, around 13% of the population has access to electricity, and 33% possess radio appliances: from Government of Malawi: 2018 Malawi population and housing census, main report

[46] Rapid Gender Assessment CARE Malawi

[47] Government of Malawi: 2018 Malawi population and housing census, main report

[48] To be noted in the last SitRep (December 2) UNICEF reports the distribution by PACHI of Braille materials to 1000 pupils with disabilities. This implies willingness to address the gap, but the overall judgement of the challenges identified is still valid

decentralized authorities and communities, which can be difficult during rapid response". The need to consolidate such mechanisms before emergencies strike is a lesson to be retained.

Coverage Key Challenges
Gaps in coverage of CwD and lack of strategies for PWD
Limited specific strategies for coverage of vulnerable groups
Uneven integrated geographical coverage of some activities
Structural limitations (power, access to radio, access to internet)

9.3. Efficiency

The MCO developed response capacity through its experience with previous emergencies, with annual exercises of contingency planning and preparedness have been carried out since 2016. An interdisciplinary core emergency team is established in case of urgent events and builds an incident team based on the nature of the emergency. The current incident leader for the COVID-19 response is the Deputy Representative and the incident manager is the Health & HIV section chief. The Health and HIV section was reorganized accordingly and arranged around three programmatic delivery areas in order to ensure the adequate emergency response, routine programming and service continuity.[49] This arrangement is highlighted as an example of good practice.

Contingency planning allowed for preparedness ahead of time; the annual contingency planning exercise of November 2019 allowed for some prepositioning of WASH supplies and some PPEs, undoubtedly providing efficiency gains. MCO arranged already in January an internal process to analyse 2020 activities and plans based on criticality. This, coupled with the concept of the CPD and how the different sections in pillars were integrated over the lifecycle of children, potentially helped to efficiently align a multifaceted response to a complex and unprecedented situation. This is an example of good practice.

The RP was formulated in a timely manner, before the first confirmed cases in Malawi. Cluster activation was also timely, with early activation at central level, and SOP available already at the end of March.

From the information provided, UNICEF has been able to utilize efficiently the funds received, through allocations for procurement and IP PCAs. The use of funds for coordination is judged as cost-effective and the support to MoHP and MoEST managed to obtain results with limited funding. UNICEF has established synergies between sections, especially in integrating WASH with health and education, CP across all sectors and RCCE as a key component for all elements of the response (COVID-19 RCCE in health, in education, in WASH, and in CP). However, the lack of a results framework including resources (inputs) does not allow for a precise assessment of use of resources per area of activity (not in the scope of a RTE in any case, as the operation is ongoing). The judgment of the ET, however, is that some opportunities for a more integrated arrangement were affected by the limited and earmarked funding received.

Funding has been a challenge for COVID-19 response. In fact, information collected indicates that additional funds were not initially made available. Usual UNICEF donors (FCDO, Ireland, Germany, and Norway) managed to support UNICEF from already programmed funds. Some informants indicate that donor coordination could have been better, and this prevented a more integrated funding allocation, aligned with RP. The following table has been extracted from the Tracking system of the Flash appeal; no additional information has been facilitated by UNICE other than the one included in the sitreps (table 1)

[49] MALAWI COUNTRY OFFICE: HEALTH & HIV SECTION: MAY-AUGUST 2020; TEAM REORGANISATION FOR EFFECTIVE COVID-19 RESPONSE

Table 9. UNICEF funding for COVID-19 Response

Donor	Amounts USD
FCDO	9,682,596
GAVI	4,105,270
Germany	4,079,141
Norway	1,235,000
Government of Ireland	640,332
ECW	295,000[50]
GPE	10,000,000

Source: Malawi Emergency Appeal, Financial Tracking (August 18, 2020) at *https://app.powerbi.com/*

FCDO provided financial support in two phases, initially through an urgent reallocation of contingency funds (GBP 1.8 million) and from June 2020, funded a wider intervention with an additional GBP 6 million.

In the context of limited funding, UNICEF managed initially to re-programme funds to be able to provide assistance. Information provided shows that more than US$600,000 was reprogrammed from the regular programme to support the COVID-19 response. In UNICEF, donors found the best partner due to capacity, experience, technical expertise, and reputation to channel additional funds for a swift response. Funds were allocated by donors mainly for supplies for the health system and to support the public health capacity to respond to direct consequences of potential need of IPC, especially at PoE. UNICEF's Education section was able to reprogramme funds from an ECW-supported floods recovery project and mobilize additional funding from ECW (US$200,000 from the First Emergency Response (FER) mechanism) and GPE (US$10 million from May 2020 to November 2021). Informants sustain the finding that UNICEF made an efficient use of limited funding with outstanding performance, although donor influence limited somewhat the multifaceted approach foreseen in the RP, with several sections receiving no funds and others under-funded.

UNICEF has been able to cover activities related to WASH and complement RCCE through the funds raised for the public health response and engaged in innovation especially for surveillance and information systems. Innovation is part of the integrated approach of the CP and it has been a key aspect of the COVID-19 response.

The MCO mobilized partners to implement activities in the field. Most of them were partners already engaged with development and C4D activities that had to switch to emergency activities. The Malawi Red Cross Society (MRCS) has been particularly instrumental in providing capacity of response at PoE. A combination of CSOs and local contractors were efficiently utilized. In particular, engagement of local contractors for rehabilitation of ETUs, to provide locally produced EPIs and to ensure the necessary infrastructure for the oxygen plant are highlighted. However, they all experienced constraints in terms of being able to deliver on time. A tentative list of IP funding is offered below:

[50] This figure does not match the documented contribution of 200,000 USD from ECW to UNICEF nor the reprogramming of the ECW funded Malawi floods emergency and recovery project.

Table 10. Funds allocations from Government of Ireland and FCDO for UNICEF COVID-19 response

Donor	Amount	Partner	Activity
Government of Ireland (€)			
	€ 168,904	UNICEF Overhead, assessment, coord.	Supplies, admin, coord.
	€ 227,388	MRCS	Health
	€ 37,037	Private Contractor for ETUs	Health/Wash
	€ 66,666	SWET	RCCE
FCDO (DFID1) (GBP)			
	£ 442,826	UNICEF: assessment, nat. cluster coord.	Supplies, admin, coord.
	£ 483,924	supply chain	Supplies
	£ 408,100	MRC	Health
	£ 73,100	UP	WASH
	£ 261,800	Private Contractor	WASH
	£ 49,280	MIJ	RCCE
	£ 39,053	SWET	RCCE
	£ 46,200	DCT	RCCE
FCDO (DFID2) (GBP)			
	£ 2,085,280	UNICEF supply chain division	supplies
	£ 796,313	CHAI	Health
	£ 132,400	UP	WASH
	£ 40,103	MIJ	RCCE
	£ 47,877	swet	RCCE
	£ 40,103	DCT	RCCE
	£ 115,500	PACHI	RCCE
	£ 660,968	Oxygen plant	Health
	£ 223,125	WHO	Health
	£ 165,550	UNFPA	Health
	£ 172,480	community masks producers	Health
	£ 26,433	ADDA	Innovation
	£ 39,694	Copper Smith	Innovation/health
	£ 154,193	LIKA	Innovation/health
	£ 229,922	LIN	Innovation/health

Source: MCO chart on funding flows from FCDO and Government of Ireland

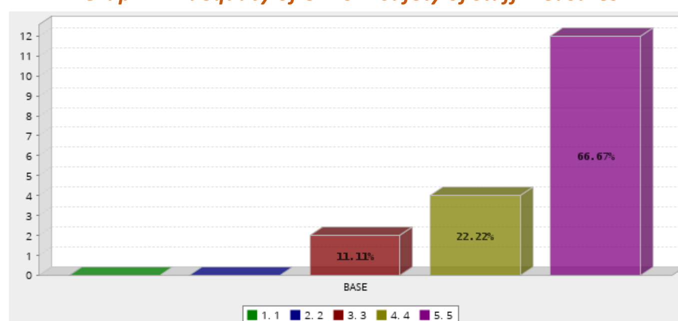
UNICEF HQs declared an L3 emergency on 20 April. A declaration usually allows for a speedy mobilization of human resources, partnership agreements and logistics (supplies). In fact, from information gathered, the L3 has not meant a significant change for the Malawi CO. Supply chain and procurement have been mainly aligned to global practices (supply portal), but information collected by the ET supports the finding that procedures for local procurement was facilitated by the corporate easing of usual requirements.

The management of some contracts with IPs have been challenging at times, involving cumbersome internal processes. Some informants highlight delays in cash transactions with partners, for example. The delays identified in some processes are not always attributable to contextual factors and informants and survey respondents report that more could have been done to take advantage of the L3-related facilitation of procedures: *"I think we could do better […] the lagging processes make it difficult to achieve our goals. There definitely needs to be eased processes during such situations"* (from the survey).

Regarding HR, the information obtained does not provide evidence of significant problems in mobilizing staff to face the operational challenges, although new staff mobilization was achieved quite late in the response. Limitations on mobility and uncertainty on the evolution of the pandemic affected the decisions to mobilize staff to the field globally. There were no requests for fast-track procedures, and no surge staff or standby partners were mobilized. The MCO supported recruitment of dedicated cluster coordinators for the response. In addition, a public health officer and a communications officer were appointed to the Public Health Institute of Malawi and Health Education Services of the MoHP.

Staff wellbeing: The situation created by COVID-19 led to measures in order to protect staff and those working in remote locations. Survey respondents strongly support the adequacy of the measures taken. The answers to the question: "*Were UNICEF measures to contain transmission in the workplace and the interactions with staff and partners adequate?*" were highly positive:

Graph 1. Adequacy of UNICEF safety of staff measures

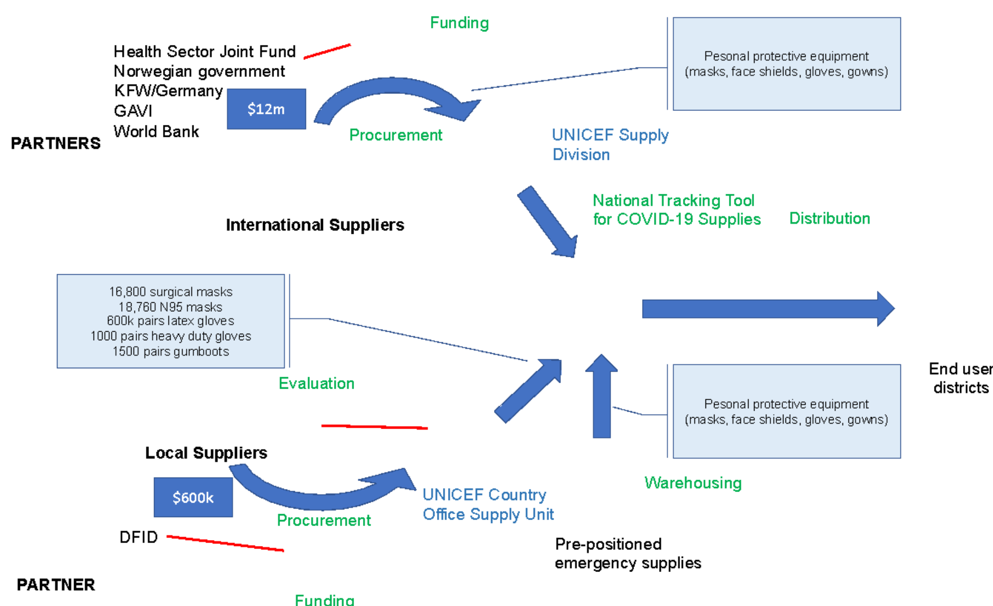


Source: DARA survey to UNICEF MCO staff (see annex 9)

Further to this, different committees monitored staff wellbeing and psychosocial support. The work done by MCO to protect staff during the outbreak appear to be an example of best practice and should be shared at regional level to build on lessons learned by the Malawi team. Also to be highlighted is the high level of motivation and engagement shown by all MCO staff during the COVID-19 response

On supplies, UNICEF became the host of the supply portal, serving all partners in Malawi, providing support, coordination, and a very efficient means to request, procure and follow up on supplies. This is retained as a good practice by all stakeholders. While delays have been noted (see below in challenges), all sections rate very positively the performance of the supplies unit that have procured what was needed to carry out response activities. The shift to establish local procurement for some of the materials needed (PPE, education) is potentially an example of cost-effectiveness[51] and is judged as good practice.

Figure 5. UNICEF Role to the Procurement of COVID-19 Supply



Source: Summary of Lessons Learned, UNICEF Malawi

Monitoring: Reliable data soon became one of the major challenges according to the informants consulted. It also affected proper planning of programming and slowed the delivery of supplies, as it took additional time to build an understanding of the situation in the field. In addition, due to movement restrictions and limitations, UNICEF's technical and programme staff had to rely on IPs and district reports to get data and information on the progress and effectiveness of the response. The lack of field presence is highlighted as one of the main limitations UNICEF has faced to adequately tackle the situation in the field. IPs were requested to produce additional information and photos to enrich the information available. This

[51] This RTE could not carry out a cost analysis due to data access and scope limitations (on going operation), but evidence of cost effectiveness is highlighted: synergies between sections and local procurement amplified the results achieved with limited funding

situation led UNICEF to strengthen innovative solutions. This should be further developed and incorporated in future plans to ensure sustainability and long-term solutions.

It must be highlighted that UNICEF internal information systems have a number of functions to capture the progress of the different programmatic areas, and the ET has to commend the comprehensiveness of the different tools accessed. The outstanding utility that captures age and gender disaggregation is also to be commended.[52] This is not always transferred to the externally accessible information documents.

Established platforms to capture and share feedback, such as U-Report, SMS and the Humanitarian Field Monitoring Dashboard, became a reference. The extension of e-surveillance to additional districts, and the support to districts for eIDSR within, is also retained as lessons to build on.

On Communications, UNICEF worked successfully with partners and media to generate compelling stories, which have a crucial role in fundraising and advocacy on the impact of COVID-19 on children and families.

Innovation: it should be noted that UNICEF has created a culture of innovation across all sections, integrated in the different pillars of the CP. The COVID-19 response has strengthened the relevance of innovative approaches and has become an opportunity to develop tools and pilot them. The m-quarantine, SMS messaging, Laboratory Information Management Systems (LIMS), DHIS2 and different e-surveillance modalities are examples of dynamic approaches. The Humanitarian Field Monitoring Dashboard is a good example of integrating information in real time. The caveat is that most innovative solutions require time to consolidate and integrate systematically, rather than being novel attempts. And actually capturing of data from some districts has been challenging. But the situation created by COVID-19 is an opportunity to identify solutions in which to invest going forward.

The survey supports the relevance of innovative approaches in all sections, the only exception being the drone initiative, which is rated low, in coherence with some information from interviews.

Efficiency Key Strengths
Preparedness and contingency planning
Timeliness of the planning process for COVID-19 RP
Activation of Incident response team, arrangements of the health section
Supply portal
Culture of innovation, and innovative solutions applied
Staff wellbeing arrangements, and staff engagement

Challenges

UNICEF had to adapt its RP to the funding provided and even though this was done efficiently, it limited the scope UNICEF's response.

Delays at different levels are identified across the board, with some examples worth highlighting: while the RP dates from March, and the peak of cases happened in June, the ETUs assessments took place in July (*CHAI progress report*), and their rehabilitation is yet to be completed in some cases (October 2020). The "*Lab and health facility assessment*" is dated 31 July, a tool that was instrumental to address gaps and needs on equipment. Most of the supply funded by FCDO *"could not be in the country by the end of August as had initially been envisaged."*[53] The oxygen plant will become a milestone in terms of improving capacity of the health system but was only completed in November; LIMS connectivity is just now, in November, being extended and tablets distributed.

The evaluation identifies some bottlenecks explain these issues but further analysis of internal procedures is required. For example, the lack of clarity on donor availability until June delayed commitments; the mobilization of partners was sometimes problematic, as the situation was unknown and issues of capacity were raised; the bottlenecks in the supply chain affected supplies reaching the country, as Malawi was not

[52] We refer for example to the "Malawi_COVID-19 Global SitRep" facilitated by the PPM section
[53] Progress narrative report, DFID, August 20, 2020

in the priority list for accessing global supplies for PPE, test and ICU equipment; and the delays of local contractors, affected as well by restrictions, are examples of factors affecting a timely delivery of results[54].

Monitoring the response based on IP reports and non-systematic feedback tools becomes a main challenge in a situation with restrictions on mobility. Usual monitoring at district level has been affected, including nutrition status and protection related monitoring activities. E-surveillance and e-reporting are still uneven and with significant gaps from some districts as published in 2018. *"The differences between IDSR technical guidelines and actual practice were huge",*[55] and informants and survey respondents contend that gaps remain; the limits established in mobility have affected UNICEF capacity to correctly monitor the response and data collection tools.

The challenge of capturing data on CwD, and on disabilities as a whole has not been properly solved and will require attention. As an example, the outcome of the Education cluster's COVID-19 response plan formulates a specific mention of reaching CwD, but the indicators do not capture CwD-related information. This is applicable to other instruments for monitoring UNICEF's response (CP, health, nutrition, WASH, etc.). However, the ET notes that UNICEF took feedback into account from monitoring reports in the field and supported the distribution of braille materials to about 1,000 children with disabilities in 17 learning centres.[56]

Efficiency Key Challenges
Funding of the RP and donor coordination
Delays in IPs contractual arrangements
Implementation delays due to a variety of factors
M&E and programme follow up and situation analyses affected by mobility restrictions
Need to consolidate the innovative solutions proposed
M&E challenges due to restriction of mobility for monitoring and specific challenges on CwD data

9.4. Effectiveness

"The overall goal of the MCO COVID-19 Response Plan is to minimize morbidity and prevent and address secondary impacts of COVID-19."[57]

Effectiveness is evaluated based on progress toward achieving established targets and to what extent the outputs contributed to reaching the outcomes.

Progress toward targets, as initially defined in the formulation in Annex 1 of the RP, is assessed based on the HPM indicators, as included in the SitReps, and confirmed by the internal monitoring system based on rounds uploading information in a matrix.[58]

The table in annex 15 intends to offer an aggregation from the SitReps of the progress in achieving targets, choosing one SitRep per month, as they offer aggregated progress. It is difficult to reach conclusions from this source, even if in most cases results overcome the targets. Significant progress is documented in the SitRep of 2 December, when an overall achievement of intended targets is achieved (the lack of progress of social policy in supporting CUCI is not attributable to UNICEF).

Most of the indicators in health do not progress over time, and this is particularly worrisome regarding the access to essential services for children, reported as below target. The same applies to other areas of intervention, as in C4D, where the number of people reached with messages is impressive, but the number of people sharing their concerns is limited (and the same figure is shown since June, only modified in the last SitRep, maybe indicating a backlog of data not introduced previously). CP figures show a steady

[54] The RT notes the improvement of testing capacity in Malawi reported in December. The inclusion of rapid antigen tests will improve the capacity of the health system to better characterize the pandemic in Malawi
[55] Wu, Tsung-Shu & Kagoli, Matthew & Kaasbøll, Jens & Bjune, Gunnar. (2018). Integrated Disease Surveillance and Response (IDSR) in Malawi: Implementation Gaps and Challenges for Timely Alert. 10.1101/363713.
[56] UNICEF SitRep, December 4, 2020
[57] UNICEF COVID-19 Response plan, revised 2020.08.25_ page 5: "Covid-19 response strategy"
[58] Malawi covid-19 SitRep data_round template, a total of12 rounds of data collection since 25 March until December.

progress over time, exceeding the targets. For nutrition, the frequentation of SAM has some variation, but the result overcomes the target eventually. Yet the indicator does not capture challenges in nutrition surveillance nor on Vitamine A and macronutrient distribution.

Although education reports limited progress to targets from June to September, it shows a sudden increase of access to distance learning after 9 October, which is incoherent with the reopening of schools. In judging the effectiveness of distance learning, some challenges are captured from different sources (see later in challenges).

The assessment from these sources (SitRep monitoring, HPM indicators as per Annex 1 of the RP) does not do justice to the eventual effectiveness of UNICEF intervention, as a consequence of the weakness in clearly defining the logframe with specific outputs, activities and related targets in the RP, and how the achievement of outputs contributes to the outcome intended. The HPM indicators, as published, only partially reflect the progress to targets of the activities carried out.

Eventually, most of the RP activities have been integrated in the "outcomes and output monitoring matrix" of the CP 2019-2023 (version of 7 September). The integration of the activities in the logframe of the CPD is, in principle, a reasonable option and will eventually facilitate integration in long term planning, but the outcomes of the CPD do not capture what is intended in an emergency response.

The RP is essentially input oriented, lacks a comprehensive results framework of reference and has been adapted to available donor funding, such as the FCDO logframe. The RTE can also indirectly judge effectiveness through the achievement of results related to the funding provided by FCDO.

From the FCDO funding request, a results framework for the response is provided and the intended outcome is clearly established in a logframe with nine outputs and related indicators. While the impact indicator is adapted from the UNICEF overall CPD indicator including morbidity and mortality prevention and reduction, ***"Girls and boys grow up in resilient, inclusive and child-friendly communities that are supported by an enabling environment and systems that provide an equitable chance in life, thereby, morbidity and mortality related to COVID-19 are prevented and reduced in Malawi",*** the outcome is very much targeted toward strengthening the health system ***"The capacity of health systems in Malawi is strengthened to prevent, contain and treat COVID-19 infection"***. The nine outputs encompass the public health response, including the support to coordination, supplies and awareness campaigns, and Output 8 includes some indicators for continuity of care of basic services.[59]

This formulation is focused on the public health dimension of the response and intends to reach the impact (change) through the decreased mortality and morbidity achieved through the outcome. This logframe offers a clear arrangement of the logic of intervention but does not capture the integrity of the UNICEF MCO response plan.

A no-cost extension was requested due to implementation delays in a number of activities, from the installation of the oxygen plant to the carrying out of the Knowledge, Attitude and Practices (KAP) survey, to the procurement and installation of IT to link labs, and the need to continue WASH activities at PoE. Overall, beyond the delays and operational challenges experienced, the outcome is achieved, even if some information indicates that rapid response teams at district level are uneven in its capacity of reaction. The attribution between outputs and outcome of that logical framework could also be discussed, but lies beyond this RTE.

While the above is understandable, that is, the need to establish specific results frameworks for donors with adapted outputs and indicators, the ET notes the lack of a clear arrangement of the formulated four areas of activity UNICEF in the RP into expected outcomes and related outputs, activities and indicators.

The RTE cannot comprehensively judge the achievement of results, from a quantitative perspective, due to the limited systematic information available, and because the operation is still ongoing. This requires the ET to conduct qualitative analysis from the information collected, examining the progress and the challenges identified per area of activity. This better suits the theory-based approach as it allows the ET to

[59] COVID19 Response Extension Proposal to DFID Malawi, 260520

match progress towards the change established in the RTE ToC. The ET will therefore comment on different dimensions of effectiveness of the established four areas of intervention in the UNICEF RP:

1-Infection and Prevention Control (IPC) and provision of critical medical and WASH supplies and services

The information collected shows a high level of effectiveness in this area of activity, based on the provision of inputs. UNICEF has been able to activate the response by reprogramming early on and with the contingency supplies available. Furthermore, UNICEF swiftly reorganized the health section to fit the challenges of the response and immediately convened partners to activate coordination mechanisms for a MoHP-led public health response. Donors supported the leadership of UNICEF.

UNICEF has contributed critically to provide health system staff with adequate training, tests capacity and adequate protective equipment to deal with the possibility of COVID-19 cases and this is confirmed by informants and by different sources of data. UNICEF has supported the development of guidelines, SOPs, case management tools, etc., to provide health service providers with standardized means for adequate case management, preparedness and response; UNICEF also supported the establishment of the LIMS, in addition to other virtual initiatives, such as e-surveillance and mQuarantine

The WASH intervention has been directed to ensure adequacy of WASH resources in reception centres at PoE and in related health facilities. In this sense, UNICEF has provided refurbishment to several ETU including WASH infrastructure.

Challenges

Limited capacity of the health system to absorb support, especially at district level, with structural limitations such as shortage of staff, weak management, shortage of funding and lack of allowances, in addition to poor equipment and storage capacity, are the main challenges faced during the pandemic. Although these are structural issues beyond the responsibility of UNICEF, however, they effected the MCO in the support to district health authorities. The constraint in providing mentorship by the trained staff to other health facilities (trainers to trainees) also indicates weak capacity within the health system to build from the support provided.

While key informants at the national level acknowledge a commendable engagement by UNICEF in local governance support and district response plan arrangements, information from district officials mainly highlight that the response provided by UNICEF IPs was not aligned with district response plans, that it was provided for a short time and was not timely, and in most cases, supplies have been insufficient to carry on with activities.

The limited availability of COVID-19 tests kits has affected the capacity to adequately monitor the outbreak and spread of the disease, nor refine the response in terms of capacity and follow up. The important dimension of linking laboratories in a digital platform has experienced some challenges and a backlog of data is still being addressed. E-surveillance reporting is also experiencing gaps in obtaining data from districts, although the UNICEF Sitrep of 4 December reported a significant improvement of testing capacity in Malawi, with more than 290,000 antigen tests available. This will require additional effort for health information systems and case management.

The support provided has been of a short-term nature, and while some elements contribute to a permanent strengthening of the health system capacity (training, laboratory capacity, oxygen plant, ETU refurbishment), challenges remain in consolidating what has been achieved. Moreover, the need to provide services of public health and WASH at PoE remains, and support is maintained only through a no cost extension.

The WASH section has been struggling with shortage of funding and weak GoM leadership. Initially a limited distribution of WASH supplies from contingency plans was made available, but informants and FGD participants contend that distribution of buckets and soap has been very limited. Many informants from community level (FGD) mention difficulties purchasing soap as a limitation to ensuring hygienic practices. Gaps in reception centres and the absence of WASH in more than 400 schools has also been reported and challenges to WASH in health facilities remain prevalent.

2- Risk communication & community engagement (RCCE) including digital engagement and rumours monitoring

To achieve results, UNICEF built on the consolidated capacity of UNICEF C4D experience, established tools and partners, while developing new strategies due to the limitation on movement. As noted in annex 14, RCCE has reached about 12 million people in Malawi with mostly distant messaging, but also through on-site activities such as vans, theatre and community awareness. These activities reached a substantial number in the last period (as reported in October), probably due to the situation in the field allowing for an extension of activities. The Humanitarian Field Monitoring Dashboard provides additional evidence on the success of messaging campaigns and on the challenges in some districts. Partnership with media was also crucial to enhance outreach and solidity of messages.

RCCE encompasses accountability and CwC as feedback mechanisms have been put in place and community participation encouraged. The restrictions related to COVID-19 may have affected this component, but evidence collected from secondary sources and FGD participants shows that the population in Malawi is aware of the symptoms, risks and measures that need to be taken.

Challenges

There has been some confusion of messages and priorities, including a contradiction of public messages from political authorities, and a subsequent misunderstanding that the risk of transmission is somehow low. Low incidence of disease transmission has not helped either. Informants mention the cumbersome process to get messages validated for dissemination and the frequent "free-riders" in the field disseminating confusing messaging, leading to potentially damaging behaviour, such as avoiding meat consumption, or abandoning social distance and protective measures, as captured in FGD at district level. Additionally, resistance by health staff to adopt protective measures had to be addressed, with mixed success.

Access to RCCE messaging in rural communities is also limited due to poor access to radio and the[60] influence of gender determinants regarding communication means.[61] In some cases, informants mention stigmatization related to COVID-19 cases in rural communities, challenging RCCE effectiveness ("*Quarantine and isolation of suspected COVID-19 cases fuelled stigmatization especially in rural areas,"* from survey respondent). FGD captured the reluctance to access health care in case of respiratory symptoms for fear of being diagnosed as a potential COVID-19 patient. There is also a fear of being contaminated, as people see health centres as potential transmission points.

Limited community engagement in the response has been reported by informants due to a variety of factors, not least the access constraints for the UNICEF and IP teams due to mobility restrictions, as well as incorrect understanding about the risk of COVID-19, its transmission, and the influence of external actors in its dissemination. Even with consolidated feedback mechanisms in place, gaps are prevalent in closing the feedback loop, and ensuring community accountability mechanisms.

Several contextual factors in Malawi have affected the effectiveness of the RCCE messaging, specifically the priority shift of public health measures (put on hold by the presidential election campaign, with mass rallies in May and voting in June) and the Supreme Court ruling against the containment measures, confusing the messages being sent as well as the prioritization of response measures. Risk perception in May seems to have been very limited, and the peak of cases was recorded in June/July. FGD participants also mention the reporting in the international media about US President Trump's ambivalence toward the pandemic and the confused response in the UK over the crisis. Malawi is not immune to the mishandling of the pandemic abroad and the apparent confusion in the developed world about how best to combat coronavirus.

[60] In Malawi, around 13% of the population has access to electricity, and 33% possess radio appliances: Government of Malawi: 2018 Malawi population and housing census, main report

[61] Rapid gender assessment

It must also be noted that in relations to the findings from a recently published World Bank (WB) research paper,[62] that the most widely adopted preventive measure in Malawi has been handwashing (almost 100 per cent of respondents), while using masks and gloves has been adopted by less than 40 per cent of respondents. Some misconceptions prevail in Malawi, as over 20 per cent of respondents think that Africans are immune to COVID-19, and 28 per cent think that coronavirus cannot survive in warm weather. FGD participants raised some interesting misconceptions that can be useful to take into consideration (see annex 10).

Challenges in RCCE are also related to the different coordination platforms (UN Country Team, cluster system, MoHP subgroups). The Ministry of Information's role posed an additional challenge to coherent development and implementation of messaging and coordination (See Coordination section). Additionally, political priorities in May-June concerning the election presented a barrier to adequate messaging to the population.

The results achieved on the activity: *"Number of people sharing their concerns and asking questions/clarifications for available support services to address their needs through established feedback mechanism"* appears modest and below target (see Annex 15). The limited use of feedback mechanisms is consistent with decreased engagement in community accountability mechanisms, and ultimately in participation and engagement. The limitation on movement has affected the reinforcement of AAP and closing the feedback loop, in turn affecting provision of answers to challenges raised and addressing community participation.

3- Assessing and responding to the immediate secondary impacts of the COVID-19

In this aspect, UNICEF is engaged with partners to support government efforts to ensure continual, risk-aware provision of social support services to vulnerable populations through social cash transfers (CT). The HCT has established a caseload of the urban population to benefit from a CT program, COVID-19 Urban Cash Initiative (CUCI), benefitting 185,000 households, where UNICEF is providing technical assistance.

In this context, UNICEF is supporting the government with registration of beneficiaries, e-payment mechanism, communication plan, and setting up of a grievance redress mechanism for CUCI enabling the Government to effectively expand its social protection system to accommodate increased needs resulting from covid-19 for over 185,000 households in Malawi's four major cities. UNICEF will support by developing the response plan, mobilize funding for a CUCI call centre and developing a communication plan for CUCI. The MCO is also committed to develop evidence to measure the socio-economic impacts of COVID-19 to inform tailored response programming.

UNICEF supported the continuation of parliamentary works, providing logistical and analytical support to Malawi's Parliament during the passing of two budget proposals (June and September) to ensure safety, hygiene and distancing measures were respected and that budget clusters had all the necessary information on the tabled budget documents. Challenges faced by fiscal policies facing increased demands triggered by COCID 19 in Malawi have been taken into consideration with UNICEF support.

Challenges

The dimension of the socioeconomic impact is yet to be established, and the mitigation measures are generally based on assumptions. The FGD information discloses that in the context of high prevalence of informal economic activity it is challenging to measure the actual impact, as coping mechanisms, that were not accounted for, are put in place. All informants, though, report a decrease in earnings from informal economic activities. This is confirmed by the WB research mentioned, where 80 per cent of respondents report loss of income in their business or from remittances, and 60 per cent from a decrease in wages.

While CUCI was going to be implemented in November 2020, delays may affect the appropriateness and effectiveness, if implementation is not anchored in structural measures to avoid further socio-economic deterioration.

[62] Socio economic impacts of COVID-19 in four African countries, Anna Josephson Talip Kilic Jeffrey D. Michler; World Bank Policy Research Working Paper 9466, November 2020

The need to establish a reliable baseline for the consequences of COVID-19 in socioeconomic terms is becoming urgent and, while partners are engaged in such a study, challenges remain.

4- Continuity of health, WASH, education, nutrition and protection services

This area of activity has been consistently foreseen in the planning documents and included in IP Programme Cooperation Agreements (PCAs). However, evidence of a decrease in utilization of services, and challenges in the offer and demand, have been reported across the country.

The continuity of basic health services has been affected by the prioritization of the health system to address COVID-19 related challenges. This has diverted human and material resources from critical basic services *(source: KI, EHDO, survey respondents)*, along with weak capacity at district level and unclear district coordination and leadership. On the other hand, users and clients have developed an aversion to using health services on the perception of increased risk of being infected by COVID-19 (from KII, survey respondents, FGD participants). This combination of restricted offer and contracted demand can be harmful in the medium term, and already some consequences have been detected in the coverage of the Enlarged Programme of Immunization (EPI) and access to MNCH. Nutrition related programmes, such as Vitamine A, monitoring of nutrition status of children, nutritional supplements for children, have also been affected.

The WASH section aimed to cover the needs of health and education centers, critical in the context of the COVID-19 response, with scarce funding and weak institutional support. UNICEF WASH supported the development of business continuity plans for all five water boards in the country, channelling World Bank funding and introducing innovative solutions adapted to the situation (solar powered networks, pre-paid systems, etc.). This is an example of how UNICEF has used a critical situation to address existing structural challenges, an example of best practice.

Education has established strong engagement with the MoEST to reinforce capacity for distance learning and home-based schoolwork during school closures, and to provide support to back-to-school campaigns (schools reopened in September). While the targets as formulated seem modest, this has to be understood in the context of the wider institutional support and the cluster complementarities. Regarding child protection issues, the response plan struggled with a lack of funding, and initially targeted limited PSMHS activities and support for children without parental care to be included in the HPM system.[63] In both activities, targets have been revised upwards significantly, apparently due to synergies and reprogramming of resources, and results have progressed accordingly. In addition, the CP section has been engaged in supporting the Child Helpline and GBV Helpline and providing specific support to priority District Social Welfare Offices and Malawi Police.

It's important to note the links between CP and education. Since March school closures have resulted in the loss of critical protection environments for school children and adolescents, including the weakening of community protection mechanisms. UNICEF has followed up on this issue and advocated to re-establish community and district-based protection referral pathways.

Challenges

Relevant issues related to continuity of services of health, education and CP remain a challenge to be addressed. Aspects linked to offer (allocation of resources, both human and material, to COVID-19) and issues of demand (risk perception of communities) still need to be assessed. An additional challenge will be the case management and follow up of COVID-19 survivors, as they may become an additional burden for health services, with eventual complexities of follow-up and treatment that can further challenge health system capacities. The recently reported increased capacity for testing[64] and the increased number of reported cases from January 2021 is likely to further divert attention from basic services and will require specific measures to maintain basic services functioning, in addition to case management and quarantine measures for contacts.

[63] additional indicators have been established by the CP cluster on GBV prevention messaging and case reporting
[64] UNICEF sitrep, September 4

FGD respondents highlight the overcrowded situation of maternity wards in many districts and the additional restrictions applied that limit access to services ("*UNICEF was working through existing systems which may not have been effective in adequately responding to Covid-19 especially at community levels",* survey respondent). A rapid gender assessment by the Ministry of Gender, Community Development and Social Welfare (MoGender) already provides insights and actions to be taken.[65]

The Humanitarian Field Monitoring Dashboard clearly identifies some gaps in access to WASH, access to distance learning, messages of COVID-19 at school and remedial classes, as well as challenges in nutrition recommendations. This may indirectly show gaps to be addressed related to RCCE messaging *(from U-report and HFMD).*

Access to distance learning has proved challenging despite efforts carried out in terms of arranging radio and online tools and support for homework. From the U-Report poll, 64 per cent of respondents say they have not accessed distance learning programmes. A wider sample of a telephone survey finds that less than 20 per cent of households with children aged 6 to 18 years old had access to distance learning and identifies inequities between the wealth quintiles and between the rural and urban populations. The reasons for this seem to be varied, but lack of power, equipment and radios pay a role. FGD participants highlight challenges on classroom sizes and problems accommodating shifts, and the consequences of the limited attendance of pupils.

The situation created by COVID-19, the disruption of institutional presence at field level and the lack of follow up, has prompted, according to informants, a situation where the protective environment at community level has been affected. Youth participants in the FGD at district level have expressed their willingness to engage more substantially in social mobilization, information and participation, and have said the response to COVID-19 has largely ignored the voices of young people. This information may indicate a field to be built on to address community accountability and identify young change agents at community level.

An additional note on gender and PSEA, as described by informants and documents, and confirmed by the survey (mean score above 4 -scale of 1-5- for all sections), strongly indicated that gender-related issues and PSEA have been integrated in the response. There is an outstanding level of awareness of these issues at the MCO level, achieved through training (including for IPs) and the adequate formulation in all documents, including operational ones, such as PCAs. Gender disaggregation is also systematically included in programmatic and monitoring documents, and guidance has been provided on including a gender marker in resource mobilization (financial and human).

As such, the MCO developed key intervention areas, such as special mechanisms for reporting on human right abuses including PSEA, collecting and analysing data of COVID-19 secondary impacts on children and women, and technical support for the inclusion of specific rights, needs and vulnerabilities of women and children.

This also responds to the engagement of the RO to provide support to the gender focal point in the MCO, which also provides guidance on gender mainstreaming to all clusters in the context of the COVID-19 response.

[65] A Rapid Assessment Study of Teenage Pregnancies and Child Marriages During COVID 19 In Malawi *Prepared for Ministry of Gender, Community Development and Social Welfare*

Effectiveness Key Strengths
Health: Swift support to public health, supplies, PPEs, training Permanent improvements: oxygen plant LIM, ETUs
RCCE: Awareness of COVID-19 measures reached a wide audience
RCCE: Feedback mechanisms (Humanitarian Tracking dashboard)
SP: Awareness of socio-economic consequences: CICU as an integrated initiative with GoM
Continuity of Services: problem identified, addressed in all programmatic documents and PCAs
Education: strong engagement with MoEST for distance and online learning
CP: targeting street children, defining vulnerable and CwD in programmatic documents

Effectiveness Key Challenges
Health: Weak health system unable to absorb support Short term approach of the RP, weak system preparedness for the future
RCCE: Confusion of messages from different sources, Low adherence to recommendations Limited community engagement and participation
Social Policy: Lack of reliable tools for measuring consequences Delayed implementation of CICU
SP: Awareness of socio-economic consequences: CICU as an integrated initiative with GoM
Continuity of services: Decrease of service utilization, offer and demand challenges, Nutrition related activities affected
Education: Low coverage and challenges of access for many children
CP: Limited coverage, disruption of community mechanism for CP, lack of monitoring and strategies for Cwd

9.5. Coordination

UNICEF plays a critical role as a UN lead coordination agency in Malawi, based on previous experience in other emergency situations (Cyclone Idai, Cholera outbreaks, EVB preparedness) and provided early capacity for the COVID-19 response to convene stakeholders. UNICEF was also able to support initial arrangements for a coordinated public health response. This is an example of best practice. It is also noted that early mobilization of dedicated cluster leads was beneficial to the response. It is noted that engagement of the RO in helping to articulate the response, as well as the support provided to coordination and technical capacity of the MCO sections, enabling them to perform their coordination role.

UNICEF's leadership of the public health response was arranged by a tacit delegation from WHO, which has limited capacity in the country. UNICEF was crucial to establishing Emergency Operations Coordination (EOC) with MoHP, with CDC and WHO technical assistance, establishing a command centre involving the head of health services for MoHP and the deputy of MIPH. The EOC established its own chain of subcommittees to address complementary dimensions of the public health response including surveillance, PPSMH, RCCE, labs, and supply and logistics. All these elements fit into UNICEF integrated approach and have been operational and active to allow for a swift response.

While going through a presidential election, the GoM created a Presidential task force which led to a lack of clarity to the overall institutional coordination framework. The GoM triggered the activation of a so-called cluster system under the leadership of DoDMA which integrated the RC and the HCT. This can be considered an adapted version of the usual IASC cluster system, with some additional institutional areas of interest. Within these arrangements UNICEF led the clusters of Protection, RCCE, WASH, Nutrition and co-lead Education with SCF, also playing a key role in the Health cluster.

The MCO and partners attempted to create a real time information flow and ensure the engagement of the deputy of MIPH, and Chief of health services, in the health cluster. Different partners used different platforms and modalities of information management, while UNICEF supported innovative e-surveillance and m-quarantine tools. However, gaps in information management are reported for most of the clusters, especially systematic feedback from districts.

The WASH cluster is traditionally one of the main UNICEF areas for coordination. UNICEF led the cluster and had to struggle with political interferences, changes to GoM ministries and challenges in information management and field monitoring. Structural challenges within the WASH sector are prevalent in Malawi and an approach of "build back better" has been adopted, with focus on service continuity (see above under Effectiveness). The role of UNICEF in this cluster has been praised by partners and institutional informants.

For some time, some confusion affected the RCCE coordination as the C4D group of the cluster system, participated in by line ministries, was somehow overrun by the RCCE subcommittee of the health-led EOC, which was further aggravated by a change of leadership for RCCE from MoHP to MoInformation. Harmonization of messages was affected, and some informants highlight challenges in getting through a unified and coherent message.

The Protection cluster is led by UNICEF and includes CP. The cluster coordinates 30 partners and has presence in all districts, although partner capacity gaps are reported in 11 of the 38 districts. The cluster has supported MHPPS activities and established mobile phone platforms and child helplines. Challenges have been identified at PoE in terms of protection of returnees, and activities have been carried out in refugee camps. However, the challenges identified in terms of referral pathways and case management have been only partially addressed, and field presence and monitoring have been affected by the pandemic, especially in terms of AAP and providing a response to the feedback received.

The nutrition cluster, co-led by UNICEF, struggles with weak nutritional surveillance which affects community management of acute malnutrition (CMAM). An increase in admissions of children with SAM has been recorded but gaps in data collection protocols prevail. The need for a SMART survey will be addressed by the cluster shortly. The cluster integrates activities with education and child protection clusters.

The Education cluster is co-led by UNICEF and SCF and has drawn up a COVID-19 cluster response plan, supporting the MoEST in developing tools and materials for distance learning and to ensure a phased reopening of schools. Funding provided by ECW's First Emergency Response (FER) and GPE has been significant and allow for the establishment of a contingency plan for 2021. Inter-cluster coordination with nutrition (take home rations, micronutrient supplementation), WASH (4,600 schools with no access to water, provision of basic WASH package), protection (CP services at school), health (sanitization and disinfection of schools) and RCCE (awareness) is established in the plan. The cluster integrates the local education group (LEG) and the education in emergency (EiE) platform.

UNICEF has been actively engaged with inter-cluster coordination within the UNCT and is in close contact with the RCO. In addition, UNICEF has channelled funds from FCDO to UNFPA and WHO for the public health response, which has required additional UN partners coordination.

Regarding coordination at district level, most informants highlight weak capacity and inadequate guidance to achieve productive coordination. The replication of the cluster system at district level is challenging and, as such, ad hoc arrangements have been attempted. Major INGOs have a focal point per district to engage with local authorities on issues of interest. District officials have expressed their complaints on the top-down approach that some partners apply when reaching districts in the context of COVID-19 response, not engaging with existing district plans and the accountability to district authorities not existing.

Internal coordination at the MCO is judged by respondents as optimal, from the EMT to all sections being on the same page. The culture of integrating programming and implementation stemming from the CPD contributes to avoiding the usual siloed approach in emergencies and makes internal coordination occur more seamlessly. The concept of the Incident Management mechanism is an example of best practice.

Coordination Key Strengths
Leading coordination role
UNICEF reputation and convening capacity
UNICEF supported Information Systems
UNICEF internal coordination

Coordination Key Challenges
Institutional overlapping: MoHP, DoDMA, MoInformation, Presidential Task Force, HCT
Gaps in IM
Weak district coordination
Challenging harmonization of RCCE messages

9.6. Connectedness

"The UNICEF MCO response plan is aligned with the 2020 WHO global Strategic Response Plan (SRP), Government of Malawi COVID-19 preparedness and Response Plan, UNICEF Global COVID-19 Humanitarian Action for Children appeal." [66]

Malawi is a challenging context for connectedness. According to informants, dialogue between donors and the GoM is weak and affects joint planning, as a result of mistrust emerging from the "Cashgate" scandal disclosed in 2013.[67] UNICEF plays a key role in establishing bridges and facilitating connected planning scenarios between GoM and the UN and donor community, as informants highlight the reputation and proactiveness of UNICEF. Some informants highlight the opportunity that COVID-19 provides for a substantial engagement of UNICEF sections with line ministries.

It is to be noted that all PCAs and IP formulations for the COVID-19 response are linked to an outcome of the CPD, adding new outputs related to COVID-19 emergency response, providing the basis for an adequate connectedness and coherence of UNICEF intervention. There is an opportunity to consolidate this linkage and provide a longer-term integration of COVID-19 response into programmatic processes.

On RCCE, the MCO intervention is broadly coherent with the recently published global RCCE strategy; the ET recommends below to ensure the alignment with the main objectives of the strategy and revisit the indicators proposed as a possible source of guidance for the next phase.[68]

The RTE also captured from different sources the relevance of the local governance support, and the pilots to establish procedures and learning to a decentralized management. This is coupled with the information from district officials on the need to establish systematic connectedness between national and district plans, not always in place, and where UNICEF can play a key role. KII with GoM officials also show there is some frustration with district-level coordination, as UNICEF and its IPs take the lead in organizing interventions at district level. This sometimes leads to interventions being implemented without district engagement. District officials consulted requested more engagement of IPs with district plans.

Regarding learning and integrating UNICEF regional guidance, it is worth noting there is general positive feedback from informants, as it is evident that after an initial situation where uncertainty was prevalent, ESARO guidance contributed critically to focus and align the response: *"As COVID was novel, response was initiated before guidance was shared by the RO. When the RO guidance came it helped sharpen the response" (from survey respondent).* Guidance on gender-related issues for MCO and for the clusters to integrate gender and PSEA in the response has been particularly praised by informants.

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[66] Quote from "UNICEF Malawi revised COVID-2019 Response Plan Rev.2 2020.08.25 "
[67] Corruption financial scandal uncovered in 2013 that prompted donors to suspend foreign aid to Malawi
[68] COVID-19. Global Risk Communication and Community Engagement Strategy", IFRC, UNICEF, WHO, December 2020

Connectedness Key Strengths
Alignment with relevant plans and strategies
Capacity to bridge among stakeholders for coherence of the response
Operational response aligned with CPD

Connectedness Key Challenges
Weak dialogue UN/GoM
Permanent integration of COVID-19 with related components in the CPD
District plans connectedness with national plans

9.7. Sustainability

Addressing sustainability in the framework of a RTE can be challenging and probably methodologically inadequate. However, the evaluation question proposed allows for some pertinent considerations.

The evaluation notes that COVID-19 areas of activity and intended results are already integrated in the CPD framework, within the respective pillars. This is already a step towards building on achievements into a longer-term perspective. The ET also notes that the input-oriented COVID-19 response requires some sort of programming-bridge, defining outputs related to the outcomes, to make this integration logically sound and permanent.

The weak health system has structural limitations and limited capacity of absorption of external support. Poor infrastructure, limited human resources and quality of care deficit have greatly impacted delivery of services; donors have created a platform to support the system given the prevalent challenges of HIV/AIDS, TB, malaria, maternal mortality, etc. This external support has created, in some cases, parallel systems and vertical programmes, rather than providing capacity building. The proposed ToC builds on the assumption that the COVID-19 response can become an opportunity to strengthen the health system in Malawi and provide the basis for reinforcement of some of the elements included in the CPD as drivers for change. There is an opportunity to reinforce health system performance and learn from the experience to better address challenges on continuity of service of education, CP, WASH and basic health and nutrition services.

On the eventual promotion of community resilience, and PSEA and GBV integration, unfortunately the situation so far is revealing some caveats. Gaps at community level in terms of accountability and engagement have been highlighted by many respondents, and issues related to GBV, with apparently weaker than before referral pathways and the acute rise in children marriages and teenage pregnancies, indicate that remedial action is necessary beyond sustainability considerations.

Resilience must be applied as well to the health system, as it is one of the weak links in Malawi affecting community resilience. As one respondent stated: "*If surveillance capacity building consolidates, the chances of a resilient health system are high*". UNICEF has been building capacity and providing system strengthening activities that should lead to a resilient health system and to more empowered communities able to demand quality health services.

The extent to which UNICEF will be able to address the identified challenges will probably determine to what extent the next phase of the response will be able to consolidate resilient communities.

The evaluation has highlighted the short-term nature of the COVID-19 RP. Revision of the CPD to integrate aspects of COVID-19 response is crucial to be coherent with the challenges to come, as COVID-19 will probably stay in the environment for some time. Respondents have stated: "*COVID-19 as a chronic situation, should be incorporated in all programming, resilience included, to integrate into long term plans".* In the context of Malawi, challenges on availability of funding and donor support will be crucial.

The RTE notes, however, that MCO is already going through a MTR that will address this challenge of integrating COVID-19 response in long-term planning. Bridging between the RP that is already finalising and the long-term framework may be necessary to address some of the challenges identified.

Challenges

The evaluation has identified challenges that should be taken into consideration in defining sustainability approaches, among them:

- Challenges in continuity of basic services, affected by preferential resource allocation to COVID-19 responses that need to be reverted (ethical consideration on beneficence and justice).[69] Low Income Countries (LIC) countries will need to establish acceptable guidelines on priority for resource allocation and define alternatives to highly intensive and resource consuming health care solutions. The concept of HSA already in place, and the concept of High Dependency Unit (HDU), could be an alternative to consider. FGD informants highlight the already overcrowded wards in some district hospitals and the already existing challenges on staff ratios, issues that will condition any option.
- Foreseeable economic downturn that can affect financing of health and education: While this is an additional factor in an already deprived situation and high levels of poverty, global institutions (WB and IMF) can be flexible in the financial arrangements required to overcome the downturn, but shortage of donor funding is likely, affecting the opportunities above.
- Foreseeable psychological hardship due to the increase in GBV, child pregnancies and teen marriages should be considered for future programming, when developing and establishing referral pathways of psychosocial support.

10. Conclusions and lesson learned

10.1. Conclusions

The rapid escalation of COVID-19 has transformed the pandemic from a health emergency into a broader and much more complex phenomenon, which has immediate and medium term social and economic consequences on society as a whole, and on vulnerable communities in particular.

The MCO reacted swiftly to the initial challenges, establishing a RP in line with those established by the UN and the GoM, addressing the reinforcement of the health system, supporting the supply of PPE and other medical materials, enhancing RCCE to promote behavioural change and promoting mechanisms to ensure continuity of health care, education and the protection of the most vulnerable. Amid uncertainty at local and regional level and a dire situation affecting the entire world, the MCO managed to maintain focus and deliver, contributing critically to the response to COVID-19 in Malawi.

The evaluation notes the input-oriented RP. The initial input dimension of the response is acceptable, focused on reinforcing IPC through supplies, which was the main challenge at the time, and with high uncertainty on the way the pandemic would evolve. This most likely occurred across the world, but it would appear that time could have allowed for more outcome-oriented planning, especially when revisions to the RP were adopted over the period evaluated.

The option retained has been to link the activities included in the different areas of the RP with the CPD matrix. As stated above, this is potentially a positive arrangement in order to facilitate integration of COVID-19 activities with the long-term planning and ensure alignment with the CPD outcomes. However, the current integration does not provide a clear picture of what is to be achieved through the COVID-19 response and how this will contribute to the overall outcome. The evaluation concludes that a bridge programme ensuring progress toward the re-formulated COVID-19 related outputs would be necessary before integrating the COVID-19 response into the long-term CPD.

[69] Lucinda Manda-Taylor, Samson Mndolo, Tim Baker; Critical care in Malawi; Malawi Medical Journal 29 (3): September 2017

Theory of Change

The hypothesis proposed in the ToC as the framework for this RTE has been useful to align the response to an implicit change: the contribution to enhance the drivers for change, that is, the reinforcement of systems, enhanced community engagement and integration with the CPD based on the lessons learned from the response put in place.

The ToC is based on the assumption that the UNICEF COVID-19 response will be able to reinforce the capacity of the health system's and community accountability mechanisms while addressing needs in education, CP and WASH triggered by the pandemic in Malawi. This hypothesis has been confirmed and provided a valid reference for the evaluation. The identified opportunities and challenges will complement the picture, but the need to establish a new log frame or ToC for an intermediate period between the emergency response and the long-term outcomes in the CPD has emerged as a key finding.

However, the hypothesis may be challenged by the fact that one of the consequences of the pandemic and its institutional impact somehow weakens community-based mechanisms, affecting the provision of basic services. While the impact of COVID-19 has been limited in Malawi, the secondary impact on socio economic conditions, on children and on young girls is a major concern. In this sense there is the opportunity to align UNICEF programming to these new priorities and contribute to permanent change.

It is therefore pertinent to highlight the aspects identified to be taken into consideration in future programming as opportunities to reach permanent change, as in the RTE hypothesis.

Opportunities for a permanent change triggered by COVID-19 Response
● Opportunity for a permanent strengthening of the health system: training, oxygen plant, ITUs, WASH in health facilities, data management (DHMIS, eDHIS, LIMLIMS), district health system reinforcing ● Opportunity to improve WASH in education, and consolidation of durable solutions: solar powered water systems, prepaid meters, etc. ● Opportunity to raise profile of protection issues: child marriage, early pregnancies, GBV referrals ● Opportunity to improve profiling of vulnerable and CwD for social protection and as subjects of tailored aid programmes ● Opportunity to consolidate strengthening of Local Governance and support the coherence between national and district planning frameworks

We offer here a summary of **the good practices** identified, **challenges** to be addressed and **lessons learned** that will frame the recommendations.

Examples of Good Practice	
Preparedness and contingency planning	MCO has established a periodic preparedness and contingency culture that allows it to be better prepared for unexpected events, even if COVID-19 is of a dimension that could not be properly foreseen.
Gender rapid assessment	Gender challenges are significant in Malawi, as in other neighboring countries. The pandemic has put at risk progress achieved in dealing with gender-related issues. The quick Rapid Assessment carried out with the support of UNICEF and other partners can be a powerful tool to help focus on the challenges to be addressed.
Integration of Gender and PSEA awareness including PCAs and partner training	MCO has a significant culture of awareness on gender and PSEA issues, including training of IPs and integration of gender and PSEA across pillars and sectors.
Supply chain arrangements through the supply portal	UNICEF has been able to utilize procurement capacity and to coordinate with suppliers in order to be able to offer different contexts the necessary supplies in times of competing needs and has been able to deliver in Malawi. The balance between external and local procurement has proven an adequate option to be learned about, and the usefulness of L3 procedures to facilitate processes retained.
Support to Points of Entry screening and management	UNICEF has been able to adapt the response to emerging changes, and in this sense addressing the challenge in points of entry, with the need to establish reception and screening areas, has been outstanding. The baseline situation of facilities has been challenging and gaps in WASH and accommodation need to be addressed.
Coordination leadership and dedicated cluster staff	UNICEF has played a leading role in various relevant dimensions: Establishing internal coordination and adaptation, convening a public health response plan, providing supplies for all stakeholders and co-leading the clusters of responsibility, and enhancing inter-cluster integration.
Innovation initiatives, including U-report feedback, e-surveillance, Lab Information System, m-quarantine, etc.	MCO has already established an innovation dimension in its CP, which has been instrumental to expand solutions in a challenging situation of movement limitation and need for real time data collection. The effort must be consolidated but overall provides a lesson of good practice.
Staff wellbeing arrangements	MCO established adequate mechanisms to preserve health safety of staff, providing support and follow up, and ensuring staff wellbeing and participation, while preserving capacity to deliver. Staff motivation and engagement remained outstanding
RCCE massive reach out, and feedback established: U-report, Humanitarian Tracking dashboard	MCO has leveraged its experience in C4D and the innovative approaches available to reach out to the overall population and to establish feedback mechanisms and monitoring data on the different areas of activity. A wealth of experience to build on for future programme related communication

Several challenges emerge as a result of the short-term nature of the Response Plan (most of the contracts with IP are ending in November) and the structural weaknesses of the country.

Moreover, the planned integrated UNICEF response has been only partially applied, as donors only support health related aspects of the Response Plan. While the Education section was able to mobilise funding from specific education platforms, CP, WASH, and Nutrition have received little to no attention from donors.

The findings highlighted by this RTE show that much of the previous progress achieved in community participation and engagement became "dormant" during the pandemic, due mainly to the limitation of

movements and of UNICEF staff follow up, absence of support partners, limited referral patterns and mistrust in institutions that have been perceived as distant or absent by communities. Attention should be paid to rebuild confidence and provide support to revive the protective environment in the communities.

The COVID-19 pandemic has been a setback for the health and wellbeing of adolescent girls and young women, and Malawi is no exception.[70] The increase in child marriages has been documented and attention will be needed to address the consequences in the short and medium term. The MCO is aware and has been participating in gender related assessments[71] and articulating measures though the CP cluster. Including specific actions in the UNICEF MCO planning frameworks is necessary as well

It is clear from this exercise that access limitations to the field have affected the normal roll out of critical activities which benefit children, including access to health services, immunization, nutrition implications, MCNH, and especially CP-related mechanisms for case management and referral. It is to be expected that the disruption of access to education, as referred to in the report, will be eventually addressed if schools remain open, but an effort will be needed to engage pupils that decided to drop out, and remedial classes will be necessary in many cases.

Of particular concern are the socioeconomic consequences to be expected, as noted in all the estimations available.[72] This will mainly affect the already deprived layers of the population, especially in urban environments and with special concern for CwD. This comes as one of the gaps identified in the RTE and recommendations to address those vulnerabilities are expanded below.

From the evidence collected, the RTE has identified immediate challenges potentially affecting the wellbeing of children and vulnerable groups of interest for UNICEF. Challenges are multi-causal and related to contextual factors that can be complex to address. However, we highlight them here in order to facilitate the eventual UNICEF contribution to addressing some of them, as proposed in the recommendations

Systemic and Contextual Challenges identified
- The COVID-19 has affected the ***offer and demand of basic health services.*** This may lead to health consequences for women and children, and raise some ethical concerns on the way resources are allocated, as provision of MCNH, immunization, nutrition and integrated care of child diseases are affected by the pre-eminence of COVID-19, and may cause increase morbidity and mortality to the most vulnerable. The way that perceived risks of COVID-19 have affected the demand also needs to be addressed, and the offer of services reinforced with specific measures. An additional challenge will be the management of COVID-19 survivors and related consequences, a new cohort of chronic patients likely adding to TB and HIV multimorbidity patterns of the country, and the competing allocation of capacity and resources for upcoming COVID-19 massive testing and vaccination. - ***Education-related challenges:*** The initial approach on distance learning with school closures is challenging in Malawi. Safety in schools, shifts affecting normal schooling in overcrowded classrooms, promotion of non-formal learning, reintegration of teens and provision of social services through schools are still challenging. Measures to revert the situation must be scaled up, and there is a need to learn from this process and invest in home-based learning in case school closures should be maintained. Moreover, WASH structural gaps in many of the schools should be addressed to allow for a safe and COVID-19 friendly environment at school. - ***Planning processes:*** COVID-19 preventive measures, RCCE and IPC must be incorporated in all programming to address a situation that can be protracted for some years. While a MTR is on-going, an instrument to bridge

[70] Centring adolescent girls and young women in the HIV and COVID-19 response. The Lancet, December 12, 2020, https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2932552-6

[71] MALAWI COVID-19 RAPID GENDER ANALYSIS, MAY 2020, and A Rapid Assessment Study of Teenage Pregnancies And Child Marriages During COVID 19 In Malawi September 2020, both by Ministry of Gender social development and social welfare,

[72]IFPRI: Short-term Impacts of COVID-19 on the Malawian Economy: Initial Results; Bob Baulch, Rosemary Botha, and Karl Pauw; ECAM: An Assessment of the Impact of Coronavirus Disease (Covid-19) on the Economy and Labour Market in Malawi; Socio economic impacts of COVID-19 in four African countries, Anna Josephson Talip Kilic Jeffrey D. Michler; World Bank Policy Research Working Paper 9466, November 2020

both processes may be adequate to address the challenges identified. This planning needs to include a logframe where outputs relate to outcomes in order to integrate those into the CPD. Essentially, this would ensure addressing the offer of basic services and community perceptions to revert the inhibition of demand, while addressing Nutrition, Protection, Education and WASH gaps.

- ***Social policy:*** The needs for cash support will eventually be better characterized, but while the decision to address the ultra-poor in urban settings is adequate, the CUCI is being delayed and its continuation will depend on a better understanding of the socioeconomic impact of the pandemic in Malawi. Additional vulnerabilities related to CwD and albinism need to be factored into social protection programmes.

- ***Protection***: Community-based protection mechanisms became "dormant", children out of school were put at risk, integration of CP with social services, nutrition, HIV and education has been affected by the lack of UNICEF presence in the field and the diversion of attention of district welfare authorities to COVID-19 related issues. The increase in teen pregnancies and child marriages, as well as the increased risks of GBV, require enhancing community engagement on protection-related mechanisms and refocusing on service provision and referral.

- ***RCCE and AAP***: a lot has been done to raise awareness and to capture feedback from communities; Challenges remain in reverting risk perception towards the health system and improving awareness of CP related issues. FGD highlights the fact that more has to be done to incorporate influencers and youth into behavioral change and to improve trust in information sources. The next phase should be refocused to address the **accountability gap:** More engagement with communities will be needed on issues affecting them (access to health services, protection, referral); closing the feedback loop is largely unaddressed.

- ***Health system equity challenges*** will remain substantial in case of new relapses of COVID cases and even to care for the survivors of the outbreak so far. An additional challenge will be the management of COVID-19 survivors and related consequences, a new cohort of chronic patients likely adding to TB and HIV multimorbidity patterns of the country, and the competing allocation of capacity and resources for upcoming COVID-19 massive testing and vaccination. The response to COVID-19 outbreaks is likely to divert resources and efforts that already existing health challenges require, and the containment and mitigation measures adopted have further negatively impacted economic growth and may affect short- and medium-term development prospects in Malawi. Those consequences will affect the socioeconomic situation for most of the population and impact the health status, especially for the more vulnerable. The paradigm of socioeconomic determinants for health appears very relevant in the context of the consequences of COVID-19[73].

Issues of equity on allocation of resources will be relevant for UNICEF; in Malawi mortality of children and women is associated mainly to preventable causes, and is greatly influenced by socioeconomic determinants: poorest quintiles, rural versus urban, etc. UNICEF's mandate requires redefining priorities considering lessons learned from the COVID response so far.

The contextual situation in Malawi, with high prevalence of HIV and TB, should prompt linking IPC previously established measures with the ones required for a new respiratory pathogen, such as COVID-19. Further to the potential for testing based on existing capacity at district level through the GenXpert devices in place, it should be possible to build on the already established familiarity with dealing with infective TB patients (with the need for protective equipment and isolation) to incorporate COVID-19 measures systematically. The health system in Malawi is able to notify, diagnose and manage a significant number of TB cases yearly, and this should provide some guidance on establishing protocols for COVID-19 patients in the current limited-level of spread at community level. The number of notified TB cases in 2019 in Malawi was 17,140. Of these, 9 per cent were children 0-14 years and 35 per cent were women,[74] while the cumulative number of COVID-19 cases has been 5,900, 275 aged 0-19 years old, and 1,877 women.

The table below exemplifies that in order to be cost-effective and equity-principled in terms of health budget allocations, prevalent main causes of DALYs for children and women in Malawi should be addressed; decisions must be made from a public health perspective that will require strong public opinion awareness and institutional backing.

[73] WHO Afro has defined a tool kit and provides guidance to reduce the health equity gap through action on the determinants of health. https://who-afro.ctb.ku.edu/#toolkit

[74] https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&lan=%22EN%22&iso2=%22MW%22

Table 11. Examples of burden of disease and mortality in Malawi compared with COVID-19

COVID-19 cases in Malawi (2020)	6,025[75]
COVID-19 cases in children 0-19	279
COVID-19 cases in women over 19	1,769
COVID-19 deaths in Malawi	185 (2020)
Number of neonatal deaths	15,386 (2017)[76]
Number of deaths from Pneumonia in under 5	4,070 (2017)[77]
Under 5 mortality rates (per 1000)	41,6 (2019)[78]
Maternal mortality rate (per 100.000 live births)	439[79]
TB incidence, cases	27, 000 (2019)[80]
TB case fatality ratio 2019	27% (7,290 deaths)[81]
Reported number of children 0-14 receiving ART	48,000 (2019)[82]

Source: ET elaboration, all data sources in footnotes

The GoM lacks credibility in front of donors and international stakeholders since the "Cashgate" scandal in 2013, and despite UNICEF efforts to support leadership and capacity building, GoM institutions tend to play a secondary role. Some of the key aspects of health sector delivery are actually provided through donor support in parallel to the MoH functions of accountability, its regulatory role and leadership.

Health sector support is mainly donor driven through the Health Sector Joint Fund (HSJF), and the traditional implementing modalities of the Global Fund or GAVI when dealing with substantial health problems (HIV, TB, Malaria, EPI) are still creating vertical programmes and skipping health system reinforcement.[83] Malawi's health system needs to build on the capacity established for those programmes and for future challenges. Health sector donors (HSJF) should rearrange the strategy to provide the MoHP with the necessary financial and technical capacity to ensure leadership and include the required decentralization to districts. UNICEF is better positioned to advocate for an integrated and horizontal health sector support that will be more adequate to deal with the challenges identified. The increase of testing capacity and eventual availability of vaccines for COVID-19 is an additional challenge that can be turned into an opportunity to reinforce the health system performance and health information management.

10.2. Lessons learned

The ET has identified several key lessons learned from good practices and challenges developed previously. We take stock of the MCO internal lessons learned exercise (Early Lessons Report-Consolidated-Jul 22) and expand that initial exercise highlighting the following:

Public health versus focus on children needs: In the exceptional situation triggered by COVID19, attention was immediately driven to public health related issues, such IPC, testing capacity oxygen availability and

[75] COVID-19 figures in the table from PHIM SitRep Nov 29, 2020
[76] https://ourworldindata.org/country/malawi
[77]https://data.unicef.org/country/mwi/
[78] https://ourworldindata.org/country/malawi
[79] https://www.unicef.org/malawi/situation-children-and-women-malawi
[80] https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&lan=%22EN%22&iso2=%22MW
[81] https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&lan=%22EN%22&iso2=%22MW
[82] https://data.unicef.org/country/mwi/
[83] The GF and GAVI are already introducing elements of health system reinforcement in their strategies.

health system reinforcement. While this is reasonable it is also of key importance for UNICEF not to lose the focus on child needs and vulnerabilities, especially in LIC. The MCO has a commendable CPD with a strong integrated approach to address the challenges over the lifecycle of children and should have been advocating for it to be supported by donors or other resources in order to be able to prevent and eventually address the unwanted consequences for children and mothers in terms of GBV, CP, Education, MCHN and immunization coverage, among others. While these consequences were difficult to foresee at the beginning, the risk was highlighted by regional and global bodies (among others UNICEF HQ), and the UNICEF CO should learn from this experience to advocate for those aspects not to be side-lined.

Short term response versus integrated programming: While the pandemic outbreak was determined globally by high levels of uncertainty on the modalities and best options to address the challenges it is becoming clear that COVID-19 is here to stay and adaptation of programmes will be needed to include this new dimension. The initial short term and reactive input-oriented response plan should be followed by a more structured outcome-oriented logframe and timeframe, in the form of a bridge programme to be linked to the CPD.

Supplies and local procurement: The engagement of UNICEF's supply section in the support and facilitation of the global supply portal to stakeholders in Malawi is one of the good practices identified; the lesson to be retained is the benefit for all the aid community and government bodies of such a mechanism in case of a global threat that challenges availability of supplies. An additional lesson stems from the diversification of supplies through local procurement; consolidating relations with local producers and suppliers will be key in future situations of shortage of global supplies.

Field monitoring in a context of limitation of movements: The situation created has challenged the capacity to monitor and obtain reliable information from the field. This needs to be addressed in a creative way, as future outbreaks cannot be ruled out and the need of adapted monitoring mechanisms is going to be prevalent. Third party monitoring, engaging actors able to move and capture data while following safety rules without the limitations inherent to the UN system can be an option, establishing key informants at community and district level could also be considered.

Equity challenges in allocation of resources for the health sector: Of particular importance becomes the lesson that the focus on public health response to COVID-19, while justified, has affected adequate attention to the prevalent main health challenges of women and children while the impact of the pandemic in Malawi has been so far limited in terms of morbimortality for women and children; the attention paid to the pandemic risks neglecting the main prevalent causes of mortality affecting women and children. A regional reflection should be addressed, and eventual guidelines provided for LIC. The health sector response for the coronavirus should also build on existing capacities in the local context, related with prevalent conditions like testing for TB and HIV, experience on isolation of infective TB patients, stigma management through RCCE. The choice between ICU set up and equipping versus more context-adapted "high dependency units" (HDU) should be considered.

RCCE is one of the main components of the response to COVID-19, as non-medical measures such as social distancing, limitations of mobility, handwashing and the use of face masks has been acknowledged as critical. This requires strong means for RCCE and UNICEF has been playing a key role in Malawi. However, the lesson to be retained is that RCCE in rural areas has achieved limited results due to poor access to radio and other media and the difficulties for an adequate engagement with communities. Occasional face-to-face or van messaging does not achieve a permanent awareness and behavioural change if not reinforced over time. Youth clubs at community level can be the drivers of change on awareness and practices but need more support to become the link between the new messaging and the traditional communities.

Access to distant learning: The impact of closures for the education system is particularly worrisome, and the evaluation highlights the problems identified in access to distant learning by children in rural areas or of the poor socioeconomic layers. This shows a structural limitation to be addressed in order to do not leave any child behind. The education section, cluster partners and the MoEST have tested a number of tools that will be providing guidance for the next phase.

The exacerbated vulnerability of girls and young women has been also a significant lesson captured across the board in many countries. Malawi is one of the countries with higher rates of early marriage has seen a surge of cases as a result of the pandemic, school closures and weakened community and institutional mechanisms for protecting girls. This lesson should be incorporated in future programming to decrease the risks.

Community participation and engagement remains challenging and has been weakened by the situation created by the pandemic, including community accountability mechanisms, referral and protection services availability. UNICEF should define means to address these threats for the most vulnerable through reinforcement and follow up of community engagement.

AAP challenges are still prevalent: Even if AAP has been included in all programme formulations, and is not forgotten in the response plans, it has been challenging to accomplish. It needs to be established through more sustained efforts, including identifying agents of change at community level, and engaging youth groups. Most of the AAP mechanisms do not achieve to close the feedback loop, becoming one-way communication or limited two-way communication; engagement of affected population in the response is yet to be accomplished

Innovation is part of the culture of the MCO and has been extremely useful to articulate solutions related to the COVID19 and it has been instrumental to improve capacity of response and monitoring, but needs to be factored into all the sections to address specific challenges and requires time for consolidating. The experience of piloting e-surveillance and health Information systems, including LIM, should become the basis of a wider programming to consolidate this critical capacity at the national level.

11. Gender and Human rights, including child rights

Effective humanitarian action ensures the needs of women and girls are mainstreamed and championed in any response. The Inter-Agency Standing Committee (IASC) recognised that gender-sensitive humanitarian assistance could mitigate the adverse effects of emergencies and disasters for affected populations and have a greater impact for positive change in gender roles.[84] The resulting IASC Policy Statement on Gender Equality established responsibilities for the HCT and defined specific actions actors should take to ensure that gender equality is integrated into all aspects of humanitarian response and inter-agency efforts.[85]

UNICEF has adopted a human rights-based approach (HRBA) to programming which recognizes gender mainstreaming, along with the Convention on Children's Rights (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), as one of its key components. This human rights-based approach, which is a normative framework of the UN, is embedded in the shaping of the response. Attention to the most vulnerable is based on this approach and is grounded in adequate protection measures.

UNICEF focuses on various aspects to implement gender mainstreaming into their strategy, such as advocacy, promotion of gender-specific programmes targeting women and girls, empowerment through capacity building, among others. This RTE found that the MCO response developed an inclusive HRBA and its strategies were gender sensitive. UNICEF furthermore draws from globally recognized key human rights mechanisms, such as the Committee on the Rights of the Child and the Committee on Discrimination against Women. Finally, UNICEF strives to incorporate Sustainable Development (SGD) Goal 5 in it work, achieving gender equality, and empowering women and girls.

Malawi suffers from a challenging socio-cultural environment in terms of gender and child rights-related breaches (GBV, domestic violence, working children, street children, early marriages, teenage pregnancies,

[84] The IASC committed to formulating strategies for ensuring that gender issues are brought into the mainstream; ensuring data is disaggregated by sex and age and that a gender perspective is included in analysis; developing capacity for systematic gender mainstreaming in programmes, policies, actions, and training; and, ensuring reporting and accountability mechanisms for activities and results in gender mainstreaming within the UN and its partners.

[85] IASC (1999). "IASC Policy Statement for the Integration of a Gender Perspective in Humanitarian Assistance." https://interagencystandingcommittee.org/gender-and-humanitarian-action-0/documents-public/iasc-policy-statement-integration-gender

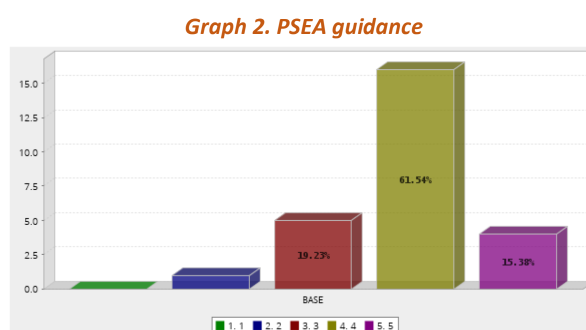
etc.). UNICEF is engaged in addressing these challenges and factors in gender and children's rights in the CPD.

The evaluation confirms the inclusive approach and the gender sensitivity in all plans and strategies of the MCO COVID-19 response, and this is noted at various levels in the report. The RO provided guidance on gender integration in different sectors and these have been instrumental in guiding the country-level COVID response. In this sense, benefits for specific groups of women and children, including vulnerable ones, need to be consolidated in the next phase of the intervention and identified gaps addressed, in line with what is foreseen in the recommendations below.

The evaluation has verified that data on gender breakdown and gender specific vulnerabilities is systematically captured. Gaps remain, though, in getting data from other child-related vulnerabilities, such as CwD, ultra-poor street children, and those who drop-out from school.

Survey respondents highly support this aspect: Respondents rated highly positively to the question, *"To what extent, on a scale of 1 to 5, have PSEA guidance and best practice been considered in the UNICEF COVID-19 response plan?".*

Graph 2. PSEA guidance



Source: DARA survey to UNICEF MCO staff (see annex 9)

The evaluation has also highlighted the engagement of the MCO gender specialist in all clusters to ensure an adequate gender perspective in all response mechanisms. In addition, UNICEF participated in the early multi-partner "Gender Rapid Assessment" that provided timely and substantive guidance on gender challenges identified related to the COVID-19 situation in the field.

12. Recommendations

The table below presents recommendations based on the challenges and lessons learned identified throughout the Evaluation. Recommendations stem from the findings and are substantiated in the conclusions. The ET has triangulated data sources and ensures strength, coherence and feasibility of the recommendations, taking into consideration, in particular, MCO staff, duty bearers and rights holders' feedback over the process of data collection.

Recommendations are arranged as five main overall strategic recommendations for the next phase, with related specific recommendations suggested for each strategic one. Recommendations included here can be actioned by UNICEF MCO, and sometimes address contextual factors that will require a wider engagement of stakeholders; The ET suggests for each one the more directly concerned section or area of responsibility for action, and indicates the relevant stakeholder, specially this is noted for directly related Government's line ministries and other.

Table 12. Recommendations

Overall strategic recommendations

Overall strategic recommendations		Priority	Action by
1.	**Contingency and preparedness:** Build into an adapted Preparedness and Contingency planning for different scenarios of COVID-19 in Malawi for 2021, including the need to foresee the eventuality of a second wave and the likelihood of a vaccine becoming available in the medium term	Critical	PPM, Supplies, Health, Education, CP, RCCE, Local governance
	• Ensure activation of supply chain mechanisms to ensure availability of critical supplies • Consolidate capacity of reception and management at PoE • Address new testing capacity at district level reinforcing Rapid reaction teams at district level, e-surveillance, m-quarantine • Promote a National Strategy for Vaccination • Education: In case of closure of schools need to intensify measures to support home learning with focus on vulnerable children • CP: Proactively reinforce prevention of GBV and risks for young girls • Local Governance: Ensure that un an eventual response IPs PCAs engage at district level with District response plans • Address identified misconceptions and promote use of essential health services	Critical	PPM Supplies All sections RCO, UNCT, MoEST, MoHP, MoGCDSW
2.	.**<u>Design a "Bridge programme</u>**" to link ongoing emergency response to the CPD: Refocus on the needs of women, children and other vulnerable groups of interest for UNICEF. Define an integrated log frame with a Theory of Change and an adapted timeframe in order to ensure action towards the following specific recommendations in an intergraded framework	Important / critical	PPM Management Section chiefs
Health	• Address issues identified affecting access to health services, offer from providers and demand by clients, challenges for continuity of basic health services: Immunization, IMCI, MCNH, Nutrition surveillance and management. • Integrate COVID19 survivors in follow up programmes as an additional chronic cohort, UNICEF focusing on vulnerable groups • Consolidate e-surveillance and eDHIS • Integrate the strategy for COVID-19 vaccination	Important	Health section Innovation Health sector donors (HSJF) MoHP
Nutrition	• Catch up with nutritional surveillance and Vit A and micronutrients distribution • SMART survey to establish nutritional status and design remedial measures of gaps identified	Important	Nutrition PPM MoPH
Education	• Need to address challenges identified on ensuring safe schools, catch up classes, WASH in schools, protection, nutrition, and non-formal education.	Important	Education CP, WASH Nutrition MoEST
WASH	• Establish a plan for addressing gaps identified in WASH at health and education centres, and phase out of PoE, where capacity of local authorities should be ensured.	Important	WASH Education Health MoAIWD
RCCE	• Prevalent challenges to be addressed in reverting risk perception towards the health system, improving awareness of CP-related issues and revert misconceptions (KAP surveys should be carried out or finalized, if already ongoing) • Define and implement initial steps to close the feedback loop to encourage	Critical	C4D, CP MoICT

	community participation, consultation and accountability through clear 2-way communication. • Engage youth clubs in community engagements processes. • Ensure coherence with global RCCE strategic guidelines: community led, data driven, local solutions and collaborative		
AAP	• Address the **accountability gap**- Closing the feedback loop: specific attention to encourage community participation, consultation and accountability through a clear 2-way communication; Engage youth clubs	Critical	CP, C4D Gender focal point, UNCT MoCECCD
Child Protection	• Enhanced Integration of CP with Education, WASH, Nutrition and Health as COVID-19 lessons learned • Activate CP at district and at community level to prevent children labour, exploitation, early marriages and pregnancies • Integrate CP with Education on dropouts, children work and CwD	Important	CP section and cluster partners (SCF) Education, Wash, Health, Nutrition sections, MoEST MoGCDSW
Focus on the vulnerable	• Address identified consequences for poor urban children without parental care, families with vulnerable socioeconomic status and CwD in urban and rural setting; specifically, on **CwD,** there is a need to make CwD visible and reachable by UNICEF programmes	Critical	MCO SP, CP MoGCDSW
Social policy	• The bridge programme should ensure that the support to CUCI builds into a renewed focus of SP measures on vulnerable to be maintained over time. • Mobilize support to newly identified vulnerable children to ensure schooling, fees waiver, kits , scholarships. Include CwD in social support programmes	Important	SP Education CP MoGCDSW
3. Advocacy with donors, HSJF, UNCT and GoM for prioritizing specific approaches for addressing health challenges and social support for children		Important	Comm. Health section CP, SP
Sector wide approach	• UNICEF to promote and advocate for a donor's **sector wide approach** focused on health system reinforcement	Important	Health section comm MoHP, Donors, WHO, HSJF
Equity and ethical reflection	• **Promote a debate** to prioritize the health sector and social policy strategies **on ethical** considerations **and equity-based decisions** to be supported for the benefit of children.	Important	Health Section, Comm, WHO, UNFPA SP RO, HQ
4. Monitoring in the post COVID paradigm		Critical	M&E
Need to enhance **field monitors** or to establish a **third-party monitoring** arrangement at field level as a way to address the gaps in field monitoring identified and improve a targeted response to the needs of the most vulnerable and hard to reach communities		Critical	M&E PPM
5. District capacity building		Important	Local Governance
• District decentralization and accountability at district level: UNICEF to build from Local Governance and Rural Development experience to create a strategic plan to extend the support to decentralization and district capacity building to allow districts to address needs of children, women and CwD • Further to a broad expansion to ensure extending district capacity to address children needs, ensure that during the bridge period IPs PCAs engage at district level with District response plans		Important	Local Governance RCCE MoLGRD