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Evaluation of UNICEF Zimbabwe's COVID19 response

EVALUATION REPORT

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VOLUME I - EVALUATION REPORT

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List of Abbreviations and Acronyms

AAP	Accountability to Affected Populations
AoR	Area of Responsibility
ARV	Antiretroviral
C4D	Communication for Development
CCCs	Core Commitments for Children in Humanitarian Action
C4D	Communication for Development
CEPI	Coalition for Epidemic Preparedness Innovations
CERF	Central Emergency Response Fund
CO	Country Office
COVAX	COVID19 Vaccines Global Access
CPD	Country Programme Document
CPiE	COVID19 vaccine post-introduction evaluation
CSOs	Civil Society Organisations
DAC	Development Assistance Committee
ESARO	Eastern and Southern Africa Regional Office
ECCD	Early Childhood Care and Development
EDF	Education Development Fund
EHA	Evaluation of Humanitarian Action
EHOs	Ethnic Health Organizations
EMOPS	Office of Emergency Programmes
ERG	Evaluation Reference Group
ESCT	Emergency Social Cash Transfer Programme
EQ	Evaluation question
EQA	Evaluation Quality Assurance
FO	Field Office
GAM	Global Acute Malnutrition
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
GDP	Gross Domestic Product
GoZ	Government of Zimbabwe
HAC	Humanitarian Action for Children
HCT	Humanitarian Country Team
HDF	Health Development Fund
HIV	Human immunodeficiency virus
HNO	Humanitarian Needs Overview
HRP	Humanitarian Response Plan
RC/HC	Resident Coordinator/Humanitarian Coordinator
HR	Human Resources
HRP	Humanitarian Response Plan
HQ	Headquarters
ICCG	Inter-Cluster Coordination Group
INGO	International NGO
IP	Implementing Partner
IPC	Integrated Food Security Phase Classification
IASC	Inter-Agency Standing Committee
IEC	Information, Education and Communication
IPC	Integrated Food Security Phase Classification
JC	Judgement Criteria
KIIs	Key Informant Interviews

LTA	Long-term agreements
M&E	Monitoring and Evaluation
MHM	Menstrual hygiene management
MHPSS	Mental health and psychosocial support
MOHCC	Ministry of Health and Child Care
MLAFWRD	Ministry of Lands, Agriculture, Fisheries, Water and Rural Development
MoPSE	Ministry of Primary and Secondary Education
MoPSLSW	Ministry of Public Service, Labour, and Social Welfare
MTCT	Mother-to-Child Transmission
NFI	Non-Food Items
NGOs	Non-Government Organization
NUG	National Unity Government
OCHA	Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Co-operation and Development
PD	Programme Document
PHEIC	Public Health Emergency of International Concern
PLHIV	People living with HIV/AIDS
PPE	Personal protective equipment
PSEA	Protection from Sexual Exploitation and Abuse
RCCE	Risk Communication and Community Engagement
RD	Regional Director
RO	Regional Office
SAM	Severe Acute Malnutrition
SBC	Social and Behaviour Change
SD	Supply Division
SDG	Sustainable Development Goals
SI	Statutory instrument
SitRep	Situation Report
SOP	Standard Operating Procedures
SPCRM	Social policy and child rights monitoring
SPRP	Strategic Preparedness and Response Plan
ToC	Theory of Change
TOR	Terms of Reference
TPM	Third-Party Monitoring
UN	United Nations
UNCT	United Nations Country Team
UNSDCF	United Nations Sustainable Development Cooperation Framework
UNEG	United Nations Evaluation Group
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Fund
UN-SWAP	UN System-wide Action Plan
VAC	Violence against children
VAW	Violence against Women
VHW	Village Health Worker
WASH	Water, Sanitation and Hygiene
WinS	WASH in schools
WFP	World Food Programme
WHO	World Health Organization
ZCO	Zimbabwe Country Office
ZIMSTAT	Zimbabwe Statistical Agency

Executive Summary

Evaluation purpose and scope

1. This evaluation focuses on the programmatic and operational response of UNICEF Zimbabwe (ZCO) to the COVID19 pandemic. Its purpose is to provide an independent assessment of the UNICEF ZCO's Humanitarian Response of COVID19 which had accountability and learning objectives. The evaluation covers the period from March 2020 to December 2021 in geographical areas that corresponded to the COVID19 hotspots in Zimbabwe. The thematic scope of the evaluation covers health, nutrition, human immunodeficiency virus (HIV/AIDS), education, child protection, social protection and water, sanitation, and hygiene (WASH) including all humanitarian actions implemented by UNICEF and their cross-sectoral management, coordination roles (both as UNICEF and as part of their responsibilities to the Inter-Agency Standing Committee (IASC)) and complementarity among the different UNICEF sections.

Context

2. COVID19 struck Zimbabwe in early 2020, when the country already faced several challenges, including climate-related events such as drought and cyclone Idai. In addition, inflation had continued to hinder the country development and negatively affected food security and the health sector. Working with multiple government partners, civil society organizations, NGO's and other UN agencies, UNICEF's response in Zimbabwe mounted a multi-sector response funded by a variety of donors that covered almost all the provinces of Zimbabwe. Hotspots of COVID19 cases were in Harare, Mashonaland West, Mashonaland East and Manicaland provinces. The pandemic was a new kind of challenge for the country that not only required a different way of responding, but UNICEF and their partners needed to respond in a way to minimise risks to the health and performance of their staff.

Methodology

3. The team used a mixed methods approach to collect quantitative and qualitative data. UNICEF interventions were assessed using selected evaluative criteria for humanitarian assistance, namely relevance, coherence, effectiveness, efficiency, impact, sustainability, and accountability to affected populations (AAP). The evaluation also reviewed operational arrangements, including a specific attention to elements of management, strategic partnerships, and coordination. Data collection included a desk review of over 500 documents and conducted 115 key informant interviews (KIIs) based on a purposive sample of UNICEF and external stakeholders. Two online surveys were conducted, one for UNICEF staff and the other for partner organisations. A sample of selected projects was also subjected to a detailed analysis. Debrief and validation workshops with UNICEF staff were conducted to promote utilisation of evaluation results. The evaluation was managed by the UNICEF ZCO supported by a reference group that included a representative from the United Nations Resident Coordinator's Office.

Summary of findings

Main findings based on each of the evaluation questions (EQ) are as follows:

1. Relevance

4. UNICEF's ability to rapidly identify, prioritise and find solutions to mitigate challenges was facilitated by a combination of factors including a quick decision by the Zimbabwe government to declare a national disaster and set up coordinating mechanisms for the response. UNICEF faced several challenges when designing a response, including an overstretched health workforce, reluctance of government and partner staff to risk of infecting themselves and their families, school closures, lockdowns, and a lack of transportation, all of which made it difficult to access affected communities.

5. UNICEF supported the government's lead role through a combination of technical assistance,

provision of equipment and funding and capacity building. UNICEF was well-positioned for the response, using lessons from previous emergency responses while learning in real-time during the response. UNICEF conducted a programme criticality review in mid-2020 to identify which areas to prioritise during the response.

6. Data from six joint telephone household surveys during the 2020-2022 pandemic was used along with any available disaggregated national databases to prioritise vulnerability for assistance. Intervention designs were successful at mainstreaming gender equality, but sectors had mixed results in attempting to address disability and mitigate/prevent Gender Based Violence (GBV) due to the lack of visibility during lockdowns. Child rights were promoted through safeguarding trainings and communication.

2. Coherence

7. **Coordination** – UNICEF filled several internal and external coordination roles during the COVID19 response to support the Government of Zimbabwe's (GoZ) lead role. A multi-sectoral UNICEF Task Team ensured there was integration across sectors. The Nutrition section was represented by Health in the Task Team which left some gaps. UNICEF provided technical, material, and financial support for six of the GoZ-led eight response pillars set up for the COVID19 response.

8. **Linking humanitarian and development –** UNICEF based the COVID19 response on its existing country programme which meant that there were strong links humanitarian and development, with a specific focus on equity and resilience.

9. **Fundraising and governance structures –** UNICEF ZCO has been an important fund manager in the country for many years and was in a strong position to reprogramme funding and mobilise additional emergency funds despite a challenging fund-raising environment.

3. Effectiveness

10. **Achievements against response targets** - Most targets were met during the COVID19 response, with targets for Education, WASH and HIV/AIDs being exceeded. UNICEF and their partners faced challenges in meeting targets for severe acute malnutrition (SAM), numbers accessing GBV services and numbers who were able to access cash transfers. The results achieved in Education, WASH and HIV/AIDs were impressive given the funding situation and challenging operating environment.

11. **Achievement of targets based on the needs of different groups** – Interventions were effectively targeted although coverage was incomplete. UNICEF faced challenges in meeting needs for people living with disabilities and mitigating and preventing GBV due to limited reporting options and services during lockdowns, with adolescents and women with disabilities being particularly at risk.

12. **Programme quality and performance** – The overall response to COVID19, including by UNICEF, was delayed due to uncertainties about the impact of the pandemic and how best to respond. UNICEF successfully built upon lessons from previous responses, including their work with Village Health Workers (VHWs), and Community Case Workers (CCWs) who proved to be key resources for assessment information and delivery of assistance during the response.

4. Efficiency

13. There were uncertainties initially about the most efficient way to both work remotely and deliver assistance promptly to affected communities and UNICEF used a "no-regrets" approach to respond to expedite implementation. Cost analyses were conducted later by UNICEF's procurement and administration sections to identify cost-efficient options. Otherwise, the evaluation team found few examples of cost analyses for sectoral interventions apart from cash transfer interventions.

14. **Procurement** supported both UNICEF's own response and that of the GoZ. There were significant delays in identification and shipping supplies during 2020 though the timeliness of procurement improved during 2021 due to the opening of borders, easing of movement restrictions and signing of additional long-term agreements (LTA) established with local suppliers. The team was not able to track procurement timelines to end users (rights holders at a community level) due to the gaps in systems

that monitor delivery of UNICEF supplies.

15. **Interagency preparedness plans** did not include scenarios for airbourne epidemics. Some pre-positioned non-food items were quickly distributed but other essential items, notably personal protective equipment (PPE), were in short supply. Pre-existing partnerships with government, civil society, UN agencies and donors were instrumental in reaching targeted populations, including the most vulnerable, to increase the efficiency and effectiveness of the response. Partnerships with the private sector existed but were not so evident. Partners felt that UNICEF had managed the relationship efficiently although several suggested that UNICEF could have convened a virtual learning forum to share experiences and learning. UNICEF staff also expressed satisfaction with partnership arrangements although they noted the challenges of working with government officials remotely.

16. **Risk Communication and Community Engagement** (RCCE) was one of the most successful and timely aspects of the response to the COVID19 pandemic. It particularly helped to generate demand for essential services and mitigate against misinformation.

17. **Third-Party Monitoring** (TPM) missions allowed UNICEF to obtain feedback, identify obstacles and bottlenecks to delivering assistance and obtain expert advice to facilitate learning and adaptation to an evolving environment. UNICEF joint monitoring visits with partners were suspended for a time by travel bans and lockdowns during 2020-2021.

5. Impact

18. Given the limitations of the evaluation, notably the availability of baseline data and time spent in the field, it was difficult to accurately assess impact of UNICEF's response to COVID19. However, some elements of the COVID19 response were seen likely to have a lasting impact in different sectors. The quality and approach of UNICEF's response has helped to strengthen partnerships with government and NGO partners that will likely have a long-term positive impact. Partners and UNICEF staff were mostly optimistic that the impacts of UNICEF's interventions would spread beyond COVID19, citing examples from Child Protection, Education and WASH interventions.

6. Sustainability

19. There were several examples of UNICEF interventions that are likely to be sustainable, including in the Child Protection, Education, Health, and WASH sections. Prospects for sustainability were improved where interventions had been incorporated into longer-term programmes, had good community ownership and/or where they filled a previously unfilled niche, such as remote education. Faced with funding limitations donors had difficulty in finding resources to continue to pay for Village Health Workers (VHWs) who filled a critical role during the response, which has negative implications for continued community resilience.

7. Accountability to Affected Populations

20. UNICEF has made progress on Accountability to Affected Populations (AAP) over the past few years, but it has not yet been fully mainstreamed. This was apparent during lockdowns with limited access to communities and it was difficult to continue support and monitoring for such highly affected populations as people living with disabilities and victims of GBV Community feedback systems exist although some UNICEF staff respondents had doubts about their effectiveness. There were examples of UNICEF proactively seeking community engagement, including feedback on its interventions using U-Report challenge via social media although this did not occur until later in the response.

Conclusions

21. This is a summary version of the conclusions. Detailed conclusions can be found at the end of this report.

OVERALL CONCLUSIONS

The scope, spread and unpredictability of the COVID19 pandemic was a significant challenge to a global development and humanitarian system that required a response that was largely unfamiliar to staff. Not only did UNICEF need to respond to the needs of affected communities, but it needed to significantly revise its ways of working to protect the health and safety of its own and partner staff. The COVID19 pandemic tested community resilience and triggered adaptations and innovations in all sectors that can increase resilience over time.

Sustainability

CONCLUSION 1. The sustainability of UNICEF interventions varied. UNICEF drew upon the strengths of its programme and networks. The evaluation nevertheless raised questions about appropriateness and sustainability. For all sectors there was a question of what capacity was needed to improve resilience of local actors to mitigate the effects of the pandemic and respond to the next disaster. Specific examples were seen in WASH, where short-term interventions of 4-6 months were less likely to be as sustainable as interventions which had been integrated with longer term recovery interventions that were running in areas affected by cyclone Idai in 2019. UNICEF's cash transfer programme also has a viable exit strategy. Nutrition was not viewed as a priority during the COVID19 response in Zimbabwe and the resulting impact is likely to be felt for some time.

Vulnerability

CONCLUSION 2. There were remaining gaps in assessment and assistance for people with disability and vulnerable children, particularly girls. UNICEF made efforts in the intervention designs to ensure that vulnerable groups were prioritised, but implementation was variable. There was a consensus that, although UNICEF had performed well in the response, there could have been more of a focused effort to continue to support some groups that were particularly vulnerable, such as people with disability and girls at risk from GBV.

CONCLUSION 3. Substance abuse by adolescents was not sufficiently prioritised during the COVID19 response. There was significant evidence that substance abuse significantly increased amongst youth and adolescents due to the impact of COVID19 pandemic on this group. Increased substance abuse by Zimbabwe's youth is likely to be an unfortunate outcome that will remain well after threats from the COVID19 pandemic have subsided.

Programme quality
CONCLUSION 4. Preparedness needs further strengthening. Preparedness contributed to UNICEF's ability to respond to the COVID19 pandemic by streamlining procurement and administrative systems and "switching gears" to emergency response mode. Staff capacities for emergency response and scenario-based preparedness still need strengthening. I took time for UNICEF, and other humanitarian agencies, to adapt to new ways of working challenged by a lockdown, closed borders, an airborne pandemic, and other unfamiliar elements. UNICEF learned and adapted systems during the response including remote working modalities and local LTAs for procurement that are likely to change how UNICEF responds in future.
CONCLUSION 5. Risk Communication and Community Engagement (RCCE) was a valuable UNICEF contribution to the overall response. UNICEF's RCCE activities and work with community-based groups using formats tailored for specific groups, such as people with disabilities, was a trusted source that increased knowledge of COVID19 and had a positive change on behaviour.
CONCLUSION 6. Nutrition was not sufficiently prioritised during the response. Nutrition was demoted to a subsidiary of health during the response, including representation in UNICEF's COVID19 Task Force resulting in a lack of visibility.
Monitoring, information management and AAP
CONCLUSION 7. The COVID19 response provided an opportunity to learn and further improve Accountability to Affected Populations and remote monitoring systems, including Third-Party Monitoring mechanisms. UNICEF direct monitoring was limited during COVID19 with UNICEF staff not able to visit the field for extended periods. UNICEF were able to conduct TPMs that allowed them to not only monitor progress and understand how to increase the effectiveness of their support, but also help with AAP by indirect consultations with affected populations. This provided UNICEF with an opportunity to adapt remote monitoring systems while identifying areas for improvement. The evaluation team was able to track procurement up to warehouses or handover of supplies to partners, but it proved difficult to track delivery of supplies to end users.
CONCLUSION 8. Gaps in information management and reporting systems. Although UNICEF had a platform to facilitate internal information management, the evaluation team struggled at times to get the data required to carry out the evaluation. In the end, the evaluation team was able to access most of the data requested, except for some documentation for projects in the sample. When the pandemic struck, in-person coordination meetings for implementing partners, where they could share learning, were suspended. Several partner staff mentioned that the virtual coordination sessions convened by UNICEF during the pandemic should have also been seen as peer learning opportunities.

Recommendations

22. This is a summary version of the recommendations, which are linked to the above conclusions. Detailed recommendations specifying the prioritisation and stakeholder involvement can be found at the end of this report.

Sustainability
R1. Improve the sustainability of interventions by taking a longer-term perspective through integrating interventions with longer-term initiatives, strengthening partnerships with the private sector and capture learning from the cash transfer program to share experience and replicate good practice.
Vulnerability

R2. UNICEF should reinforce assistance to particularly vulnerable groups, including people with disability and vulnerable girls.
R3. Commission an assessment and develop a strategy to prevent and mitigate youth substance abuse.
Programme quality
R4. Update preparedness planning by using different scenario-based emergency simulations. This should be done as an interagency exercise with roles and priorities identified for different agencies.
R5. While continuing to improve RCCE effectiveness to support UNICEF's own programming, UNICEF should identify ways to apply this useful tool to strengthen the overall response by, for example, including RCCE in interagency disaster simulation exercises.
R6. Ensure that a future emergency response adequately reflects UNICEF's lead role in nutrition, including as head of the Global Nutrition Cluster.
Monitoring, information management and AAP
R7. Improve Accountability to Affected Populations and remote monitoring systems by promoting increased community participation in planning and decision-making, the consolidation and systematic use of community complaints and feedback with partners, improving end user tracking systems, and integrating TPM as part of preparedness planning.
R8. Promote more systematic information management by reviewing reporting and information management systems and revise to ensure they are useful and fit-for-purpose. Promote peer learning with partners and continue to increase frontline workers' access to modern technologies, equipment, and technical support.

Introduction

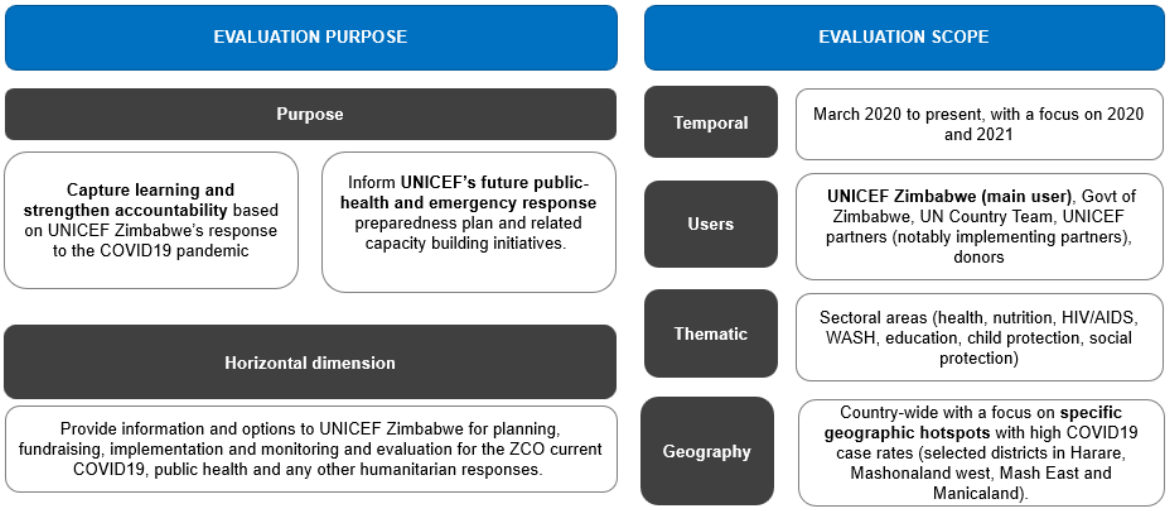
23. The COVID19 struck Zimbabwe in early 2020, when the country was already facing several challenges, including climate-related events such as drought and cyclone Idai that had struck in 2019. In addition, hyper-inflation had continued to hinder the country development and negatively affected food security, the health and education sectors.

24. Working with multiple government partners, civil society organizations, NGO's and other UN agencies, UNICEF in Zimbabwe mounted a multi-sector COVID19 response that covered almost all the provinces of Zimbabwe. Specific hotspots of COVID19 were Harare, Mashonaland West, Mashonaland East and Manicaland.

Evaluation purpose and scope

25. The evaluation focused on the period from March 2020 to December 2021 in the specific geographical areas mentioned in the TOR that corresponded to the COVID19 hotspots in Zimbabwe. The thematic scope of the evaluation covered health, nutrition, HIV/AIDS, WASH, education, child protection, social protection, including all humanitarian actions implemented by UNICEF and their cross-sectoral management, coordination roles (both as UNICEF and as part of their responsibilities to the Inter-Agency Standing Committee, IASC) and complementarity among the different UNICEF sections. Cross-cutting themes included gender, disabilities and mental health.

Figure 1 – Evaluation purpose and scope



26. The purpose of the evaluation was to provide an independent assessment of the UNICEF ZCO's Humanitarian Response of COVID19 during the period 2020-2021. The objectives of the evaluation were both accountability and learning. It aimed to assess UNICEF ZCO's humanitarian response to the COVID19 pandemic, assess the results achieved, capture and elaborate lessons learnt for future emergency responses. The **specific objectives** of this evaluation as defined in the TOR were:

- To assess the extent to which the UNICEF ZCO's COVID19 humanitarian response achieved its **intended results**, take stock of progress and performance, for internal and external accountability purposes.
- To determine the extent to which UNICEF **financing, management and governance** of the humanitarian response was **effective** in achieving the intended results.
- To identify and document **lessons learned, good practices/successful strategies, innovations, and recommendations** in implementing the COVID19 response,
- To provide the ZCO with information and options for **planning, fundraising, implementation**

and monitoring and evaluation for the remaining COVID19 response, public health, and any other humanitarian event.

27. To analyse the **equity dimension** to the response specifically looking at how the response took into consideration the needs of women and girls as well as people living with disabilities.

Table 1 – Stakeholders and anticipated use of the evaluation results

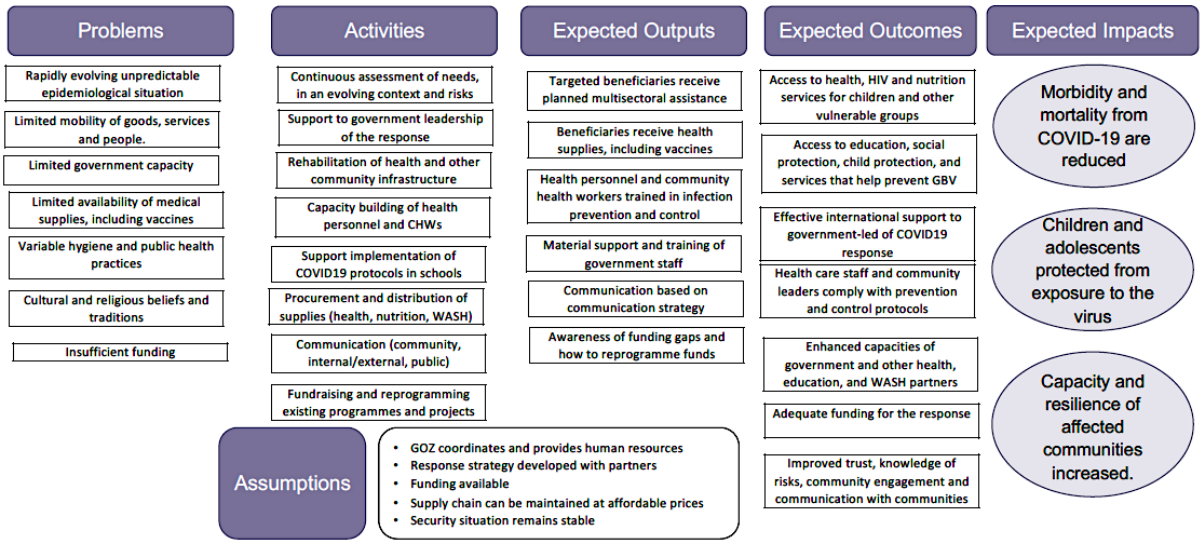
Stakeholder	Relationship	Evaluation Use
UNICEF Country Office ***(Duty bearer)***	Primary stakeholder for this evaluation of the response	Primary stakeholders for this evaluation. Interested in lessons emerging from this study at both a strategic and operational level. Will use the results to inform ongoing and future programming and strategies.
UNICEF Regional Office and UNICEF Headquarters ***(Duty bearer)***	Technical advisory role, quality assurance support	Will use institutional learning from the evaluation and identify areas of support for the Country Office.
Government of Zimbabwe ***(Duty bearer)***	Provide overall coordination for UNICEF interventions while having significant implementation role.	Improve understanding of how to optimize the partnership with UNICEF.
UNICEF Implementing partners in Zimbabwe ***(Duty bearer)***	Responsibility for implementation of UNICEF projects.	Interested in learning for future responses and to inform their own strategic and programmatic planning.
Affected communities, including recipients of UNICEF assistance ***(Rights holders)***	Ultimate target of humanitarian operations	Likely to have different types of values and expectations relative to other stakeholders. Mainly interested in whether their needs are met without a clear understanding of resources available or how humanitarian system works.
UN Country Team and peer UN agencies ***(Duty bearers)***	Coordinate and cooperate	Peer learning.
Donors to UNICEF ZCO, including HDF ***(Duty bearers)***	Funding and supporting UNICEF operations	Interested in understanding how UNICEF has performed in this challenging context for accountability purposes and learning how to increase the effectiveness of their support for future emergencies.

Theory of change

28. There was not a dedicated Theory of Change (ToC) for the COVID UNICEF's response, something which is not unusual for emergency responses. A ToC was reconstructed (Figure 2) based on the evaluation questions, relevant data in UNICEF ZCO's annual reports for 2020 and 2021, a UNICEF

regional COVID ToC, UNICEF global WASH guidance,[1] complemented by consultations with UNICEF ZCO staff. It was agreed with UNICEF ZCO that the evaluation would focus mainly on how the response was managed (Activities and Outputs) while at the same time collecting available evidence about outcomes where data was available.

Figure 2 – Reconstructed Theory of Change for UNICEF's COVID19 response



Source: evaluation team

Operational context

29. In December 2019, symptoms of a severe acute respiratory syndrome infection emerged in China, that was initially reported as a pneumonia of unknown origin. By the end of January, the World Health Organization (WHO) reported 7,818 cases in 18 countries outside China.[2] Based on genetic sequencing received from China, the disease was officially recognized as a SARS-CoV-2 virus and renamed as COVID19 on 11 February 2020 by WHO.[3]

30. Economic activity contracted in 2020 in about 90 percent of countries. In 2020, the first year of the COVID19 pandemic, the global economy shrank by approximately 3 percent, and global poverty increased for the first time in a generation.[4]

COVID19 impact on Sustainable Development Goals

31. The COVID19 pandemic has had both direct and indirect impacts on the Sustainable Development Goals (SDGs). While some progress has been hindered or reversed, certain areas have seen positive outcomes or accelerated efforts. Here are some key impacts on the SDGs identified by UNDP though various studies:[5]

- Goal 1: No Poverty: The pandemic has pushed millions of people into extreme poverty due to job losses, reduced incomes, and economic downturns.
- Goal 2: Zero Hunger: Lockdowns, disruptions in supply chains, and economic challenges have

[1] UNICEF WCARO Evaluation Technical Note #2: Theory of Change of the COVID19 response in the West and Central African region and UNICEF COVID19 Emergency Preparedness and Response: WASH Strategic Programming Framework

[2] World Health Organisation. *Novel Coronavirus (2019-nCoV). Situation Report 10.* WHO: Geneva, January 30, 2020. pp 1.

[3] Wang, H., Li, X., Li, T. *et al.* The *genetic sequence, origin, and diagnosis of SARS-CoV-2.* Eur J Clin Microbiol Infect Dis **39**, 1629–1635. Springer Publishing: Berlin. April 24, 2020. https://doi.org/10.1007/s10096-020-03899-4

[4] World Bank/World Development Report 2022.

[5] United Nations Sustainable Development Goals Knowledge Platform: https://sdgs.un.org/

exacerbated food insecurity and malnutrition in many parts of the world.

- Goal 3: Good Health and Well-being: COVID19 has overwhelmed healthcare systems, leading to significant strains on health services and resources. Progress in tackling other health issues, such as maternal and child health or combating HIV, has been hampered.
- Goal 4: Quality Education: School closures and the shift to remote learning have disrupted education systems worldwide, disproportionately affecting vulnerable students and exacerbating existing educational inequalities.
- Goal 5: Gender Equality: The pandemic has exacerbated existing gender inequalities, with women and girls facing increased domestic violence, unpaid care work, and limited access to healthcare and education.
- Goal 8: Decent Work and Economic Growth: Lockdowns and restrictions have resulted in job losses, business closures, and economic downturns, impacting decent work opportunities and economic growth.
- Goal 10: Reduced Inequalities: The pandemic has widened existing inequalities, disproportionately affecting marginalized communities, people with disabilities, and migrants.
- Goal 13: Climate Action: Temporary reductions in economic activity and travel during lockdowns led to short-term decreases in greenhouse gas emissions. However, the overall impact on long-term climate action has been limited, and efforts to address climate change have taken a backseat in some instances.
- Goal 16: Peace, Justice, and Strong Institutions: The pandemic has strained social cohesion, led to an increase in human rights abuses, and disrupted justice systems, further challenging efforts to promote peace and justice.
- Goal 17: Partnerships for the Goals: International cooperation and partnerships have been crucial in responding to the pandemic. However, the diversion of resources and attention towards the crisis has impacted progress on other SDGs.

32. While all these impacts have an influence on UNICEF's response to COVID19, UNICEF has a specific role in mitigating impacts on achievement of SDG 3, 4, 5, and 10.

Leave no one behind

33. "*Leave no one behind*" was a commitment made by UN Member States to eradicate poverty, reduce inequalities, and end discrimination, and is one of the six Guiding Principles of the United Nations Sustainable Development Cooperation Framework.[6] The COVID19 pandemic posed a challenge to the UN to fulfil commitments made. Of concern for UNICEF, was that the incidence of children living in multidimensional poverty was expected to increase by about 100 million children.[7]

COVID19 pandemic in Africa

34. As of 4 September 2022, there were 8,791,765 confirmed cases of COVID19 with 173,296 cumulative deaths reported from 47 countries and territories in the WHO Africa Region, with a case fatality rate of 2.54[8] (these data exclude north African countries in WHO's Eastern Mediterranean Regional Office). This would represent 1.46 % of the global cases and 2.6% of global fatalities. Given the remoteness of parts of the region and the widespread disruption to health services, especially in rural areas, this probably significantly under-represents the true extent of the cases and fatalities.

35. The COVID19 2021 Strategic Preparedness and Response Plan (SPRP) issued in January 2021 for the

[6] https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind
[7] UNICEF data hub: https://data.unicef.org/COVID19-and-children
[8] World Health Organisation Africa. *WHO Coronavirus (COVID19) Dashboard* as of September 4, 2022. WHO: Brazzaville, DRC. 4 September 2022.

WHO's African Region coordinated all aspects of the pandemic response for the international community, with 11 technical pillars, presented in Table 2 which then informed ongoing country data collection and analysis.

Table 2 – Technical Pillars of WHO's Strategic Preparedness and Response Plan, 2021

No.	Pillar type
1	Coordination, planning, financing, and monitoring
2	Risk communication, community engagement and infodemic management
3	Surveillance, outbreak investigation and calibration of public health and social measures
4	Points of entry, international travel and transport, and mass gatherings
5	Laboratories and diagnostics
6	Infection prevention and control and protection of the health workforce
7	Case management, clinical operations, and therapeutics
8	Operational support and logistics, and supply chains
9	Strengthening essential health services and systems
10	Vaccination
11	Research, innovation, and evidence

36. As of 4 September 2022, a total of 298.9 million people had received at least one dose of the COVID19 vaccine, representing 25.7% of the African Region's population (23.6% by the end of July 2022), while 235.9 million people had received the required number of vaccine doses in the primary series, representing 20.3% of the African Region's population (18.5% by the end of July 2022).[9] Most countries (60%) received vaccines through the COVAX facility, and the African Union vaccine procurement mechanism, AVAT. A total of 706 million doses of COVID19 vaccines were delivered in the African Region, including 66.6% from the COVAX Facility. This represented 60.8 doses per 100 population. Within two months, vaccine availability had soared to 944.9 million doses with 617.5 million administered. These included Johnson & Johnson (32.0%), Pfizer BioNTech (19.2%), AstraZeneca (13%), Sinopharm (14,2%), Sinovac (7.8%) and Moderna (5.3%).[10]

Country context

37. Zimbabwe is a land-locked country in southeast Africa, has a population of 15,178,979 million, 52 percent of whom are female and 61.4 percent live in rural areas.[11] Nine percent of the population has a disability while life expectancy was estimated at 60 years in 2021 (male). The population is young with about 41 percent below the age of 15, and the 15-24 age group accounting for approximately 36 percent of the population.[12] Sex and age disaggregated data would be required to identify the most vulnerable population groups, including those in institutions.

38. According to the UN Office for Humanitarian Affairs (OCHA), the pandemic struck Zimbabwe in early 2020 when there were accelerating humanitarian needs.[13] A devastating 2018/2019 drought, crop losses, economic shocks and escalating macro-economic challenges, and the floods in the aftermath of

[9] World Health Organisation Africa. COVID19 vaccination in the WHO African Region, Dashboard. September 2022.
[7] World Health Organisation Africa. *Vaccination Bulletin,* August 2022.
[11] Zimbabwe National Statistics Agency (ZIMSTAT).2022 Population and Housing Census: Preliminary Report on Population Figures. Harare, Zimbabwe. 2022.
[12] UNFPA, World Population Dashboard Zimbabwe. Accessed 9 November 2022.
[13] UN OCHA. Humanitarian Needs Overview: Zimbabwe. Programme Cycle 2020. New York, NY, Feb 2020.

cyclone Idai had left 7 million people (of an estimated 15.3 million) in urban and rural areas across the country in urgent need of assistance, compared to 5.5 million people in August 2019. An estimated 6 million people were severely food insecure (Integrated Food Security Phase Classification (IPC) phase 3 or higher), including 4.3 million in rural areas, and 1.7 million in urban areas.[14] 1.2 million people were facing life-threatening needs (related to critical physical and mental well-being issues) and a further 5.8 million required life-sustaining support.

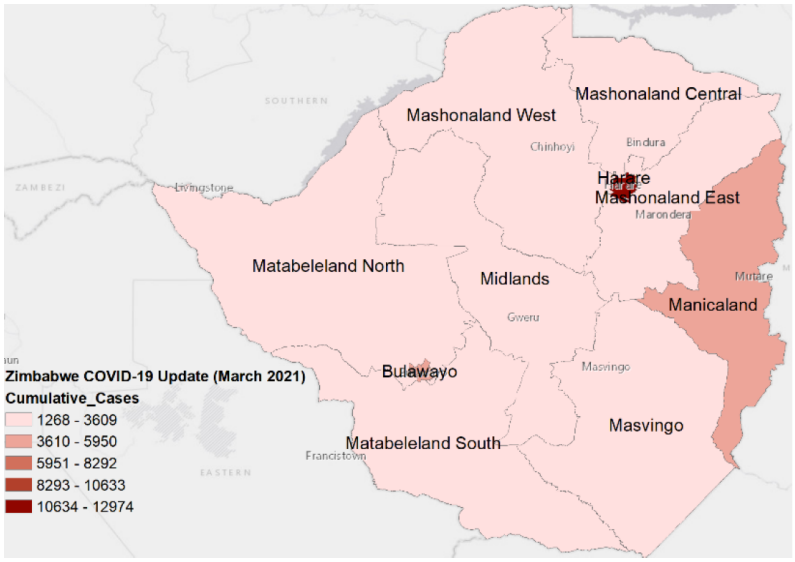
39. Over 1 million children and women required nutrition assistance. This included approximately 95,000 children under age 5 who were acutely malnourished (3.6 per cent of children under age 5), the highest level of acute malnutrition seen in decades.

40. Drought and economic challenges severely compromised people's access to basic services—including health, water, sanitation and hygiene (WASH), and education—and increased vulnerability to infectious diseases: at least 4 million vulnerable Zimbabweans were facing challenges accessing primary healthcare, including people living with HIV; some 1.2 million school-age children were facing severe challenges accessing education; and around 3.7 million people needed urgent support to access safe drinking water and appropriate sanitation and hygiene.[15]

41. The combination of climatic and economic shocks left at least 1.3 million people—mostly women and girls—at risk of GBV, and 1.2 million children in urgent need of protection support. Women and girls had to travel longer distances to access clean water, increasing the risk of GBV, while early marriage was being used as a coping mechanism by over-stretched families. 2019 saw a 24 per cent increase in reported child abuse cases and a 20 per cent increase in reported child sexual abuse cases compared to 2018. These trends would expand and accelerate during the pandemic, with a surge in cases of gender-based and child violence.[16] Consequently, in May 2020, the Global Humanitarian Response Plan for COVID19 added Zimbabwe to the priority list of countries.

COVID19 in Zimbabwe

Figure 3 – Reported COVID19 cases in Zimbabwe as of March 2021[17]



42. The pandemic struck Zimbabwe in four waves, each introducing a new strain of the virus: Alpha, Beta, Delta, Omicron between March 2020 and August 2022. New Omicron subvariants were introduced in the last few months of this period. These data likely account for a fraction of the actual cases. Modelling

[14] UN OCHA. Zimbabwe: Humanitarian Needs Overview 2020. Harare, Zimbabwe, 29 Feb 2020.
[15] ibid
[16] ibid
[17] UNICEF ZCO (2021) Multi-hazard Situation Report # 1 February – 31 March 2021.

by WHO's Regional Office for Africa suggests that due to under-reporting, the true cumulative number of infections by the end of 2021 was around 6.8 million[18] In comparison, the UNICEF situation report no. 7 for December 31, 2021, lists the confirmed cases as 213,258 or 3.1% of the WHO estimate.

Zimbabwe in the wake of COVID19 pandemic

43. During 2020, the country's annual inflation rate reached an all-time high of 837.5 per cent in July 2020, compared to 230.4 per cent in July 2019, before declining to 401.7 per cent in November 2020.[19] Food price inflation increased from 22.6 per cent in November 2019 to 385 per cent in November 2020. A rural ZimVAC assessment found that rural household incomes were reduced in 2020 by an average of 51.5 % compared to 2019.

44. There was a **reduction in severe food insecurity** during 2020 attributable to a major scale-up in humanitarian food assistance, as humanitarian partners reached an estimated 4.2 million people. Nearly 3.4 million people in rural areas were projected to face Crisis or Emergency (IPC Phase 3 or above) food insecurity at the peak of the 2020/2021 lean season (January-March) and 2.3 million people in urban communities were estimated to be food insecure in 2021; this pattern was repeated in August 2022, with another lean season looming.

45. An estimated 74,267 children under age 5 suffered from global acute malnutrition (GAM), including at least 38,425 of them with severe acute malnutrition, caused in part by a decrease in quality dietary habits and severely impacted nutrition referral mechanisms.[20] The prevalence of global acute malnutrition increased from 3.6 per cent in 2019 to 4.5 per cent in 2020, while severe acute malnutrition (SAM) increased to 2 per cent, up from 1.4 per cent in 2019. In September, ZimVAC assessed 56 per cent of the rural population as food insecure and nine out of 10 young children as lacking a minimum acceptable diet. In 2021, 24% of children 0-5 years were stunted (boys even more so than girls); only 42% of infants were exclusively breastfed for the first 6 months and only 10% of children aged 6-23 months received a minimally acceptable diet. Seasonal and chronic food insecurity increased across all regions and, particularly in peri-urban and urban areas.[21]

46. **The pandemic strongly hit the health sector**. Access and utilization of essential health services declined in April-October 2020 compared to same period in 2019, outpatient consultation declined by 49 per cent, attendance of pregnant women at the fourth antenatal visit declined by 55 per cent, and the number of people tested for HIV decreased by 45% (OCHA). Zimbabwe had an adult HIV prevalence of 12.9 per cent and was categorised as a high burden country although it met the second and third 90-90-90 UNAIDS targets.[22] However, the rate of mother-to-child transmission (MTCT) remained elevated at nearly 8.2 per cent and adolescent girls and young women continued to be disproportionately affected, accounting for 60 per cent of new HIV infections. Global data compiled by WHO from almost 350 000 patients in 38 countries indicated that people living with HIV/AIDS (PLHIV) were at increased risk for development of severe illness and death due to COVID19. This analysis found that the risk of developing severe fatal COVID19 was 38% greater in this population when compared to people without HIV infection.[23]

47. High 2020 inflation also negatively affected people's ability to pay for WASH services. Specifically, in urban areas there were severe water shortages, mainly caused by lack of treatment chemicals for which foreign currency is needed. Between 2020 and 2021, coverage of basic drinking water, and sanitation, declined from 72 to 63 per cent and from 46 to 36 per cent respectively (WHO/UNICEF Joint Monitoring Programme for WASH). Only 42 per cent of households had basic hygiene services. Access to basic water services in urban communities was 45 per cent higher than in rural areas. Challenges include weak institutional coordination and capacity, including to maintain WASH infrastructure, and

[18] UN OCHA. *Zimbabwe Situation Report* 31 Dec 2020. NY, NY.
[19] UNICEF. Humanitarian Action Plan for Children 2021: Zimbabwe. Harare, Zimbabwe. Pp 2.
[20] UN OCHA. Zimbabwe Situation Report. December 31,2020. Harare, Zimbabwe, Dec 2020.
[21] Zimbabwe Vulnerability Assessment Committee (ZimVAC). *2022 Rural Livelihoods Assessment Report.* Harare Zimbabwe. 2022.
[22] UNICEF ZCO. *Country Office Annual Report, 2020.* Harare, Zimbabwe.
[23] WHO. Coronavirus disease (COVID19) and People Living with HIV. Home, Newsroom, COVID19. 29 July 2022

insufficient water supplies.

48. Although not initially a priority when the pandemic erupted, **education** was impacted in the short and medium run. School closures, indeed, had a devastating effect on current children. Over 4.6 million children in Zimbabwe lost access to education and the protective environment provided in schools for over six months due to the pandemic, while over 1.7 million school children lost access to school feeding programmes.[24] Even after schools reopened, associated factors, such as caregiver inability to pay school fees, continued to impact learners, particularly in cyclone- and drought-affected areas.

49. **Gender parity issues**, including those prominent at the secondary level that pre-dated COVID19, remained a challenge: more girls (59 per cent) than boys (53 per cent) were enrolled in lower secondary school, and more girls (23 per cent) than boys (18 per cent) dropped out before reaching Form 4. After the first wave, the intermittent closure of schools as a COVID19 containment measure adversely affected children's learning progress, especially those with special needs and those from poor families. Government, through the Ministry of Primary and Secondary Education, with support from development partners, introduced alternative forms of learning, which included radio and online lessons, to ensure continued teaching and learning. However, this further exacerbated existing inequalities, as children from rural areas with limited network connectivity and radio signals could not access the lessons and relied largely on assignments from their parents.

50. Due to the "stay-at-home" policy, in 2020, gender-based violence cases reported through the National GBV Hotline, increased by 175% compared to 2019 with 8,563 GBV cases reported, primarily during lockdowns. Studies undertaken by African Union and UN confirms surges in violence against women (VAW) around the world being reported. Intimate partner violence, sexual harassment, domestic and sexual abuse of women and girls, in many cases by family members, are exacerbated particularly under lockdowns, movement restrictions and school closures.

51. The collateral effect also had implications for **child protection**: during the March-August 2020 lockdown, Zimbabwe recorded a 23 per cent increase in reported violence against children (VAC). [25] Even prior to the pandemic, Zimbabwe had a high incidence of violence against children, with two-thirds of girls and three-quarters of boys experiencing physical violence by a parent or an adult relative.

52. Financially distressed households reported an increase in the use of negative coping mechanisms including child labour, early marriage, and transactional sex, while economic challenges created barriers for children's return to education, especially for girls. According to the 2019 Multiple Indicator Cluster Survey conducted by the Government of Zimbabwe with support from UNICEF and partners, one woman out of three in Zimbabwe aged 20 to 49 was married before the age of 18, and 5% of girls were married before the age of 15. Poverty is a major correlation of child abuse and exploitation, including child marriage. Poverty is also the main trigger of child labour in Zimbabwe. Nearly one child out of three between 5 and 17 years in the country was engaged in child labour, involving particularly young boys living in rural areas, as well as children living with disabilities.[26] Zimbabwe also faced widespread violence against children, with two-thirds of girls and three-quarters of boys experiencing physical violence by a parent or an adult relative. Due to the lockdown, there was little access to reporting mechanisms and legal resources, and many providers curtailed services.

Response to COVID19 by the Government of Zimbabwe

53. The government also launched their COVID19 National Preparedness and Response Plan in March 2020 and declared a state of disaster. In response to the first recorded case, the government introduced mitigatory measures aimed at curbing transmissions. Zimbabwe, with support and guidance from the World Health Organisation (WHO), stratified the COVID19 responses into 8 pillars including surveillance, infection prevention and control, case management, ports of entry, risk communication and community engagement, laboratory, logistics, security, and coordination. Following the Presidential

[24] UNOCHA, UNCT Zimbabwe. Zimbabwe: Humanitarian Needs Overview 2021. 31 January 2021
[25] UNICEF, Country Office Annual Report, 2020. Harare, Zimbabwe. 2021.
[26] Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Snapshots of Key Findings. Harare, Zimbabwe: ZIMSTAT and UNICEF.

declaration of a state of emergency on 17 March 2020, the Government of Zimbabwe instituted a series of presidential decrees and statutory instruments to contain the spread the COVID19.[27]

The response to COVID19 in Zimbabwe by UN agencies and other actors

54. A 2020 Zimbabwe Humanitarian Response Plan (HRP) was launched on 2 April 2020 by the Ministry of Local Government and the UN Humanitarian Coordinator. The HRP planned for 47 humanitarian partners, including 9 national NGOs, 29 international NGOs and 9 UN entities, to implement activities nationally in support of the Government-led response to a complex, multi-hazard context.

55. The United Nations and humanitarian partners revised the HRP in July to update the response to the COVID19 outbreak integrating a multisectoral migrant response and reprioritizing humanitarian cluster responses. Rather than developing a separate COVID19 response plan, the UN chose to produce a COVID19 annex to their HRP Plan for 2020. Requirements were estimated at US$85 million to respond to the immediate public health crisis and the secondary impacts of the pandemic on vulnerable people, in addition to the $715 million required in the HRP. In fact, $256.7 million was raised to fund the HRP compared to the $800 million needed. The primary donors included the United States of America (31.8%), the United Kingdom (15.6%), the European Commission (15.5%), Central Emergency Response Fund (UN) (13.7%), Japan (6%) and Germany (5.9%).[28]

56. Within this response, GoZ established 9 pillars for the response to COVID19:

    Pillar 1 - Coordination Planning and Monitoring
    Pillar 2 - Risk Communication & Community Engagement
    Pillar 3 - Surveillance, Rapid Response Teams & Case Investigation
    Pillar 4 - Point of Entry
    Pillar 5 - National Laboratories
    Pillar 6 - Infection Prevention & Control
    Pillar 7 - Case Management
    Pillar 8 - Operational Support and Logistics
    Pillar 9 - Research

Response to COVID19

57. UNICEF's COVID19 response was guided by the GoZ's COVID19 response plan, the Humanitarian Action for Children 2021 and the COVID19 Third Wave Contingency plans. In 2021, the Humanitarian Action for Children (HAC) for Zimbabwe was mainly focused on the COVID19 response with a targeted population of 2.7 million of which 2 million were children. The response targeted about 610,057 (children: 250,733) with WASH services, about 476,926 children with nutrition services and 2.7 million (of which 1.11 million were children) with health. interventions. The response also sought to provide education services to 409,716 children, Child Protection services to 90,000 children and Social Protection interventions to cushion over 105,000 people (of which 43,155 were children) from the adverse effects of the pandemic. The response also aimed to provide HIV/AIDS services to about 70,000 adolescents and children. Communication for Development was central to the response by targeting to reach over 5 million through a RCCE strategy.

58. UNICEF and partners worked with GoZ to mount a multi-sectoral response to the pandemic and scaled up its support to government-led national and district coordination structures to support interventions to contain the COVID19 outbreak. UNICEF participated in many of the pillars set up by the Government for the COVID19 response described above while collaborating with several Ministries, notably MoHCC, Ministry of Primary and Secondary Education (MoPSE), Ministry of Public Services, Labour and Social Welfare (MoPSLSW) and Ministry of Lands, Agriculture, Fisheries, Water and Rural Development (MLAFWRD).

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[27] Magocha, J. C. (2021). Zimbabwe's social policy response to COVID19 and implications for social work. *African Journal of Social Work, 11(4),* 216-222.

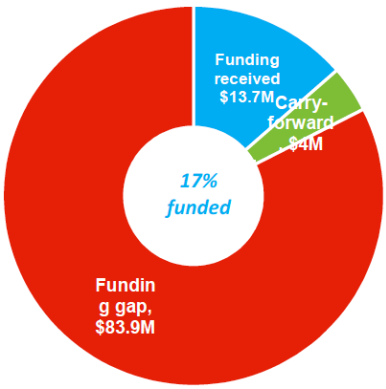
[28] UNOCHA Financial Tracking Service: Zimbabwe 2020.

Background

59. UNICEF ZCO faced a challenging funding situation. UNICEF appealed for USD 101.6 in 2020 of which only 17% had been funded by December 2020. Fundraising in 2021 was somewhat more successful, with 28% contributed of the USD 65.2 million required.

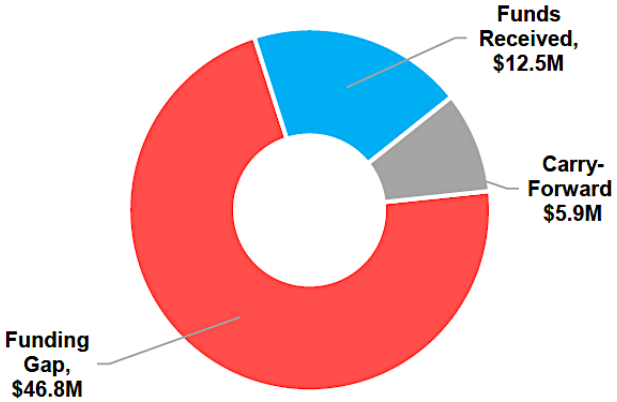
Figure 4 – Overall funding status (in USD)

as of December 2020



UNICEF ZCO Humanitarian SitRep 31 Dec 2020.

as of December 2021



UNICEF ZCO Humanitarian SitRep 31 Dec 2021.

60. The top five donors to UNICEF were the United Kingdom, Germany, the European Commission, USAID and Sweden.[29] Much of UNICEF ZCO's COVID19 response was funded through existing programmes, topped up with new funding. In 2021, the EU provided new funds for a total of USD 41 million to top up the Health Development Fund (HDF), while Sweden contributed USD 2 million in 2020.[30] Other funding through the HDF was provided by the United Kingdom, Irish Aid and the Global Vaccine Alliance (GAVI). The HDF and the Education Development Fund (EDF), had reprogrammed over USD 18.4 million to support the COVID19 response.[31]

61. A timeline of key events is provided in Table 3 below. The events are colour-coded to distinguish between external events, those applying to the UN, UNICEF-specific events.

Table 3 – Timeline of key events

DATE	UNICEF	UN	EXTERNAL EVENTS
31 Dec 2019	WHO reported of 44 pneumonia cases of an undetermined origin from Wuhan, China.		
31 January 2020	The recommendation from WHO's Emergency Committee, convened in mid-January, is to declare the outbreak as a Public Health Emergency of International Concern (PHEIC)		
11 February 2020	Based on genetic sequencing received from China, the disease was officially recognized as a SARS-CoV-2 virus and renamed as COVID19.		
11 March 2020	The Director-General of WHO declared COVID19 a global pandemic.		
20 March 2020	First case detected in the country. Contact tracing protocol initiated in Zimbabwe.		
19 March 2020	Government of Zimbabwe declares a national disaster.		
21 March 2020	Second confirmed case of COVID19. Launch of **Zimbabwe's preparedness and response plan** for coronavirus aimed at building an integrated and coordinated strategy for preventing the spread of the virus and mitigating its effects. Introduction of restriction of movement except for		

[29] UNICEF ZCO Situation Report. 31 December 2021.
[30] UNICEF Annual Report 2021.
[31] UNICEF (2020) Donors allocate additional funds to the Health Development Fund in Zimbabwe. 17 Jun 2020.

DATE	UNICEF	UN	EXTERNAL EVENTS
	essential and critical reasons. Increase the supply of potable water and measures to decongest informal and formal markets (Zim Gov).		
21 March 2020	Zimbabwe created a national COVID19 Response Task Force and an **Inter-Ministerial Committee**. Overall high-level coordination and planning was led by the Permanent Secretary for the Ministry of Health and Child Care (MOHCC) working with permanent secretaries of other ministries in support of the Inter-ministerial COVID19 Task Force.		
23 March 2020	Declaration of a **national state of disaster** due to COVID with the promulgation of a statutory instrument (SI) 76. Introduction of Public Health (COVID19 Prevention, Containment and Treatment) Regulations, 2020-SI 77		
March 2020	UNICEF coordinated the effort to fight against COVID19 and the residual emergency left by the cyclone Idai. UNICEF focused on access **to health services, on the fight against HIV/AIDS and on launching lifesaving messages**: among the others, it trained around 300 staff members with the purpose to respond to cholera, COVID19, and other disease outbreaks. COVID19 preparedness activities aimed at strengthening capacities are launched and support to increase access to health and water services is provided. Main partners: WHO and MOHCC.		
30 March 2020	Imposition of National lockdown Level 4 - measures include curfew (1800 to 0600 h), nonessential business to operate from 0800 to 1500h and abiding by WHO protocols relating to social distancing, sanitizing, and masking. Schools remained closed and public gatherings banned (except funerals) for 3 weeks, extended to 5.		
April 2020	The United Nations Secretary General launched a **global strategic framework** to support countries' paths to social and economic recovery in response to the COVID19 pandemic, including Zimbabwe, where it complemented both the government's strategic plan and the UN Humanitarian Response Plan.		
2 April 2020	Together with donors such as KfW, DFID, SIDA, Irish Government, EU and GAVI, UNICEF ZCO **reoriented part of the funding** to respond to COVID 19.		
April 2020	The Nutrition Cluster Humanitarian Response Plan (HRP) completed with an appeal to provide humanitarian assistance to 1.04 million children in need.		
17 May 2020	Level 2 lockdown measures declared indefinitely, replacing stricter Level 4 lockdown.		
June 2020	UNICEF initiated WASH Response to COVID19 in Health Care Facilities, and to grant access to water to communities. UNICEF activities also targeted districts in rural areas.		
July 2020	In July 2020 Zimbabwe issued a revised **Humanitarian Response Plan** to incorporate the response to the COVID19 pandemic.		
22 July 2020	New Level 4 lockdown declared.		
August-September 2020	Despite the difficulties, UNICEF continued to coordinate: • With the MoHCC, initiated the procurement of cholera kits and essential health supplies for management of diarrheal diseases. • The WASH sector by supporting 50 health care facilities with WASH Infection Prevention and Control (IPC) interventions. • The education sector through the provision of school material and masks and to build water resources in school environments. • The social protection sector by formally launching its Emergency Social Cash Transfer Programme (ESCT). • The child protection sector with structured psychosocial support activities. • UNICEF provided technical support to two rapid assessments with the National AIDS Council and the Ministry of Health and Child Care and distributed HIV/AIDS material and supported other communication activities.		

DATE	UNICEF	UN	EXTERNAL EVENTS
November 2020	UNICEF staff began to return to the office with a limit of 50% on staff numbers.		
1 December 2020	2021 **Global Humanitarian Overview** published including Zimbabwe (UN OCHA)		
31 December 2020	As of 31 December 2020, Zimbabwe had a cumulative total of 13,625 COVID19 cases, 11,154 recoveries and 360 deaths. Harare, Bulawayo, Matabeleland South, Midlands and Manicaland provinces accounted for 81.1 per cent of all confirmed cases in Zimbabwe. Children of school going age (5-19 years) accounted for 7.6 per cent of all reported cases.		
January 2021	**Humanitarian Needs Assessment** published by the UN Country Team (UNCT) with UNOCHA.		
	Level four lockdown measures reinstituted as large wave of COVID of 36,000 + cases.		
	UNICEF staff resumed visits to the field. Issued guidelines for face-to-face meeting with external parties.		
January 13, 2021	Traditional funerals were banned.		
February 2021	2021 **Humanitarian Response Plan** published by UNCT, delineating response to COVID among other humanitarian emergencies.		
22 February 2021	First Sinopharm COVID19 vaccination rollout targeting health workers and essential service providers.		
28 February 2021	End of level 4 lockdowns and transition to level 2.		
21 May 2021	Localised lockdown of Kwekwe city after detection of Delta variant. Curfew imposed and public gathering banned.		
June 2021	In 2021, UNICEF action largely embraced child protection sector and education beside the continuous effort for life saving messages and children in school.		
24 June 2021	Third Wave Imposition of national Level 4 lockdown: Business operating hours 0800 to 1530 h, curfew imposed from 1830 to 0600 h. Decongest offices to 40%. Only vaccinated people were allowed to resume economic activity		
8 September 2021	COVID19 lockdown reduced from Level 4 to Level 2, intercity travel allowed, and extended time for businesses operating (0800 to 1900 h) and curfew (2200 to 0500 h)		
1 October 2021	Zimbabwe receives its first 943,200 COVID19 doses of COVID19 vaccines from COVAX, primarily Sinovac and Sinopharm.		
30 November 2021	Mandatory PCR testing of all returning residents and visitors and quarantine at their cost, curfew hours increased to run from 9 p.m. to 6 a.m. Only vaccinated individuals to patronise places of worship, restaurants, and entertainment		
31 December 2021	Zimbabwe recorded 213,258 confirmed cases of COVID19, 180,570 recoveries and 5,004 deaths cumulatively through December 2021. A total of 4.1 million first doses and 3.1 million second doses of COVID19 vaccines (33.4 per cent of target population) were administered between October and December 2021.		
6 September 2022	Zimbabwe recorded 256,835 cases of COVID19, 241,052 recoveries and 5,596 deaths cumulatively through September 6,2022 A total of 6,451,857 people were vaccinated.		

Methodology

62. The evaluation was divided into three phases: inception, data collection and synthesis. The evaluation was launched after UNICEF's COVID19 response had ended and is a summative evaluation of UNICEF's response to the COVID19 pandemic. The evaluation focused on UNICEF's lead responsibilities at a strategic level and provided an opportunity for UNICEF and their partners to capture learning from the response and further strengthen their support to institutional and community resilience. While a project sample was analysed to better understand sectoral performance, a primary focus was on assessing how working together on themes and sectors as UNICEF and as part of an interagency response influenced outcomes for affected communities.

63. The evaluation team used a mixed-methods approach to collect quantitative and qualitative data as described in more detail below. A utilisation approach was used throughout the evaluation process that aimed to optimise participation by UNICEF and partner staff while respecting their workloads. For the purposes of this evaluation, affected populations are assumed to be comprised of both direct beneficiaries of UNICEF support and non-beneficiaries, including community leaders.

Evaluation questions

64. This evaluation aimed to draw evidence-informed conclusions based on OECD/DAC evaluation criteria of relevance, efficiency, coherence/coordination, effectiveness, efficiency, impact, sustainability, and accountability based on UNICEF's Core Commitments for Children in Humanitarian Action (CCC).

65. Evaluation questions (EQ) are shown in Table 3 below. The complete set of evaluation questions and sub-questions with indicators, judgement criteria (JC) and data sources can be seen in the evaluation matrix in Annex 7.

Table 4 – Evaluation Questions

EQ	OECD/DAC Criteria	Evaluation Question
EQ 1	Relevance	How relevant and appropriate was UNICEF's response in reaching populations most affected?
EQ 2	Coherence	How coherent has the UNICEF response been?
EQ 3	Effectiveness	How effective was the UNICEF response?
EQ 4	Efficiency	Was UNICEF's response efficient?
EQ 5	Impact	What impacts could UNICEF's COVID response have had?
EQ 6	Sustainability	How sustainable are UNICEF's interventions likely to be?
EQ 7	Equity and Accountability	How did UNICEF fulfil its commitments to be accountable to affected populations (AAP)?

66. The evaluation team made minor modifications to the sub-questions with the approval of the Reference Group for this evaluation to better reflect the importance of gender and advocacy. The sub-questions under Coherence/Coordination were also expanded to better reflect the different levels of both internal and external coordination. Sub-questions in Relevance (EQ1), Efficiency (EQ4) and Equity and Accountability (EQ7) were moved or modified to Coherence (EQ2) as they were a better fit under this criterion. These revisions are described in more detail in the Evaluation Matrix in the annex.

Management arrangements

67. The evaluation was managed by the UNICEF ZCO Country Office supported by a Reference Group composed of UNICEF staff plus one external member from the UN Resident Coordinator's Office in Zimbabwe.

Data collection, analysis and validation

68. The evaluation used a mixed-methods approach to data collection, starting with an inception phase that included a desk review and preliminary interviews with selected key informants.

69. The data collection phase included a review of key documents and existing secondary data and documentation, including SitReps, the HAC, needs assessments, UNICEF and partner monitoring reports, funding information, human resource data, supply data, preparedness, and contingency plans. Key informant interviews (KIIs) were also conducted using a purposive sample of stakeholders, including UNICEF staff at country/regional/HQ levels, implementing partners, development and humanitarian partners and other UN agencies.

70. A sample of 13 interventions covering the period from April 2020 to June 2022 selected during the inception phase were subjected to a detailed analysis. The sample was selected according to an analysis of the overall response and reviewed jointly with UNICEF to ensure a reasonably representative cross-section of the UNICEF response. The selection was based on five criteria: 1) scale of funding, 2) sectoral distribution, 3) geographical area, 4) temporal coverage and 5) partner diversity. An analysis of components was also conducted on annual workplans agreed with different Ministries related to the COVID19 response for education, health and nutrition. More details are provided in Annex 6.

71. **Field visits** were purposively selected to prioritise "hot spot" geographical areas where there had been relatively high infection rates and multi-sectoral assistance by UNICEF could be observed while taking account of the relatively short time available (less than two weeks). The evaluation team was split into two sub-teams to achieve greater coverage. More details of field visits, including locations visited, can be seen in Annex 3.

72. A total of 115 key informants based at district, provincial and national level were interviewed for this evaluation. Details are provided in Table 5 below and in the Annex 9.

Table 5 – Summary of key informant interviews

Organisation type	Total	M	F
UNICEF ZCO	21	12	9
Other UN	6	4	2
National Government	6	3	3
Local Government	26	12	14
International IPs	15	11	4
National Implementing partners/NGOs	19	10	9
Communities	19	2	17
Other key informants	3	0	3
Total	**115**	**54**	**61**

73. Important milestones of the analysis and reporting phase was the debrief for UNICEF staff at the end of the field mission and the **two remote validation workshops** involving UNICEF staff. One took place during a presentation of preliminary findings and emerging conclusions in October and the other workshop took place following circulation of this draft evaluation report.

74. **Data collection was also informed by an online survey** among UNICEF staff and NGO implementing partners to gain a better understanding of the response and hence complement data collected through KIIs. The survey was administered online through Survey Monkey in English.

75. The survey was based on the adapted interview guide and, recognising limited time field staff may have, it was designed so that most questions could be answered in a multiple-choice format with the possibility of adding an optional narrative. It consisted of an online questionnaire based on selected questions and sub-questions of the evaluation matrix and certain other issues relevant to the evaluation (e.g., other partnerships, use of internal resources, communication). The survey was supported by a communication strategy to encourage a response rate that helped respondents to explain the survey's

purpose, results and confidentiality principles and understand the importance of their honest feedback.

76. A total of 16 UNICEF staff responded to the survey. Responses were received from 10 national and international NGO implementing partners, many of which were collective responses by the partner organisation. While these response rates were insufficient to draw conclusions based solely on survey data, the results were consistent with data collected through interviews, the desk review and observations and were useful in strengthening the team's analysis. Data collected through the survey helped the team in answering the EQs and providing a broad perspective regarding the achievements, challenges, and barriers in the response but also examples of good practice and unintended results.

Evaluation ethics

77. During this evaluation, the team applied UNICEF ethical guidelines for evaluations,[32] OECD/DAC quality standards and UN Evaluation Group (UNEG) ethical standards for evaluation[33], notably those applicable to "do no harm", confirming consent, voluntary nature of participation, plus confidentiality and carrying out a risk assessment prior to conducting interviews.

Constraints and limitations

78. The design considered some challenges to conducting the evaluation and their potential influence on the quality of the evaluation during the inception phase to mitigate their effects. These are shown in Table 6 below.

Table 6 – Challenges and their mitigation

Challenges	Likely influence	Mitigation
Lack of letters of authorisation from concerned Ministries.	Biased data sample due to a lack of data from key stakeholder groups.	• Extension of the timeline for the evaluation to allow for the letters of authorisation to be issued. • Remote interviews with officials after the field visit.
Complex context due to political sensitivities and other factors.	Different sensitivities must be considered.	• Contextual analysis • Risk management
Time constraints.	Limited direct observation opportunities of projects or supported communities (also affected by lack of letters of authorization).	• Purposive sampling to optimize the limited number of project visits. • Triangulation of data from different sources.
Diverse stakeholders with different vulnerabilities	The diversity of stakeholders and the presence of different vulnerabilities obliged the team to develop different tools.	• Assess partners' monitoring and AAP system. • Project sampling to capture a representative view of UNICEF's response.
Potential data and document gaps	The lack of data (as well as their incompleteness of disaggregation) and documentation hindered the team knowledge concerning UNICEF's intervention.	• Use of alternative data. • Triangulation with other sources of information. • Draw up the knowledge of national experts.
Size of evaluation team	The small size of the team limited our ability to provide in-depth sectoral technical assessments for each sector.	• Clarify to stakeholders that this evaluation is aimed primarily at a strategic level. • The team used perspectives of technical staff in different agencies to triangulate data.

[32] UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis, 2015.
[33] 2020 UNEG Ethical Guidelines for Evaluation

Challenges	Likely influence	Mitigation
Time and capacity constraints	A small evaluation team, and the fact that staff from UNICEF and partners are engaged in ongoing operations placed a premium on time invested in the evaluation process, especially given the timing of the fieldwork in late November, a peak period for UNICEF and partners.	• Periodic check that priorities were appropriate for meeting evaluation objectives and producing a quality process and report. • Prioritise the needs of the primary user (UNICEF ZCO) by balancing timeliness to ensure the evaluation adds value.
Low response rate to surveys	Unrepresentative data sample.	• The survey was supported by a communication strategy to raise awareness about the surveys and motivate respondents. • Balance this data source with others as evidence for the evaluation.
Incomplete project documentation.	Data gaps contributing to an incomplete analysis.	• Triangulation with qualitative and other data sources.

79. Delays in issuance of authorisation letters by most of the concerned Ministries/Departments meant that the team was unable to interview government officials as planned during the field visit and also limited site visits in some sectors. Remote interviews were subsequently organised with government officials at a national and district level after completion of the field visit.

80. During the inception phase, 11 projects were identified for detailed analysis that together were judged to be a representative sample of the overall response. Since all documents had not been uploaded to the UNICEF intranet, the team was only able to review reports for 7 out of the 11 selected projects selected.

81. Apart from these limitations, the evaluation team found that there was a high level of engagement with the process by UNICEF staff and their partners. Most staff viewed the evaluation as a useful exercise and this, along with the logistics support provided particularly by partners in the field, greatly facilitated the team's work to mitigate these constraints and helped the evaluation team develop a reasonable evidence base on which to draw concrete conclusions.

Response to evaluation questions

82. This section presents findings for each of the seven evaluation questions listed in the evaluation TOR. A summary of findings for each EQ is followed by a narrative referencing sub-questions in the evaluation matrix. As described above in the Methodology section, findings were drawn from various sources including document review, interviews, and surveys.

EQ 1: Relevance

EQ 1	*How relevant and appropriate was UNICEF's response in reaching the most affected populations?*

83. This evaluation question looks at the extent to which UNICEF's response was adapted to the nature of the response, how successfully the response addressed and mitigated challenges at the design stage, and how UNICEF targeted vulnerable persons, including persons with disability, and integrated child rights and other equity issues.

Summary response to EQ 1

- The pandemic was a new challenge for a country that not only required a different way of responding, but also UNICEF and their partners needed to respond in a way to minimise risks to the health and performance of staff of UNICEF, partners, and communities. **UNICEF's ability to rapidly identify, prioritise and find solutions to mitigate challenges was facilitated by a quick decision by the Zimbabwe government to declare a national disaster**.
- **UNICEF responded appropriately under the difficult circumstances** and adapted to the changing context through supporting the government's leading role through a combination of technical assistance, provision of equipment and funding and capacity building.
- **UNICEF was well-positioned for the response**, using learning from previous emergency responses in Zimbabwe and the region, and conducted a programme criticality review in mid-2020 to identify priorities and adapted the response based on UNICEF's existing programme. UNICEF was also able to transition their systems relatively quickly to a remote working environment.
- **UNICEF contributed to six joint telephone household surveys** during 2020-2022 that collected assessment data and monitored the impacts of the pandemic. The data from these surveys was used with available disaggregated national databases to prioritise assistance for vulnerable groups.
- **Intervention designs were successful at mainstreaming gender equality, but sectors had mixed results in attempting to address disability and mitigate/prevent GBV** due mainly to lack of visibility during lockdowns. **Substance abuse** by youths also did not receive sufficient attention.
- **Child rights were promoted** through safeguarding trainings, communications, and other means.

Addressing and mitigating challenges

84. UNICEF ZCO was faced with several expected and unexpected challenges. Some challenges had an overall impact on the response while some challenges were more sector specific. **UNICEF's ability to rapidly identify, prioritise and find solutions to mitigate challenges was facilitated by a combination of factors** including a quick decision by the Zimbabwe government to declare a national disaster and set up coordinating mechanisms for the response,[34] UNICEF was able to quickly mobilise their existing network, fill their coordination role, negotiate with donors to re-programme funding,

[34] Mhazo AT, Maponga CC. (2022) Governing a pandemic: biopower and the COVID19 response in Zimbabwe. BMJ Global Health 2022;7.

request emergency funding from Central Emergency Response Fund (CERF) and other sources and call upon support from UNICEF at a regional and global level.

85. Interviewees and survey respondents noted that this was a global emergency and there was a shortage of many items, including personal protective equipment (PPE). Transportation and goods were limited and expensive. The region was not a priority in the context of the global response based on reported infection and mortality rates. Funding was not readily available when needed and due to movement restrictions and border closures international procurement was difficult. The response also had to contend with an unstable National economic environment.

86. Interviewees and survey respondents described challenges with an overstretched health workforce, a reluctance of government and partner staff to risk of infecting themselves and their families, school closures, lockdowns and a general lack of transportation making it difficult to access affected communities. Service providers and their families were infected. Staff and volunteers were reluctant to take risks without adequate security and appropriate compensation. Movement restrictions affected the delivery of essential services, programme monitoring, and procurement. There was an information overload[35] but few trusted sources, including social media. There were also challenges with religious groups who were resistant to vaccines and respecting social distancing guidelines. Key challenges faced by UNICEF and their partners during the response are listed in Table 7 along with mitigation approaches.

Table 7 – Challenges faced and mitigation strategies for each sector/cross-cutting issue[36]

Sector	Challenges	Mitigation
Disability	Medication for managing epilepsy was not available in local health centres and rehabilitation centres were closed. Even before COVID19, children didn't receive sufficient disability services. With the threat of COVID19, "children with disabilities took a back seat".	Ensure focus on disability through support and advocacy. Establish disability core teams to provide support. National Disability Policy launched in June 2021.
Gender	Spike in GBV - girls estimated to be seven more likely to be victims of GBV. Many girls did not return to schools due to early marriages and pregnancies.	Analysed district data and supported through communication, partners, and community level structures. In partnership with Save the Children, continued to strengthen Gender-Based Violence in Emergencies Programming platforms in 300 targeted districts under the Spotlight initiative to promote gender equitable norms attitudes and behaviours and transform harmful masculine behaviours.
Health	Reluctance to be vaccinated. Insufficient prepositioned items like masks and hand sanitizers. Health workers feared for their own lives. MoHCC did not capture data on disability status in its forms or reports so data on persons with disabilities for health facility-based activities is missing from project results.	Build capacities of key stakeholders from grassroots upwards to instil project buy-in. Data on vaccinations for persons with disabilities were collected via outreach.

[35] Constance RS Mackworth-Young, et al. (2021) Community perspectives on the COVID19 response, Zimbabwe. Bull WHO 2021; 99:85–91.

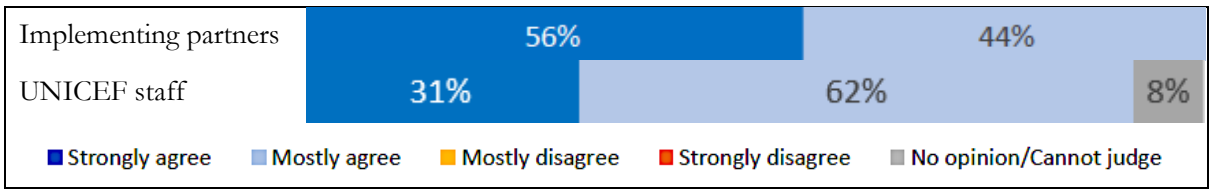
[36] Sources: UNICEF ZCO (2021) Lessons Learned Synthesis: UNICEF Preparedness for and Response to the COVID19 Emergency in Zimbabwe. March 2020–January 2021. Key informant interviews.

Sector	Challenges	Mitigation
HIV	Access to health services was limited and monitoring data shows a general decline in health service utilization of approximately 20 per cent between March and July 2020.[37]	Rapid assessments to inform guidance and programming, innovative communication approaches using different platforms and orientation of partners on remote monitoring systems.
Education	Equity issues – digital divide/connectivity, urban/rural elements. Hard to motivate students without unless teachers have been well-trained. Teacher's strikes. Teacher morale is low due to erosion in salaries, due to changes in payment modalities from dollars to Zimbabwean currency	Ministry of Education assisted to quickly deploy alternative learning interventions which included radio and TV lessons, digital platforms. catchup strategy for learning losses. Distribution of PPEs to facilitate re-opening of schools.
Nutrition	Change in diets from nutrient dense foods towards foods with less nutritional value. Disruption of nutrition services, including nutritional monitoring. Transitioning from a development approach to an approach adapted to an emergency response.	Several adaptations to maintain delivery of services, notably communication with communities and mobilizing support by community health workers.
Child protection	Increased cases of child abuse during COVID 19 response. Children more reluctant to disclose on the phone vs face to face. Lack of privacy. Related limitations in providing psychosocial support to affected children due to transport problems, accessibility, and privacy. Young girls venturing into sex work, child marriage.	Virtual approaches combined with training of Community Childcare Workers to make home visits.
WASH	A long-standing severe water and sanitation crisis was aggravated by the COVID19 pandemic that increased demand for access to clean water.[38] Poor infrastructure in health facilities and schools. Limited funds. Urban water and sanitation struggling with a shortage of chemicals.	WASH response started with a no-regrets policy. Rapid reallocation of resources. Prioritisation using tools such the WASH FIT tool[39] for health facilities to determine where funds should be allocated.

87. Partners reported that UNICEF support at a district level was limited until mid-2020. Once implementation had begun, there was a consensus amongst government and NGO partners that UNICEF's programming was largely relevant and appropriate as described during interviews and responses to surveys as shown in Figure 5.

[37] UNICEF's HIV Programming in the Context of COVID-19: Sustaining the gains and reimagining the future for children, adolescents and women Compendium of innovative approaches in Eastern and Southern Africa, July 2020
[38] Human Rights Watch (2022) World Report 2022: Zimbabwe.
[39] https://washfit.org/#/

Figure 5 – UNICEF addressed challenges identified at the design stage[40]



Source: survey data.

Interventions adapted to needs, priorities and vulnerabilities

88. **UNICEF was well-positioned for the response**, benefiting from learning from previous responses in Zimbabwe, including a cholera response, and regional/global learning from the Ebola epidemic. COVID19 interventions built on UNICEF's existing programme and most sectors adapted to the changed context relatively quickly. UNICEF ZCO carried out a programme criticality assessment in late March 2020[41] to identify and rank priority activities within each sector and develop an action plan for the response. Given all the unknowns about the impact of the COVID19 pandemic and movement restrictions, the focus on Risk Communication and Community Engagement (RCCE) proved to be very important and helped inform not just UNICEF's response, but the overall response by helping to better understand COVID19 hotspots and vulnerability.[42]

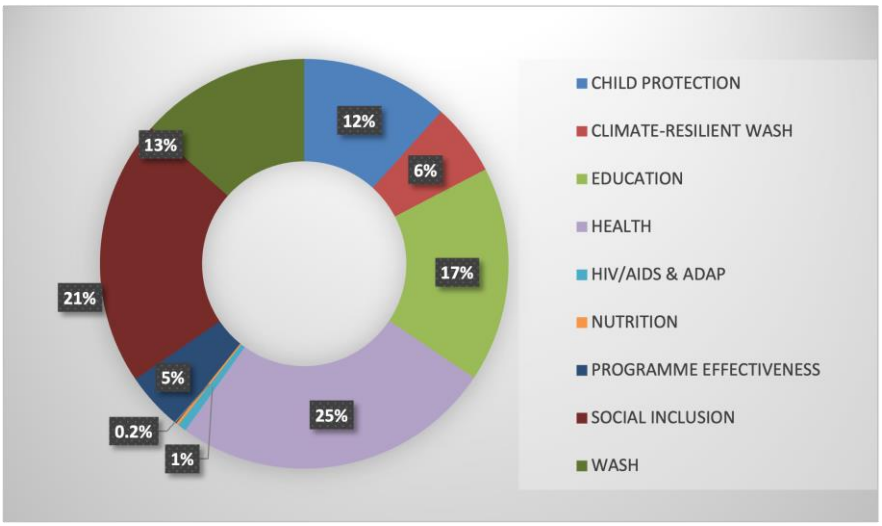
89. Although there was a consensus amongst interviewees and survey respondents that **UNICEF's initial response was not completely aligned with the needs and priorities of communities, it rapidly evolved to be better targeted** over the course of implementation due to UNICEF's previous investments in capacity building of structures at district and community levels. Village Health Workers, for example, were already known to be one of the most trusted sources of information for communities and the design of the response allocated them an important role.[43]

90. **To assess needs UNICEF ZCO also collaborated with the Zimbabwe Statistical Agency (ZIMSTAT) and the World Bank** to conduct six telephone household surveys between November 2020 and April 2022[44] to collect disaggregated data for the ongoing assessment and monitoring of the socio-economic impacts of COVID19. These assessments provided insights into the extent that communities were respecting guidelines to prevent the spread of COVID19, food insecurity status and poverty rates.

91. Sectors which absorbed the bulk of financial resources during UNICEF ZCO's COVID19 response were **Health, WASH, Education and Child Protection** (Figure 6). UNICEF's interventions took the form of supplying non-food items (NFI), information in video and audio disability friendly formats, media outreach, Community resources persons capacity building, caregivers and children with disability counselling and psycho-social support.

[40] The full statement in the survey was "*UNICEF successfully addressed and mitigated challenges identified at the programme design stage*".
[41] UNICEF ZCO Programme Criticality exercise presentation. 29 March 2020.
[42] This finding is consistent with contribution by RCCE throughout the region. See UNICEF (2022) Lessons Learned from the RCCE Response to COVID19 in the Eastern and Southern Africa Region.
[43] UNICEF (2020) Cyclone Idai: Integration of multisectoral C4D interventions into the humanitarian response in Malawi, Mozambique and Zimbabwe. Case Study.
[44] ZIMSTAT et al. (2020 – 2022) Monitoring COVID19 Impact on Households in Zimbabwe Reports 1-6.

Figure 6 – COVID19-related expenditure by sector/activity 2020-2022



Source: UNICEF ZCO. Database "COVID19 Expenditure by Outcome & Grant: 2020 – To Date" and COVID19 Expenditure by Outcome & Activity: 2020 – To Date". Data extracted on 14.12.2022.

Targeting vulnerability and disability

92. Databases maintained by the Ministry of Public Service, Labour and Social Welfare were used to address the lack of information on COVID19 pandemic amongst vulnerable groups including children and adolescents with disabilities and caregivers. Radio and Television awareness campaigns on prevention of abuse, exploitation and violence perpetrated against children and adolescents with disabilities.

93. Interviews and survey respondents found that disability received attention during assessments but was not always reflected in the design of interventions. The programme criticality exercise covered educational needs and legal assistance to vulnerable children, including people living with disabilities and GBV survivors.[45] For example, the interventions were designed with TV lessons that catered for children with hearing impairments. Sunrise Sign Language Academy partnered with UNICEF and the National AIDS Council to translate messages on COVID-19 and HIV in sign language to use on their WhatsApp group for those with hearing impairment to promote prevention measures.[46]

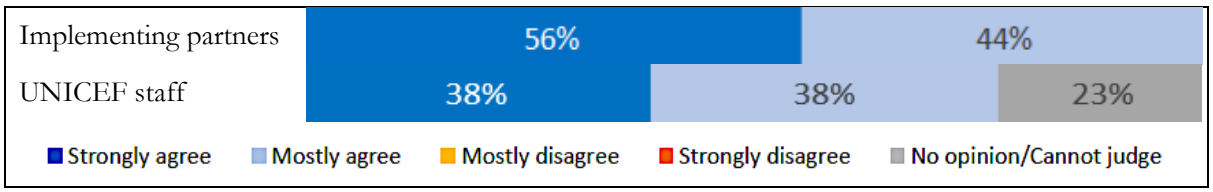
94. UNICEF's identification and targeting of vulnerability was overall ranked highly by stakeholders (Figure 7) with gaps being identified by respondents in preparedness design (e.g., pre-positioned stocks) and substance abuse by youth despite widespread warnings about the long-term consequences.[47]

[45] UNICEF Programme Criticality Exercise 29 March 2020. UNICEF Presentation.

[46] UNICEF's HIV Programming in the Context of COVID-19: Sustaining the gains and reimagining the future for children, adolescents and women Compendium of innovative approaches in Eastern and Southern Africa, July 2020

[47] See, for example, Marandure BN, Mhizha S, Wilson A, Nhunzvi C (2023) Understanding the nature of substance use in Zimbabwe: State of the art and ways forward: A scoping review protocol. PLOS ONE 18(3): e0272240.

Figure 7 – UNICEF identified and targeted vulnerable persons[48]



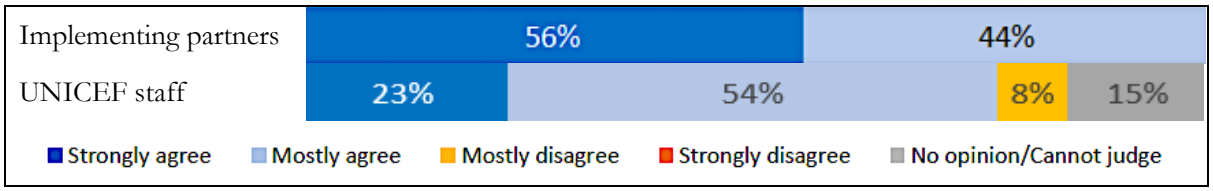
Source: survey data.

Integration of rights

95. Intervention designs were based on humanitarian principles of neutrality and independence with the involvement and capacitating communities and local governance structures. Child rights were promoted through safeguarding trainings, communications, and other means. UNICEF funded the Department of Social Development's programme of assisting and ensuring that unaccompanied children were repatriated or unified to their districts of origin, including funding an implementing partner that helped with identification, temporal placement, tracing, and reunification of unaccompanied children.

96. UNICEF and partner survey respondents were largely positive about UNICEF's approaches to gender, child rights and equity issues (Figure 8). Some respondents noted that even though it was urgent to respond to COVID19, UNICEF tried to ensure that interventions were inclusive. Many UNICEF staff felt that one gap was that there were more incidences of GBV that were being reported.

Figure 8 – UNICEF integrated gender, child rights and other equity issues[49]



Source: survey data.

EQ 2: Coherence and coordination

EQ 2	*How coherent and coordinated has the UNICEF response been?*

97. This question looks at the coherence and connectedness of UNICEF's response, including achievements against planned results, the extent to which these planned results were updated as needed, the main contributing factors and obstacles to achievement and the timeliness of the response.

Summary response to EQ 2

Coordination

- **UNICEF had multiple coordination functions** during the COVID19 response: internally, with implementing partners, as a lead agency for clusters, as a member of the Humanitarian Country Team and as an important support for the Government of Zimbabwe's lead role.
- **A UNICEF Task Team of staff helped internal integration across sectors**. Members were from the WASH, Supply Section, Education, Health, and communications sections. There was strong internal coherence between health, WASH and social protection including harmonisation of messaging. Education and WASH also provided a focus for a multi-sectoral response. The

[48] The full statement in the survey was "*UNICEF identified and targeted vulnerable persons, including those with disability*".
[49] The full statement in the survey was "*UNICEF integrated gender, child rights and other equity issues in needs assessments, planning, implementation, monitoring and reporting of response and recovery interventions*".

Summary response to EQ 2

Nutrition section was represented by Health and was not a member of the Task Team which created some problems.

- **UNICEF provided technical, material, and financial support for six of the eight response pillars** established by the GoZ for the COVID19 response. NGO partners were appreciative of the facilitation role that UNICEF played with relevant line Ministries.
- **Coordination with other UN agencies** resulted in timely and consistent guidance for the response.

Linking humanitarian and development

- **UNICEF based the COVID19 response on its existing country programme** which meant that there were humanitarian and development linkages, with a specific focus on equity and resilience, in areas where they had ongoing development programmes.

Fundraising and governance structures

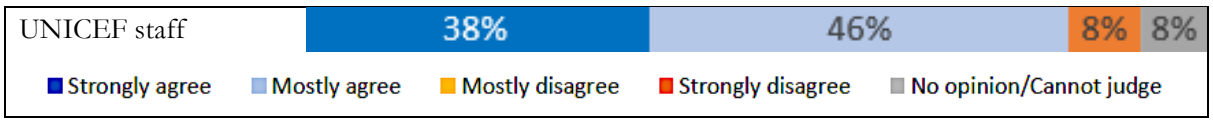
- **UNICEF ZCO has been an important fund manager** in the country for many years and was in a strong position to reprogramme funding and mobilise additional emergency funds.

Integration between sectors

98. While at a global level, external partners saw UNICEF's COVID19 global response in 2022 as mainly focused on vaccine delivery while being 'quiet' on other areas of the response.[50] This was not the case in Zimbabwe where **UNICEF took a multi-sector approach**. External interviewees noted the strong coherence between health, WASH, and social protection, including harmonisation of messaging. As Figure 9 illustrates, UNICEF ZCO staff were more neutral regarding sectoral integration.

99. **UNICEF formed an internal Task Team** in mid-2020 that initially met twice weekly and was largely seen to be effective (Figure 9). Members included staff from the WASH, Supply Section, Education, Health, and communications sections. The Task Team helped in ensuring integration across sectors. The Nutrition section was represented by Health and was not a member of the Task Team. This was reported to be only partially successful, with interviewees suggesting that a lesson learned was that nutrition should be represented in similar internal Task Teams in future.

Figure 9 – UNICEF's response was well-integrated between sectors[51]



Source: survey data.

UNICEF coordination

100. **UNICEF had multiple coordination functions during the COVID19 response in Zimbabwe**, internally with implementing partners, as a lead agency for clusters, as a member of the Humanitarian Country Team and an important supporting partner for the Government of Zimbabwe who led the response. UNICEF initially coordinated with the government at national level but eventually transitioned to work directly at provincial and district levels.

101. **Strong coordination was critical during this response, including UNICEF's global collaboration role with WHO**, the Coalition for Epidemic Preparedness Innovations (CEPI), the Global Alliance for Vaccines and Immunization (GAVI) that established a mechanism for the

[50] Dr Julia Betts (2022) Evaluation of the UNICEF L3 Response to COVID19.
[51] The full statement in the survey was "*UNICEF's response was well-integrated between sectors*".

development and distribution of COVID19 vaccines.[52] The COVID19 Vaccines Global Access (COVAX) provided a platform for working together with the Government of Zimbabwe to develop policies and Standard Operating Procedures.

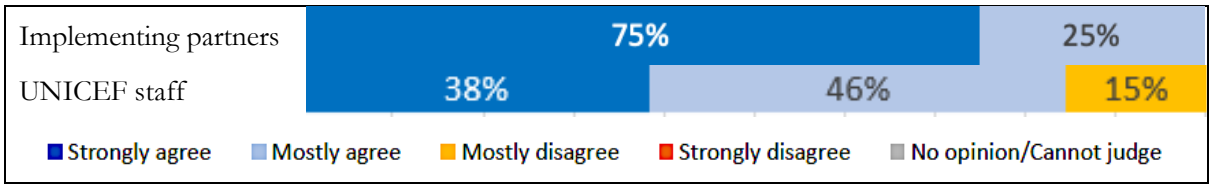
102. **UNICEF also provided technical and financial support for six of the eight response pillars established by the government for the COVID19 response**, notably support to 1) Coordination, Risk Communication and Community Engagement (RCCE), 2) Infection Prevention and Control (IPC), 3) Case Management and 4) Logistics and Procurement.[53] UNICEF also participated in a weekly "check in" meeting by all the COVID19 task teams initially chaired by the MOHCC permanent secretary and subsequently by a dedicated coordinator appointed by the Prime Minister's office. Three operational plans were developed and implemented.

103. **A key UNICEF contribution was to provide the government with** tools like laptops and Zoom licenses so that they could convene remote meetings. UNICEF also supported data management and provided some vehicles for case management. HIV partners were oriented on various remote systems used for programme monitoring.

104. **Coordination with other UN agencies resulted in timely and consistent guidance for the response**.[54] UNICEF partnered with the United Nations Educational, Scientific and Cultural Organization (UNESCO), as well as Education sector co-lead, Save the Children International, to support the Ministry of Primary and Secondary Education's research and remote teaching and learning capacity.

105. Both UNICEF staff and implementing partners ranked UNICEF's coordination role relatively favourably in the surveys (Figure 10). Most respondents cited the **helpful role that UNICEF played with the relevant line Ministries** to, for example, promote child protection surveillance, prevention, and response and help ensure that services were accessible with adequate capacity.

Figure 10 – UNICEF's response was well-coordinated



Source: survey data.

Linking humanitarian and development interventions

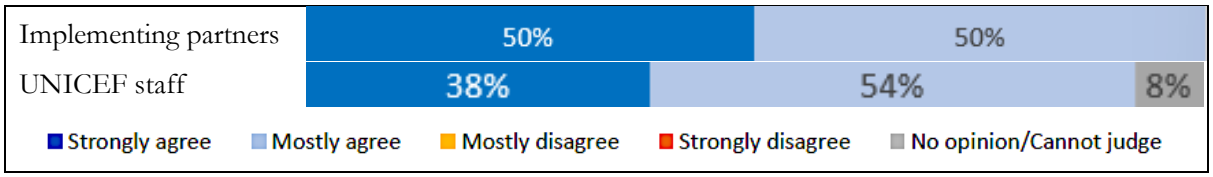
106. **UNICEF based its response on its existing programme.** The COVID19 response thus provided a basis to link humanitarian and development through an intersectoral response to ensure equity in essential interventions and enhance resilience against future shocks. This was accomplished in different ways. In some cases, emergency interventions were integrated with long-term programmes such as strengthening community health workers, a cyclone Idai WASH recovery programme with the World Bank and collaboration that installed solar powered water systems between the African Development Bank and UNICEF.[55] UNICEF used Emergency Cash Transfers during the COVID19 response and commissioned a series of studies to assess the effectiveness, targeting and resilience of the mechanism. U reports and radio sessions were leveraged to provide communities, including adolescents and young people, with relevant information and services related to COVID19.

107. Interviewees and survey respondents (Figure 11) agreed that UNICEF had developed strong links between humanitarian and development initiatives. Implementing partners noted that many interventions had been designed using a Nexus lens while mainstreaming gender. Others mentioned

[52] Andy Featherstone et al. (2023) Inter-Agency Humanitarian Evaluation of the COVID19 Humanitarian Response.
[53] UNICEF (2021) Zimbabwe Humanitarian Situation Report, 31 December 2021.
[54] UNICEF (2021) Lessons Learned Synthesis Key Findings UNICEF Preparedness for and Response to the COVID19 Emergency in Zimbabwe. March 2020–January 2021.
[55] UNICEF (2022) Country Office Annual Report 2022: Zimbabwe.

the consistency of UNICEF's response with its goal of creating resilient communities.

Figure 11 – UNICEF successfully integrated humanitarian and development approaches[56]



Source: survey data.

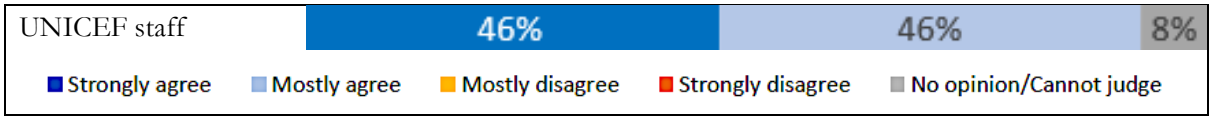
Fundraising and governance structures

108. **UNICEF ZCO has been an important fund manager in the country for many years** and prior to COVID19 were already involved in the management of several bilateral and multi-donor long-term grants, both as a fund manager and an implementing partner. Due to the country's challenging economic and political context and uncertainties of donor funding streams, UNICEF ZCO's 2021 annual risk assessment rated 'very high' the risk of partial achievement of planned results. To manage this risk, UNICEF developed a comprehensive Resource Mobilisation strategy and action plan.[57]

109. Given this experience and capacity, **UNICEF was in a strong position** to reprogramme funding and mobilise additional funding for an emergency funds, including a USD 1 million allocation from the UN Central Emergency Response Fund (CERF) in 2021.[58] Even so, UNICEF only managed to raise 17 percent of USD 84 million requested in 2020 and 28% of the USD 65.8 requested in 2021.[59] However, these figures should be seen against the 26 percent and 17 percent funding raised against the 2020 and 2021 HRP requirements respectively, which is an indication of the relatively low priority given to Zimbabwe by donors in the COVID19 response.[60]

110. UNICEF staff were largely agreed in the survey (Figure 12) that the **fundraising and governance of UNICEF was appropriate for the COVID19 response** pointing to examples like reprogramming funds to respond to the school closures, repurposing of USD 1.4 million allocated by FCDO/UK to development projects and USD 625,000 from USAID for assessments.

Figure 12 – Fundraising and governance structure aligned with the intended results[61]



Source: survey data.

[56] The full statement in the survey was "*UNICEF's fundraising and governance structure was aligned with the intended results for the response*".
[57] UNICEF (2022) Internal Audit of the Zimbabwe Country Office. November 2022.
[58] UNICEF ZCO Consolidated Emergency Report 2021.
[59] UNICEF (2020) Multihazard Annual Situation Report # 6 January – December 2020 and UNICEF (2021) Zimbabwe Humanitarian Situation Report, 31 December 2021.
[60] https://fts.unocha.org/
[61] The full statement in the survey was "*UNICEF's fundraising and governance structure was aligned with the intended results for the response*".

EQ 3: Effectiveness

EQ 3	*How effective has the UNICEF response been?*

111. This question examines the extent to which UNICEF achieved their planned results, what factors influenced results, the effectiveness of their partnerships and what role surge played during the response.

Summary response to EQ 3

Achievements against response targets

- **UNICEF reported that most targets were met or exceeded during the COVID19 response**. Targets set for Education, WASH and HIV/AIDs were exceeded. UNICEF and their partners faced specific challenges with admissions to severe acute malnutrition (SAM), numbers accessing GBV services and numbers who were able to access cash transfers.
- **The results achieved in Education, WASH and HIV/AIDs were impressive given the funding situation**. Education and WASH were however both able to make use of reprogrammed funding and collaboration with long-term development projects funded by other organisations.
- The team did not receive documentation for all the projects originally selected, but an analysis of those documents received showed **54% of projects showed reasonable progress**.

Achievement of targets based on the needs of different groups

- **Interventions appeared to be effectively targeted although coverage was incomplete**. Violence against children and women significantly increased due to limited safe reporting options and services during lockdowns, with adolescents and women with disabilities being particularly at risk.
- **The reliance on data from the government was a limitation** since disaggregated data for disability was not readily available from for health, nutrition, and education sectors.

Programme quality and performance

- **The overall response to COVID19, including by UNICEF, was delayed** due to uncertainties around the impact of the pandemic and how best to respond although feedback from partners were positive about UNICEF's response.
- **UNICEF built upon lessons from previous responses**, including their work with Village Health Workers who proved to be a major resource during the response.
- **UNICEF ZCO's response was guided by needs**, communicating critical messages and supporting children with NFI and deliberate targeting for vulnerable groups in some sectors. Nutrition, disability and GBV were areas where improvements were needed.

Achievements against response targets

112. UNICEF reported that **most targets were met during the COVID19 response**. Targets set for Education, WASH and HIV/AIDs were exceeded (Table 7). UNICEF and their partners faced specific challenges with admissions to severe acute malnutrition (SAM), numbers accessing GBV services and numbers who were able to access cash transfers. As described below, cash transfers were a relatively successful intervention that had the potential to expand but was constrained mainly by a lack of financial resources.

Table 8 – UNICEF Programme targets and achievements[62]

SECTOR	INDICATORS		UNICEF and IPs		
		Targets		Total results	%
NUTRITION	# of children aged 6–59 months with SAM admitted to community-based treatment programmes	22,176	Girls	6,226	50%
			Boys	4,853	
			Total	11,079	
	# of children aged 6–59 months receiving vitamin A supplementation	476,926	Girls	199,024	83%
			Boys	199,023	
			Total	398,047	
HEALTH	# of children and women accessing primary health care in UNICEF-supported facilities	2,700,000	Female	1,888,059	94%
			Male	642,820	
			Total	2,530,879	
WATER, SANITATION AND HYGIENE PROMOTION	# of males and females accessing a sufficient quantity of safe water for drinking, cooking and personal hygiene	610,057	Female	428,886	133%
			Male	373,024	
			PLWD**	7,298	
			Total	809,208	
	# of people reached with critical water, sanitation, and hygiene supplies (including hygiene items) and services	125,000	Female	186,686	287%
			Male	172,326	
			PLWD	0	
			Total	359,012	
CHILD PROTECTION	# of children and caregivers accessing mental health and psychosocial support	90,000	Female	72,998	147%
			Male	59,245	
			PLWD	13,401	
			Total	132,243	
	# of women, girls and boys accessing gender-based violence risk mitigation, prevention or responses interventions	90,000	Female	14,274	26%
			Male	8,923	
			PLWD	-	
			Total	23,197	
EDUCATION	# of children accessing formal and non-formal education, including early learning	409,716	Girls	1,275,000	415%
			Boys	425,000	
			Total	1,700,000	
HIV & AIDS	# of pregnant and breastfeeding women, children and adolescents living with HIV who continue to receive prevention of mother-to child transmission and treatment services	60,000	Female	30,521	74%
			Male	13,855	
			Total	44,376	

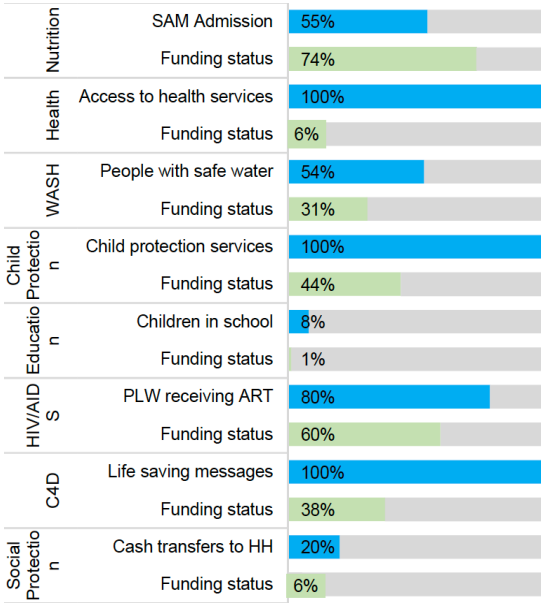
[62] Source: Summary of Programme Results. Situation Report, December 2021. UNICEF ZCO.

SECTOR	INDICATORS		UNICEF and IPs		
		Targets		Total results	%
SOCIAL PROTECTION	# of vulnerable households receiving cash transfers to support access to basic services	25,000	Total	9,851	39%
C4D	# of people reached with messages on access to services	5,000,000	Female	6,827,767	265%
			Male	6,402,554	
			Total	13,230,321	

113. **The results achieved in Education, WASH and HIV/AIDs were impressive**, given the funding situation (Figure 13). Education and WASH were, however, both able to make use of reprogrammed funding and collaboration with long-term development projects funded by other organisations.

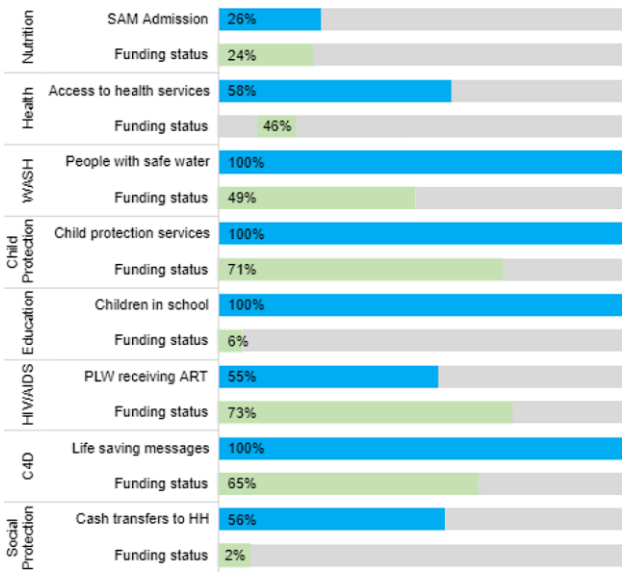
Figure 13 – UNICEF funding status per sector

(as of December 2020)



UNICEF ZCO Humanitarian SitRep 31 Dec 2020

(as of December 2021)



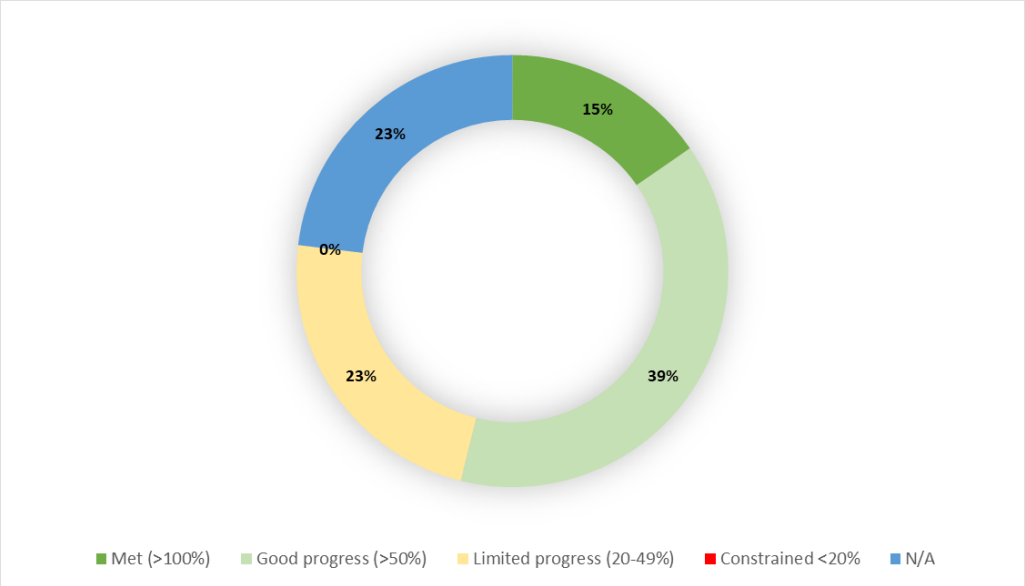
UNICEF ZCO Humanitarian SitRep 31 Dec 2021

114. The effectiveness of the response was seen particularly for women and children, capacity building, communication, and innovations in education according to UNICEF staff survey respondents and interviewees.

Analysis of the project sample

115. As described in the Methodology section, the team did not receive documents for all the projects in the sample. An analysis of the results of **thirteen selected projects from different sectors by the evaluation team found mixed progress**, of which 54% showed reasonable progress (Figure 14). Progress for three of the projects could not be assessed since there were either no quantitative indicators or the indicators for the project were no longer relevant. The other results were generally consistent with the results displayed in Table 8 above. Additional details are provided in Annex 6.

Figure 14 – Project sample: achievements against objectives (n = 13)

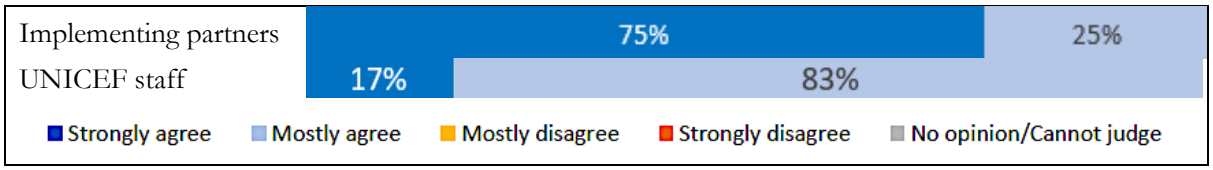


Source: UNICEF partner reports

Achievement of targets based on the needs of different groups.

116. Survey respondents agreed that interventions were effectively targeted (Figure 15). One of the contributing factors mentioned by survey respondents was the effectiveness of protocols put in place to ensure that vulnerable cases were handled in a way to protect staff.

Figure 15 – UNICEF achieved its targets based on the needs of different groups[63]



Source: survey data.

117. Interviewees and survey respondents felt that needs of women and children had been well targeted. However, they noted that **violence against children and women had significantly increased** due to limited safe reporting options and services during lockdowns, with adolescents and women with disabilities being even more at risk. Girls with disabilities were prioritised to receive with girl's kits.

118. **UNICEF and other agencies relied largely on data from the government, and this limited the amount of data that could be collected on disability**. This was the main reason why disaggregated data for disability was not available for health, nutrition, and education. Mandatory COVID19 prevention measures were often not disability inclusive. Special ZIMCARE schools, schools for the visual and hearing impairment were closed and did not offer online education although at the design stage the interventions targeted children with disabilities as a priority.

UNICEF Surge

119. **Restrictions on movements within the country and across international borders largely restricted any physical deployment of UNICEF staff or standby partners into Zimbabwe**, unlike other large scale emergency responses. As described above, one of the main factors that ensured the success of UNICEF's response was local capacities in the form of community- and district-level structures. At the same time, there was a need for external support, but this came in the form of

[63] The full statement in the survey was "*UNICEF achieved its targets based on the needs of different groups including children, the disabled and women*".

guidance and advice without a need for physical deployment of personnel, especially since UNICEF staff were themselves working from home for extended periods.

120. **The main capacity gap observed by the team was staff in UNICEF's Human Resources section** which was overstretched dealing with staff issues during certain phases of the response when it was dealing with threats and infections within the families of UNICEF staff members.

Programme quality and performance

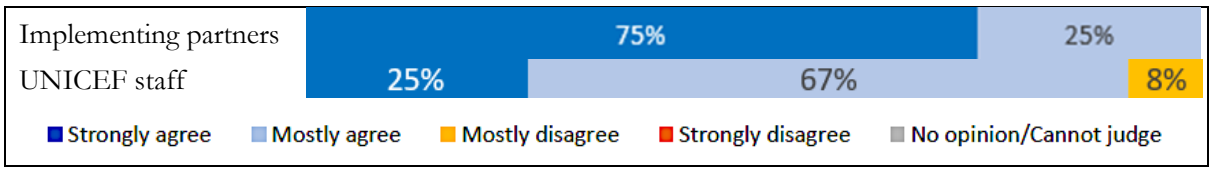
121. While the **overall response to COVID19 was delayed** due to uncertainties around the impact of the pandemic and how to mitigate these, feedback from partners and government interviewees at all levels (district, provincial, national) was positive about UNICEF's support. There was a recognition of the challenges that everyone had faced and felt that UNICEF support, ranging from technical support, capacity building, helping to maintain the cold chain, WASH systems, to government agencies had been what they needed at any given time.

122. It was evident that **UNICEF had learned and applied lessons from previous responses** that they built upon during the COVID19 response. UNICEF worked effectively with Village Health Workers to increase the uptake of adopt health seeking behaviours and subsequently immunization.[64] Remote programming was scaled up during the response although roll-out of some services to remote areas was slow and many people lacked the technological resources to facilitate access.[65]

123. Feedback from NGO partners during interviews and the survey (Figure 16) was similarly positive. **Partners felt that UNICEF ZCO's response was according to need**, communicating critical messages and supporting children with NFI. In WASH, there was deliberate targeting for vulnerable groups during registration and water points were made easy access to people with disabilities. The main area for improvement cited was that coverage was limited due to funding limitations. One partner suggested that the response would have benefited from more attention to anticipatory action.[66]

124. UNICEF staff responding to the survey mostly felt that UNICEF had delivered a high-quality integrated response. The **main areas for improvement cited were that UNICEF needed to strengthen their work with line Ministries** in the work under Disaster Risk Mitigation in both systems and policy development to allow them to better respond in emergency situations, strengthen resource mobilisation, and shorten procurement procedures and improve reporting formats.

Figure 16 – UNICEF's service delivery was well- integrated and of high quality



Source: survey data.

125. As noted above, **Nutrition, disability and GBV were areas where improvements were needed**. All these areas were influenced by children confined to their homes who were not being monitored and outreach/feedback mechanisms were not functioning as well as they should. In the case of Nutrition, as described above under EQ2, this sector had a relatively low profile and had difficulty in adapting to an emergency. Funding was also cited as an issue, attributed to contractual arrangements with the donor but the team found no evidence that the donor had been approached to reprogramme funding.[67]

[64] UNICEF (2020) Cyclone Idai: Integration of multisectoral C4D interventions into the humanitarian response in Malawi, Mozambique and Zimbabwe. Case Study.

[65] UNICEF (2021) Lessons Learned Synthesis Key Findings UNICEF Preparedness for and Response to the COVID19 Emergency in Zimbabwe. March 2020–January 2021.

[66] Anticipatory action, which is also sometimes referred to as 'early action' or 'forecast-based financing' is defined here as "…*an activity taking place between an early warning trigger, or a high-probability forecast and the actual occurrence of the corresponding disaster in order to mitigate or prevent the humanitarian impact of the anticipated disaster*".

[67] AAN Associates (2021) Summative Evaluation of the Accelerated Community Actions for Reducing Stunting in Zimbabwe.

EQ 4: Efficiency

EQ 4	*Was UNICEF's response efficient?*

126. This question examines the extent the response was implemented in an economical and cost-conscious way and whether procurement facilitated scale-up. This question also looks at how timely the response was, what was the contribution of preparedness measures, partnerships, risk mitigation and monitoring to efficiency.

Summary response to EQ 4

- **Cost analyses** were conducted by UNICEF's procurement and administration sections. The team found few examples of cost analyses for sectoral interventions apart from cash transfer interventions.
- The impacts of COVID19 and the right way to respond was uncertain and UNICEF and partners **had to learn how to work remotely and deliver assistance efficiently** at the same time as responding.
- **UNICEF undertook procurement both for its own response and on behalf of the government**. There were significant delays in identification and shipping supplies in 2020. Procurement timelines improved in 2021 due to opening of borders, lifting of restrictions on movements and because additional LTAs had been established with local suppliers.
- It proved difficult **to track procurement timelines to determine when goods reached the beneficiaries** using UNICEF systems.
- **Interagency preparedness plans did not include scenarios for airbourne epidemics**. Some pre-positioned non-food items were quickly distributed but other essential items, notably PPE equipment, was in short supply.
- **Strong partnerships** with government, civil society, UN agencies and donors were instrumental in reaching targeted populations, including the most vulnerable, to increase the efficiency and effectiveness of the response. Partnerships with the private sector were present but not that evident.
- **Partners felt that UNICEF had managed the relationship efficiently** although several suggested that UNICEF could have convened a virtual learning forum to share experiences and learning. UNICEF staff also expressed satisfaction with partnership arrangements although they noted that efficiency had been adversely affected since it had been difficult to deal with government officials remotely.
- **RCCE has been amongst the most successful and timely aspects of the response** that has helped in generating demand for essential services and mitigating misinformation.
- **Successive TPM missions allowed UNICEF to obtain feedback**, identify obstacles and bottlenecks to delivering assistance and obtain expert advice to facilitate learning and adaptation to an evolving environment. UNICEF joint monitoring visits with partners were affected by the travel bans and lockdowns during 2020-2021 when UNICEF was much more dependent on TPM, community structures, social media, and mobile phones to collect monitoring information.

Efficiency of the response

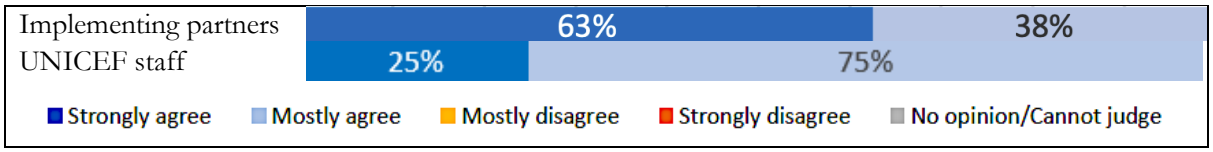
127. Evidence of cost analyses were found in procurement and UNICEF's administration, such as when comparing costs of TPM with monitoring by UNICEF staff. **The team did not find evidence for cost analyses in sectoral interventions** apart from HACT cash transfers in Social Policy.

128. Many interviewees and survey respondents described how they been **learning along the way** since the impacts of COVID19 and the right way to respond was uncertain. UNICEF preparedness was geared towards waterbourne and there were key gaps in pre-positioned stocks to respond to airbourne

pandemic, particularly since UNICEF's supply chain dependent largely on international procurement. UNICEF had to adapt their internal and external administrative systems to function remotely by electronic means. UNICEF managed to transform their systems although most government systems remained paper-based, which adversely affected efficiency.

129. Implementing partners and UNICEF staff responding to the survey felt that UNICEF had tried to follow value for money principles (Figure 17), noting that UNICEF managed to transfer money and eventually deliver most supplies efficiently during implementation. Survey respondents also noted that during an emergency, short cuts were bound to occur which affect efficiency of processes.[68] One of the main sources of inefficiencies cited was the reliance on government structures at a national level.

Figure 17 – UNICEF's response was implemented in an economical and cost-conscious way



Source: survey data.

Timeliness of the response

130. As described above, it was not until mid-2020 that the response started to get momentum due to the unfamiliar context of COVID19 where its likely impacts were unknown but posed significant personal risks. Different factors contributed to this, including:

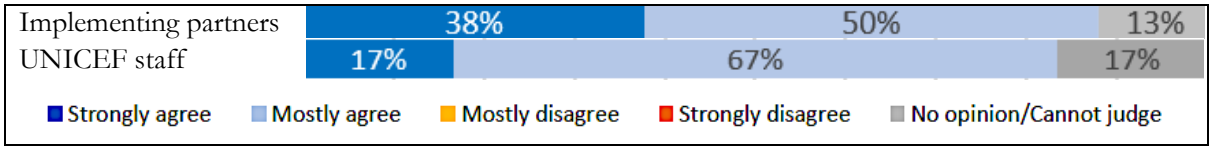
- From March 2020 when UNICEF HQ activated a work-from-home policy until mid-2020, partners reported they received relatively little UNICEF support at a district level.
- UNICEF used their existing global procurement system. Since there was a global shortage of key items (e.g., PPE) and, since the Southern Africa region was not a global priority during the COVID19 response, procurement took time.
- Funding was limited and some donors initially insisted on using the global procurement system.
- Transportation was limited and expensive.

131. By mid-2020 interventions were gaining momentum. For example, radio lessons had been developed for schools and were on air.

Procurement

132. UNICEF undertook procurement both for its own response and on behalf of the government. Much of UNICEF's procurement prior to the COVID19 pandemic had been international procurement due to a combination of factors such as relatively easy access to markets in South Africa and an unstable economic environment in Zimbabwe. This focus on international procurement proved problematic due to restrictions imposed by the COVID19. Most survey respondents nevertheless felt that procurement was an important part of the response ((Figure 18).

Figure 18 – UNICEF's international and local procurement facilitated the response



Source: survey data.

133. UNICEF procured a broad range of items for the COVID response: PPE, vaccines, educational

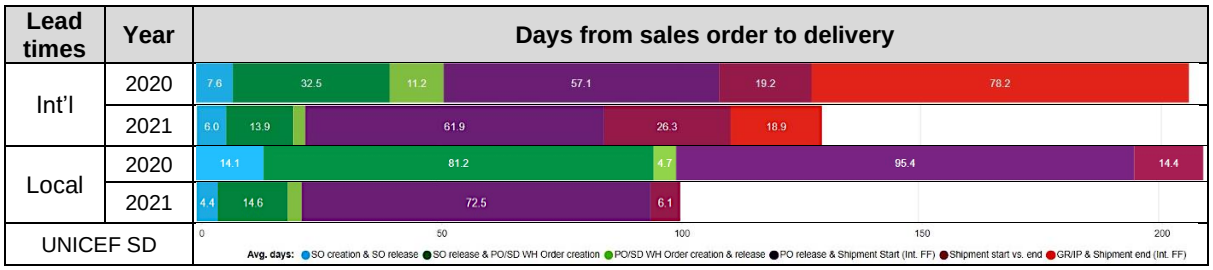
[68] Examples of shortcuts are described in UNICEF (2022) Internal Audit of the Zimbabwe Country Office.

materials, communications materials, jerry cans, soap, buckets with tap and borehole spares. Partners and UNICEF staff said that supplies for children with disabilities and their caregivers had been prioritised. While UNICEF was quick to draw down on its preparedness education interventions, e.g., "School in a Box" and hygiene kits, other items were slow to arrive. There were also initial delays in delivering equipment for boreholes, which was resolved after UNICEF gave permission to partners to procure directly.

134. As can be seen in data provided by UNICEF's Supply Division shown Figure 19 and Figure 20 below, for an emergency response **there were significant delays in identification and shipping supplies during 2020**. This time was reduced by around half in 2021 due partly to opening of borders and lifting of movement restrictions but also because additional LTAs had been established with local suppliers.

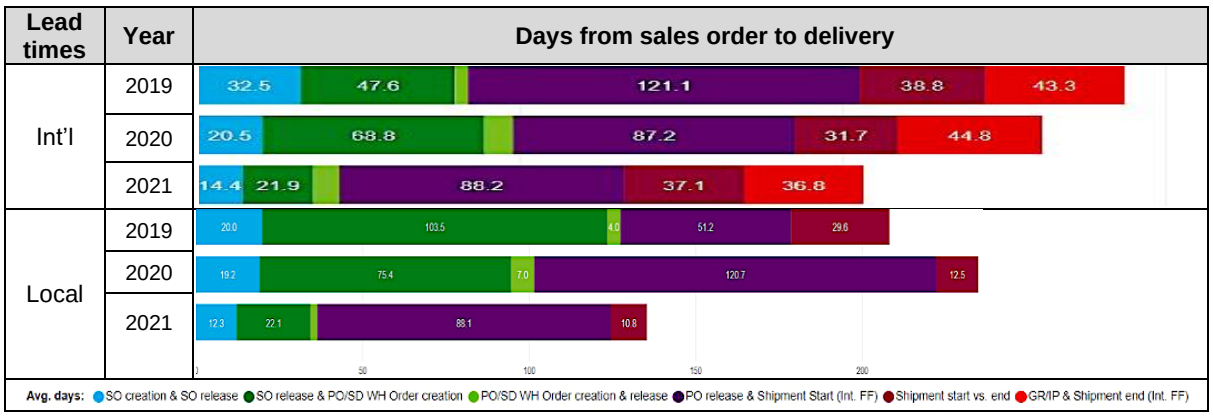
135. Note, however, that **these timelines do not show when goods actually reached the targeted beneficiaries in communities** (rights holders) since the responsibility for tracking the goods from the point of delivery to beneficiaries lies with individual UNICEF sectors.[69] In practice, however, it proved difficult for the evaluation team to track the complete supply chain up to the end users. In some cases, it was reported that education supplies and textbooks were delivered to the district capital, yet lengthy delays were often experienced before they were distributed to individual schools.

Figure 19 – COVID procurement lead timelines



136. Comparison between COVID-related procurement and overall procurement indicates that UNICEF's **prioritisation of emergency supplies resulted in significant improvements in delivery times**, except for local procurement, during 2020. By 2021 local procurement was improved thanks in large part to LTAs with local suppliers as described above.

Figure 20 – Lead timelines for all procurement



Source: UNICEF Supply Division

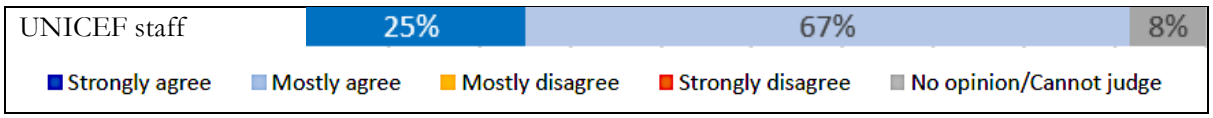
Contribution of preparedness to the response

137. Interviews and reviews of UN preparedness plans found an emphasis mainly on drought, landslides,

[69] UNICEF Procedure on Monitoring Document Number: PROCEDURE/ DAPM/2022/004. 04 October 2022. UNICEF has recognized this gap and is currently piloting a "Last Mile Supply Monitoring Project" to improve visibility and reliability of supply data and enable end user monitoring.

cyclones and civil violence. so many agencies hadn't been exposed to scenario-based preparedness for epidemics except for waterborne diseases Pre-positioned non-food items like jerry canes, soap, buckets were distributed within a short period of time. PPE equipment was however not in stock and proved difficult to get. Response protocols were also quickly activated in line with L3 procedures[70] but, as described above, UNICEF and their partners had to learn how to respond in this new situation. Most UNICEF staff responding to the survey nevertheless said that emergency procedures and pre-positioned stocks had facilitated a scale-up (Figure 21).

Figure 21 – Preparedness measures allowed UNICEF to efficiently scale up[71]



Source: survey data.

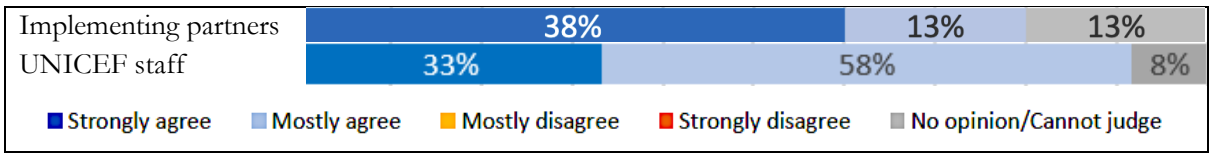
Efficiency of the partnership

138. This evaluation agreed with UNICEF's Real Time Assessment that **strong partnerships with government, civil society, UN agencies, donors, and the private sector were instrumental in reaching targeted populations**, including the most vulnerable, to increase the efficiency and effectiveness of the response.[72] UNICEF's main partnerships were led by government, working closely with WHO in health. UNICEF also expanded their engagement with civil society organisations for risk management and community engagement. These included the Apostolic Women's Trust, who proved to be a strategic partner in providing community feedback and preventing gender-based violence GOAL International mobilized road shows for community engagement which were viewed as very effective. UNICEF held partner coordination meetings every two weeks and provided training to partners online. UNICEF arranged for partners to be issued with a letter to get access to communities during lockdowns.

139. Implementing partners were mostly satisfied with their partnership with UNICEF (Figure 22) citing examples such as UNICEF's help in obtaining permits for their travel while movements were restricted. A request by survey respondents and interviewees was that **UNICEF could have convened a virtual forum to discuss approaches they were using and what was working and what was not**. This was done previously, for example during the cholera response, and was found useful.

140. UNICEF staff responding to the survey were satisfied overall with their partnership arrangements while noting that efficiency had been adversely affected during lockdown since it had been difficult dealing with government officials remotely, including the need to hand carry many documents.

Figure 22 – UNICEF partnership modalities enabled partners to perform their roles efficiently



Source: survey data.

141. While it was a component of UNICEF's response strategy, partnerships with the private sector were not evident in many sectors. A UNICEF-commissioned lessons learned exercise recommended **further analysing public-private partnerships to identify additional strategic entry points and opportunities**.[73]

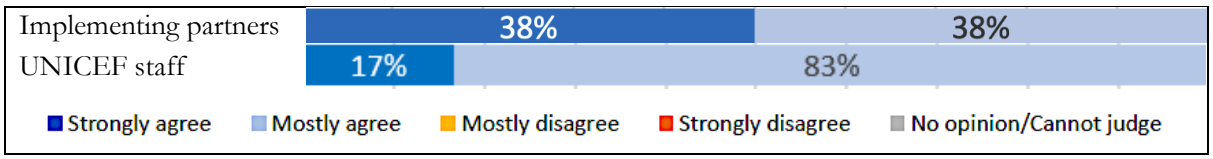
[70] https://www.corecommitments.unicef.org/unicef-emergency-procedures
[71] The full statement in the survey was "*Preparedness measures, including pre-positioned supplies, allowed UNICEF to efficiently scale up*".
[72] Jayne Webster et al. (2021) Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID19 in Eastern and Southern Africa. Oxford Policy Management
[73] UNICEF (2021) Lessons Learned Synthesis Key Findings UNICEF Preparedness for and Response to the COVID19 Emergency in Zimbabwe. March 2020–January 2021.

Risk management and mitigation

142. UNICEF's risk management principles included accepting risk when benefits outweigh costs while anticipating and managing risk by contingency planning and mitigating identified risks. The evolution of the COVID19 crisis required constant risk assessments and mitigation.[74] An internal audit conducted in 2022 concluded that although UNICEF ZCO was working in a challenging risk environment, the Country Office was generally managing well. [75] The audit noted that UNICEF ZCO is required to maintain multiple risk registers and has experience in this area.

143. **RCCE played a key role in this response in Zimbabwe**. As with other countries in the region, this was considered to be one of the most successful and timely aspects of the response that has helped in generating demand for essential services[76] and mitigating misinformation. The success of the RCCE and associated activities, such as mobile trucks that helped to communicate key messages while providing entertainment,[77] was a major reason for the general agreement on the survey (Figure 23).

Figure 23 – UNICEF's risk mitigation measures improved the efficiency of the response



Source: survey data.

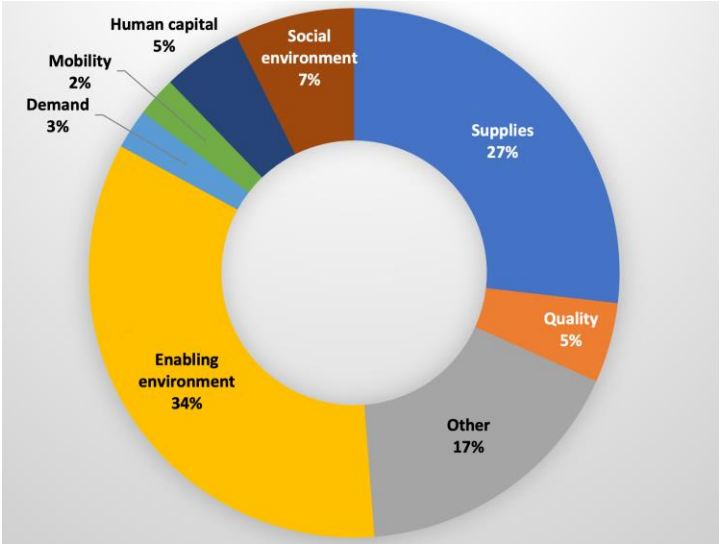
Use of monitoring data

144. **Monitoring provided another example of where UNICEF needed to adapt existing mechanisms** and tools to a new situation. Before COVID19 restrictions UNICEF staff conducted joint monitoring visits with partners periodically and resulted in recommendations. This was affected by the travel bans and lockdowns during the last quarter of 2020 and part of 2021 when UNICEF was much more dependent on CHWs, community structures, social media, and mobile phones to collect monitoring information.

145. As described above, UNICEF staff were not allowed to travel for monitoring visits for over a year and they adapted by greater use of remote monitoring and activating their LTA for TPM while updating the TPM Standard Operating Procedures to ensure they were fit-for-purpose for the COVID19 response.[78] Successive TPM missions allowed UNICEF to obtain feedback contact with partners and members of affected communities, identify obstacles and bottlenecks to delivering assistance and obtain expert advice to facilitate learning and adaptation to an evolving environment. As shown in Figure 24 below, the main bottlenecks identified were supplies and the "enabling environment", which included elements such as lack of suitable communication materials/equipment, access to services, lack of allowances for voluntary workers and restricted movement for caregivers.

[74] Ibid.
[75] UNICEF (2022) Internal Audit of the Zimbabwe Country Office.
[76] Jayne Webster et al. (2021) Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID19 in Eastern and Southern Africa. Oxford Policy Management.
[77] See UNICEF (2023) Mobile trucks ignite interest in information-starved communities in Zimbabwe.
[78] Zimbabwe UNICEFZCO-SOP/PE/8.1.5_2021-002: Standard Operating Procedure (SOP) Field Monitoring Update.

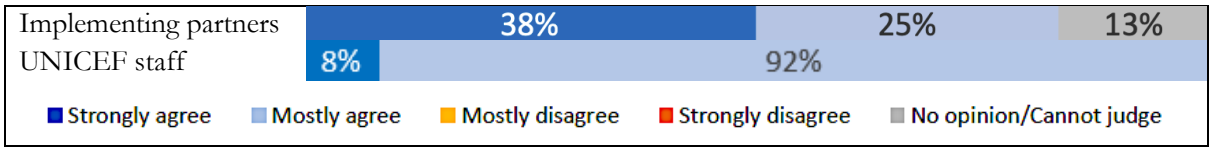
Figure 24 – Bottlenecks identified by successive TPM missions



Source: UNICEF TPM Reports

146. **Partners mostly agreed that monitoring informed their response** (Figure 25). Once UNICEF staff conducted periodic joint monitoring visits with partners, they resulted in evidence-based recommendations. Previously these were affected by the travel bans and lockdowns during the last quarter of 2020 and part of 2021 when UNICEF was much more dependent on CHWs, community structures, social media, and mobile phones to collect monitoring information.

Figure 25 – UNICEF's monitoring informed decision-making



Source: survey data.

EQ 5: Impacts

EQ 5	*What impacts UNICEF's COVID response likely to have had?*

147. This evaluation question looks at whether the benefits of UNICEF's response are likely to have made a difference in the lives of affected communities and whether the response had other unforeseen impacts.

Summary response to EQ 5

- With such a limited scope it was difficult for the evaluation to assess impact of UNICEF's response to COVID19. However, **some elements of the COVID19 response were seen likely to have a lasting impact** in different sectors. **The quality and approach of UNICEF's response has helped to strengthen partnerships** with government and NGO partners that will likely have a long-term positive impact in future.
- **Partners and UNICEF staff were mostly optimistic that impacts** of UNICEF's interventions would spread beyond COVID19, citing examples from Child Protection, Education and WASH interventions.

148. Given the limitations of the evaluation, notably the availability of baseline data and time allocated to the field visit, it was difficult for the evaluation to accurately assess the impact of UNICEF's response.

One of the main impacts on children of the pandemic was the delayed implementation of the SDGs,[79] notably those SDGs focusing on health (SDG 3), education (SDG 4), gender (SDG 5), and addressing vulnerabilities (SDG 10). Based on a preliminary analysis by the evaluation team analysis, the following elements of the COVID19 response were seen likely to have a lasting impact in Zimbabwe:

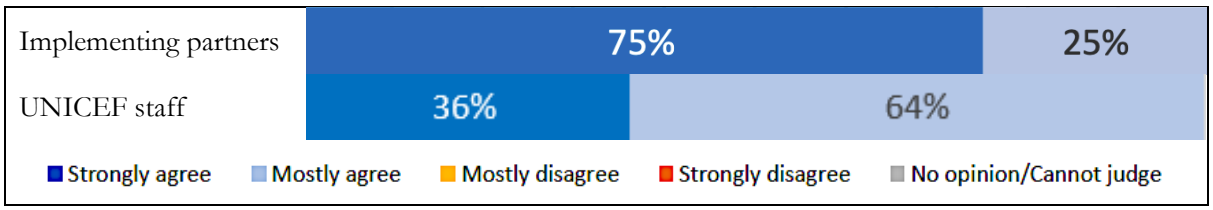
- **HEALTH** - Provision of PPE and training in COVID19 vaccine post-introduction evaluation and relevant Standard Operating Procedures contributed to a reduction in infections amongst health staff[80] and a more effective workforce. UNICEF communications resulted in demystification of COVID19 and helped improve vaccination rates in communities.
- **EDUCATION** – UNICEF contributed to children continuing their education through remote support and training. Produced a catchup learning guide to accelerate learning recovery reengagement.
- **CHILD PROTECTION** – UNICEF interventions helped in mitigating Protection from Sexual Exploitation and Abuse (PSEA) and GBV. UNICEF and international partners helped local organisations to work with community volunteer members and established WhatsApp groups so that reported cases could be rapidly addressed. UNICEF's impact was positive in the areas of returnees and family reunion reunifications,[81] sometimes after an absence of up to a decade.
- **HIV/AIDS**. More than 8,000 children, adolescents and young people living with HIV, including pregnant and breastfeeding girls and their infants, were reached by UNICEF with psychosocial and health service support in partnership with Africaid through virtual approaches facilitated by trained Community Adolescent Treatment Supporters and Young Mentor Mothers. The electronic service delivery manual to facilitate these activities was finalized. Peers check on clients' antiretroviral (ARV) supply and provide reminders for clinic appointments, ARV refill and viral load monitoring.
- **SOCIAL POLICY** – The Government's Net One cash transfer programme was based in part on UNICEF's model of social harmonized cash transfers and has helped to sustain vulnerable groups. Community Based Parent to Parent Support Groups were revitalized or initiated and some of these have income generating activities so they can continue.
- **WASH** – WASH was expanded and upgraded in health facilities, schools, and communities. The proximity to WASH facilities has created time for girls and women for other activities apart from water collection and made them safer. Health officials pointed to lower incidence of waterbourne diseases.

149. **The quality and approach of UNICEF's response helped to strengthen partnerships with government and NGO partners that will likely have a long-term positive impact in future**. UNICEF is supporting the production of a documentary which will showcase the government's work with partners.

150. NGO partners responding to the survey (Figure 26) were quite optimistic about the likelihood of impacts in the long term in terms of how governance structures had been capacitated and the impact on water systems for women and vulnerable groups.

[79] United Nations (2020) Policy Brief: The Impact of COVID19 on children. April 2020.
[80] UNICEF ZCO Consolidated Emergency Report 2021.
[81] UNICEF ZCO (2020) Multi-hazard Situation Mid-Year Report: (January-July 2020)

Figure 26 – UNICEF's response has likely made a long-term difference to communities[82]

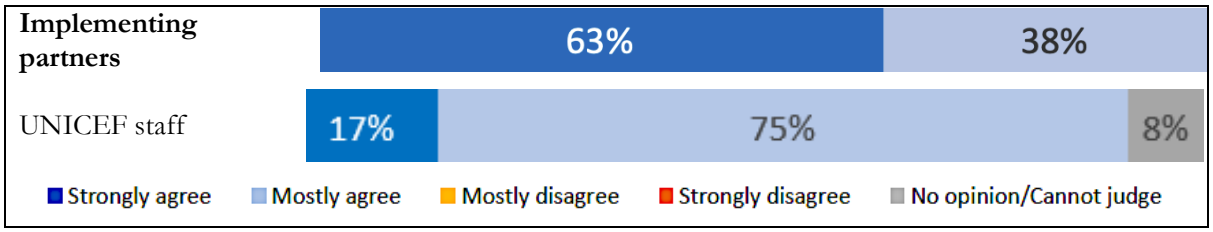


Source: survey data.

Contributions to other impacts

151. Partner and UNICEF staff were optimistic that impacts of UNICEF's interventions would spread beyond COVID19 (Figure 27). Improvements to WASH infrastructure were observed to have prevented diarrheal transmission in cholera/typhoid hotspots. District capacities to manage health emergencies was improved and was observed in their efforts to contain measles outbreaks. Remote capacity building of community-based Peer Educators had helped to prevent GBV and PSEA.

Figure 27 – UNICEF response contributed to other impacts on affected communities[83]



Source: survey data.

Unintended outcomes and impacts

152. **UNICEF interventions were seen to have made positive contributions** overall in analysing unintended outcomes and impacts. The support by UNICEF and other agencies to the host government to enable them to coordinate and manage the response with IT tools through material support and capacity building were likely to capacitate the government to extend coverage to remote communities. The only significant example of an unintended impact which was not caused by UNICEF, but where they had a potentially important role was in **assessing and mitigating the increase in substance abuse** due, in part, to the repatriation of young people from South Africa and Mozambique during the pandemic.[84]

EQ 6: Sustainability

EQ 6	*How sustainable are UNICEF's interventions likely to be?*

153. This evaluation question benefits of UNICEF's response are likely to continue to benefit affected communities after they have been completed and whether the response resulted in enhanced emergency preparedness to mitigate impacts of emergencies in future.

Summary response to EQ 6

- **There were several examples of UNICEF interventions that are likely to be sustainable,**

[82] The full statement in the survey was "*UNICEF's response is likely to have made a long-term difference in the lives of affected communities, including women and vulnerable groups*".
[83] The full statement in the survey was "*UNICEF response contributed to other impacts of other interventions that had long term impacts on affected communities*".
[84] This was mentioned under EQ1. There are several studies of this subject – see, for example, Marandure BN, Mhizha S, Wilson A, Nhunzvi C (2023) Understanding the nature of substance use in Zimbabwe: State of the art and ways forward: A scoping review protocol. PLOS ONE 18(3): e0272240.

including in Child Protection, Education, Health and WASH interventions. Prospects for sustainability were improved by incorporation into longer-term interventions, good community ownership and/or where they filled a previously unfilled niche.

- **Donors expressed reluctance to continue to pay for Village Health Workers** who filled a critical role during the response and will be important for continued community resilience.

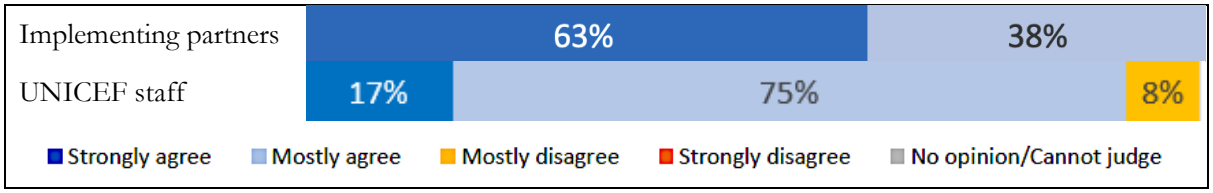
Likelihood that benefits will continue

154. Government and NGO partner interviewees pointed to **several examples of UNICEF interventions that are likely to be sustainable** after the response had ended. Some of these have been listed under EQ5 (Impact) above. Other examples of sustainability referred to include:

- **Health -** Improved capacity of district health team to manage co-infections. Efforts to promote positive health-seeking behaviours among religious sects that were initially resistant.
- **Education -** Radical changes to education modalities where training to teachers in online education and the development of related telecommunications infrastructure were key elements.
- **WASH**-FIT (WASH for health facility improvement tool). COVID provided an opportunity to introduce this in Zimbabwe. Launched 2019. This was seen as a useful tool that involved staff of health facility in the assessment and risk assessment and reassessment based on the budget available.

155. Survey respondents were positive about the sustainability of many remote access and community-based interventions that were set up (or strengthened) during the COVID19 response since they had helped **UNICEF to extend their coverage to remote areas and to facilitate access to vulnerable individuals within communities** (Figure 28).

Figure 28 – Benefits of UNICEF's response are likely to continue[85]



Source: survey data.

156. The team nevertheless found **limited evidence of exit plans or costed "business plans"** for UNICEF COVID19 interventions. Exceptions were seen with some of the WASH projects that had been incorporated into longer-term interventions and the Emergency Social Cash Transfer programme which had already been partially handed over in two districts to the government with plans in place to continue to hand-over.[86] Without COVID as a common "enemy" to be conquered, some health clubs seemed to be searching for their purpose although some had set up income-generating activities. Other examples were seen in WASH, where rehabilitation or construction water and sanitation systems had been accompanied by the establishment or strengthening of community-based management systems.

157. **Sustainability in some of the short-term projects with a 4-6 month-long timeframe, was uncertain**. After only a year of operation some 20-30% of the taps in such projects were reported as non-functioning. Not all committees had viable cost recovery schemes. This contrasted with projects in areas affected by cyclone Idai where UNICEF had incorporated emergency interventions with long-term initiatives where systems were much better maintained and managed.

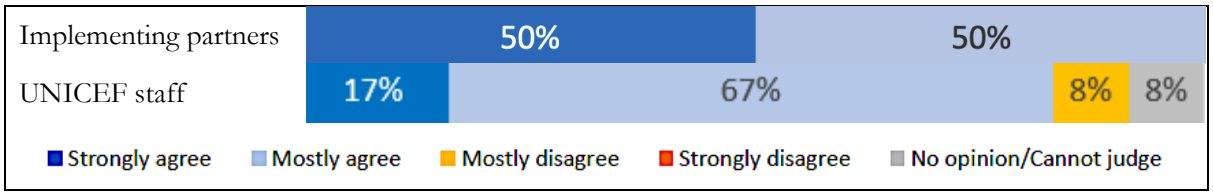
158. It was envisaged to continue Helpline assistance that enabled partners to reach survivors in the hard-to-reach areas with GBV perpetrators. UNICEF has refurbished two production studios at the Ministry

[85] The full statement in the survey was "*Benefits of UNICEF's response are likely to continue to benefit affected communities after they have been completed*".
[86] *Humanitarian Cash Transfers strengthen Social Protection Systems in Zimbabwe* – accessed 27 February 2023.

of Primary and Secondary Education (MoPSE) and they will continue to produce radio lessons and other digital content. Survey respondents pointed to Radio and TV lessons, as well as digital learning, which have become a permanent mode of lessons delivery within the blended learning approach. Likewise, it was expected that Parent to Parent Support Groups would continue to support children with disabilities.

159. Most survey respondents thought that the COVID19 response would help to mitigate the effects of future disasters. Some pointed to Radio and TV lessons as part of digital learning as examples that have become a permanent mode of lessons delivery within a blended learning approach.

Figure 29 – UNICEF's response will mitigate the effects of natural disasters in future[87]



Source: survey data.

160. **One concern was that due to funding limitations donors were having difficulties finding resources to continue to pay for VHWs** and there was uncertainty whether the government would be able to continue. Given the critical role that VHWs played during this response, it will be important to find a sustainable model to reinforce resilience.

EQ7 Accountability to Affected Populations

EQ 7	*How did UNICEF fulfil its commitments to be accountable to the affected population?*

161. This evaluation question examined the extent that communities were involved in the identification of needs, design, and implementation of the UNICEF response and how they used community feedback.

Summary response to EQ 7

- **UNICEF has made progress on AAP over the past few years, but it has not yet been fully mainstreamed.** This was apparent during lockdowns with limited access to communities and it was difficult to continue support for people living with disabilities and monitoring GBV.
- **There were examples of UNICEF proactively seeking community engagement**, including feedback on its interventions using U-Report challenge via social media although this did not occur until later on during the response.
- **Community feedback systems exist although some UNICEF respondents had doubts about their effectiveness**.

162. **UNICEF has made progress on AAP over the past few years.**[88] Some NGO partners have mechanisms in place but as can be seen from UNICEF staff response to the survey **it was not felt that AAP had yet been mainstreamed**. This was highlighted during lockdowns when access to communities was problematic, notably with difficulties in continuing support to people living with disabilities and monitoring GBV which showed a marked increase during lockdowns. NGOs reported that, although not many complaints had been received on their hotlines, most of them were related to GBV. As described above under EQ4, it was challenging to track supplies from the supplier to the end

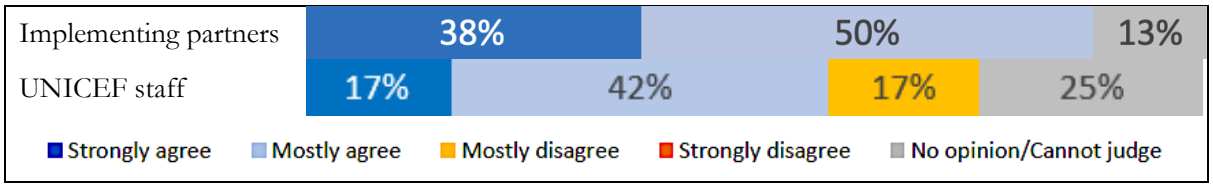
[87] The full statement in the survey was "*UNICEF's response enhanced emergency preparedness and will mitigate the effects of natural disasters in future*".
[88] UNICEF (2022) Internal Audit of the Zimbabwe Country Office. November 2022.

user, an issue that had been raised in previous evaluations.[89]

163. As described above under EQ4 (procurement), the team was unable to track emergency supplies from the supplier to the end user. This is an issue that directly concerns AAP, an issue that has already been raised in previous reviews and evaluations.[90]

164. Survey respondents (Figure 30) and interviewees noted the challenge of accessing and consulting with communities during this emergency, including with children when schools were closed.

Figure 30 – Communities were involved in the UNICEF response[91]

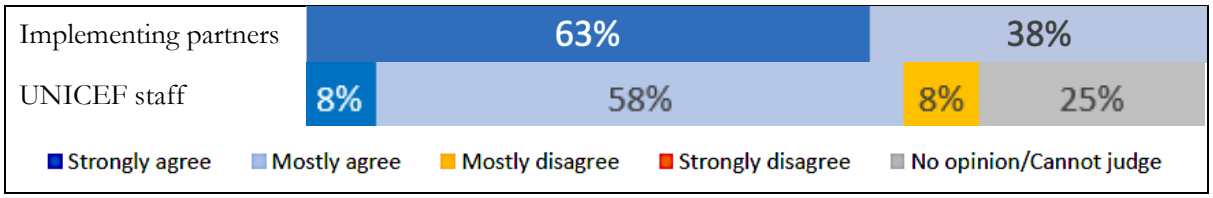


Source: survey data.

165. There were nevertheless **many examples of UNICEF proactively seeking community engagement**, including feedback on its interventions. In early 2022, UNICEF launched a U-Report challenge via SMS, Facebook Messenger and other communication channels designed to improve access and confidence in COVID19 vaccines.[92] The reporting platform was seen by partners as very relevant, answering children's questions about COVID19 in child-friendly language. Assessments mostly included participation of community leaders. A respondent to the partner's survey noted that some of UNICEF's activities were directly responding to the mapping exercise which consulted children with disabilities and their caregivers and asked about their priority needs.

166. Survey respondents acknowledged that **community feedback systems exist although UNICEF respondents had doubts about their effectiveness** (Figure 31). The U-Report platform was seen as very relevant, which answered children's questions about COVID19 in child-friendly language. It was evident that the standards of the feedback systems varied widely between partners. A recent internal audit recommended that UNICEF consolidate these different feedback systems to improve coherence and make it easier to use community feedback to inform programming.[93]

Figure 31 – UNICEF and their partners used community feedback[94]



Source: survey data.

[89] Jock Baker et al. (2019) Independent Real-Time Evaluation of UNICEF's response to Cyclone Idai in Mozambique, Malawi and Zimbabwe.
[90] UNICEF (2022) Internal Audit of the Zimbabwe Country Office. November 2022 and Jock Baker et al. (2019) Independent Real-Time Evaluation of UNICEF's response to Cyclone Idai in Mozambique, Malawi and Zimbabwe.
[91] The full statement in the survey was "*Communities were involved in the identification of needs, design and implementation of the UNICEF response*".
[92] The campaign was launched in Zimbabwe and five other countries in the region - see UNICEF Launches First Ever U-Report Challenge to Boost COVID19 Vaccine Uptake in Africa. 26 January 2022.
[93] UNICEF (2022) Internal Audit of the Zimbabwe Country Office. November 2022.
[94] The full statement in the survey was "*UNICEF and their partners have collected community feedback on services provided and used this feedback to improve the quality of their interventions*".

Lessons learned

This section presents selected key lessons learned that will be useful for UNICEF staff when revising preparedness approaches or implementing a response during similar emergencies, whether in Zimbabwe or elsewhere.

167. UNICEF ZCO's response to the COVID19 pandemic **demonstrated the value of building upon and adapting the existing programme to deliver humanitarian support** to save lives and mitigate suffering while establishing or reviving structures, such as community health committees, that can have an impact beyond the pandemic.

168. **A key factor in preparedness is to invest in community health systems before emergencies strike** to strengthen links between health facilities and communities. Important anticipatory action steps to take ahead of emergencies should be to:

- Review the status of VHWs and fill any necessary gaps in personnel and/or capacity building needs. Identify sustainable means to incentivize VHWs and motivate them.
- Equip CHWs with IT materials so that they can access and relay information.
- Equip VHWs with protective clothing, including raincoats (since they use bicycles) for rainy seasons.

169. **RCCE provided a very important contribution** to the COVID19 response, not just for UNICEF, but the humanitarian community at large.

170. The importance of having a civil society organization(s) like **religious leaders, youth and other key influencers to engage as strategic partners to achieve shared objectives**.

171. **Nutrition needs a higher profile during an emergency response**. Nutrition was not represented on the COVID19 Task Force which limited its voice and did not give this sector the attention it deserved.

172. **Strengthen logistics** for the procurement and distribution of equipment to district facilities. An important lesson emerging from the COVID19 response was that there is a need to balance Long Term Agreements (LTA) for international and local suppliers.

173. **Importance of engagement with the local private sector**. Specific lessons from the COVID19 response included the importance of long-term agreements for supply of emergency items to mitigate constraints on international procurement and support local manufacturing capacities. Partnering with businesses like supermarkets was helpful in supporting dissemination of health promotion and risk communication messaging.

174. **Facilitate learning exchanges such as**:

- **Exchanges between different city councils** facilitated the adoption of better practices reported by another. For example, the City of Harare learned to (a) engage local residents to handle and benefit from fees to provide some services such as waste management (b) localise the infrastructure of water supply and responsibilities and (c) retain the responsibility of replacing stolen water equipment to cushion citizens from unnecessary expenses by deducting the corresponding amount from rate charges that citizens pay.
- **Mechanisms that facilitate peer learning** and stock-taking activities are essential for strengthening both UNICEF and partner staff.

Conclusions and Recommendations

175. This chapter presents conclusions emerging from findings and analysis during this evaluation. They are structured as follows:

- An overall statement for the overall response to the crisis.
- Conclusions and recommendations based on an analysis of evidence collected during the evaluation.

176. As described in the Methodology section, emerging conclusions were discussed with stakeholders during a validation session and UNICEF staff will be provided with an opportunity to validate, prioritise and further develop recommendations.

OVERALL CONCLUSIONS

The scope, spread and unpredictability of the COVID19 pandemic proved to be a significant challenge to the global development and humanitarian system that required a response that was unfamiliar to most staff. Not only did UNICEF need to respond to the needs of affected communities, but it needed to significantly revise its ways of working to protect the health and safety of its own and partner staff. The COVID19 pandemic impacted children through its socioeconomic effects, stay-at-home policies, disruption to education and basic services, and increased child protection risks. The COVID19 pandemic tested community resilience and triggered adaptations and innovations in all sectors that could increase resilience.

While the unknowns of the pandemic caused some delays in rolling out assistance, UNICEF ZCO's contribution was widely viewed as appropriate by the government, WHO and UNICEF's implementing partners. After the government had declared a national disaster in March 2020, UNICEF ZCO was able to benefit from several enabling factors and was able to adapt relatively quickly to support a good quality response to the pandemic. Key factors that facilitated UNICEF ZCO's response included:

- Proactive response by the government and subsequent willingness to devolve UNICEF support to district level.
- Application of lessons learned from previous emergency responses, most recently lessons from the response to cyclone Idai in 2019.
- Pre-existing networks with the government, other humanitarian agencies and affected communities that knew and trusted UNICEF.
- Easy access to technical advice and operational guidance based on lessons learned that could be drawn from UNICEF regional and global resources to fill any gaps in knowledge to enable them to respond effectively to an unfamiliar emergency.
- Systems that enabled a relatively quick transition to remote working arrangements for UNICEF and partners.

The recommendations below are organised by thematic area and are linked to conclusions. All eight recommendations were confirmed to be relevant and a priority for UNICEF ZCO during the validation workshop. Although the recommendations are mainly aimed at strengthening emergency preparedness based on learning from the response to COVID19, their implementation will also help to improve long-term programming by strengthening resilience of communities. Three of the recommendations, Recommendations 3, 7 and 8, should be seen as time sensitive and should be implemented as a matter of urgency.

Sustainability

R1. UNICEF should improve sustainability of their emergency interventions.

Linked to findings: *EQ1, EQ3, EQ6*	**Priority:** Low
Stakeholders involved: Deputy Representatives for Programmes and Operations, Resource Mobilization and Partnership Specialist, Social Policy Specialist (Social Protection), Supply and Logistics manager and C4D Manager	

Overall, this was a solid response by UNICEF that drew upon the strengths of UNICEF's programme, networks with support from the region and UNICEF HQ. The evaluation nevertheless raised questions about appropriateness and sustainability, notably lack of a "business case" of some of the interventions. UNICEF adapted their existing programme and preparedness to respond to COVID19 as other crises. The networks UNICEF has established with the government, WHO, NGOs and communities helped UNICEF to largely achieve their targets as part of a team effort. Some areas where improvement was needed were still evident, some of which had been observed during previous emergency responses.

For all sectors the COVID19 pandemic raised a question of what capacity was needed to improve resilience of local actors, including communities themselves, to mitigate the effects and respond to the next disaster. Specific examples were seen in WASH, where short-term interventions of 4-6 months were less likely to be as sustainable as interventions which had been integrated with longer term recovery interventions that were running in areas affected by Cyclone Idai in 2019. Nutrition was not that visible during the COVID19 response in Zimbabwe and there is a risk that the impact is likely to be felt for some time even though the investment case in nutrition has been proven.[95] The allowances given during the response (per diems, etc.) for all sectors are also likely to have a longer-term disruptive impact on sustainability.

Apart from cash transfers (Emergency Social Cash Transfers) under Social Policy that linked its intervention to the Government's own Social Protection programme and the Health section that supported the links between the Ministry of Health and Child Care and Econet to scale up free access to COVID19 information, evidence suggested that our partnerships with public and private sectors could contribute to improving quality and strengthen sustainability of our programmes.

To improve sustainability, UNICEF should:

- Take a longer-term perspective when designing emergency strategies and plans and integrate interventions with longer-term impact, beyond the immediate emergency response.
- Assist partners and communities to develop costed business cases for interventions that are expected to be sustained after the response has ended.

Engage with the private sector as one approach to strengthen sustainability. This could include formalizing long-term agreements for supply of items like PPE from local manufacturing to strengthen capacity for local manufacturing and reduce dependence on off-shore procurement channels that were significantly constrained and posed a risk. This is with the knowledge that in general, procurement of medical supplies and equipment cannot be done at local level due to quality control and assurance issues. A waiver will be needed from the supply division before doing so, and this might not always be obtained.

- Partnering with identified businesses could support dissemination of social behaviour change and risk communication messaging.
- Capture learning from the cash transfer program (ESCT) to share experience of how sustainability considerations were incorporated in its design and explore how might be replicated.

[95] UNICEF West and Central Africa (2021) Reaching out to n partners in the time of COVID19: Key Results for Children Prevention of Stunting.

Vulnerability

R2. UNICEF should jointly develop a mean to reinforce assistance to particularly vulnerable groups, including people with disability and vulnerable girls, during an emergency response.

Linked to findings: *EQ1, EQ2, EQ3, EQ4*	**Priority: Low**
Stakeholders involved: Deputy Representative for Programmes, Chief of Child Protection, Child Protection Officer (Disability), Program Specialist (Gender and Human Rights) and Emergency Specialist	

There were remaining gaps in assessment and assistance for particularly vulnerable people, such as people with disability and vulnerable girls. UNICEF made efforts in the intervention designs to ensure that vulnerable groups were prioritised, but implementation was variable. For example, a combination of reliance on government systems, cultural issues, and specific characteristics of the COVID19 pandemic, including movement restrictions meant that there were significant uncovered needs for people with disability, people living with HIV and increased vulnerability to GBV, pregnancies and early marriage. There was a consensus that UNICEF had performed well in the response and had mitigated the effects of COVID19 through innovative approaches including use of diverse communication modalities, remote systems and continuously adapting through learning. At the same time there could have been more of a focused effort to continue to support some groups that were particularly vulnerable.

Limited access to affected communities could be addressed during future emergency responses by:

- Working with MoHCC and other concerned Ministries to improve inclusion of vulnerable groups particularly in need through assessments, meeting specific needs and monitoring the welfare of identified groups in an integrated way.
- Strengthening community-based networks and AAP systems to capacitate communities to mitigate key risks, for example GBV for children and related threats.
- Promoting convergence for UNICEF's community based social service inter-sectoral/cluster workforce (health, education, child protection, WASH) supported by an information management system to monitor gaps and progress in meeting objectives.
- Developing early warning mechanisms and anticipatory action for groups identified as particularly vulnerable and at risk during a disaster response.

Programme quality

R3. UNICEF should support GoZ with an assessment and development of a multisectoral strategy and approach with partners with an aim of preventing and mitigating substance abuse by youth.

Linked to findings: *EQ1, EQ3, EQ4*	**Priority:** High (*to be implemented within the next six months*).
Stakeholders involved: Deputy Representative for Programmes, Chief of HIV/AIDs and Adolescent Development and Chief of Health & Nutrition	

Substance abuse by adolescents was not sufficiently prioritised during the COVID19 response. There is a significant amount of evidence that substance abuse significantly increased amongst youth due to the situation caused by the COVID19 pandemic, though numbers are uncertain. Factors contributing to this increase included large numbers of youths repatriating from other countries in the region, boredom during lockdown, lack of alternative ways of earning a livelihood. Increased substance abuse by Zimbabwe's youth is likely to be an unfortunate outcome that will remain well after threats from the COVID19 pandemic have subsided. Such a strategy to prevent and mitigate substance abuse should consider:

- A multisectoral response will be required with strong leadership.[96]
- Advocacy and communication as an integral component of this strategy.
- Support from parents and caregivers as a critical component.

R4. UNICEF should update their preparedness by strengthening preparedness using different scenario-based emergency simulations, review and revise. This could be done as an interagency exercise, notably as scenario-based simulations.

Linked to findings: *EQ1, EQ3, EQ4, EQ7*	**Priority: Low**
Stakeholders involved: UNICEF Emergency Specialist, Chief of Health and Nutrition and Chief of Child Protection	

Preparedness contributed to UNICEF's ability to respond to the COVID19 pandemic by streamlining procurement and administrative systems, making available pre-positioned supplies and generally "switching gears" to emergency response mode. Staff capacities for emergency response and scenario-based preparedness need strengthening. It nevertheless took time for UNICEF, and other humanitarian agencies, to adapt to new ways of working challenged by a lockdown, closed borders, an airborne pandemic, and other unfamiliar elements. UNICEF learned and adapted systems during the response including remote working modalities and local LTAs for procurement that are likely to change how UNICEF responds in future. Specific areas of focus when implementing this recommendation should include:

- Support preparedness and resilience-building contents into the professional development of frontline workers, including addressing disability and GBV (see Recommendation 2).
- Support the integration of different emergency scenarios related training content into in-service curricula and post-graduate courses (e.g., health care in an emergency).
- Advocate for and support the integration of innovative sessions on psychological support, well-being, and emotional implications of coping with the crisis situation into capacity building activities.

R5. While continuing to improve RCCE to support UNICEF's own programming, UNICEF should identify ways to apply this useful tool to strengthen the overall response by, for example, including RCCE in interagency disaster simulation exercises.

Linked to findings: *EQ1, EQ2, EQ3, EQ7*	**Priority: Medium**
Stakeholders involved: C4D Manager	

UNICEF's RCCE activities and work with community-based groups using formats tailored for specific groups, such as people with disabilities, was a trusted source that increased knowledge of COVID19 and had a positive change on behaviour. This capacity proved to be very important during the response due to the impact of the COVID19 pandemic, notably restrictions on movement and reliance on other forms of information, including social media, which was often unreliable. UNICEF has already begun to engage with the UN Resident Coordinator's office, UNDP, WHO and UNFPA to augment evidence generation to inform ongoing RCCE interventions.

[96] It seems most likely that MoPSLSW will lead this initiative since it was reported to have already set up a task force focused on substance abuse.

R6. A future emergency response should adequately reflect UNICEF's lead role in nutrition, including as head of the Global Nutrition Cluster, so that it can assume a profile and role appropriate to the response.

Linked to findings: *EQ2, EQ3*	**Priority: Low**
Stakeholders involved: Deputy Representative – Programmes, Chief of Health and Nutrition, Emergency Specialist andNutrition Manager	

Nutrition was insufficiently prioritised during the response and was effectively demoted to a subsidiary of health during the response, including in UNICEF's COVID19 Task Force. The nutrition programme was also development-oriented and had some difficulties adjusting to the new context. The response for nutrition was nevertheless in-line with global guidance to ensure continuity of essential services including screening and treatment for wasting, protecting breastfeeding and provision of other essential nutrition services. Although Zimbabwe was one of the first countries in the region to re-start surveys and house-to-house data collection the lack of visibility during the response may still have negative longer-term consequences. Specific attention should be given to:

- Giving UNICEF's nutrition section an independent voice when planning and coordinating a response so that it is embedded in and enables other sectoral interventions.
- Nutrition outcomes are clearly articulated in emergency response interventions.

Monitoring, information management and AAP

R7. UNICEF should improve the Accountability to Affected Populations and remote monitoring systems.

Linked to findings: *EQ3, EQ4, EQ7*	**Priority:** Medium
Stakeholders involved: Deputy Representative for Programmes and Operations, Supply and Logistics Manager and Chief of Programme Planning and Monitoring	

The COVID19 response provided an opportunity to learn and further improve Accountability to Affected Populations and remote monitoring systems, including Third-Party Monitoring mechanisms. UNICEF monitoring was limited during COVID19 with UNICEF staff not able to visit the field for extended periods. UNICEF were able to activate an LTA to conduct TPM that allowed them to not only monitor progress and understand how to increase the effectiveness of their support, but also help with AAP by indirect consultations with affected populations. This provided UNICEF with an opportunity to adapt remote monitoring systems while identifying areas for improvement.

The evaluation team was able to track procurement up to warehouses or handover of supplies to partners, but it proved difficult to track delivery of supplies to end users. There have been recommendations in previous evaluations and audits[97] that UNICEF ZCO established supply End User Monitoring procedures to gain a more realistic picture of delivery times, but these have not yet been put into place.

UNICEF should give priority as a matter of urgency to the following:

- Adopt the seven pillars of the global UNCEF AAP approach in ways of working, including participation, information and communication, feedback and complaints, PSEA, local capacity development and evidence-based decision-making and coordination in a holistic approach.

[97] This was also a recommendation in the November 2022 UNICEF Internal Audit of the Zimbabwe Country Office and Baker J., et al. (2019) Independent Real-Time Evaluation of UNICEF's response to Cyclone Idai in Mozambique, Malawi and Zimbabwe.

consolidation and systematic use of community complaints and feedback with partners.[98] Test using disaster simulations and capture learning from future emergencies and train staff.

- Develop a joined-up system to track procurement seamlessly from the time supplies are ordered to delivery to the end user at a community level.
- Consider Third Party Monitoring as part of preparedness planning, testing approaches using different scenarios.

R8. UNICEF should promote more systematic information management and use of peer learning with partners.

Linked to: *Methodology (Limitations and Constraints), Annex 5, finding EQ4 and EQ7.*	**Priority:** High (*to be implemented within the next six months*).
Stakeholders involved: Deputy Representatives for Programmes and Operations, Chief of Programme Planning and Monitoring, Information, Communication and Technology Specialist and Implementing Partnerships Management Officer	

Although UNICEF has a common platform that is supposed to facilitate information management, the evaluation team struggled at times to get the required data. In the end, the evaluation team get most of the data requested except for reports for some of the projects in the sample. Amongst the reports received the team found even fewer final reports that included a review by UNICEF staff.

When the pandemic struck, in-person coordination meetings for implementing partners, where they could share learning, were suspended. Several partner staff mentioned this gap and suggested that UNICEF could have also been used as opportunities for more systematic peer learning. Specific attention should be given to:

- Reviewing reporting and information management systems and revise to ensure they are useful and fit-for-purpose.

Continuing to increase frontline workers' access to modern technologies, equipment and technical support.

[98] This was also a recommendation in the November 2022 UNICEF Internal Audit of the Zimbabwe Country Office

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