Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa

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Namibia

Key highlights from a real-time assessment based on qualitative data

Oxford Policy Management

Preface

UNICEF's Eastern and Southern Africa Regional Office (UNICEF ESARO) commissioned Oxford Policy Management (OPM) to carry out a Real-Time Assessment (RTA) of UNICEF's response to COVID-19 in countries in the region.

This report outlines the findings from the Namibia country case study. Drawing on the qualitative data gathered during the course of interviews with key informants, the report provides an overview of the findings, emerging themes, and lessons to be learned. The report format follows the outline provided by UNICEF ESARO for regional reports, adapted for a country-level analysis.

The RTA team includes the following members: Jayne Webster (Team Leader), Rashid Zaman (Project Manager), Elizabeth Harrop (Adviser – Gender and Social Protection), Georgina Rawle (Adviser – Education), Bilal Hakeem (RTA Coordinator), Kandi Shejavali (Monitoring and Evaluation (M&E) Expert), Deogardius Medardi (M&E Expert), Lauren Mueenuddin (M&E Expert), Denis Tiren (M&E Expert), and Nicola Wiafe (Research Analyst). Lauren Mueenuddin conducted the interviews and drafted this report, which was then reviewed by members of the project leadership.

We are grateful to UNICEF ESARO's evaluation section, specifically to Urs Nagel, Bikul Tulachan, and Yasmin Almeida, for their invaluable collaboration and guidance on the conceptualisation, design, and the technical delivery of the RTA work. In addition, UNICEF consultant Karen Hickson provided useful inputs.

List of abbreviations

AAP	Accountability to Affected People
CO	Country Office
CWD	Children with Disabilities
DWN	Development Workshop Namibia
ECD	Early Child Development
EPP	Emergency Preparedness Platform
ESAR	Eastern and Southern Africa Region
ESARO	Eastern and Southern Africa Regional Office (of UNICEF)
GBV	Gender-Based Violence
GRN	Government of Namibia
IPC	Infection Prevention and Control
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MNCH	Maternal, New-born, and Child Health
MoEAC	Ministry of Education, Arts and Culture
MoHSS	Ministry of Health and Social Services
OPM	Oxford Policy Management
PPE	Personal Protective Equipment
PSEA	Prevention of Sexual Exploitation and Abuse
RCCE	Risk Communication and Community Engagement
RTA	Real-Time Assessment
SSOP	Simplified Standard Operating Procedures
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

Executive summary

Introduction

Young Girl being vaccinated Credit: © UNICEF Namibia/2016/Mutseyekwa

Namibia recorded its first COVID-19 case on 14 March 2020. As at January 2021, the Johns Hopkins Coronavirus Resource Centre cites a total of 32,425 COVID-19 cases to date in Namibia, and 319 deaths.

This is a case study of the UNICEF response to COVID-19 in Namibia. This study forms part of a broader real time analysis (RTA) of UNICEF's COVID-19 response in eastern and southern Africa. The RTA was 'light touch', with a tight timeline. Due to this, only a small sample of stakeholders were interviewed, and the broad sectoral focus precluded in-depth analysis. The research was undertaken between December 2020 and January 2021.

The study aimed at answering **four overarching questions**: (i) how has UNICEF adapted to the COVID-19 pandemic and to evolving needs?; (ii) how can the implementation and quality of the Country Office's (CO's) COVID-19 response be characterised?; (iii) what are the emerging themes?; and (iv) what are the early lessons?

Themes emerging from the findings

Notable positives from UNICEF Namibia's response to COVID-19:

- UNICEF's COVID-19 response was dynamic and was adapted according to developments in the pandemic timeline.
- UNICEF contributed greatly to early needs assessment and projections of population needs through the Socio-Economic Impact Survey of COVID-19 undertaken early in the pandemic.
- UNICEF moved beyond a uniquely medical COVID-19 prevention and case management response toward a programme to ensure the continuity of essential services in education, water, sanitation, and hygiene (WASH), health, and child protection.
- The UNICEF Namibia Country Office (CO) response was strengthened by its pre-COVID-19 work in key sectoral systems-strengthening activities, including in education, health, and child protection (particularly gender-based violence (GBV) prevention).
- Close collaboration with government line ministries and partner NGOs was instrumental in ensuring the continuity of basic services despite national lockdowns affecting education, health, WASH, GBV prevention, education, and child protection.

Adaptation in the COVID-19 response:

- Light management decision-making structure at UNICEF CO;
- Donor flexibility allowing for re-programming of funds for COVID-19 prevention activities; and
- Capitalising on UNICEF's comparative advantage in international procurement.

Implementation of the COVID-19 response:

- UNICEF's strong systems-strengthening work in the pre-COVID period allowed for continuity of services in the child protection, education, WASH, and health sectors;
- Intensive risk communication and community engagement (RCCE) actions in populated settlements in major cities;
- Provision of WASH supplies to informal settlements;
- Commitment to maintenance of child protection; and
- Continuation of GBV prevention activities.

Notable challenges encountered in the Namibia CO's response to COVID-19 included:

- Inadequate advance emergency planning and lack of expertise in preparedness;[1]
- Resource inadequacies;
- Unavailability of timely data to inform decision making;
- Massive fluctuations in the prices of internationally procured supplies, particularly personal protective equipment (PPE);
- Shortages in critical supplies due to price hikes resulting in fewer supplies being available; and
- Re-programming of donor funds for COVID-19 activities affecting the realisation of other planned activities.

Vulnerable populations: The following populations were identified by respondents as being particularly vulnerable in the medium to long term as a result of COVID-19:

- poor households in informal settlements and rural areas;
- people who are immunocompromised due to high prevalence of HIV; and
- children who may face discrimination due to their disability, ethnicity, or because they are not living with their biological parents.

Lessons learned/ suggested action points

Suggestions by respondents to inform UNICEF Namibia's programming in the medium to long term included:

- Strengthen UNICEF's emergency planning expertise.
- Create a mechanism to guard against excessive fluctuations in pricing for international procurement of supplies in emergencies.
- Maintain a strong presence in informal urban settlements working on RCCE messaging for WASH and maintenance of early child development (ECD) activities.
- Advocate with the Government of the Republic of Namibia (GRN) for more resources for the management and staffing of the units managing of child protection, prevention of GBV and children in conflict with the law.

[1] Key challenges cited in Online Survey responses for Namibia

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1. Introduction

1.1 Background

Global context: The effect of COVID-19 on global economies and on individual lives has been unprecedented. As at 28 December 2020, the worldwide total of confirmed cases was almost 80 million, with over 1.75 million deaths.[2]

The global socio-economic crisis has caused fragile economies to falter and has caused major disruptions in the basic and essential health, education, and social protection services that serve vulnerable populations throughout the world. Countries where clear progress has been made in improving the lives and wellbeing of children are seeing reversals in health, nutrition, and education outcomes. Although children are not the first victims of direct coronavirus-related mortality and morbidity, the UNICEF's Executive Director has stated that '*children are the 'hidden victims of this pandemic'*.[3]

Long-standing negative effects on children will be felt for generations to come and will exacerbate already existing inequalities and vulnerabilities for children in low-income countries. More than 1 billion children are at risk of falling behind due to school closures aimed at containing the spread of COVID-19.[4] Disruption in essential maternal, newborn, and child health (MNCH) services (e.g. immunisation, antenatal care, institutional delivery, nutritional support, and HIV care and treatment) in health centres will bring about excess mortality for women and children, due to non-accessibility of services and malnutrition-related deaths. Efforts to mitigate the transmission of COVID-19 are also disrupting food systems, devastating livelihoods, and threatening food security. A commentary in *The Lancet* (disseminated in a UNICEF press release[5]), warned of the pandemic's potential to worsen the pre-existing crisis of malnutrition and tip an additional 6.7 million children over the edge to become wasted during the pandemic's first year.[6]

1.2 Case study scope, approach, and methods

Purpose of the RTA case study: The overall objective of the RTA is to assess UNICEF COs' response to the COVID-19 pandemic in terms of adaptation, implementation, and quality of programming. More specifically, the objective was to collect, analyse, and synthesise evidence on achievements, lessons learned, and challenges for programming and operations planning at the individual country level.[7] The study also seeks to highlight emerging themes and early lessons.

The key informant interviews (KIIs) seek to provide a better understanding of UNICEF's country-level implementation through one-on-one discussions with staff working on the ground. These

[2] WHO Coronavirus Disease (COVID-19) Dashboard, available at https://covid19.who.int/ (last accessed 28 December 2020).
[3] Fore, H. Don't let children be the hidden victims of COVID-19 pandemic. UNICEF https://www.unicef.org.uk/press-releases/dont-let-children-be-the-hidden-victims-of-covid-19-pandemic-unicef/
[4] UNICEF (n.d.) 'COVID and education', available at https://data.unicef.org/topic/education/covid-19/
[5] UNICEF: An additional 6.7 million children under 5 could suffer from wasting this year due to COVID-19. https://data.unicef.org/topic/nutrition/child-nutrition-and-covid-19/
[6] Headey, D. et al (2020) Impacts of COVID-19 on childhood malnutrition and nutrition-related mortality The Lancet https://doi.org/10.1016/ S0140-6736(20)31647-0
[7] OPM (2020) 'Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa. Inception Report, OPM, Oxford.

key informants included UNICEF country-level staff in Operations, Programming and Management; counterparts at UNICEF's key government social sector line ministries; UN partner agencies, UNICEF's implementation partners; and frontline workers in the public sector and/or working with national civil society organisations.

Our KIIs for Namibia focused on operational and programmatic adaptations, new approaches to reaching the most vulnerable, and new types of partnership to accelerate results for children across Namibia. The KIIs did not, however, cover all UNICEF sectors (health, education, WASH, RCCE, nutrition, and child protection) equally, nor did they allow us to speak to all partners in the COVID-19 response in Namibia. As such, this case study is not an exhaustive review of UNICEF interventions in Namibia, nor does it represent the views of all staff and partners.

Whilst drawing upon some key data from documents provided by the CO in Namibia, the case study findings are otherwise drawn almost exclusively from nine KIIs undertaken with UNICEF and its counterparts: four interviews with UNICEF country staff; three interviews with UN or governmental counterparts; and two interviews with UNICEF partners/frontline workers. These respondents were selected from a larger sample (provided by UNICEF ESARO) of UNICEF CO staff, UNICEF key partners, and frontline workers collaborating on the ground.[8]

UNICEF CO focal points aided in the scheduling of one-on-one Zoom calls between international M&E experts (OPM team) and the nine respondents in the selected sample. Annex A.3. provides a list of interviewees by category. These KIIs were conducted using key informant guides to help focus the discussion. Although a guide was used, the KIIs were very informal in nature and lasted between 1 and 1.5 hours each. The interviews were recorded with the explicit permission of the respondents and with a guarantee of confidentiality of responses. Interviews in Namibia were conducted remotely in December 2020 and January 2021.

Specific attribution of findings to individuals will not be included in this report. The interviews were conducted with an explicit agreement to ensure respondent confidentiality in the hope of eliciting the most honest responses.

It should be noted that the Namibia case study drew on a relatively small number of KIIs. Interviews were scheduled around the holidays so many respondents were not available. Interviews were then scheduled in mid to late January 2021 in order to try to obtain a larger sample of respondents, before drafting findings, but this was only partially successful. This relatively small number of KIIs is a limitation of the Namibia case study.

1.3 Summary of impact of Covid-19 in Namibia

Namibia is one of the 21 countries with UNICEF offices overseen by UNICEF ESARO. The region's first case of COVID-19 appeared in South Africa on 5 March 2020.[9]

Namibia has a population of 2.5 million people and is a high to middle income country with relatively high life expectancy (64), high adult literacy (91%), and high rates of primary school enrolment (97%). Yet despite Namibia's overall high achievements in key social sectors, there still remain communities in Namibia that are vulnerable. Many children experience malnutrition, poor access to WASH facilities, and uneven access to essential health services such as immunisation, nutritional support, and case management for infectious diseases. Inadequate hygiene

[8] OPM agreed with UNICEF that deep dive assessments will be limited to 10-14 key informant interviews.
[9] Wikipedia (2020) 'COVID-19 pandemic in Africa', available at https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Africa (last accessed 27 December 2020).

practices such as open defecation, poor sanitation facilities, and a lack of sufficient child protection and ECD services leave many Namibian children at risk.

> 'The UN socio-economic impact analysis for Namibia estimates that the income shock from the Coronavirus crisis will result in a 4.4%-point increase in poverty. In other words, 105,600 more people will be in urgent need of social protection, including 45,400 children'. **Taken from the Draft UNICEF Namibia End of Year Results Summary**

COVID-19 in Namibia: As at January 2021, the Johns Hopkins Coronavirus Resource Center cites a total of 32, 425 COVID-19 cases to date with 319 deaths in Namibia. The first two cases of COVID-19 were reported from Windhoek district to the Ministry of Health and Social Services (MoHSS) on 13 March 2020. The National Health Emergency Management Committee Special Committee on COVID-19 Response was convened on 14 March 2020 by the Minister of Health and a national health emergency was declared.

Early challenges in the COVID-19 response in the Namibian context included lack of PPE, and lack of isolation units and facilities in the country for special cases in closed settings such as police holding cells and prisons. There were also inadequate ICU facilities and equipment, as well as insufficient technical expertise at referral hospitals for COVID-19 case management.[10]

Figure 1: Epi-curve of COVID-19 cases and COVID-19-related deaths

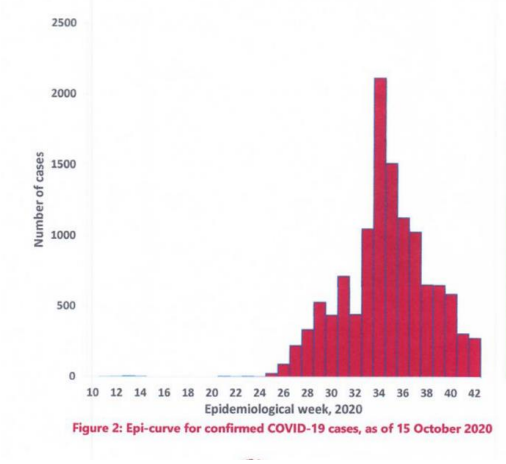
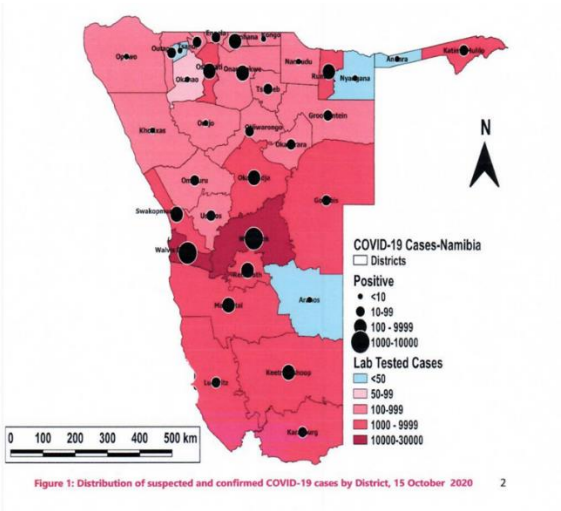


Figure 2: Regional distribution of COVID-19 cases, March–November 2020



[10] WHO/Ministry of Health and Social Services, Republic of Namibia COVID_19 Sit Rep 1 – March 15, 2020 https://www.afro.who.int/sites/default/files/2020-04/SITREP%201.pdf

2 Findings

UNICEF in Namibia: According to a KII respondent UNICEF's presence in Namibia is relatively small s compared to UNICEF programs in neighbouring countries. UNICEF in Namibia has an annual budget of $5m Euros for five years, totalling approximately $26m Euros.

Government and UN COVID-19 Response: The joint UN and Government of Namibia (GRN) response to COVID-19 was the operational strategic framework for Namibia.

With early projections of sharply decreased government revenue and effects on children's wellbeing, UNICEF played an important advocacy role. This focused on the need to protect and 'ring-fence investments in children', enhancing spending efficiencies and exploring innovative financing for child wellbeing.

As part of the overall UN response to the pandemic in Namibia, UNICEF supported data collection regarding the Namibian population's needs in the face of the COVID-19 pandemic and made projections on the socio-economic impact. These projections helped inform the development of key recommendations on specific interventions by GRN and the UN system, to mitigate the impacts of COVID-19 on vulnerable families and children. Additionally, partly thanks to UNICEF's budget analysis, the GRN's overall spending in social sectors reached a high of 50.8% of the total budget, helping to sustain outcomes for children during the crisis.[11]

UNICEF collaborated with multiple agencies such as line ministries (including the Ministry of Health, Ministry of Social Welfare, Ministry for Gender Equality, Home Ministry, and Ministry of Education, Arts and Culture (MoEAC)), NGOs, and other technical and financial partners. UNICEF also collaborated with sister UN agencies (such as UNESCO, UNFPA, WHO, UNDP, and UNAIDS) to support the development of COVID-prevention guidelines for schools and health centres. UNICEF also worked closely with the World Food Programme for logistics support.

ADAPTATION

2.1 UNICEF Namibia CO's adaptations to the COVID-19 crisis

Following the announcement of the first COVID-19 cases in Namibia, the national lockdown affected high rates of unemployment, losses in learning for children, interruptions in school feeding programmes, and disruptions in the provision of MNCH and child protection services. School closures affected 600,000 learners, and over 370,000 children who are dependent on school meals for their nutritional needs. It is further estimated that 4,000 girl-learners have become pregnant during the COVID-19 lockdown period, exposing them to risk of sexually transmitted infections, including HIV.[12] Especially at risk were families in urban settlements, who required support for preventive hygiene practices to control the potential spread of COVID-19.

To respond to these emerging needs, the Namibia CO **adapted its programming** but remained rooted in the UNICEF Namibia Country Programme, which has the following goal: 'All Namibian

[11] UNICEF (2020) Country Annual Report 2020 Namibia End of Year Results Summary Narrative Report, 2 Feb 2021, UNICEF, Windhoek.
[12] ibid

children from ages 0–10 years have improved access to quality and equitable MNCH, education, child protection, ECD, civil registration, nutrition and WASH services by 2023'.

UNICEF programming was **adapted** in order to:

- Sustain access to essential health, HIV and nutrition services to at least 2019 levels, while increasing the capacity of the health sector to identify and treat more children with acute malnutrition in a timely manner;
- Increase access to handwashing facilities in urban informal settlements, and infection prevention and control (IPC) in health facilities and schools (including ECD centres in marginalised communities);
- Ensure continuity of learning, especially for children in underserved communities, and including sustained access to ECD services in informal settlements; and
- Support implementation of the GRN's COVID-19 National Response Plan with significant UNICEF investment toward COVID-19 supplies.[13]

UNICEF contributed direct support to eight of the ten COVID-19 response pillars, including critical interventions in RCCE, operational and logistics support (procurement), continuity of essential health services, surveillance (data management), ports of entry, and case management (COVID-19 in children).[14]

'*UNICEF Namibia CO was able to take some very bold decisions quickly to respond to the COVID-19 situation.'* **Quote from KII**

ADAPTATIONS

Operational adaptations

- Enhanced coordination with GRN on COVID-19 response at national and subnational levels;
- Resource mobilisation for COVID-related activities;
- Scaling down pre-COVID programming; and
- Moving to remote work modalities.

Programming adaptations

- More investments in data collection for population needs assessments;
- Increased international procurement for emergency supplies;
- Expansion of population coverage with a shift toward urban informal settlements at risk in terms of COVID-19 transmission;
- Greater focus on at-risk children (e.g. those who are homeless or without parental supervision);
- Intensification of WASH and IPC messaging and provision of WASH supplies;
- Greater focus on RCCE activities with a focus on COVID-19 prevention messages;
- Programming to adapt to school closures and move toward at-home learning; and
- Local solutions such as new programme agreements, local procurement, and supporting the direct implementation of activities by the government.

[13] UNICEF (2020) Country Annual Report 2020 Namibia End of Year Results Summary Narrative Report, 2 Feb 2021, UNICEF, Windhoek.
[14] Ibid.

IMPLEMENTATION

2.2 Effectiveness of the UNICEF response to COVID-19 in Namibia

The effectiveness of UNICEF Namibia's COVID-19 response is presented along four dimensions: (a) offsetting the negative effects of the pandemic on access to basic services; (b) reaching the most vulnerable and ensuring equity; (c) meeting programming standards and protocols; and (d) ensuring community engagement.

Based on the online survey results, the Namibia CO gave itself a score of 4 out of 5 in regard to whether UNICEF met the targets for its COVID response.

2.2.1 Extent to which UNICEF has been able to contribute to offsetting the negative effects of the pandemic on access to basic services (ensuring coverage and scale-up)[15]

UNICEF played an important role in helping GRN sustain essential service delivery in key sectors. UNICEF developed the *Continuity of Essential Service and Monitoring Guidelines* and used the Johns Hopkins University projections for COVID-19's impact on MNCH services as a guide to programming. UNICEF also built upon on its comparative advantage in procurement services to sustain critical supply chains and capitalised on its ability to achieve economies of scale in the supply of emergency supplies, such as PPE for frontline workers.

Health, nutrition, and HIV: In 2020, UNICEF supported scale-up of Quality of Care interventions in MNCH in 21 out of 35 public hospitals and added an e-birth notification to increase birth registrations. UNICEF provided technical support in adapting HIV services during the COVID-19 pandemic to ensure the continuity of the Prevention of Mother to Child Transmission services. UNICEF worked with the Ministry of Health to sustain antenatal care visits including nutritional support to children with acute malnutrition. By October 2020, a total of 791,534 consultations had been registered at Primary Health Care centres, compared to a 2019 baseline (and 2020 target) of 811,800. UNICEF also supported the MoHSS with an integrated service package including immunisation, Vitamin A supplementation, and screening for acute malnutrition, which reached children under five in eight out of 14 regions.

To prevent COVID-19 transmission in health facilities, UNICEF procured PPE for an estimated 2,000 frontline health workers. IPC standard operating procedures (developed with UNICEF support) informed the capacity building of 1,655 health care workers, against a target of 1,000.[16]

> '*UNICEF worked closely with MoEAC on producing learning content and printing material for home-based learning to offset learning losses due to school closures*.'
> **KII respondent**

Education: UNICEF supported the MoEAC in reducing the effect of the sudden school closures in March 2020 (due to COVID-19), and in preparing for school reopening in the second half of the year. Targeting all 600,000 learners from pre-primary to Grade 7, MoEAC distributed over 5 million paper workbooks in a number of different subjects and made them available online. Another 6,763 learners with visual impairments continued learning in Braille. All schools received the *Guidelines on the Prevention and Management of COVID-19 In and Around Schools*, as well as posters to be displayed for learners, educators, and community members.[17] UNICEF further

[15] The KIIs also tried to elicit judgements about the quality of UNICEF interventions on a number of criteria, but it was difficult to use the RTA's rating methodology (scores from 1–5) in a qualitative interview. The KII methodology does not lend itself to the generation of quantitative ratings. As such this report does not report scores of any type.
[16] UNICEF (2020) Country Annual Report 2020 Namibia End of Year Results Summary Narrative Report, 2 Feb 2021, UNICEF, Windhoek.
[17] UNICEF (2020) Country Annual Report 2020 Namibia End of Year Results Summary Narrative Report, 2 Feb 2021, UNICEF, Windhoek.

supported the development of an internal dashboard for MoEAC to ensure that schools are providing ongoing information on COVID-19.

ECD: UNICEF supported a national ECD awareness-raising campaign that communicated key messages about age-appropriate play, child feeding (including protection of breastfeeding in the context of COVID-19), hygiene, early learning, and early identification and access to services for children with disabilities (CWD). This campaign reached an estimated 1.6 million viewers, readers, and/or listeners (over 70% of Namibia's population).[18] Social mobilisation approaches were used to ensure parents and guardians of CWD continued accessing and attending rehabilitation services for their children during lockdowns. In addition, parents were provided with information on where to access available community resources in the regions, and rehabilitation professionals in Namibia.

Child protection: The UNICEF Namibia CO provided training to social workers and police, especially on GBV, to support children with parents in isolation, as well as training on online child protection.[19] UNICEF also continued to provide critical support to the running of the GBV protection units, managed by the Namibian Police. These walk-in services were provided within the vicinity of hospitals or service delivery by the Namibian Police stations in the 14 regions. Specifically, UNICEF provided support on:

> *'UNICEF provides critical support to domestic violence and GBV units, and to the Unit for Children in Conflict with the Law managed by the Ministry of Gender Equality Poverty Eradication and Social Welfare.'* **KII respondent**

- Child witness training to on how to handle children or vulnerable witnesses in court;
- Information on different development stages of children to enable them to ask the right questions in court;
- Mental health assessments and psycho-social support services in the regions; and
- Training of the Namibian Defence Force on how to deal with children in conflict with the law.

The seventeen GBV protection units also manage cases of sexual violence against minors and deal with cases of children in conflict with the law. These units are supported by UNICEF and UNODC CEOP (renovation, computer, training in child protection), but are still highly undermanned throughout Namibia. In Windhoek, for example, a team of four social workers are responsible for the management of all cases of rape, domestic violence, and violence against children. These social workers are also responsible for the management for all child protection and GBV cases, including witness preparation and representation in court. UNICEF helped support this unit during the national lockdowns in Namibia, a period when increases in protective services were especially needed.

UNICEF's pre-COVID work with this unit allowed for a continuation of essential services, including social work, GBV, and child protective services. This is being ensured through the development of case management guidelines that take into account COVID-19 and close collaboration between relevant sectors, through emergency pillars at regional and national levels.

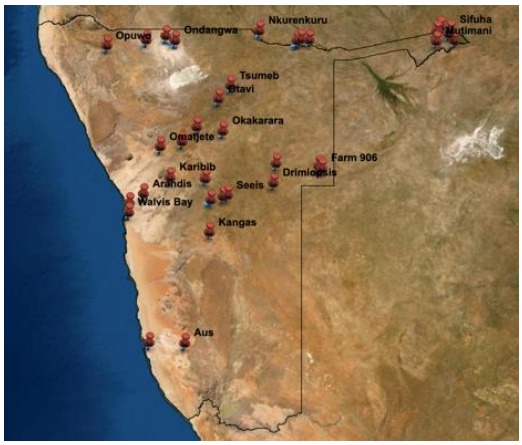
Protection of vulnerable children
As part of the UN system, UNICEF supported evidence generation on the socio-economic impact analysis of COVID-19, which provided key recommendations on specific interventions by GRN and the UN system, to mitigate the impacts of COVID-19 on vulnerable families and their children and in support of economic recovery and growth. Partly thanks to UNICEF's budget analysis and advocacy, which also fed into the ongoing process to develop the Harambee Prosperity Plan II, GRN's overall spending in social sectors reached a high of 50.8% of the total budget, helping to sustain outcomes for children

[18] Ibid.
[19] RTA online survey results

WASH: UNICEF'S Community-Led Total Sanitation Task Force disseminated messages on handwashing and served as a platform to install 48,230 Tippy Taps (with soap), reaching over 217,000 people in two regions with highly populated informal settlements.

UNICEF's partnership with Development Workshop Namibia (DWN)

With UNICEF support, DWN launched a project to help reduce COVID-19 infection transmission among informal settlement dwellers by installing Tippy Taps, a hands-free washing facility. To date, 65,000[20] Tippy Taps have been installed throughout Namibia (see the map to the right).



DWN volunteers explaining the use of Tippy Taps

DWN has been working on providing COVID-19 RCCE through door-to-door visits in townships and informal settlements. DWN volunteers talk to residents of the homes where the Tippy Taps are installed and explain the importance of handwashing for disease prevention. The mobile volunteers work from house to house educating household members on COVID-19 and its prevention. More than 100,000 flyers have been distributed to date in six languages.

ECD: With technical support from UNICEF and the EU, DWN has been testing a pilot programme to support children and their families to promote home-based ECD during the COVID-19 pandemic. Through this programme, kindergarten teachers provide learning materials, food vouchers, information, and support to the households of children enrolled in their centres. The teachers develop activities for children and guidance for parents to facilitate home-based learning and how to safeguard against COVID-19.

RCCE: UNICEF supported the national RCCE response plan by developing, among other initiatives, a social listening dashboard to rack and manage COVID-19 rumour and misinformation. Monthly reports are tracked and analysed to provide regular proactive communication, and engage with the public and at-risk populations, to help alleviate confusion and avoid misunderstandings. According to the COAR report: '*To date, 750,000 of the targeted 1 million people were reached with prevention and access to service, disability-inclusive messages. Also, 75,700 of the targeted 100,00 people shared their concerns and asked questions/clarifications to available support services to address their needs, through the organised COVID-19 tollfree hotline and COVID-19 Communication Centre feedback mechanism'.*[21]

[20] Tippy Tap Database for Namibia Townships: https://arcg.is/1DDaz4
[21] UNICEF (2020) Country Annual Report 2020 Namibia End of Year Results Summary Narrative Report, 2 Feb 2021, UNICEF, Windhoek.

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

Protection of the most vulnerable households and children in Namibia: According to projection and analysis made at the start of the pandemic, UNICEF was able to help identify vulnerable populations. These included poor households in informal settlements and rural areas, people who are immunocompromised due to high prevalence of HIV, and children who may face discrimination due to their disability, ethnicity, or because they are not living with their biological parents, among other reasons.

UNICEF ensured that the planned COVID-19 rapid assessment tool of the RCCE includes communities' information needs and communication preferences. These are key questions to gain an understanding of people's views and perceptions; and inform the development of the CO's complaints and feedback mechanisms. The tool will also help identify barriers to accessing COVID-19 information and feedback mechanisms.

> UNICEF developed a partnership between the Namibian Police, the National Defence Force and Correctional Services, during which they trained 400 personnel to enforce lockdown and movement restrictions in a child-sensitive manner.
>
> ***Source**: UNICEF (2020) Country Annual Report 2020 Namibia End of Year Results Summary Narrative Report, 2 Feb 2021,*

People in informal settlements: At subnational level, UNICEF has supported community engagement and systems strengthening in four priority regions. In Khomas and Erongo regions, the aim was to accelerate preparedness to contain the spread of COVID-19 and minimise loss of life, in close collaboration with other development partners.

Women and girls: Women and girls have been at especially high risk during the COVID-19 emergency in Namibia. There have been grave losses in educational achievements and school-based nutrition support due to school closures. There has also been decreased use of clinical maternal and child health services such as prenatal care, delivery and post-natal care with impacts on the health of women and new-borns. Disruptions in child and social protection services also occurred during lockdowns, putting women and girls at risk of domestic and sexual violence. Adolescent health services have also been curtailed, resulting in an increase in teenage pregnancy.

2.2.3 How UNICEF has been able to meet programming standards and protocols and ensure community engagement?

UNICEF met programming standards by maintaining reporting and supervision, and other monitoring and tracking guidelines, to ensure that programming was taking place as intended and was of good quality: '*Amidst the difficult programme environment due to the pandemic, UNICEF Namibia ensured timely development and implementation of the Annual Monitoring Plan, Annual Work Plan, and related reports were realized'*.[22]

To monitor implementation in the field, UNICEF has undertaken programmatic visits and spot checks in line with M&E requirements. UNICEF supported a newly established NGO (Namibia Partnership Solutions) to provide support to the implementation of the PSEA interventions using a targeted equity approach, in hot-spot areas with the highest risk populations in eight regions.

[22] UNICEF (2020) Country Annual Report 2020 Namibia End of Year Results Summary Narrative Report, 2 Feb 2021, UNICEF, Windhoek.

2.3 How has the UNICEF Namibia CO utilised preparedness and contingency planning during the COVID-19 response, and how has it revised COVID-19 response plans based on the evolving needs of the population?

Respondents in the UNICEF CO KIIs stated that (unlike other countries in the ESA region) Namibia has experienced fewer health and climate-related emergencies. As such, the CO did not have pre-existing plans in place that were easily activated to respond to the COVID-19 crisis.

> *'The pandemic is unprecedented and existing EPP and risk management measures did not foresee this. However, the CO was able to capitalise on existing strong national systems to respond'.* **Namibia Country Response on Preparedness in the RTA Online Survey**

2.4 What is known about needs in Namibia and how UNICEF has determined and verified those needs

The Namibia CO has a good understanding of existing vulnerabilities affecting women and children because of its solid routine monitoring mechanisms, such as the Namibia Intercensus Demographic Survey (2016), and the Multiple Overlapping Deprivation Analysis 2020 (not yet published). Specific to the COVID-19 crisis, UNICEF is supporting the government to measure the socio-economic impacts of the pandemic, with a view to influencing resource allocation toward scaling up social protection and policy response for full economic recovery and growth.

UNICEF is currently supporting the review and analysis of data from the District Health Information System (DHIS2) to establish a baseline for coverage of key MNCH interventions. This data will continue to be collected and monitored as part of technical support to the GRN on MNCH services. Other work being undertaken includes rapid perception and behaviour risk assessments. UNICEF is also monitoring school compliance with COVID-19 safety guidelines through existing data platforms in education (including the Education Management Information System and rapid response surveys).

QUALITY

2.5 What we know about the quality of the UNICEF response to COVID-19

According to KIIs, UNICEF has worked for many years on systems strengthening in the Namibian social sector, in terms of the education, health, and child protection supply chains. This pre-COVID systems strengthening has allowed it to contribute significantly to the maintenance of basic essential services during the COVID crisis. The Namibia CO's response to COVID-19 was also considered to be timely.

> **Best practice**: UNICEF's work on vital registration allowed birth and death registration to continue unfettered during the national lockdowns.

UNICEF's pre-COVID systems-strengthening work in Namibia

UNICEF undertook work with some key ministries pre-COVID-19 to strengthen technical capacity, meet material needs, and provide management support as part of its systems-strengthening approach in Namibia. This fundamental work at the systems level allowed for a more robust response during the COVID crisis.

UNICEF has provided critical support to the Unit of Vital Registration, which registers all births and deaths in Namibia. This has included providing material, financial, and technical support to increase the recording of vital events (births, deaths, and marriages) and has helped establish vital registration units (including e-birth notifications) in 34 state hospitals. A pilot study, supported by UNICEF, showed that these hospital-based birth and death registration units were responsible for an increase in vital registration from 30% to 70%. This acts as the path to legal citizenship and a gateway to other Namibian social services, such as health education and social protection measures provided by GRN. This important strengthening work allowed for this key government function (registration of births and deaths) to continue unabated during the COVID-19 crisis.

Monitoring progress and achievements

UNICEF is currently monitoring key indicators on its reaching of beneficiaries with key messages and services for the response, which are reported on a bi-monthly basis at UNICEF global level. These indicators will be used to monitor project implementation and reported accordingly. Coverage indicators for school-based interventions are collected through routine education sector reporting mechanisms and reported accordingly. UNICEF is also routinely collecting data and reporting on the distribution of PPE to frontline health workers.

New partnerships

British High Commission
UNICEF advocated for the provision of Braille paper (valued at NAD 350,000) from the British High Commission to the MoEAC; and a donation of food parcels, masks and sanitisers which were donated to 50 parents of CWDs (0-8 years old) in the Khomas region from TIKA (valued at NAD 30,000).

Disability Benefits Trust
UNICEF successfully leveraged resources through the Disability Benefits Trust, which resulted in the donation of 50 blankets, food parcels, hand sanitisers, and 119 masks. These benefited school-going CWD in Zambezi region and were valued at NAD 65,000.

European Union
UNICEF successfully achieved resource mobilisation of US$ 400,000 thanks to the European Union, which supported continuity of ECD interventions at household level in informal settlements of Khomas Region during the COVID-19-related closure of ECD centres.

3 Emerging themes/Conclusions

The following key positive conclusions can be drawn from UNICEF Namibia's performance in the COVID-19 response:

3.1 Emerging positives

POSITIVES IN ADAPTATION

- A light decision-making structure that allowed the CO to re-programme monies very quickly for COVID activities.
- Re-prioritisation of activities toward the procurement of supplies and equipment, relying on UNICEF's comparative advantage in international procurement.
- Strong collaboration with the education sector that allowed UNICEF and MoEAC to quickly develop a rapid response to deal with school closures and methods for out-of-school learning.
- Strong collaboration with the Ministry of Health to ensure continuation of essential health services.

POSITIVES IN IMPLEMENTATION

UNICEF's comparative advantage in the procurement of essential supplies from the global market when no other organisations had the ability to do so in country.

3.2 Challenges encountered in UNICEF Namibia's implementation of the COVID-19 response

CHALLENGES IN IMPLEMENTATION

- The Namibia CO did not have extensive experience in emergency planning.
- The Namibia CO experienced a lack of access to emergency funding.
- A KII informant stated that one of the challenges faced by the COP during the emergency was a massive price hike for key commodities such as PPEs. The price of commodities quoted at the time of ordering was increased dramatically at the time of receipt in the field. These price hikes caused major issues in budgetary management during the crisis.

3.3 Medium- to long-term implications for vulnerable children and their communities in Namibia, and implications for UNICEF's strategy and action in the medium to long term

- National austerity measures have affected investments in the social sector first
- Vulnerable household falling into poverty
- Major learning losses for children
- Increases in malnutrition

4 Lessons learned/Suggested action points

The UNICEF CO may consider the need to:

1. Improve preparedness for an effective response, strengthening related systems and prepositioning supplies to the extent possible.
2. Strengthen UNICEF's emergency planning expertise.
3. Maintain the Namibia CO's light decision-making structure.
4. Simplify bureaucratic procedures to enable timely responses even in non-emergency situations.
5. Create a mechanism to guard against excessive fluctuations in pricing for international procurement of supplies in emergencies.
6. Maintain a strong presence in informal urban settlements and continue collaboration with local partners on RCCE messaging on WASH and maintenance of Early Child Development (ECD) activities.
7. Advocate with the GRN for more resources for the management and staffing of the units managing of child protection, prevention of Gender Based Violence and children in conflict with the law.

Annex A Regional context

A.1 Countries in eastern and southern Africa with UNICEF COs

The map below shows the countries with UNICEF COs that fall under the purview of UNICEF ESARO.

Figure 1 Countries in ESAR with UNICEF offices

A.2 UNICEF response to COVID-19 in ESAR

Excerpted from OPM's Inception Report[23]

Soon after the pandemic was declared by the World Health Organization (WHO), the UNICEF country offices and regional office in ESAR began working with the governments and the development partners in the region to respond to the pandemic with the aim to reduce transmission and mitigate the impacts of COVID-19. The region received nearly US$350 million, which is approximately 18% of UNICEF's global Humanitarian Action for Children (HAC) to respond to COVID-19.

UNICEF is responding to COVID-19 in the Eastern and Southern Africa Region (ESAR) mainly through two distinct but complementary pathways, namely, programmatic response and operational response. [As part of the programmatic response], UNICEF is…working to ensure the continuity of ongoing basic essential services[24] in the region. Further details on these responses based on the information included in the ToRs of the RTA is outlined below.

Programmatic response

The programmatic response to COVID-19 in ESAR is aimed to minimise the impact of the pandemic on women and children by ensuring the continuity of basic essential services and adapting the services to incorporate safety measures and COVID-19 transmission prevention activities, more specifically:

- Ensuring access to essential health and nutrition services, including sexual, reproductive, maternal, new-born, child and adolescent health (SRMNCAH) and HIV;
- Supporting government to provide distance and home learning through eLearning platforms and take-home packages, and promoting and supporting the early and safe re-opening of schools;
- Ensuring availability of water and other lifesaving commodities;
- Identifying and protecting children and adolescents in the most vulnerable households and circumstances, such as children with disabilities, children deprived of their liberty, refugee, internally displaced, migrant and returnee children, and girls who face increased risk to e.g. child marriage as a result of the pandemic;
- Providing support to caregivers on how to talk to children about COVID-19, managing their children's mental health and well-being and; supporting the continuity of learning whilst schools and centres are closed;
- Adapting and refining standard COVID-19 response measures to support children and families living in challenging settings such as refugee camps, informal settlements, rural areas and densely populated urban and peri-urban areas;
- Expanding sustainable social protection programmes (including cash top ups to existing beneficiaries and identifying new beneficiaries including the borderline poor), including gender-sensitive measures such as cash transfers to support girls' re-entry to school;
- Helping finance ministries access international funding opportunities to invest in health, WASH, social protection systems and social welfare services;

[23] OPM, Inception Report for the Real-Time Assessment (RTA) of UNICEF's Ongoing Response to COVID-19 in Eastern and Southern Africa, 10 November 2020.
[24] Basic essential services comprise health services (including sexual, reproductive, maternal, new-born, child and adolescent health); nutrition; social welfare, child protection and gender-based violence; access to and retention and performance in education and learning; WASH, including in schools (including menstrual hygiene management), health facilities, households and communities; social protection; HIV.

- Strengthening community platforms to facilitate community surveillance of COVID-19, early response to new clusters, referrals for testing, and education on appropriate health and WASH practices, while keeping health professionals safe;
- Supporting risk communication and community engagement (RCCE) for the COVID-19 response;
- Supporting coordination mechanism and evidence generation;
- Supporting the procurement and supply of essential commodities for treatment and prevention; and
- Identify and protect children and adolescents who may be more vulnerable to developing serious complications of COVID-19.

Operational response

UNICEF's operational response to COVID-19 in the region is aimed to protect its staff and implementing partners from the harmful effects of COVID-19 and its response measures. This includes measures like:

- Protecting staff most at risk of complications, reducing overall exposure through teleworking and adopting measures to protect staff with critical functions;
- Simplifying internal procedures, adopting digital signatures and setting emergency protocols in place; and
- Declaring a global Level-3 (L3) emergency on 16th April 2020 and putting in place emergency procedures associated with L3 declaration.

Continuity of essential services

UNICEF support to continuity of essential services across programmatic areas includes supporting strategy, design and implementation (UNICEF, 2020) in:

- **Health services:** In collaboration with the governments, WHO and other development partners, UNICEF is working on communication activities at health facilities, in the communities and at schools. UNICEF is also working on capacity development and development of guidelines on the continuity of essential health services including SRMNCAH and HIV.
- **Nutrition:** UNICEF is working on ensuring continuity of nutrition programmes including management of acute malnutrition, vitamin A supplementation and expansion of Family Mid-Upper Arm Circumference (MUAC) services.
- **Child Protection and Gender-based Violence (GBV):** UNICEF is protecting refugee, internally displaced, migrant and returnee children including reaching children on the move with registration, vulnerability assessments, family tracing and reunification and basic counselling support services; advocating for releasing children from detention; providing life-saving sexual and gender-based violence services including prevention of child marriage; facilitating community-based mental health and psychosocial support (MHPSS) for children, their parents and caregivers; and supporting social welfare services for example, by ensuring that children without parental or family care are provided with appropriate alternative care arrangements.
- **Access to education and learning services:** UNICEF is supporting distance/ home-based learning, and plans for safe re-opening and keeping schools open. This includes an emphasis on girls' access to distance learning and data collection on the negative consequences of school closure on girls (e.g. early pregnancy and child marriage).

- **Water, Sanitation and Hygiene (WASH):** UNICEF is providing critical WASH supplies as well as training of the health facility and community health workers on Infection Prevention and Control (IPC).
- **Risk Communication and Community Engagement (RCCE):** UNICEF's communication campaign reached 86% of the population with information preventative measures and on how to access services related to COVID-19 pandemic. UNICEF also support partners on rumour management tools and strategies to mitigate pandemic misinformation.
- **Supply:** As of 28 July, UNICEF delivered Personal Protective Equipment (PPE), oxygen sets and diagnostics worth of US$ 21 million to all the countries in the region.
- **Social Protection:** UNICEF is engaging with government and partners to promote the use of shock responsive / adaptive social protection intervention to reduce vulnerabilities, poverty and improve the linkages with essential services and over 13 million households received cash transfers.

There remains significant uncertainty on what will be the trajectory of the COVID-19 pandemic in ESAR due in part to incomplete understanding of its immunology, epidemiology, clinical management, both acute and longer-term outcomes, and effective strategies for influencing and sustaining preventative behaviours amongst the population. UNICEF country offices are supporting national governments in 21 ESAR countries across a number of programme areas that provide essential services to the population and particularly to children, women and other vulnerable groups. It is critical that these programmes continue to be delivered and adapted to maintain and extend where needed the reach (particularly to the vulnerable), and quality of these services. To this end, country offices have developed COVID-19 response plans which they are implementing. However, given the general lack of evidence-based good practices, together with the non-static nature of the pandemic, it is essential that these response plans are able to adapt to the changing transmission and impacts of the pandemic.

A.3 Interviewees – Namibia

Interviewees by organisational category	
Front line workers	**4**
Namibian government staff	2
NGO/INGO	1
UN agency	1
UNICEF Partners	**2**
Namibian government staff	1
Bilateral (foreign government) staff	-
NGO/INGO	1
UN Agency	-
UNICEF staff	**3**
TOTAL	**9**

Interviewees by sector	
Education	1
WASH	1
Health	1
Early child development	1
C4D	1
Child protection	1
Other (statistics)	1
Other (coordination)	2
TOTAL	**9**

A.4 RAG Rating: Namibia

Key:
Green: Meets or surpasses expectation;
Amber: partially meets expectation;
Red: Below expectation

Programme adaptation		RAG rating
Approaches to meeting evolving environment/ operating context	To what extent does the country office have the ability to identify and serve the most vulnerable and hard to reach women and children through its programming? For example, use of gender analysis during needs assessment; use of indicators disaggregated by gender, age and disability, including age- and gender-disaggregated adolescent-specific indicators (10-14; 15-19; or 10-19); participation in e.g. inter-agency working group on gender; partnerships with civil society organizations representing persons with disabilities etc.	
Approach to promoting local solutions	To what extent is the country office developing action plans and local solutions in response to these?	
Support for evolving institutional gaps	Have adaptations been developed across all programmatic areas?	
Implementation		
Preparedness and contingency planning	To what extent did country office's existing preparedness and contingency planning processes contribute to the implementation of COVID-19 emergency and mitigation response?	
Implementation as planned	To what extent do response (emergency and mitigation) plan activities and modalities contribute to the achievement of planned objectives?	
Coverage vs need	To what extent did the COVID-19 response (emergency and mitigation) activities target the coverage of vulnerable population?	
Equity vs gaps	To what extent was gender mainstreamed into institutional systems and processes during implementation? Such as gender-responsive human resourcing and policies, incorporation of gender sensitive and gender transformative approaches throughout the programme cycle, and accountability for results on gender. This indicator above focuses on the 'feedback and complaints' pillar, while the indicator below focuses on the 'PSEA' pillar.	
	To what extent did the COVID -19 response (emergency and mitigation) consulted with the affected people, including the most vulnerable groups?	

	To what extent has accountability to affected people (AAP) been undertaken as part of implementation including Prevention of Sexual Exploitation and Abuse by humanitarian personnel (PSEA)? AAP is defined as "An active commitment to use power responsibly by taking account of, giving account to, and being held to account by the people humanitarian organizations seek to assist" but it is a broad concept consisting of seven pillars: participation (Safe, appropriate, equitable and inclusive opportunities for girls, boys, women and men of all ages especially the most vulnerable and marginalized groups, to participate in decisions that affect them); information and communication (Safe, appropriate, equitable and inclusive access to life-saving information as well as information on people's rights and entitlements and how to exercise them); feedback and complaints; PSEA; strengthening local capacity; evidence-based advocacy and decision-making; and coordination and partnerships.	
Participation	To what extent does the country office coordinate and collaborate with and complement existing work on COVID-19 response (emergency and mitigation)?	
Quality		
Focus on most essential interventions	Perception and evidence that most essential services in the country have been the focus of COVID-19 response activities	
	Evidence that selected essential services have been maintained as part of the COVID-19 response	
Quality of assistance delivered	Quality of assistance delivered	
Timeliness	To what extent has the country office been successful making programming adaptations and delivering them in a timely manner?	
Robustness of verification system	Are there adequate oversight and accountability mechanisms in place, including effective monitoring, feedback loops and reporting systems including AAP and PSEA?	
Average RAG rating: Namibia		

Annex B Data collection tools

B.1 KII Guide for UNICEF Country Offices

Adaptation

1. What have been the **most critical COVID-19-related operational adaptations** required by your country office? *[Note to interviewer: This question pertains to operational aspects such as remote working, putting Level 3 Simplified Standard Operating Procedures in place, etc.]*
2. What have been the **most critical COVID-19-related programming adaptations** required by your country office? *[Note to interviewer: This question pertains to substantive programming aspects.]*
3. Based on your country office's responses to the online questionnaire, we know that you have made **increased use of local solutions** in responding to COVID-19 restrictions. Can you tell me what that has meant in terms of implementation successes and challenges, as well as in terms of quality of product or service?
4. To reach the most at-risk and most vulnerable groups of women and children in the COVID-19 context, to what extent is your country office able to **fill the gaps** (in geographic areas, for example) vacated or not reached by others?

Implementation

5. Can you describe your country office's efforts to **sustain basic essential services** despite COVID-19 crisis, *specifically* with regard to how successful you have been in (a) ensuring coverage and (b) scaling-up? *[Note to interviewer: Here, 'basic essential services', refers to health services (sexual, reproductive, maternal, newborn, child and adolescent health), nutrition, social welfare, child protection and gender-based violence, access to and retention and performance in education and learning, WASH, including in schools (including menstrual hygiene management), health facilities, households and communities, social protection, HIV.]*
6. Given the description you just provided, on a scale of 1 to 5 *[where 1=low and 5=high]*, could you please **rate** the extent to which your country office has been successful in **sustaining basic essential services**?
7. How have the most vulnerable and excluded groups of women and children been **identified** in the context of the COVID-19 pandemic?
8. If the **method of vulnerable and excluded group identification** represents a change to how vulnerable groups were identified pre-COVID-19, could you briefly describe the nature of that change?
9. To what extent is **data on the most vulnerable groups sufficiently disaggregated** to provide information on different categories of vulnerable groups?
10. Can you describe your country office's efforts **to assess and meet the needs** of the most at-risk and vulnerable groups of women and children in the COVID-19 context? *[Note to interviewer: Here we are aiming to understand if the country office has any needs assessment mechanism in place to understand evolving population needs in the COVID-19 context; and how the country office has gone about meeting those needs].*
11. To what extent has **ensuring gender equality** been taken into account during implementation of the COVID-19 response?
12. What **role have Accountability to Affected Populations (AAP)**[25] **mechanisms**, including Prevention of Sexual Exploitation and Abuse by humanitarian personnel (PSEA), **played** in the overall response to COVID-19? *[Note to interviewer: If the interviewee doesn't say anything about whether outputs of AAP mechanisms have led to programme or management decisions, probe to ask whether*

[25] *[Note to interviewer: AAP is described in UNICEF's ESARO's AAP guidelines 2020, see here.*

this is the case. Also probe to find out how community engagement has been affected, if this has not specifically been mentioned up to this point, especially in terms of monitoring and feedback loops.]

13. What **role have preparedness and contingency planning (at the national, sub-national, and country office levels) played** in the overall response to COVID-19? In your response, please also make reference to the extent to which your country office is making use of the Emergency Preparedness Platforms (EPPs)[26], any lessons learned, intentions to update the EPPs and the extent to which your country office had the 'right' partners in place for the COVID-19 response? *[Note to interviewer: Only ask if not adequately evoked in earlier responses but do probe on EPPs and 'right' partners if not specifically mentioned earlier.]*

14. To what extent has **guidance from UNICEF headquarters** informed your country office's COVID-19 response? *[open ended]* *[Note to interviewer: Here, we are aiming to get at how useful UNICEF HQ guidance has been, but we are avoiding use of the word 'useful' to avoid bias and allow the interviewee the maximum freedom to respond as they wish.]*

Quality of Response

15. In what ways has your country office and its partners **ensured** that implementation of the COVID-19 response is taking place **as intended and is of good quality**? One aspect of this is how your country office has ensured that it meets **programming standards and protocols** in the COVID-19 context, so please speak to that as well in your response. *[open ended]* *[Note to interviewer: Probes to include: how relevant, effective, efficient the support has been; how multi-sectoral the support has been; are girls and women targeted with specific gender-sensitive approaches which recognize their increased vulnerability and risks; are children/adolescents with disabilities and refugee, internally displaced, migrant and returnee children included]*

16. Given the description you just provided, on a scale of 1 to 5 *[where 1=low and 5=high]*, could you please **rate** the extent to which your country office has been successful in **meeting programming standards and protocols**? *[Note to interviewer: You may choose to introduce this question with the following:* This last question in this section is linked to one I just asked about ensuring that you meet programming standards and protocols, so there may be some overlap but I'd like to ask it from another angle:*]*

17. How are you monitoring the quality of your interventions and, in this process, are you using any new **remote monitoring methods**? *[Note: If the interviewee doesn't say anything about negative consequences to IP monitoring, probe whether this is the case].*

Lessons for Future Programming

18. Could you take a moment to recap the successes you perceive in your country office's COVID-19 response and talk about what you think accounts for those successes and how you think they can be built upon? *[Note to interviewer: Only ask if the successes have not adequately been mentioned in the interview up to this point.]*

19. What have been the **most critical challenges (bottlenecks and barriers) confronted** in the course of your country office's effort to support the COVID-19 response effectively? *[Note to interviewer: Only ask if the challenges haven not adequately been mentioned in the interview up to this point. Please be sure to make the following specific probes, if L3 SSOPs have not yet been specifically mentioned: If your CO is putting Level 3 Simplified Standard Operating Procedures (L3 SSOPs) in place, are there any issues around lag times?]*

20. What, in your opinion, are **solutions** to address these challenges to ensure that UNICEF programming reaches the most vulnerable groups?

21. Which COVID-19-related adaptations would it be useful to **keep as a permanent part** of your country office's programming and operations?

[26] *[Note to interviewer: "The UNICEF Emergency Preparedness Platform (EPP) is described in UNICEF's guidance note on Preparedness for Emergency Response (December 2016), see here.*

22. Are there **new/emerging vulnerable groups** of women and children that your UNICEF country office and your in-country partners should consider focusing on as you further respond to COVID-19 in the medium and long term? *[Note to interviewer: If women and children with disabilities are not specifically mentioned in the response, please probe on considerations for that group. Also check if migrant children and other vulnerable sub-groups are of special concern in the country.]*

23. Lastly, before we wrap up the interview, I'd like to give you the opportunity to share any additional thoughts you might have that would contribute to the objectives of the real-time assessment; i.e., is there anything you'd like to add that UNICEF should consider as it reviews its response to date and as it plans ahead? *[This question is optional, only to be asked if time allows].*

B.2 KII Guide for UNICEF Partners

Preliminaries

1. What is your programmatic area of work generally (setting aside the COVID-19-related activities for a moment)?
2. What is your geographic area of work generally (setting aside the COVID-19-related activities for a moment)?

Adaptation

3. What have been the **most critical elements of the response to COVID-19** in your work?
4. What has been the **focus of UNICEF support to/collaboration with your work** during the COVID-19 response?
5. How is that **different from UNICEF support/collaboration prior** to the pandemic?
6. What have been the **most critical changes** required to sustain **basic essential services** in the geographic area where you work to meet new and emerging COVID-19 needs, and how has UNICEF supported/collaborated on those changes? *[Note to interviewer: 'basic services' refer to health services (including sexual, reproductive, maternal, newborn, child and adolescent health), nutrition, social welfare, child protection and gender-based violence, access to and retention and performance in education and learning, WASH, including in schools (including menstrual hygiene management), health facilities, households and communities, social protection, HIV.]*

Implementation

7. Given the description you just provided, on a scale of 1 to 5 *[where 1=low and 5=high]*, could you please **rate** the extent to which your organization has been successful in **sustaining basic essential services**?
8. What role have **pre-existing preparedness and contingency planning (at the national, sub-national, and institutional levels)** had in your overall response to COVID-19? *[open ended]*
9. **Who have been the most vulnerable and excluded groups** of women and children most affected by COVID-19?
10. **How** have these vulnerable groups been **identified**?
11. Can you describe your entity's efforts **to assess and meet the needs** of the most at-risk and vulnerable groups of women and children in the COVID-19 context?
12. To what extent has UNICEF support/collaboration helped you reach your **intended beneficiaries, including the most vulnerable and excluded groups of women and children, in the response to COVID-19?** *[open-ended]* *[Note to interviewer: UNICEF support may include the following: supplies like PPE, communication messages, cash assistance, training, support for specific programmes e.g. primary health care, nutrition, education, child protection, gender programming, GBV prevention and response etc.]*
13. Given the description provided, on a scale of 1 to 5 (*where 1=low and 5=high),* **to what extent have the most vulnerable and excluded groups of women and children received support**, in response to COVID-19?
14. How **critical** has **UNICEF's support/collaboration** been in meeting the needs of **the most vulnerable and excluded groups of women and children,** as part of the COVID-19 response?

Quality of Response

15. How **timely** has UNICEF's COVID-19 response been so far, based on its support to/collaboration with your work?

16. Give the description you just provided, on a scale 1 to 5 *(where 1=low and 5=high)*, could you please rate the **timeliness of UNICEF's COVID-19 response**?

17. In what ways has UNICEF **ensured** that implementation of the COVID-19 response is taking place **as intended and is of good quality**? *[Probes: how relevant, effective, efficient the support has been] [open-ended]; are girls and women targeted with specific gender-sensitive approaches which recognize their increased vulnerability and risks; are children/adolescents with disabilities and refugee, internally displaced, migrant and returnee children included]*

18. Could you please rate, along the categories that I'll read to you, how **easy** is it for you and your colleagues **to contact UNICEF** to make suggestions/requests, to complain, or to provide feedback? Is it:

    a. Very easy;
    b. Easy;
    c. Somewhat easy;
    d. Not easy; or
    e. Don't know/not sure?

    Could you please elaborate on what informed your rating? *[open-ended]*

19. Is it your experience that when UNICEF asks for your opinions on a programme approach or operations that UNICEF **will change the programme approach or operations in line with your feedback**?

Lessons for Future Programming

20. As we near the end of our interview, could you take a moment to summarize what you think accounts for the **successes** (i.e., any successes you perceive) **of UNICEF's support to/collaboration with your work** in the context of the COVID-19 response, and how can these be built upon?

21. What accounts for any **gaps in the design and implementation of UNICEF's support to/collaboration with your work** in the context of COVID-19 response activities?

22. What, in your opinion, are the **major challenges** that will require **more attention** in the next few months and in the longer term as a result of COVID-19?

23. What in your opinion are the **solutions, local or otherwise,** to address these challenges and how could UNICEF support or enhance support to such local solution(s)?

24. Are there **new/emerging vulnerable groups** of women and children that UNICEF and other partners should consider focusing on as they further respond to COVID-19 in your area of operation?

25. Lastly, before we wrap up the interview, I'd like to give you the opportunity to share any additional thoughts you might have that would contribute to the objectives of the real-time assessment; i.e., is there anything you'd like to add that UNICEF should consider as it reviews its response to date and as it plans ahead? *[This question is optional, only to be asked if time allows].*

B.3 KII Guide for Frontline Workers

Preliminaries

1. What is your organization's programmatic area of work in general, setting aside for a moment the COVID-19-related activities?

2. What is your organization's geographic area of work, again without considering, for a moment, the COVID-19-related activities?

Adaptation

3. What has been the **focus of UNICEF support to your work** during the COVID-19 response?

4. How is that **different from UNICEF support prior** to the pandemic?

5. In the COVID-19 context, what have been the **most critical changes** required to ensure **basic essential services** in the area where you work? *[Note to interviewer: 'basic services' refer to health services (including sexual, reproductive, maternal, newborn, child and adolescent health), nutrition, social welfare, child protection and gender-based violence, access to and retention and performance in education and learning, WASH, including in schools (including menstrual hygiene management), health facilities, households and communities, social protection, HIV.]*

6. **Implementation**

7. What role has **pre-existing preparedness and contingency planning (at the national and sub-national levels and at your organization's level)** had in the overall response to COVID-19?

8. Who have been the **most vulnerable and excluded groups of women and children most affected** by COVID-19?

9. How have these vulnerable groups been **identified**?

10. Can you describe your organization's efforts **to assess and meet the needs** of the most at-risk and vulnerable groups of women and children in the COVID-19 context? *[Note to interviewer: Here we are aiming to understand if there is a needs assessment mechanism in place to understand evolving population needs in COVID-19 context and then of course how the respondent's organization has gone about meeting those needs.]*

11. To what extent has UNICEF support helped you reach your **intended beneficiaries, including the most vulnerable and excluded groups of women and children, in the response to COVID-19?** *[Note to interviewer: UNICEF support may include the following: supplies like PPE, communication messages, cash assistance, training, support for specific programmes e.g. primary health care, nutrition, education, child protection, gender programming, GBV prevention and response etc.]*

12. Given the description provided, on a scale of 1 to 5 (*where 1=low and 5=high),* to what extent has UNICEF's support helped you reach the most vulnerable and excluded groups of women and children, in your response to COVID-19?

13. How **critical** has **UNICEF and its partners' support** been in meeting the needs of **the most vulnerable and excluded groups of women and children,** as part of your work in the COVID-19 response? *[Note to interviewer: Only ask this question if it isn't clear on the basis of what's been shared in the course of the interview up to here and if time permits.]*

Quality of Response

14. How **timely** has UNICEF's COVID-19 response been so far?

15. Give the description you just provided, on a scale 1 to 5 *(where 1=low and 5=high)*, could you please rate the **timeliness of UNICEF's COVID-19 response**?

16. In what ways has UNICEF and its partners **ensured** that implementation of their support in the COVID-19 response is taking place **as intended and is of good quality**? *[Probes: how relevant, effective, efficient the support has been]*; *are girls and women targeted with specific gender-sensitive approaches which recognize their increased vulnerability and risks; are children/adolescents with disabilities and refugee, internally displaced, migrant and returnee children included]*

17. Could you please rate, along the categories that I'll read to you, how **easy** is it for you and your colleagues **to contact UNICEF or UNICEF partners** to make suggestions/requests, to complain, or to provide feedback? Is it:

    a. Very easy;

    b. Easy;

    c. Somewhat easy;

    d. Not easy; or

    e. Don't know/not sure?

    Could you please elaborate on what informed your rating?

18. When UNICEF or a UNICEF partner asks for your opinions on a programme approach or operations, is it your experience that UNICEF or its partner **will change the programme approach or operations in line with your feedback**?

Lessons for Future Programming

19. As we near the end of our interview, could you take a moment to summarize what you think accounts for the successes (i.e., any successes you perceive) of UNICEF's support to your organization's COVID-19 response and how can these be built upon?

20. What accounts for any gaps in the design and implementation of UNICEF's support to your organization's COVID-19 response activities?

21. What are the **challenges** that will require **more attention** in the next few months and in the longer term as a result of COVID-19?

22. What in your opinion are **solutions**, local or otherwise, to address these challenges and how could UNICEF support or enhance support to such local solution(s)?

23. Are there **new/emerging vulnerable groups** of women and children that UNICEF and other partners should consider focusing on as they further respond to COVID-19 in your area of operation?

24. Have **female frontline workers** received adequate support in light of potential increased burdens and responsibilities at home and in the community? *[open-ended]*

26. Lastly, before we wrap up the interview, I'd like to give you the opportunity to share any additional thoughts you might have that would contribute to the objectives of the real-time assessment; i.e., is there anything you'd like to add that UNICEF should consider as it reviews its response to date and as it plans ahead? *[This question is optional, only to be asked if time allows].*

B.4 Standard introduction and consent (all interviews)

The objective of this interview is:

- *to understand how population needs are assessed and action plans developed to respond to these; how effectively the UNICEF CO has monitored changing needs and made adaptations; what are the barriers, challenges and successes?*
- *to understand how effective these processes were in contributing to the COVID-19 response; explore the link between existing preparedness process, COVID-19 response plan and implementation*.
- *to understand how plans were developed implemented; what adaptations were made; what were the successes and why? what were the barriers and why?*
- *to explore quality and effectiveness of partnerships in relation to COVID-19 response*
- *to understand the quality of the response.*

Hello, [state name of interview participant]

Thank you for making yourself available for the interview today. My name is [state name], and I am a member of the Assessment Team engaged by UNICEF ESARO to undertake a real-time assessment of the support the country offices in the region have provided to the COVID-19 response.

Your feedback will inform this analysis, including aspects of adaptation, implementation, and quality that UNICEF should consider in the upcoming months at all levels.

Your input is valuable, but participation in this interview is entirely voluntary. Whether or not you participate will have no consequence on any aspect of your relationship with UNICEF. Please be aware that even if you initially agree to participate in this interview, you may stop participating at any time. You may also skip any specific question that you do not wish to answer.

Your responses will be kept confidential and anonymous. No one except the Assessment Team (OPM researchers and UNICEF evaluation staff) will have access to them.

The interview should take approximately 45 minutes.

With that introduction, unless you have any questions at this point, I'd like to request your explicit consent for participation in, and the recording of, this interview.

Do you agree to participate in this interview, given the stipulations I just laid out?

➔ If *Yes*, continue the interview.
➔ If *No*, end the interview (and search for an alternative respondent).

*[Note to interviewer: Before starting off, ask the interviewee to please, in their responses, to the extent possible, **distinguish between the emergency response** (containment and case management) activities and the activities associated with the **mitigation of unintended consequences** of containment measures. Keep this in mind throughout the interview so that you can probe whenever the distinction is not clear.]*