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Evaluation of the UNICEF Level 3 response to the global coronavirus disease 2019 (COVID-19) pandemic

Summary**

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The present evaluation was commissioned in late 2021, several months into the COVID-19 pandemic, to shed light on how UNICEF operationalized its very first global Level 3 activation, including the results it achieved, the challenges it faced and the opportunities it seized to best address the needs of the affected populations between January 2020 and March 2022. The purpose of the evaluation was also to provide strategically and operationally relevant inputs to UNICEF senior management and technical staff on how to best manage future public health emergencies.

The evaluation concluded that UNICEF was generally well positioned to respond to the needs created by the COVID-19 pandemic, thanks to its consolidated emergency response experience, its capillary decentralized structures and the embedding of a UNICEF staff member (from the Public Health Emergencies team) within the World Health Organization. The evaluation also recognized the relevance of the adaptive capacity of UNICEF on two different fronts: first, the delivery at scale of programmatic results in such sectors as risk communication and community engagement, social protection/cash assistance, mental health and psychosocial support and education; and second, a strategic involvement – with de facto operational contributions – in the implementation of the Global Health Response Plan, the United Nations framework for the immediate socio-economic response to COVID-19 and Access to COVID-19 Tools Accelerator, including COVID-19 Vaccines Global Access (COVAX).

Futhermore, the evaluation acknolwedged the added value of UNICEF supply to the overall response, primarily through the large-scale procurement of personal protective equipment, test kits (diagnostics) and related therapeutic support (such as

* E/ICEF/2023/9.

** The evaluation report summary is being circulated in all official languages. The full report is available in English from the UNICEF Evaluation Office website (see annex).
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hospital beds, oxygen concentrators and ventilators), as well as the strengthening of cold chain infrastructure. That notwithstanding, the evaluation highlighted the global supply chain difficulties which, paired with the challenges of centralized supply arrangements, slowed down implementation on the ground.

In addition, the evaluation pinpointed specific shortcomings of the response including: countries' different levels of preparedness to the pandemic; the uncertainties about the role of UNICEF within a global health emergency in the early months of the pandemic, the strained state of some international partnerships, as well as uneven attention accorded to gender, equity and accontability to affected populations.

Building on the finding and conclusions presented in the report, the evaluation put forward eight recommendations to both address the underlying issues and challenges identified in the report and to further strengthen the response of UNICEF to future public health emergencies.

Elements of a draft decision for consideration by the Executive Board are provided in section IV.

I. Introduction and background

1. More than two years from its onset, the coronavirus disease 2019 (COVID-19) pandemic was continuing to have a lasting impact across the world. Over 500 million confirmed cases and 6.3 million deaths were reported as of June 2022. New variants continued to create waves with alarming rapidity.

2. This report summarizes the findings of an independent evaluation of the UNICEF global response to the COVID-19 pandemic that was conducted in 2022. The evaluation's objectives were:

(a) To examine the appropriateness, effectiveness and efficiency of UNICEF work in response to the COVID-19 pandemic;

(b) To examine the coherence and effectiveness of UNICEF collaboration and coordination efforts with partners in responding to COVID-19.

3. The evaluation covered the pandemic response of UNICEF from January 2020 to March 2022. It was conducted under the conditions of COVID-19, including UNICEF still under a Level 3 emergency declaration during 2022; travel and movement restrictions ongoing; and a strong directive to avoid burdening overstretched country offices. It prioritized the use of existing data and information, analysing 89 independent evaluations alongside UNICEF corporate documentation and data. Interviews were conducted with 111 stakeholders, comprising both UNICEF staff and management, and external partners and stakeholders. A desk review was undertaken of the response activities implemented in 21 UNICEF country offices. An in-depth assessment was also conducted with respect to the response implemented by seven additional countries. A consultation meeting was held with UNICEF staff and management in June 2022 to discuss the findings and conclusions of the evaluation and validation meetings were organized with a series of UNICEF divisions in October 2022.

4. The present summary report presents the main findings, conclusions and recommendations of the evaluation. It is mindful that, while lockdowns have ceased in many parts of the world, the disease itself is far from over.

II. Evaluation context

5. **Unprecedented impacts on children:** During 2020, when the world saw extensive domestic and international shutdowns, 1 in 7 children lived under stay-at-home policies for the majority of the year. Specific effects of both the pandemic and national responses to it included:

(a) **Increased poverty**, with a 15 per cent increase in the number of children living in multidimensional poverty in 2020, up to 1.2 billion globally; and a vastly increased number of children needing humanitarian assistance;

(b) **The largest suspension of face-to-face education in history**, which affected up to 94 per cent of students across the world, and particularly children with disabilities;

(c) **The greatest disruption to immunization services ever known**, with 30 million children missing routine immunization in 2020 and 25 million un- (or under-) vaccinated children in 2021;

(d) **Increased child protection risks** in a challenging combination of confinement measures on the one hand, and disrupted violence prevention and response services on the other;

(e) **Intensified gender inequalities**, including adolescent pregnancy, gender-based violence, loss of livelihood, increased violence, and huge increases in unpaid care work.

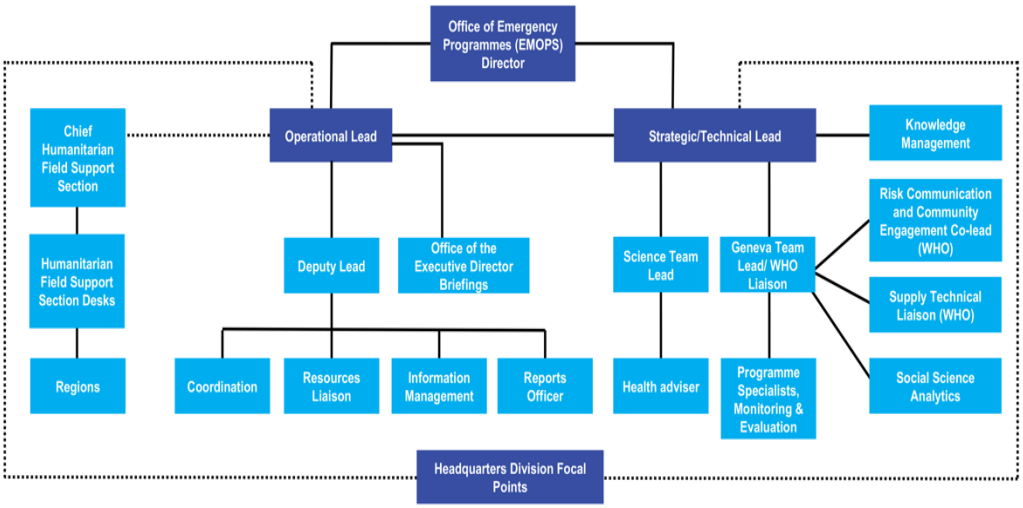
6. **Inequality in COVID-19 vaccination coverage** continues in 2022, with Africa having the lowest COVID-19 vaccine coverage globally.

A. What were UNICEF organizational arrangements for the response?

7. UNICEF had early sighting on the emergence of COVID-19 as a public health concern thanks to the co-location of a staff member from its Public Health Emergencies team within the World Health Organization (WHO) office in Geneva. Meetings in early January 2020 raised the concern of a cluster of undiagnosed disease in Wuhan, China; the issue was subsequently elevated within UNICEF headquarters, and a corporate response activated.

8. **Management structures:** A global secretariat for COVID-19 was established in January 2020, divided into an operational response and a strategic and technical branch, with nine working groups. The Director, Office of Emergency Programmes, was designated Global Emergency Coordinator for the response. Figure I provides the structure of the secretariat.

Figure I
UNICEF global secretariat for COVID-19



Source: Evaluation team, adapted from UNICEF documentation.

9. Under Level 3 emergency procedures, regional directors enhanced the oversight and accountability of UNICEF regional- and country-level responses. Country representatives were authorized to make the necessary adjustments to their country programmes and regular resource allocations in consultation with Governments.

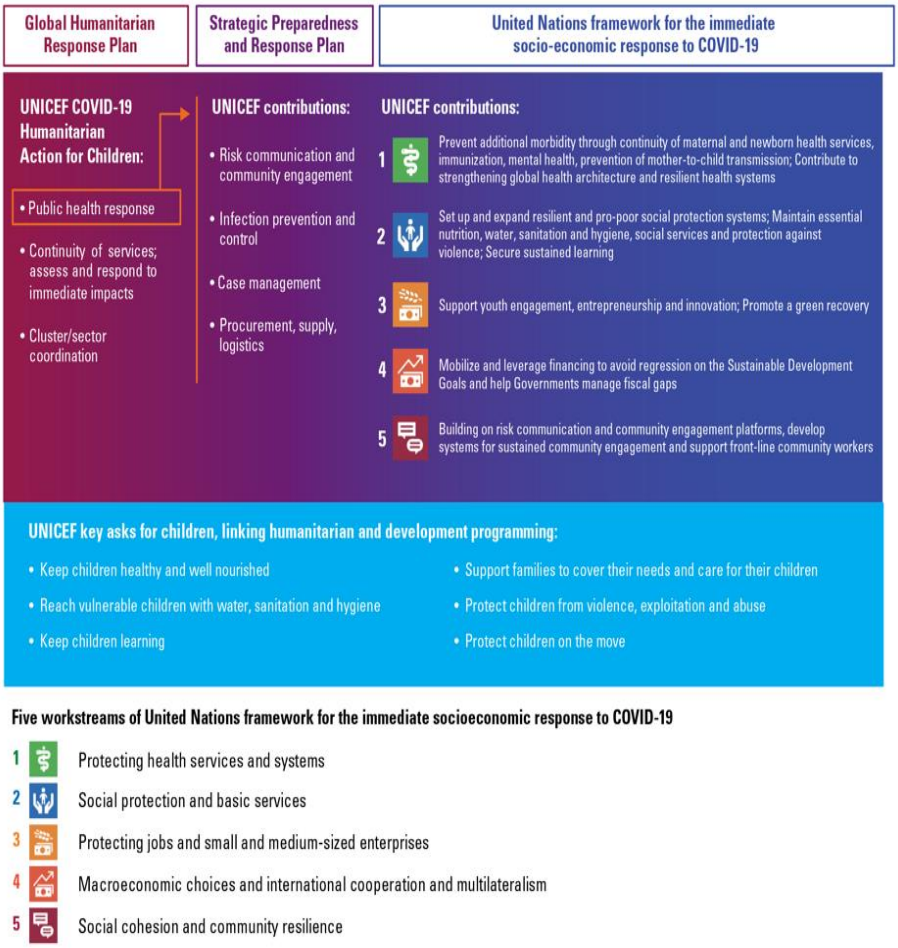
10. **Strategic frameworks:** UNICEF launched its first COVID-19 global Humanitarian Action for Children (HAC) appeal on 17 February 2020, and initial emergency procedures in March 2020. The organization's first-ever global Level 3 Scale-Up Corporate Emergency Activation Procedure was launched on 16 April 2020 for an initial period of six months. It was subsequently extended until 15 January 2021 and then deactivated on 1 July 2022.

11. At country level, draft COVID-19 response plans were prepared by more than 90 UNICEF country offices, and were completed by mid-March 2020, applying the indicators and priorities of the global HAC. In 2021, the global COVID-19 HAC appeal was discontinued, and the COVID-19 response was integrated into seven regional appeals (for non-HAC countries) and stand-alone appeals. A global COVID-19 chapeau HAC for 2021 consolidated the regional HACs and defined the integration of the COVID-19 response in the 2021 appeals.

B. What position did UNICEF adopt in the global pandemic response?

12. UNICEF aligned its approach to global United Nations frameworks for tackling COVID-19, including the United Nations Global Humanitarian Response Plan, the WHO Strategic Preparedness and Response Plan and the United Nations framework for the immediate socio-economic response to COVID-19 (see figure II).

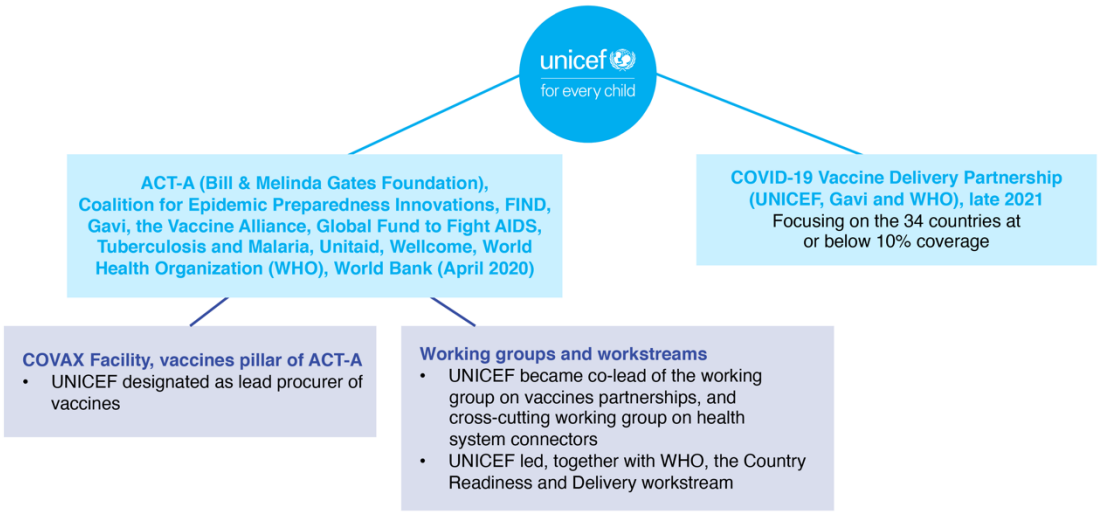
Figure II
The role of UNICEF within the wider international response



Source: "UNICEF Response to the COVID-19 Pandemic", Background paper for the Executive Board, June 2020.

13. Although UNICEF was not initially engaged by partners in the governing body of the global Access to COVID-19 Tools-Accelerator (ACT-A), in 2021 it became co-lead of the vaccine pillar and health system and response connectors, which sought to support the role of UNICEF in the global collaboration for the development, production and equitable access to COVID-19 testing, treatment and vaccines (COVID-19 Vaccine Global Access (COVAX)). UNICEF also ended up co-leading the Country Readiness and Delivery workstream with WHO. In late 2021, UNICEF partnered with WHO and Gavi, the Vaccine Alliance to launch the COVID-19 Vaccine Delivery Partnership.

Figure III
The role of UNICEF in international vaccination structures



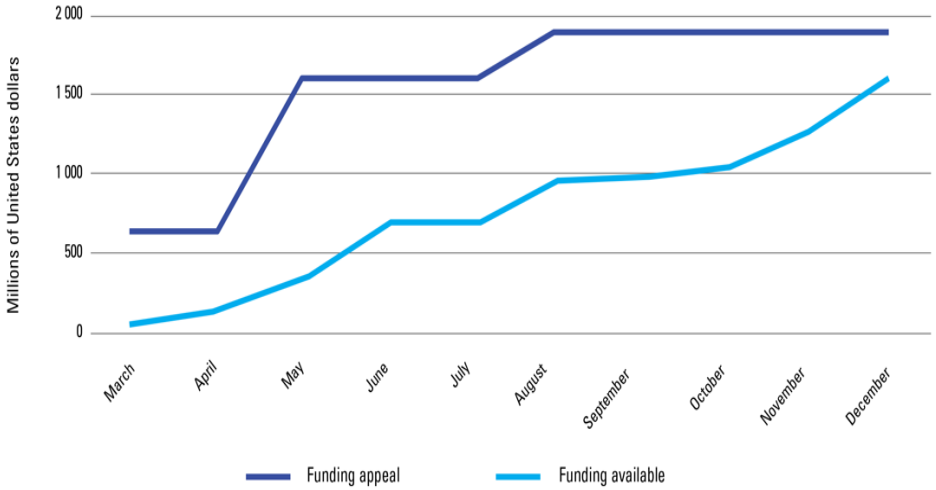
Source: Evaluation team.

C. How well funded was the UNICEF response?

14. The response was extremely well funded. In total, $1.6 billion was raised under the global COVID-19 HAC, accounting for 84 per cent of the funds requested. However, funding was not evenly spread across regions, with the Europe and Central Asia, Latin America and Caribbean, West and Central Africa and South Asia regions all receiving lower volumes than requested.

15. UNICEF ACT-A appeals were also well funded, with 80 per cent of the 2021 appeal raised ($776 million against $969 million requested) and 66 per cent of the 2022 appeal mobilized ($837 million against $1.27 billion requested). In addition, the separate ACT-A Supplies Financing Facility, established to receive funds dedicated to support low- and middle- income countries to access, purchase and receive COVID-19 supplies via UNICEF procurement services, had received $1.12 billion by March 2022.

Figure IV
Funding appeals and funding available for the 2020 COVID-19 response (UNICEF global COVID-19 Humanitarian Action for Children appeal)*



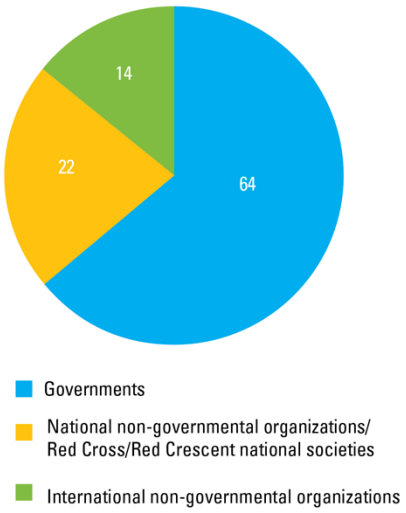
* Funding available includes funds received in the current year and repurposed funds with agreement from donors.
Source: UNICEF COVID-19 Global Response situation reports (March–December 2020).

16. Of the total funds raised under the 2020 COVID-19 HAC, UNICEF had utilized $1.29 billion by 31 December 2020. Of this:

(a) $531.4 million (41 per cent) was used for supplies (including personal protective equipment, diagnostics and oxygen);

(b) Nearly $537.8 million (42 per cent) was transferred and committed to implementing partners. Out of this amount, more than half in 2020 went to partner governments (see figure V).

Figure V
Funds transferred to implementing partners (per cent), 2020



Source: Evaluation team, generated from UNICEF internal data.

III. Findings of the evaluation

A. How well prepared was UNICEF for the global pandemic?

17. The evaluation suggests that UNICEF was corporately well positioned to respond to the needs of the populations affected by the COVID-19 pandemic. Its advantages included: (a) considerable emergency response experience accumulated in the past in all regions of the world; (b) consolidated decentralization structures; and (c) the co-location of a UNICEF Public Health Emergencies staff member within WHO.

18. At country level, however, the evaluation highlights that the level of UNICEF preparedness planning was uneven. Where high-quality and relevant preparedness plans were in place – notably in UNICEF country offices with a strong emergency team and prior experience in managing emergencies – these supported swift adaptation and rapid response to COVID-19. To the contrary, where UNICEF country offices had limited preparedness plans, or where plans were tailored to respond more to natural disasters or political upheavals/conflict than to a disease outbreak, adaptive capacity was notably constrained.

19. Many country offices with prior emergency experience also had existing infrastructure which supported pandemic preparedness, including pre-positioned contingency stocks, well-developed supply chains including for cash transfers, and extensive immunization programmes. By building on their existing infrastructure and partnerships, these country offices were able to scale up their responses more effectively (see box I).

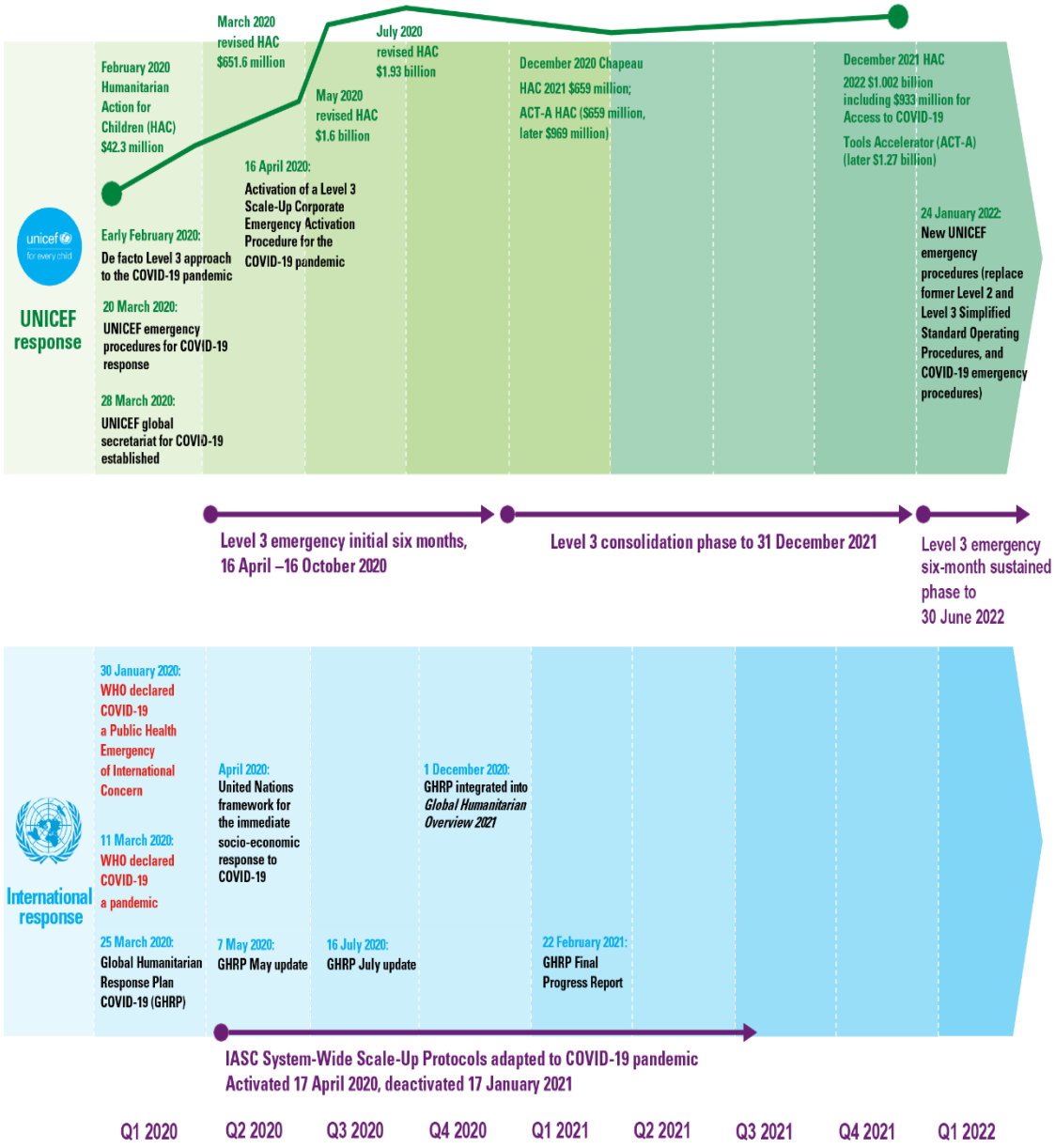
Box I
Examples of preparedness infrastructure and experience conducive to the response

- In **Afghanistan, Pakistan, Somalia and Yemen**, the scale of pre-positioning of supplies, and the robust supply chains developed for emergency conditions, helped to facilitate the transition to emergency response.
- In **Malawi**, the UNICEF cash response to COVID-19 benefited from an established shock-responsive social protection mechanism which was prepared for scale-up under emergency conditions.
- In **Rwanda**, the existing supply and cold chain strength of UNICEF provided infrastructural preparedness for vaccine deployment under the COVID-19 response.

B. How well did UNICEF management systems/structures, resources and procedures support a flexible and timely response to COVID-19?

20. UNICEF successfully grasped the opportunities presented by its early insight into the COVID-19 outbreak, and commenced internal discussion and preparation in early January 2020. Its formal declaration of a Level 3 emergency on 16 April 2020 arrived later than that of some other United Nations agencies and over a month after the WHO global pandemic declaration of COVID-19 (11 March 2020). However, the internal emergency machinery of UNICEF was already in full flow.

Figure VI
Timeliness of the UNICEF corporate emergency response structures in relation to international movements



Source: Evaluation team, based on analysis of UNICEF documentation.

21. The swift early response by UNICEF was marked by corporate-level uncertainty regarding the organization's precise role within a global health emergency. The early corporate narrative within UNICEF – as for most international agencies – placed health at the centre. During this stage, though, UNICEF underwent a period of intensive internal debate regarding its role and potential contribution to the pandemic. The role of some units within the UNICEF Programme Group was unclear while this debate was under way, while country offices experienced confused coordination and a lack of cohesion vis-à-vis the headquarters response.

22. A more cohesive narrative emerged in mid-2020, as the UNICEF role in the pandemic response – and particularly the effects of socioeconomic shutdowns – became clear. Streamlined resource allocations and other procedural flexibilities, such as the option to reprogramme resources at country level, to reprofile budgets with non-governmental organization partners, and to expedite partnership

agreements at country level, were gradually introduced and supported country-level responses.

23. In 2021, parallel management structures were established for the ACT-A response, including the COVAX Facility. This had the effect of focusing the UNICEF COVID-19 response, at least in the eyes of external stakeholders, around vaccination efforts, meaning that the UNICEF strategic and programmatic response was not externally perceived as "whole of UNICEF".

24. UNICEF was well positioned for remote working, with some departments and units having mechanisms and systems already in place. Special human resources measures were introduced to ensure business continuity, alongside measures to support staff mental health and well-being, and UNICEF also frequently played a lead role in United Nations coordination for staff health and safety from COVID-19 at country level. However, arising from the dual mandate of UNICEF, a tension arose in attitudes to remote working: some staff with an emergency background felt that the flexible approach of UNICEF disadvantaged the organization in the eyes of external stakeholders, while others appreciated the "people first" human resource model adopted by the organization.

C. How well did UNICEF respond to population needs, especially the needs of the most vulnerable?

25. UNICEF invested considerably in analysing needs during the pandemic, with country and regional offices, as well as headquarters, conducting a wide range of studies and assessments. It also supported national data needs (see box II for examples).

Box II
Data generation and analysis efforts in support of the response

UNICEF country office analysis, review and studies, 2020 and 2021:

- **Colombia:** Rapid needs assessment to measure the living conditions of Venezuelan refugee and migrant households in Colombia during the pandemic.
- **Democratic Republic of the Congo:** Use of integrated outbreak analytics, based on learning from the 2018 Ebola outbreak in the country.
- **State of Palestine:** Knowledge, attitudes and practices survey to better understand the factors driving the behaviours of Palestinians concerning COVID-19.

UNICEF support to national data needs:

- **Georgia:** UNICEF supported the Government with research, the results of which were used for adjusting targeted social assistance under pandemic conditions.
- **Indonesia:** UNICEF supported the Government's analytical capacities for the pandemic response, e.g., with mobile assessments of all health facilities and tracking immunization rates.
- **Madagascar:** UNICEF and the National Institute of Statistics supplied the Government with the results of a socio-demographic survey to inform national decision-making on the COVID-19 response.

26. Access restrictions challenged data gathering during the early phase of the response, as did both Governments' reticence to provide data or grant research permissions and the paucity of national data on COVID-19 incidence. Some UNICEF country offices responded with mobile data collection, and by establishing data collection platforms for partners to insert the relevant information.

27. The range of COVID-19-related evidence widened during the subsequent phases of the response and UNICEF efforts in this area contributed to the strengthening of the global evidence base on the pandemic, thus enhancing countries' better understanding of their population's needs. Disaggregation by

population group was, however, inconsistent, and intersectional indicators (e.g., disability, ethnicity, caste and class) remained limited even where sex- and age-disaggregation were available. Such gaps were quite critical given the disproportionate effects that the pandemic had on societies' most vulnerable population groups.

28. Another significant gap existed in converting the COVID-19 studies and research findings into programmatic adaptations aimed at improving the living conditions of specific target groups. Recurring concerns across the evidence base included:

(a) Gender inequalities;

(b) Indigenous groups;

(c) People without identification cards and stateless populations;

(d) Border populations;

(e) Persons with disabilities.

29. At the same time, vulnerable groups which activities on the ground were often aimed at, were not necessarily consistent with those listed as corporate priorities for COVID-19. Examples included:

(a) Children in religious institutions, e.g., in Nigeria;

(b) Border populations, e.g., in Colombia, Haiti and Kazakhstan;

(c) Women and children in quarantine facilities, e.g., in Cambodia and Zimbabwe;

(d) Indigenous communities in Peru and Venezuela (Bolivarian Republic of);

(e) Venezuelan migrants in Peru;

(f) Marginalized urban areas in Buenos Aires, Argentina, and Caracas, Venezuela (Bolivarian Republic of).

30. An extensive body of guidance was issued by UNICEF headquarters and regional offices on how to best enable programmatic adaptations based on evidence. Overall, country offices appreciated the availability of such guidance, although they often found it quite overwhelming. Interestingly, the guidance in question adopted the sectoralized approach of UNICEF organizational arrangements, although country offices frequently implemented multisectoral programmes.

31. Despite the challenges on the ground, UNICEF adaptive capacity remained strong, with extensive programmatic adaptation at all levels. Risk communication and community engagement, social protection, and mental health and psychosocial support programming in particular expanded considerably to meet children's and households' needs, while educational programmes gradually increased their reliance on remote delivery during the school closures. Moreover, programming in such areas as health, water and sanitation and nutrition increased the provision of operational and policy-level support. Table 1 provides examples.

Table 1
Examples of programmatic adaptation

Area	Example adaptations	Country/regional examples
Health	• Delivery of medical kits, supplies such as personal protective equipment and other items • Training local frontline workers • Supporting vaccination (major efforts) • Support to real-time data systems and platforms on COVID-19 • Adaptation of national protocols and guidelines	• Procuring essential supplies, e.g., oxygen concentrators in Burundi and Pakistan and ultracold chain freezers in Pakistan • Responding to vaccine hesitancy, e.g., in Kazakhstan • Expanding social media channels, e.g., a partnership with Facebook in Turkey, reaching over 78 million individuals with COVID-19-related information
Water, sanitation and hygiene (WASH)	• Providing services in health centres, schools and early childhood development centres • Technical support to Governments • Support to monitoring and evaluation systems	• Setting up WASH points in public spaces with heavier traffic, including markets and hospitals in Colombia • Developing the Blue Soap initiative in Burundi • Providing foot-operated hand-washing facilities in Zimbabwe
Nutrition	• Direct provision of nutrition supplies • Expanding storage capacity • Providing guidance and technical support	• Helping to accelerate National Strategy for Food Security and Nutrition implementation, to mitigate the secondary impacts of COVID-19 in Cambodia • Adjusting emergency nutrition protocols for the treatment of both severe and moderate wasting in Zimbabwe
Education	• Supporting remote learning, e.g., through digital platforms • Direct provision of education to remote communities • Advocating with Governments for the opening of schools • Direct support to families (cash) • Skills support to out-of-school adolescents and others	• In Kazakhstan, connecting schools to the Internet, providing content for teachers in delivering digital/blended learning • Setting up a new television station in the Lao People's Democratic Republic, serving 2 million children • Providing distance learning systems, including tablets loaded with offline self-paced interactive learning materials, in the State of Palestine
Social protection	• Vertical and horizontal expansion of government-led social protection programmes (cash transfers) • Advocacy support for excluded groups • Piloting new modalities, e.g., mobile phones and virtual cards • Use of digitalized cash transfers	• Supporting the planning and coordination of social protection payments for households made vulnerable by COVID-19 in Ghana • In Cambodia, supporting the Government to design and deliver a one-off lockdown cash transfer programme • In the Dominican Republic, providing data, technical and financial support for cash transfers to 2,700 families with children living with disabilities
Child protection	• Advocating to see child protection professionals as essential workers • Development/adaptation of national guidelines on child protection during COVID-19 • Setting up "online courts"	• In Greece, developing national guidelines on child protection programmes in the COVID-19 context • Providing child protection training to COVID-19 quarantine facility staff, positioning volunteer social workers in quarantine centres in Zimbabwe • Deploying student social workers in Somalia

Mental health and psychosocial support	• Direct provision of services • Providing capacity strengthening for national authorities/civil society • Using social networks for monitoring mental health during the lockdown	• Supporting the Government of the United Republic of Tanzania to train mental health and psychosocial support teams • Building the capacities of psychologists in the local departments of the Ministry of Emergencies in Kazakhstan
Risk communication and community engagement	• Founding and co-leading the Collective Service on risk communication and community engagement • Supporting national risk communication and community engagement strategies and plans • Expanding delivery through remote methods	• In Ghana, partnering with four civil society organizations to disseminate COVID-19 preventive messages • In Colombia, partnering with local, community and youth-based organizations to roll out a communication strategy with information on COVID-19 prevention

Source: Evaluation team, drawing on evaluations and UNICEF documentation including country office annual reports, corporate annual reports and other documents.

32. The timeliness of the different activities implemented as part of the response was mixed. UNICEF swiftly established the corporate structures and machinery of the organization's response to COVID-19, as well as funding appeals and emergency procedures. Closer to the ground, however, most countries experienced at least some delays owing to three main factors: (a) the supply chain, with almost all regions reporting late delivery of supplies (see paragraph 36); (b) risk aversion, also attested by a 2020 internal audit; and (c) perceived burdensome reporting requirements from headquarters and a sense of a proliferation of ad-hoc and duplicative coordination mechanisms. Some systemic factors supporting timeliness were also identified (see box III).

Box III
Factors supporting timeliness

- Emergency capacity and experience.
- Flexible working systems alongside prior investment in information technology systems (remote working).
- Pre-existing relationships with Governments and donors, with trust already in place.
- Pre-existing agreements with implementing partners and suppliers.
- Entry points into multiple line ministries.
- Flexibility to adapt and re-prioritize development programming (and funding).
- Flexibility in support systems, e.g., human resources, finance, supply and reporting functions.
- Ability to leverage television, social media and other mechanisms for communication.
- Prior engagement in systems-strengthening work.

Source: Drawn from evaluations and desk/case study evidence.

33. Gender and equity concerns were corporately prioritized in strategic documents but received only patchy and uneven programmatic attention on the ground, in part due to variable management attention and funding. While all the country offices examined had implemented some form of gender equality or gender-based violence programming, far fewer had made efforts to mainstream the issue into their programmes.

34. Accountability to affected populations strategies and approaches were both unprioritized and inconsistent. Supporting factors included having systems in place prior to the pandemic, adequacy of funding, and senior management prioritization of these concerns. Where these were absent, and where contextual impediments existed, this prioritization and implementation were far weaker.

35. The supply chain played a major role in the response, particularly around large-scale procurement arrangements of personal protective equipment, test kits (diagnostics) and related therapeutic support (such as hospital beds, oxygen concentrators and ventilators), as well as cold chain infrastructure strengthening. Adaptations included:

(a) Use of special contracting procedures to expedite processes and payments;

(b) Deployment of financing tools to make advance payments or firm commitments to suppliers;

(c) Development and use of a joint tender for personal protective equipment purchase with other United Nations agencies;

(d) Use of a warehouse budget to finance pre-positioning of personal protective equipment and other supplies;

(e) Creation of additional warehouse space to pre-position personal protective equipment supplies;

(f) Creation of logistics partnerships to support timely delivery;

(g) Decentralizing some stocks for regular programmes from Copenhagen, Denmark, to supply hubs globally.

36. However, external difficulties alongside the challenges of a centralized approach created delays on the ground. UNICEF incurred some reputational risks due to a lack of promised delivery.

37. UNICEF advocacy gained momentum over time, with the uncertain corporate positioning in the early phase of the pandemic response impeding clearly articulated positions. However, as clarity emerged, UNICEF upscaled its advocacy at country and global levels, and eventual successes included vaccine provision, schools reopening, and the release of children in detention under pandemic conditions. Box IV provides some examples.

Box IV
Country- and regional-level advocacy

- In **Brazil**, UNICEF engaged with the five largest telecommunication companies, the Congress and the Minister of Telecommunications to increase school connectivity and provide free broadband to students and vulnerable groups.
- In the **Democratic People's Republic of Korea**, UNICEF advocacy efforts with high-level government officials on the importance of joining the COVAX Facility led to the Government securing at least 20 per cent of COVID-19 vaccines for 2021.
- In **Mongolia**, UNICEF advocated with the Government to top up the child grant programme, resulting in extra cash to all 1.3 million children from April to December 2020.

38. UNICEF also adapted its monitoring and evaluation systems to pandemic conditions, with remote approaches supporting real-time monitoring, and a wide range of studies and assessments conducted, including a real-time assessment rolled out across seven regions. The comprehensive approach to learning validates the organizational aim of a "learning culture" during the pandemic period.

D. How well did UNICEF engage in partnership in the global response to COVID-19?

39. **United Nations relationships:** UNICEF played key strategic and operational roles in the Global Health Response Plan, the United Nations framework for the immediate socio-economic response to COVID-19 and ACT-A, including COVAX. Its contributions in areas such as social protection, health campaigns, education and WASH were highly valued, with partners praising the organization's proactive and supportive approach. Table 2 provides example areas of leadership and cooperation.

Table 2
UNICEF contributions to global coordination response mechanisms

System-wide plan	UNICEF roles and contributions
Global Health Response Plan • Public health response • Continuity of services • Cluster/sector coordination	• Sustaining public health services, including immunization campaigns and procurement of health supplies, maternal and child health and nutrition support

	• Founding and co-leading the Collective Service on risk communication and community engagement, providing support to the consolidation of structures and mechanisms for a collective approach to risk communication and community engagement • Education, WASH, social services, social protection, child poverty and socioeconomic support • Vaccine preparedness and delivery • Leadership of education, WASH and nutrition clusters, and child protection area of responsibility
United Nations framework for the immediate socio-economic response to COVID-19 • Protecting health services and systems • Social protection and basic services • Social cohesion and community resilience	• Sustaining public health services, including immunization campaigns and procurement of health supplies, maternal and child health, and nutrition support • Risk communication and community engagement • Education, WASH, social services, social protection, child poverty and socioeconomic support • Resilience activities at community level (livelihoods, social protection, etc.)
ACT-A (COVAX)	• Procurement of vaccines and immunization supplies, diagnostics, treatments (medicines and oxygen) and personal protective equipment • Logistics, supply chain and storage • Country preparedness and readiness • Supporting roll-out, including but not limited to risk communication and community engagement

40. External United Nations partners in 2022, however, perceived the UNICEF COVID-19 response in 2022 to be largely focused on vaccine delivery, with the organization being considered "quiet" on other areas of the global response. Moreover, some relationships in the area of vaccine delivery, in particular, came under strain, with territorial concerns and mindset differences impeding partnership. While UNICEF unquestionably holds the greatest United Nations expertise and capacity in vaccine supply chains, and particularly cold chain systems, concern arose that its determination to "hold on" to this area of work, despite various offers of support from other agencies, was coming at a cost to delivery – and thus hindering the provision of vaccines to countries and people in need. Tensions here continue unresolved, and further work is required to transcend boundaries, overcome territorial concerns, and place the greater good to the fore of international action.

41. At country level, UNICEF played a central role in key areas of the national response, including vaccination. Table 3 provides examples.

Table 3
Support to national COVID-19 responses

Supporting national data production/needs assessments under COVID-19
• In **Zimbabwe**, UNICEF worked with the Zimbabwe National Statistics Agency to conduct household surveys of the effects of COVID-19 on the population. This helped to influence policy decisions and government allocation of social sector spending.
Supporting government risk communication and community engagement strategies
• In **Iraq**, UNICEF coordinated and led the United Nations COVID-19 risk communication and community engagement plan, in partnership with the Federal Ministry of Health and United Nations partners. • In **Nepal**, UNICEF initiated and co-led the Government's Crisis Media Hub and developed more than 500 multimedia assets, shared across government and risk communication and community engagement member channels.
Helping to develop national COVID-19 response plans
• In **Bangladesh**, UNICEF supported the Government to implement the Bangladesh Preparedness and Response Plan for COVID-19.

• In **Myanmar**, UNICEF supported the development of the Ministry of Education's COVID-19 response and recovery plan, in collaboration with other partners.
Developing guidance with ministry partners
• In **Ghana**, UNICEF supported the Ghana Health Service with the development of food and nutrition guidelines for COVID-19 isolation centres. • In **Malawi**, UNICEF supported the development of business continuity plans for all five water boards in the country, to help sustain continuity of service during COVID-19.
Supporting national mental health services
• In **Cambodia**, UNICEF provided television and radio spots and videos to support information campaigns by the Ministry of Health. • In **Kazakhstan**, UNICEF partnered with key government ministries and the Citi Foundation to train school and kindergarten psychologists to provide remote psychological support to families and adolescents experiencing the effects of COVID-19.
Supporting national efforts at digitalization in support of service delivery
• In **Colombia**, UNICEF developed support groups on WhatsApp and Facebook to share key messages on the prevention of COVID-19, psychosocial care, health and nutrition care, and activation of gender-based violence and child protection protocols. • In **El Salvador**, UNICEF created virtual and hybrid accelerated education modalities to prevent dropout and facilitate the reintegration of excluded students into the education system.
Supporting vaccination
• In **Burundi**, UNICEF helped the Government to develop an electronic platform for COVID-19 testing and vaccination. • In **Haiti**, UNICEF collaborated with the Government in developing a plan aimed at vaccinating 62 per cent of the total population and provided logistical and financial support for the distribution of vaccines and the preparation and implementation of vaccination. • In the **Lao People's Democratic Republic**, UNICEF supported the establishment and regular convening of a high-level COVAX partner forum, facilitating information-sharing and joint advocacy.

42. Expansion of implementing partnerships supported the delivery of the response, and enabled UNICEF to expand its working modalities for response delivery, including through new technologies. Expansions took place among the private sector and with civil society, as shown in table 4.

Table 4
Cooperation with implementing partners

Partner	Country example
Private sector partners	
Restaurant associations Technology companies Telecoms providers Media companies – TV/radio Local musicians, arts figures, social media influencers Google Soap manufacturers Diagnostics firms	• **Sudan** – Partnerships with TV and radio stations enabled children's access to virtual lessons and learning opportunities. • **United Republic of Tanzania** – Partnership with the Tanzania Women Chamber of Commerce reached 20,000 women entrepreneurs with COVID-19 prevention awareness messages. • **Uzbekistan** – Partnership with a large supermarket chain enabled UNICEF communication materials to air in 80 stores that serve thousands of customers daily.

Suppliers of health-care items, personal protective equipment Supermarket chains Insurance companies Banks	
Civil society	
Diaspora Faith groups/religious leaders Local civil society organizations/community-based organizations National networks/federations, e.g., of medical staff	• **Madagascar** – A public-private partnership between UNICEF and the National Order of Medical Doctors allowed for nearly 150,000 consultations to take place, identifying nearly 9,000 suspected COVID-19 cases. • **Pakistan** – The Pakistan Pediatric Association collaborated with UNICEF on producing and disseminating training materials on COVID-19.

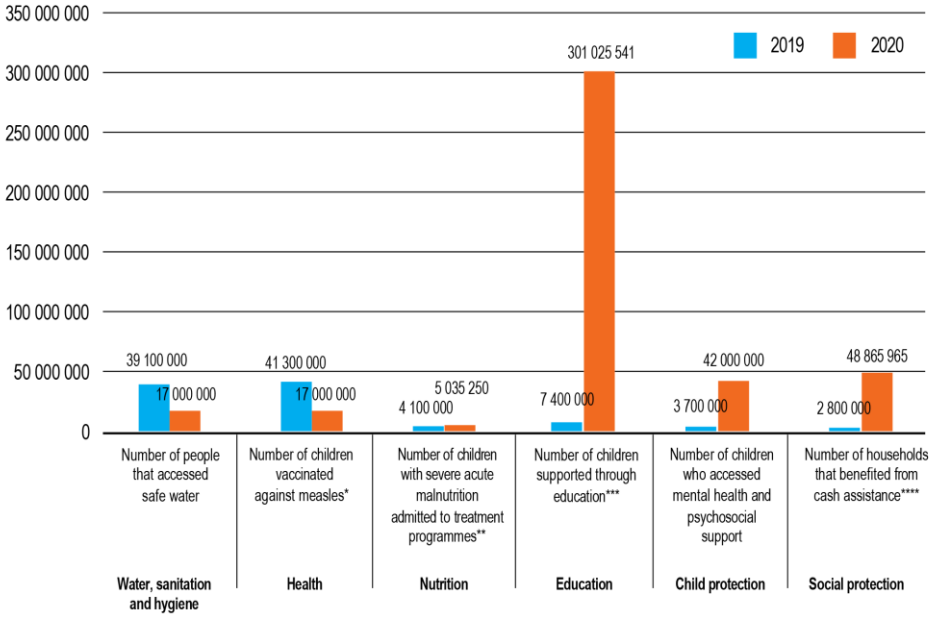
43. Implementing partners highly valued: (a) the open communication between themselves and UNICEF, and a sense of being seen as an "equal partner"; (b) the willingness of UNICEF to support programme adaptation during the pandemic; (c) UNICEF forging of links between themselves, Governments and other partners as part of the response; and (d) the provision of personal protective equipment and other equipment where available/necessary.

E. What did the COVID-19 response achieve for populations in need during the pandemic?

44. UNICEF delivered significant and at-scale results during 2020 and 2021 in response to the needs created by COVID-19. In 2020, it scaled up extensively to deliver significant results in education, mental health and psychosocial support, risk communication and community engagement, cash assistance and the treatment of malnutrition, in particular. UNICEF also met or mostly met its HAC strategic priority targets in three of four areas in 2020.

45. Figure VII shows the extent of UNICEF scale-up in education, mental health and psychosocial support, cash assistance and malnutrition treatment. It also indicates a reduction in access to safe water and measles vaccination (attributed to the shift from community-based WASH supply to facility-based service provision).

Figure VII
Comparison of selected key programme indicator results, 2019–2020



* Aged 6 months to 15 years in 2019; not specified for 2020.
** Aged 6–59 months in 2020; not specified for 2019.
*** In 2019, the figure represents the number of children who accessed formal or non-formal basic education, including early learning. In 2020, the figure accounts for the number of children supported with distance/home learning.
**** In 2020, this includes 47,109,287 households benefiting from new or additional social assistance measures provided by Governments to respond to COVID-19, with UNICEF support.

Sources: inSight (COVID-19 SitRep Indicators Dashboard) and UNICEF, "Responding to COVID-19: UNICEF Annual Report 2020", 2021 (available at www.unicef.org/publications).

46. Significant results were also observed in 2021, including: notable increases in live births delivered in UNICEF-supported health facilities; increases in the number of children supported to prevent stunting and other forms of malnutrition; an increasingly higher amount of people reached with disability-inclusive programming and provided with skills development programmes; and more people gaining or regaining access to water services for drinking and hygiene. However, there were declines in the numbers of children receiving community-based mental health and psychosocial support; women, girls and boys accessing gender-based violence risk mitigation, prevention or response interventions; and people gaining or regaining access to sanitation services. Table 5 compares some key programme indicator results for 2020 and 2021.

Table 5
Comparison of selected key programme indicator results, 2020 and 2021, by Global Area (where compatible data are available)

Global Results Area	Selected results 2020	Selected results 2021
Health	**30.5 million** live births delivered in health facilities with support from UNICEF.	**38.9 million** live births delivered in health facilities supported by UNICEF.
	8.7 million children with suspected pneumonia received antibiotics.	**8.75 million** children with suspected pneumonia received antibiotics.
	Almost 244 million children received services for the prevention of stunting and other forms of malnutrition.	**Nearly 336 million** children received services to prevent stunting and other forms of malnutrition.
	5 million children with severe acute malnutrition treated.	**2.4 million** children with severe acute malnutrition admitted for treatment.

Education	**48 million** out-of-school children participated in early learning, primary or secondary education.	**48.6 million** out-of-school children accessed education.
	More than 43 million children were provided with learning materials.	**42 million children** (18.1 million in humanitarian settings) received learning materials.
	7.7 million children participated in skills development programmes for learning.	**33 million** children benefited from skills development programmes.
Protection from violence and exploitation	**47.2 million** children, adolescents and caregivers were provided with community-based mental health and psychosocial support.	**12 million** children, adolescents and caregivers were provided with community-based mental health and psychosocial support (8.4 million children and adolescents; 3.6 million parents and caregivers).
	6 million adolescent girls received prevention and care interventions to address child marriage through joint programming with the United Nations Population Fund (UNFPA).	**7.6 million** adolescent girls received prevention and care interventions to address child marriage through joint programming with UNFPA.
	4.2 million children in 126 countries who experienced violence were provided with health, social work and justice services.	**4.4 million** children who had experienced violence were reached with health, social work and justice services across 129 countries.
	Approximately 17.8 million people were reached with gender-based violence risk mitigation, prevention or response interventions in 84 countries.	**8.6 million** women, girls and boys accessing gender-based violence risk mitigation, prevention or response interventions.
	Close to 4.2 million children and women across 126 countries were afforded with safe and accessible channels for reporting sexual exploitation and abuse, a fivefold increase from 2019.	**3.2 million** people with access to safe channels to report sexual exploitation and abuse.
Living in a safe and clean environment	**17 million** additional people gained access to safe drinking water.	**33.3 million** people gained or regained access to water services for drinking and hygiene.
	13.4 million additional people gained access to basic sanitation services.	**8.4 million** people gained or regained access to sanitation services.
Having an equitable chance in life	**31 countries** reported that measurement, analysis or advocacy led to policies and programmes that reduced child poverty.	**33 countries** reported that measurement, analysis or advocacy led to policies and programmes that reduced child poverty.
	UNICEF-supported cash transfer programmes reached over **130 million children in 93 countries**.	UNICEF-supported cash transfer programmes reached nearly **133 million** children in **95 countries**.
	In 2020, UNICEF reached more than **2.2 million children with disabilities across 144 countries** through disability-inclusive development and humanitarian programmes.	UNICEF reached more than **4.8 million children with disabilities across 148 countries** through disability-inclusive programming, including in humanitarian situations.

Source: UNICEF Annual Report for 2020 and 2021.

47. COVID-19 vaccine delivery expanded greatly in 2021, with nearly 1 billion doses delivered to countries requiring support. UNICEF also made significant contributions under the Global Humanitarian Response Plan in health and other areas. Several evaluations identified areas of programmatic strength, including risk communication and community engagement, social protection, mental health and psychosocial support, evidence and data, and health systems strengthening, alongside some which could be enhanced for results achievement, including gender and disability – ensuring a multisectoral approach, and working on digital inclusion.

F. Conclusions

48. The evaluation concluded that UNICEF was comparatively well positioned to meet the demands of COVID-19, though the road from preparedness to corporate response was neither straightforward nor easily achieved. Despite early corporate attention, it took time for the organizational narrative to reflect the pandemic's full spectrum of programmatic dimensions and, therefore, to reflect an appropriately rounded response. However, as the breadth of needs created by the pandemic became clear, the organization's mature and comprehensive emergency response systems gathered momentum to respond.

49. UNICEF successfully scaled up its response to meet demands on the ground. A significant proportion of global vaccine delivery can be attributed to the actions of UNICEF, and the agency's role in providing risk communication and community engagement and social protection services has shielded many from both disease transmission and social and economic disaster. Its advocacy work has supported the reopening of schools and, with it, enabled millions of children to continue their education in comparative safety. An area of challenge has been the supply chain, which faced acute global difficulties. Although many adaptations were made, it struggled to meet demands on the ground.

50. COVID-19 has also shone a light on the internal tensions of a double-mandated organization. Country offices with long emergency experience, and with relevant preparedness plans in place, adapted swiftly to the demands of COVID-19, while some more traditionally development-focused offices struggled. A disjunction has also emerged related to human resourcing approaches, with staff from a more development-focused background valuing the human-centred approach adopted by UNICEF to its staff, while some of those from emergency backgrounds, more accustomed to the "stay and deliver" ethos of humanitarian assistance, were concerned about effectiveness and reputational risk. In a world where boundaries are becoming increasingly blurred, emergency capacity across the full UNICEF "house" is increasingly essential.

51. While at country level, pre-existing relationships with Governments, implementing partners and the private sector have played a major role in supporting the response, at international level, some partnerships have experienced strain. The sense of territorialism which has crept into the issue of vaccines delivery requires course correction. There is also a sense from external partners that the UNICEF corporate response to COVID-19 has become concentrated largely on vaccination, and that in being "mainstreamed", the wider dimensions of the response are at risk of being lost.

52. Overall, however, UNICEF has demonstrated its confidence in launching a complex response at global scale. In this vein, its existing systems have been stress-tested and responded with capability. Going forward, however, lessons can still be learned and improvements made. The evaluation offers eight recommendations which recognize the strength and maturity of the UNICEF response to the COVID-19 pandemic, and propose measures for future qualitative enhancement.

G. Recommendations

53. **Recommendation 1: In line with recommendations from the 2020 Humanitarian Review,[1] develop a clear corporate narrative for the role of UNICEF in public health emergencies.**

[1] UNICEF, *Strengthening UNICEF's Humanitarian Action: The Humanitarian Review: Findings and Recommendations*, 2020.

Rationale: The early phase of the response was characterized by a period of internal debate within UNICEF primarily focusing on what the role of UNICEF should be. Given the diversity of views on this, a clearer corporate understanding of the role of UNICEF within public health emergencies, which recognizes the wider effects of such crises, as per the Core Commitments for Children in Humanitarian Action and the findings of the Humanitarian Review, will support preparedness and generate a stronger sense of "one organization" under conditions of acute pressure.

Specific actions:

(a) At senior management level, conduct an emergency preparedness exercise, mapping out UNICEF corporate positioning in public health emergencies, and building on the Core Commitments for Children for public health emergencies. Clearly articulate commitments and response modalities, notably when such an emergency happens in a conflict setting versus a non-conflict setting;

(b) Prepare contingency plans and corporate communication narratives on the "whole of UNICEF" role in such an emergency situation;

(c) Ensure that all divisions/units are sighted on their role in public health emergency response, to ensure a more cohesive internal and external narrative;

(d) Develop protocols for pre-financing commitments for both procurement and programming, in future public health emergency responses.

54. **Recommendation 2: Refresh the corporate narrative on the priority of COVID-19.**

Rationale: External perceptions, particularly from United Nations partners, are that the UNICEF response to COVID-19 has become focused on vaccination, and that the wider dimensions of the response risk losing momentum. It will be important to ensure that the corporate narrative reflects the significance of COVID-19 in the programmatic work still to be undertaken on the ground.

Specific actions:

(a) Internally, consider how a more consistent approach and narrative can be adopted to partners across different parts of the UNICEF "house";

(b) Reflect the continued social and economic effects of COVID-19 in corporate external communications and reporting, including the 2023 UNICEF Annual Report;

(c) Ensure the reflection of the social and economic effects of COVID-19, and the wider dimensions of the response, in Executive Board meetings and agenda items.

55. **Recommendation 3: Consider undertaking a functional review of the public health emergency capacity of UNICEF across the organization.**

Rationale: Currently, UNICEF, like many international agencies, is battling both humanitarian and development crises on multiple fronts. Many crises are now protracted, with the boundaries between "development" and "humanitarian" action increasingly unclear. Public health emergencies span these boundaries.

The 2020 Humanitarian Review recommended increased technical capacity at all levels for public health emergencies.[2] For any future pandemic, it is clear that both development and humanitarian action will be needed. UNICEF staff corporately, therefore, need to possess emergency response skills and to be able to respond to public health emergencies at different levels.

[2] Ibid.

Specific actions:

(a) Conduct a functional review of public health emergency capacity across UNICEF as an organization, its skills and expertise, with a view to considering how its existing emergency capacities can be broadly extended across the UNICEF "house";

(b) Seek to build emergency response capacity in all UNICEF staff, as applicable to their working area.

56. **Recommendation 4: Build preparedness for public health emergency response across UNICEF.**

Rationale: The pandemic has highlighted the varying degrees of preparedness for public health crises across UNICEF country offices. It is critical that staff in all country offices are trained in emergency preparedness and that all offices have appropriate emergency preparedness plans in place.

Specific actions:

(a) Ensure that each country office/regional office has a preparedness plan in place for public health emergencies;

(b) Require each country office/regional office to conduct a simulation exercise of its Business Continuity Plan;

(c) Clarify UNICEF positioning on risk during public health emergencies – whether risk-averse, risk-tolerant or risk-hungry.

57. **Recommendation 5: Revisit the global ethos of partnership in vaccines in particular.**

Rationale: COVID-19 has highlighted both the strengths and weaknesses of UNICEF international partnerships in the pandemic response. In the specific area of vaccine provision, reconsidering the ethos of partnership will help to rebuild relationships and maximize outcomes for those who still badly need UNICEF support.

Specific actions:

(a) Engage with partners to discuss – with an open mind – respective comparative advantages and opportunities for collaboration and partnership in both vaccine delivery and country preparedness. Approach roles from the perspective of "greatest benefit to those in need" rather than territorial concerns.

58. **Recommendation 6: Also in line with findings from the Humanitarian Review, reassess supply chain and procurement requirements and procedures for public health emergencies.**

Rationale: The UNICEF Supply Chain function has undergone considerable reflection and lesson-learning since the COVID-19 response. As the Humanitarian Review notes, however,[3] improvement can still be undertaken, and most specifically on local procurement, where UNICEF has room to enhance scope for country offices to undertake their own procurement, particularly under emergency conditions.

Specific actions:

(a) Reconsider the Core Commitments for Children levels of preparedness, potentially expanding these to enable large-scale public health responses where needed;

[3] The Humanitarian Review recommends that UNICEF "strengthen the integration of supply needs in programme planning and response, especially on supply-driven programming in public health emergencies".

(b) Specifically consider how local procurement and other adaptations could help to maximize emergency response under pandemic conditions;

(c) Redress reputational effects at country level by communicating externally the lessons UNICEF has learned in its Supply Chain function since COVID-19.

59. **Recommendation 7: Intensify the focus on equity and gender in emergency response.**

Rationale: The response to the emergency conditions of COVID-19 has shown an unsystematic approach to gender and equity at best. A clearer articulation of why equity and gender matters in public health emergency response, and how it should be considered at all levels, will support equitable outcomes.

Specific actions:

(a) Clarify the role of gender in public health emergency response by creating an initiative led by the Office of Emergency Programmes to communicate the role of gender and equity in all emergency responses;

(b) Embed gender and equity considerations in all HACs and their approval processes, more from a "transformative" perspective than from a "quantitative" one;

(c) Require corporate reporting on HACs to include gender and equity considerations.

60. **Recommendation 8: Define and establish the corporate-level knowledge management and learning system for public health emergencies.**

Rationale: The pandemic response has shown up several fault lines in UNICEF knowledge management, guidance and learning systems for emergencies – ranging from the volume to the quality of learning products and guidance produced.

Specific actions:

(a) Conduct a consultation exercise with country offices regarding the volume, quality and relevance of guidance and learning products generated during 2020 and 2021, with a view to mapping out real-world demands during corporate emergency conditions;

(b) Map the range of learning products produced internally during the pandemic, including internal websites, guidance, learning and other exercises, and review scope for their rationalization in light of demands in any future event;

(c) Develop, for emergency situations which require rapid adaptation and innovation at corporate level, an organization-wide "clearing house" or vetting system to ensure that learning and guidance produced is a) demand-driven, b) relevant to needs, and c) of a quality and design that speaks to country office needs on the ground. Define the role of regional offices within this system.

IV. Draft decision

The Executive Board

1. *Takes note* of the annual report for 2022 on the evaluation function in UNICEF (E/ICEF/2023/18) and its management response (E/ICEF/2023/19);

2. *Also takes note* of the evaluation of the UNICEF Level 3 response to the global coronavirus disease 2019 (COVID-19) pandemic, its summary (E/ICEF/2023/20) and its management response (E/ICEF/2023/21).

Annex

Evaluation of the UNICEF Level 3 response to the global coronavirus disease 2019 (COVID-19) pandemic

1. Due to space limitations, the evaluation report of the UNICEF Level 3 response to the global coronavirus disease 2019 (COVID-19) pandemic is not contained within the present annex.

2. The report is available from the UNICEF Evaluation Office website: www.unicef.org/evaluation/executive-board.