EVALUATION REPORT

December 2019

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Independent Real-Time Evaluation of UNICEF's response to Cyclone Idai in Mozambique, Malawi and Zimbabwe

Volume II – Annexes

EVALUATION OFFICE

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United Nations Children's Fund
Three United Nations Plaza
New York, New York 10017

December 2019

The full evaluation report can be accessed through the following link:
https://www.unicef.org/evaldatabase/index_103929.html

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ANNEX 1:
Terms of Reference

TERMS OF REFERENCE – Final Draft

Title/PURPOSE	To undertake an RTE of the UNICEF's response to Cyclone Idai in Mozambique, Malawi and Zimbabwe
RECRUITING OFFICER	Evaluation Specialist, UNICEF Evaluation Office
CONTRACT MODALITY	Individual Contracts (3 international and 3 national consultants)
Location of Assignment	Home based with travel to Kenya, Mozambique, Malawi and Zimbabwe. Will report to UNICEF New York (UNICEF House, 3 UN Plaza - 44th Street between 1st Ave and 2nd Ave)
Language(s) required	English and Portuguese
Duration of Contract	01 June – 30 September 2019

A. Background

Impact and damages of Cyclone Idai

On 14 March 2019, tropical cyclone Idai made landfall in Mozambique and also brought devastation to Malawi and Zimbabwe, the worst sudden-onset emergency, as measure by people affected, to hit southern Africa in two decades. The storm is estimated to have caused more than 1,000 deaths and displaced more than 240,000 people. A total of 3 million people required assistance in the three affected countries, including 1.5 million children. UNICEF had country programmes in all three countries prior to the cyclone, which positioned the organization to play a key role in the emergency response.

The catastrophic effects of the tropical depression which caused Cyclone Idai came in waves, with the cyclone's landfall in Beira only following a series of heavy rains and flooding in the provinces of Zambezia and Tete (**Mozambique**) and in the southern districts of **Malawi.** On March 8, the President of Malawi declared a state of disaster. On March 11 in **Mozambique**, the government recommended activating the 'Institutional Red Alert' to enable full operation of the emergency coordination mechanism. The following day the United Nations humanitarian country team (HCT) convened a meeting to take stock of the situation. Following its landfall on March 14th in Beira (Sofala Province), Cyclone Idai progressed inland, causing torrential rains in eastern parts of **Zimbabwe** (Chimanimani, Nyanga and Chipinge districts) and in central **Mozambique**, where rivers overflowed, flood waters rose to above six meters and a damn burst (Buzi).

Of the three affected countries, Mozambique was hit the hardest, with approximately 1.85 million people in need (including 1 million children) and communities initially displaced to 130 transit centres. Approximately half of the yearly agricultural production was destroyed, with damage caused to more than 50 health facilities and 3,500 classrooms in schools.

UNICEF's response

On March 26, following activation of the scale up for Mozambique by the Inter-Agency Standing Committee (IASC), UNICEF's Executive Director activated the L3 Corporate Emergency Activation Procedure (CEAP) for the response in Mozambique and the L2 CEAP for Malawi and Zimbabwe. While an inter-agency flash appeal was launched for Mozambique to request US$281.7 million[1] over three months, UNICEF in parallel launched an appeal for a total of $136.3 million for the three affected countries ($102.6 million for Mozambique, $18.4 million for Zimbabwe and $15.3 million for Malawi) for the period March–December 2019.

UNICEF's response in the three affected countries was informed by the varying scale of the disaster and the differing contexts in each country. Overall, in the first few weeks of the crisis, UNICEF provided critical support to affected populations across WASH, health, nutrition, education and child protection sectors. With over 3,000 reported cases of cholera in Mozambique alone, UNICEF efforts focused on treatment and prevention of waterborne diseases, ensuring that affected communities had access to safe water and sanitation (e.g., through vaccination campaigns, water treatment, water trucking for transit centres, restoring and support to water supply systems, etc.). Concerns over Cyclone's Idai devastating effects on agricultural production were compounded by critical food insecurity levels that pre-dated the emergency in certain areas,[2] leading UNICEF to target 390,000 children for treatment of severe acute malnutrition (SAM) across the three countries. On the education front, UNICEF focused on re-establishing and guaranteeing access to educational services through the provision of tents and quick repairs for schools that had been destroyed or damaged as well as learning spaces and educational material. In the first month of the response, UNICEF also closely looked at partnerships with the national social protection system and WFP to help communities absorb the shock through a phased approach of vouchers and cash transfers.

Approximately 2 months after the onset of the emergency, the life-saving mode of the response was gradually phasing out, with displaced communities starting to return to their places of origin or resettle to new locations. The challenges linked to the recovery phase are presenting themselves in different forms, yet with a common underlying query of how to reconstruct and restore basic services, while laying the ground for increased resilience and more sustainable solutions (how to 'build back better').

B. Purpose and objectives of the evaluation

UNICEF's Evaluation Office is proposing a multi-country real-time evaluation of UNICEF's response to Cyclone Idai[3] in Mozambique, Malawi and Zimbabwe to generate timely feedback and learning on key elements of UNICEF's response, while complying with UNICEF's Evaluation Policy requirements.[4] Given that this is a rapid-onset emergency, the value of rapidly available evidence-based findings and the support they can provide in informing the upcoming transition to the

[1] Unless otherwise stated, all amounts shown are in US dollars.
[2] e.g., in Zambezia Province stunting rates prior to Cyclone Idai were reportedly 41%.
[3] Cyclone Kenneth response will also be considered as part of the analysis.
[4] UNICEF's Evaluation Policy states that all short-term L2 and L3 emergencies must be evaluated at least once.

recovery phase, makes a strong case for an RTE of the response to Cyclone Idai to be conducted at this point in time.

Purpose

The RTE of UNICEF's response to Cyclone Idai in Mozambique, Malawi and Zimbabwe is expected to have a strong learning purpose on several fronts: i) providing feedback loops, both operationally and programmatically, into the initial phase of UNICEF's response to the crisis; ii) informing the planning and direction of ongoing recovery efforts; iii) identifying lessons to strengthen the future preparedness levels of UNICEF country offices and governments; and iv) supporting the learning of regional offices and headquarters vis-à-vis the activation of emergency procedures in the future. In this sense, the evaluation is expected to yield learning that will be useful and applicable beyond the country office level in the three affected countries. Finally, the RTE will strengthen UNICEF's accountability towards affected populations, as well as partners and stakeholders supporting the response at large, and should be thus conceived as an intrinsic component of the humanitarian response itself.

In line with this purpose, the RTE is expected to generate actionable recommendations on how to strengthen ongoing recovery efforts from Cyclone Idai and how to improve future preparedness, response and planning for recovery after sudden-onset emergencies.

Objectives

The objectives of the evaluation are as follows:

a. In line with the learning component mentioned above, the evaluation will determine UNICEF's response to Cyclone Idai in Mozambique, Malawi and Zimbabwe vis-à-vis issues of appropriateness/relevance, effectiveness,[5] coverage, connectedness[6] and coordination/partnerships.[7]

b. Assess the extent to which UNICEF adhered operationally and programmatically to the Core Commitments for Children in Humanitarian Action (CCCs).

c. Assess the extent to which emergency preparedness and organizational readiness have enabled the **affected countries** to respond more effectively and efficiently. This should include reviewing the extent to which UNICEF has systematically incorporated lessons learned from previous crises into its preparedness strategies in the current response; how the Emergency Preparedness Platform (EPP), SOPS, HR/surge capacities; data and monitoring systems; social protection/shock responsive systems in place, etc. have all enabled the countries to respond rapidly.

d. Examine the extent to which the country offices have considered equity during the response, including how UNICEF has been gender-responsive across its efforts and sensitive to the needs of the most vulnerable groups affected by the emergency (e.g., communities in hard-to-reach areas; people with disabilities; separated, unaccompanied children, etc.).[8] Along these

[5] The timeliness of UNICEF's action will be looked at as part of the 'effectiveness' criterion.
[6] Connectedness can be conceived as the equivalent of the 'sustainability' criterion applied to humanitarian action.
[7] Reference to the OECD-DAC evaluation criteria is made, with the understanding that these categories were being modified/finalized at the time this ToR was being developed.
[8] Findings, conclusions and recommendations of the RTE are expected to reflect these considerations.

lines, the evaluation should be informative about the ways in which Cyclone Idai affected different categories of people and the extent to which UNICEF has, in turn, incorporated this knowledge as a key driver of its response.

e. Finally, the evaluation is expected to distil lessons and make recommendations for adjusting and improving the response and planning for recovery after sudden-onset emergencies.

By showcasing what UNICEF has done well so far and identifying key gaps and the areas that will require more focus (in terms of efforts and funds) in the next stage of the response, the evaluation is also anticipated to have an instrumental role in supporting fundraising efforts for the recovery phase.

C. Expected users

The expected primary audience of this RTE is UNICEF management and staff at the field, country, regional and headquarters levels involved in the response to Cyclone Idai. Secondary audiences include: the larger community of partners (government and other implementing partners); populations affected by the emergency, the UNICEF Executive Board and interested UN Member States; donor agencies that support emergency programmes with technical and financial resources at all levels, among others. The evaluation findings will also feed into the Inter-Agency Humanitarian Evaluation scheduled for Mozambique in Q3 2019. Finally, the final evaluation report will be publicly available on UNICEF's Evaluation page.

D. Special considerations

The design and timing of the RTE will pay due consideration to other required evaluative exercises that are automatically triggered by scale-up activation, i.e., the Operational Peer Review (OPR)[9] and the Inter-Agency Humanitarian Evaluation (IAHE).[10] While these exercises respond, by design, to different information needs and objectives,[11] the RTE will make sure to harness information yielded by the OPR, which is planned to take place before the RTE in May 2019. The RTE will, in turn, make available key findings to the IAHE, which will be conducted later in the course of the year.

Moreover, the RTE will consider that Mozambique for Cyclone Idai is the first L3 System-Wide Scale-Up Activation since the IASC reforms and the issuance of the Scale-Up Protocols.

The design and planning of the RTE will factor in the diverse magnitude of the crisis in the three countries. With the emergency phase largely over at the time the RTE will

[9] An OPR must be conducted within 90 days of the L3 declaration (for L3 emergencies). In the case of Cyclone Idai in **Mozambique**, it is planned to take place in May 2019.

[10] An IAHE must be conducted between 9-12 months from scale-up activation. No IAHE will be conducted for the response in Malawi not Zimbabwe (as these are L2 emergencies).

[11] OPRs are not assessments nor evaluations; they provide the HC/HCT with an opportunity to reflect on direction/performance of the response and should be seen as 'course correctors' for the first response. Their focus of OPRs is generally on: leadership arrangements; implementation of HPC; coordination; mechanisms for accountability to affected populations. IAHEs generally assess whether the collective results of an emergency response meet Strategic Response Plan objectives and the needs of affected populations. As stated by the IAHE process guidelines (2018) they are 'not an in-depth evaluation of any one sector or of the performance of a specific organization and, as such, cannot replace any other form of agency-specific humanitarian evaluation, joint or otherwise, which may be undertaken or required.'

be conducted, the emergency response and recovery efforts will be covered in equal measure by the exercise.

E. Evaluation scope

The RTE will cover UNICEF's response in the three countries affected by Cyclone Idai (Mozambique, Malawi and Zimbabwe), starting from early March 2019, when the very first wave of devastation struck Malawi and the Mozambican provinces of Tete and Zambezia, prior to the cyclone making landfall in Beira. Mozambique will represent a relatively greater focus of the evaluation given this is where the impact of the cyclone was the greatest. Pre-emergency issues will be looked at only in relation to contingency planning and preparedness and the extent to which they affected UNICEF's response to the emergency.

Given the real-time nature of the exercise, the timeframe will cover the ongoing response until the evaluation team is deployed to the field. The evaluation will assess UNICEF's humanitarian action across urban and rural locations affected by the cyclone, including areas of displacement (accommodation centres), return, relocation and resettlement, where present, and hard-to-reach areas, wherever possible. Along these lines, primary data collection from key informants will be prioritized in the most affected areas of the countries, including (but not limited to): Zambezia, Manica and Sofala provinces (Mozambique), Nsanie, Chikwawa and Phalombe districts (Malawi) and Chimanimani and Chipinge districts (Zimbabwe).

Programmatically, the evaluation will cover UNICEF's multisectoral interventions in the areas of WASH, health, nutrition, education, C4D, child protection and social protection. The RTE will cover UNICEF's role as cluster lead, as relevant, as well as its responsibilities to respond to the needs of affected populations in sectors where it has no cluster leadership obligations. The RTE will also assess, from an operational standpoint, the availability and management of supplies, human and financial resources and partnerships which feed into the response. Advocacy, communications and fundraising will also be assessed to the extent to which they were factors that affected (facilitated/hampered) the response.

An assessment of any ongoing humanitarian programming that does not pertain to UNICEF's response to Cyclone Idai in the three countries is beyond the scope of this evaluation.[12] One exception to this will be UNICEF's response to Cyclone Kenneth, which hit Cabo Delgado (Mozambique) at the height of the response to Cyclone Idai and will therefore be covered by the RTE. The RTE will gauge the 'immediate effects' that UNICEF's humanitarian action had on the affected countries. Yet, given the nature of the exercise and context, it will not isolate the change and attribute it to UNICEF's specific intervention (or, in other words, evaluate 'impact'). As mentioned above, given the recurrent and cyclical nature of natural hazards in the affected countries, the evaluation will try to reflect and gather evidence on the extent to which UNICEF has contributed, over time, to improving preparedness/resilience to rapid-onset disasters – with the understanding that considerations on the specific impact of UNICEF's response to Cyclone Idai on future preparedness levels pertain to future exercises.

While clusters will be a focus of the OPR and IAHE, the RTE will nonetheless provide an analysis of UNICEF's coordination/cluster

[12] For example, Zimbabwe and Malawi had HACs in place prior to Cyclone Idai which are excluded from the scope of this RTE.

responsibilities and how well it balanced these with its more 'operational' role. Due to time limitations, the evaluation will *not* address the efficiency of UNICEF's response[13], which would imply a lengthy costing exercise and comparisons with alternative implementation approaches. The timeliness of UNICEF's action will nonetheless be addressed as a key facet of its effectiveness. The RTE will only gauge whether or not UNICEF has taken into consideration protection from sexual exploitation and abuse (PSEA) in its programming in the context of Cyclone Idai – however, it will not systematically assess the results of such programming, given that this would require additional time and different sets of competencies.

F. Indicative evaluation questions

In line with the objectives outlined above, the following two tables list a set of general overarching questions and a more specific set of queries/subquestions, respectively, that will drive the evaluation. They will be fine-tuned, revised and reduced, as deemed appropriate, to ensure relevance and utilization of the exercise once the evaluation team is onboard and the RTE Reference Group established.

Overarching RTE Questions	Evaluation Criteria
1. How appropriate is UNICEF's response strategy (present and planned) in reaching the most affected populations?	Relevance/ Appropriateness
2. To what extent has UNICEF achieved/is UNICEF achieving its intended results, and within the planned timeframe (consider HAC, response plans, monitoring, adherence to CCCs, etc.)?	Effectiveness
3. To what extent was the affected population, including persons with disability, adequately identified, targeted and reached by UNICEF and its partners?	Coverage
4. To what extent is UNICEF's response contributing to longer-term goals of enhancing prevention of future emergencies, mitigation of negative effects of future natural hazards (resilience/sustainable solutions) and preparedness?	Connectedness
5. How effectively and efficiently has UNICEF coordinated its response both internally and externally (with key actors such as other UN agencies, CSOs and developing partners, national and local governments)?	Coordination
6. To what extent have gender and disability dimensions been integrated into the needs assessment, planning, implementation, monitoring and reporting of the response, as well as into recovery planning?	Coverage/Equity
7. How accountable have UNICEF and its partners been to affected populations? What has been extent/quality of community engagement?	Relevance/ Appropriateness

[13] Or, in other words, whether the least costly resources possible were/are used to achieve results.

RTE Subquestions	Evaluation Criteria
1.1. To what extent is UNICEF's response aligned with and tailored to the needs of affected populations? 1.2. What tools (i.e., methodologies, situation analysis, needs assessments, data systems etc.) were used to gauge these needs? What was the quality/ appropriateness of these tools? 1.3. To what extent have affected populations been involved in the needs assessment, delivery and management of humanitarian assistance? 1.4. To what extent was the initial response by the CO and RO informed and enabled by elements of preparedness in place prior to the crisis? 1.5. How internally coherent/consistent has the response been between the various sectors of UNICEF's response? How integrated was UNICEF's approach across key sectors when addressing key priorities (e.g. WASH, C4D on cholera, etc.)? 1.6. To what extent was the response designed to complement activities of other humanitarian partners operating in the three countries? 1.7. How coherent is UNICEF's response with the priorities/responses of affected governments? 1.8. How consistent has the response been with core principles of humanitarian action?	Relevance/ Appropriateness
2.1. How realistic/feasible are planned targets (e.g., in the HAC) and to what extent are they based on situation analysis and updated as new information becomes available? 2.2. What factors contributed to success and what factors constrained UNICEF's success (e.g. Cyclone Kenneth; HR surge; fundraising; communication w/donors and NatComs)? What role have COs, the RO and headquarters had in this? 2.3. How timely was the response? 2.4. To what extent did the emergency preparedness planning influence CO capacity to respond? 2.5. How aligned was the supply component with the overall emergency response? What have been the specific and most significant contributions of supply to the response? 2.6. To what extent has UNICEF been able to adapt its response to the changing needs on the ground (e.g., transition from drought to flood; Cyclone Kenneth, etc.)? 2.7. What role has 'principled' innovation[14] played in needs assessment and the response? 2.8. Were there any unintended consequences of the humanitarian assistance (positive and negative)?	Effectiveness

[14] Innovation has gained increasing attention across the humanitarian world in the past few years given its 'potential to improve humanitarian practice by introducing new and better ways to respond to emerging challenges…'. Further, 'it can be defined as a process of improvement and adaptation to context, involving a number of stages: problem specification, solution identification, piloting and testing and adapting, scaling where appropriate'. Despite the 'positive and transformative' role it can have, it poses a series of potential ethical dilemmas which academics have unpacked and attempted to contain by developing a series of principles that humanitarian action should abide by (see June 2015 Occasional Policy Paper 'Principles for Ethical Humanitarian Innovation', University of Oxford Refugee Studies Centre).

RTE Subquestions	Evaluation Criteria
3.1. How successful has UNICEF been in reaching the most vulnerable groups (communities in hard-to-reach areas; people with disabilities; unaccompanied/separated children; pregnant women, etc.)? 3.2. How successful has UNICEF been in ensuring youth participation during the response?	Coverage
4.1. How successfully have recovery considerations been incorporated into planning and relief interventions? 4.2. To what extent is UNICEF's response specifically contributing to improving the resilience of local government systems and their capacity to prepare, respond and mitigate the effects of an emergency? (Explore effects on governments' new 5-year plans and UNICEF business-as-usual projects and partnerships.) 4.3. To what extent has the response set the groundwork to contribute to the humanitarian development continuum?	Connectedness
5.1. How effectively has UNICEF balanced its 'internal' operations with cluster coordination/leadership responsibilities? 5.2. To what extent are considerations of comparative advantage applied in designing and implementing the response and, as applicable, recovery efforts? 5.3. How well did UNICEF support the governments at different levels (districts, city, provincial, central) in coordinating the response? And clusters/national non-governmental partners? 5.4. How effective was the CO in coordinating the setup of and delivery of new stations at the heart of crisis?	Coordination/ Partnership (at national/decentralized levels)
6.1. What are/were the specific gender and equity dimensions of the emergency? 6.2. What particular challenges or good practices have arisen in working with vulnerable groups? 6.3. Were activities and practices (including assessments, innovations, etc.) implemented based on ethical principles (respect for autonomy, beneficence, non-maleficence, justice)?	Gender and disability

G. Approach and methods

The RTE will adopt a mixed-methods approach, including a desk review of existing secondary data and documentation (e.g., relevant findings from parallel inter-agency evaluations/ reviews (including the OPR); SitReps; HAC; needs assessments; monitoring indicators and reports; funding information; HR data; supply data; country office preparedness and contingency plans reflected in the Emergency Preparedness Platform (EPP); McKinsey report on the application and codification of lessons learned, etc.); focus group discussions and key informant interviews with a purposive sample of stakeholders (i.e., affected community members and leaders; UNICEF staff at country/ regional/headquarters levels; government

representatives; implementing partners; development and humanitarian partners and other UN agencies); and observation.

To guarantee inclusion, accuracy and credibility of the evaluation's findings, primary data collection and subsequent analysis will be sex- and age-disaggregated to the extent possible. Data collection should further attempt to gather the views of the diverse universe of stakeholders/social groups affected by the intervention, particularly the most vulnerable (e.g., people with disabilities; hard-to reach communities; populations who have not moved from places of origin despite loss but have encountered significant destruction of assets and livelihoods; unaccompanied/separated children; returnees; resettled communities, etc.).

Data and information collected will be triangulated to ensure soundness and cross-validated at key points in time, as deemed relevant by the evaluation team, through in-country briefings with stakeholders. Without compromising the independence of the exercise, RTEs are by design participatory in nature and built around the regular interaction with key stakeholders. Along these lines, prior to the departure of the evaluation team from each country, an exit workshop will be arranged as an opportunity for the evaluators to share findings and recommendations at the country level and for stakeholders, in turn, to validate such findings prior to the finalization of the evaluation report.

H. Limitations and anticipated challenges

Key limitations will include the typical time constraints affecting RTEs, access and availability of data in emergency contexts and the need to balance timeliness with depth of information and well-substantiated findings. Further challenges that can be anticipated relate to the multi-country nature of this evaluation which covers three countries diversely impacted by the cyclone and, in fact, three separate responses to the emergency.

I. Norms and standards

Guidance documents mentioned below are those that the evaluation team is expected to comply with:

- United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System 2016;[15] (including impartiality, independence, quality, transparency, consultative process);
- Ethical Guidelines for UN Evaluations;[16]
- UNICEF Ethical Guidelines and standards for research and evaluation;[17]
- UNEG guidance on integrating human rights and gender equality and UN System-Wide Action Plan (UN-SWAP) on gender equality; [18]
- Relevant ALNAP guidance for evaluation and real-time evaluations of humanitarian action;[19] results-based management

[15] UNEG Norms and Standards for Evaluation, 2016. Available at: http://www.unevaluation.org/document/detail/1914.
[16] UNEG Ethical Guidelines, 2008. Available at: http://www.unevaluation.org/document/detail/102.
[17] UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis, 2015. https://www.unicef.org/supply/files/ATTACHMENT_IV-UNICEF_Procedure_for_Ethical_Standards.PDF.
[18] http://www.unevaluation.org/document/detail/1452.
[19] https://www.alnap.org/system/files/content/resource/files/main/alnap-evaluation-humanitarian-action-2016.pdf; https://evaluation.msf.org/sites/evaluation/files/real_time_evaluations_of_humanitarian_action.pdf.

principles (theory of change applied in the emergency should be determined by the evaluation team)

J. Management and governance arrangements

Evaluation Office and regional office:

The RTE will be co-managed by UNICEF's Evaluation Office (EO) in NY, and the ESARO Regional Evaluation Advisor. This is in line with UNICEF's Evaluation Policy, which prescribes that the EO and Regional Offices are responsible for managing evaluations of L3 and L2 emergencies, respectively. They will provide the overall guidance to the evaluation.

Evaluation Reference Group:

An RTE Reference Group will be established to ensure ownership from relevant stakeholder groups of the RTE process, provide expert advice, inputs and support to the RTE as the evaluation unfolds. The RTE Reference Group should include representatives from EMOPS, Programme Division, Supply Division, the regional office and country offices affected by Cyclone Idai. The reference group will have the following responsibilities:

a. Provide inputs in the inception phase to influence the approach of the evaluation, and, where necessary, provide information and institutional knowledge as key informants;

b. Support the work of the evaluation team by facilitating connections with key informants and ensuring the team has relevant reference documents;

c. Review selected evaluation products (inception report and final/penultimate report) and provide written comments to the evaluation team through the evaluation manager; and,

d. Where feasible, contribute to the post-evaluation management response, action plan and dissemination strategy.

Country offices:

The three country offices will be responsible for hosting the evaluation team and providing a work space, and providing documentation, data and materials that are not readily available within headquarters and the regional office. Each CO will appoint a focal point for this evaluation who, in liaison and strong coordination with the Evaluation Office and ESARO, will provide logistical support and act as resource staff for the exercise, including helping to arrange for interviews with key stakeholders.

K. Evaluation team composition, responsibilities and required qualifications

Team composition and responsibilities:

The evaluation will be conducted by a 9-person team including 3 international consultants (one team leader, one WASH/cholera expert and one other subject matter expert) and 2 national consultants in each country. One member from UNICEF's EO in NY will be 'embedded' in the team and will provide logistical support and assist with data collection and report writing. ***Individual contracts will be issued to each team member.***

- The evaluation team is expected to execute the following tasks:

  a. Develop a realistic work plan for the evaluation;

  b. Execute the evaluation to respond to the questions stipulated in the terms of reference (or subsequent revisions of the evaluation questions);

c. Generate evaluation products and deliverables as shown in the table below, and in accordance with contractual requirements;

d. Provide written responses to comments from the Reference Group, and update report accordingly; and

e. Provide regular updates to the evaluation managers.

Required Qualifications:

Team Leader

i. extensive experience in emergency response, preferably with a UN agency

ii. experience in conducting and managing multidisciplinary evaluations, including evaluating rapid-onset emergencies for UNICEF, other UN agencies or other international partners at the global, regional or country levels

iii. knowledge of latest methods and approaches in humanitarian evaluation, especially participatory methods and accountability to affected populations, and RTEs

iv. familiarity with UNICEF's emergency response, including the Core Commitments to Children preferred

v. excellent oral and written communication skills (in English)

vi. knowledge of qualitative and quantitative methods

vii. experience managing a team

viii. experience with the ethics of evidence generation; experience collecting data from vulnerable groups; familiarity with ethical safeguards

Two Senior Evaluators

i. extensive knowledge of UNICEF's programmes in emergency contexts highly desirable, and of UNICEF's corporate emergency procedures preferred

ii. WASH/cholera or other technical expertise relevant to UNICEF's emergency operations

iii. extensive experience in emergency response, preferably with a UN agency

iv. a minimum of five years' experience evaluating humanitarian action

v. familiarity with UNICEF's emergency response, including the Core Commitments to Children

vi. knowledge of qualitative and quantitative methods

vii. experience with the ethics of evidence generation; experience collecting data from vulnerable groups; familiarity with ethical safeguards

viii. excellent ability to communicate and write in English

Two National consultants (in each country)

i. experience working on research, studies or evaluations

ii. experience in primary data collection in affected communities; including leading focus group discussions and using participatory methods

iii. qualitative data analysis skills

iv. experience in programme monitoring

v. experience with the ethics of evidence generation; experience collecting data from vulnerable groups; familiarity with ethical safeguards

vi. good ability to communicate and write in English (and Portuguese for Mozambique consultants) and local languages (Chichewa for Malawi, Kishona in Zimbabwe)

L. Timeframe and deliverables

Tentative timeframe and deliverables

Task/Deliverable	
ToR drafted	3 May 2019
Evaluation team recruited	17 May 2019
RTE Advisory Group set up	17 May 2019
Finalization of ToRs	24 May 2019
Inception and desk review of key documentation and data	14 June 2019
Malawi mission (1 week)	17-21 June 2019
Mozambique mission (2 weeks)	24 June-5 July 2019
Zimbabwe mission (1 week)	8-12 July 2019
Travel to Nairobi/UNICEF Regional Office and mission (2 days)	15-16 July 2019
Submit first draft of evaluation report	August 2019
Submit final evaluation report	September 2019

The RTE is expected to produce the following outputs:

1. Brief Inception Report (including draft time-line summarizing key events and response)
2. Short interim reports from each of the 3 countries (to be submitted prior to the consolidated report)
3. Concise and fully edited report in English, with country-specific sections and one consolidated section, including detailed timeline summarizing events and response[20]
4. Oral briefings/PPT/workshop for different audiences at different points in time of the evaluation cycle, containing preliminary findings and emerging conclusions/ recommendations.

[20] The timeline will include both internal (UNICEF) milestones and external events.

ANNEX 2:
'Real-Time' Action Plans

UNICEF MALAWI RTE – Action Planning

July 14, 2019 *(v. 190723)*

RTE Team – Follow-up actions

- On 21 June 2019 the RTE team debriefed UNICEF **Malawi** Country office on preliminary findings and emerging conclusions from their in-country data collection efforts (June 17th-20th 2019). The RTE team visited the following locations in **Malawi**: **Nsanje district** (Bitilnyo camp), **Chikwawa district** (Chikuse camp and Namitcheni village), **Phalombe district** (Mileme village) and **Zomba district** (Nakhombe village), **Blantyr**e and **Lilongwe**.
- The next milestone for the RTE will be the **debrief in Nairobi 16th July** when the team aims to have another presentation that includes a synthesis for the three countries along with draft recommendations targeted both at headquarters/regional level and individual countries.
- After the draft report is circulated, probably during the latter part of August, it may be useful **to have a call to have a high-level review of findings, conclusions and recommendations.**
- As described in the Inception Report, the **structure of the evaluation report** will depend on how much commonality is found between countries.
- It was agreed that **any additional documents to inform the evidence base** for the RTE team could be forwarded to Mekonnen who will, in turn, share with the evaluation team.

UNICEF Malawi – Areas identified for immediate follow-up

Since it will be some weeks before the RTE report is finalized, the following section identifies **immediate suggested actions that UNICEF Malawi could take** while waiting for the report to be finalized. These include:

1. **Planning and accelerating implementation for the recovery phase.** Follow-up on related conclusions would include:
   - Ensuring that **coverage is based on needs and** includes communities not residing in camps.
   - Strengthening **accountability to affected populations** (AAP) by promoting greater information flows about incoming assistance/entitlements, enabling systematic complaints, feedback systems and participatory approaches.

UNICEF Malawi – Areas identified for immediate follow-up continued

- Using **opportunities to raise standards** in affected communities, operationalizing 'building back better' approaches to include aspects of flexibility in the design of infrastructure-related services (planned improved school construction designs is a good example of this).
- Considering **disability and gender** more systematically when planning and implementing interventions.
- Increasing capacity development for government coordination.

2. Improving **information management and coordination** at different levels.
3. Improving **monitor ing systems** in capturing **outcomes.**

Based on the above list of immediate actions, suggested ways forward are listed below.

Immediate follow-up actions
1. Recovery planning & implementation
• Organize a **workshop involving partners** that would result in clear guidance for recovery. Discussion questions (in a working group format?) should include related conclusions listed above.
2. Updating assessments, information management and coordination
• Lead an **updating of assessments** to ensure that UNICEF is using its comparative advantage in specific sectors both as an implementor and coordinator to meet needs of the most vulnerable. • Plan **regular coordination meetings** to address the gap between Lilongwe and Blantyre. • Strengthen **education** information management systems. • Strengthen **integration** across sectors within UNICEF (e.g., health and child protection?).
3. Improve monitoring systems
• Make use of **outcome data** collected by partners, while harmonizing tools and procedures through PCAs. • **UNICEF cluster coordinators should be conversant with new 2018 Sphere standards,**[21] which includes the Core Humanitarian Standard (CHS), since this will be a key reference for cluster members. Online training is available and Sphere training can be requested.

[21] https://www.spherestandards.org/handbook-2018/

UNICEF Mozambique RTE – Action Planning

July 5, 2019

RTE Team – Follow-up actions

- Feedback from participants in the workshop on July 4th was that **almost all of the emerging conclusions presented were viewed as relevant**, which the RTE team has taken as an indication that they are on the right track as they continue to build and analyse the evidence base and develop recommendations for the draft report. One exception was the conclusion regarding value for money (VFM), with feedback indicating that there was a need for a clearer description of what is meant by VFM. The other area requiring additional follow-up was to look more carefully at the evidence base for social protection and innovation. There was also a suggestion by one of the working groups to look more closely at partnerships as a resource.
- The next milestone for the RTE will be the **debrief in Nairobi 16th July** when the team aims to have another presentation that includes a synthesis for the three countries along with draft recommendations targeted both at headquarters/regional level and individual countries.
- After the draft report is circulated, probably during the latter part of August, it may be useful **to have a call to have a high-level review of findings, conclusions and recommendations**.
- As described in the Inception Report, the **structure of evaluation report** will depend on how much commonality is found between countries.
- It was agreed that **any additional documents to inform the evidence base** for the RTE team could be forwarded to Claudio or Zlata, who would then upload it to the RTE Dropbox.
- **Inter-Agency Humanitarian Evaluation (IAHE**): Jock had attended the HCT on Thursday in Maputo, where he had described methodological options during the data collection phase (currently planned for September 2019), including potentially a HH survey. Using the Humanitarian Response Plans (HRP) and the Operational Peer Review (OPR), the main question that the IAHE will aim to answer is how the collective international humanitarian system contributed to the response from the perspective of affected communities and the government. The UNICEF RTE has been specifically designed to complement the IAHE, since the RTE focuses mainly on implementation, with only one out of the six questions looking at coordination

UNICEF Mozambique – Areas identified for immediate follow-up

Since it will be some weeks before the RTE report is finalized, there was a reflection on the conclusions and recommendations discussed during the validation workshop to identify **immediate actions that UNICEF Mozambique could take** while waiting for the report to be finalized. These include:

1. **Planning and accelerating implementation for the recovery phase**, both in terms of providing guidance for clusters that UNICEF is leading and for the UNICEF programme itself. Follow up on related conclusions would include:
   - Ensuring that **coverage is based on needs, including both resettlement sites** and affected communities.
   - Strengthen **accountability to affected populations** (AAP) through promoting greater information/transparency about entitlements, participatory approaches and complaints and feedback systems.
   - Using **opportunities to raise standards** in affected communities, operationalizing 'building back better' approaches to include aspects of flexibility in the design of infrastructure-related services (e.g., designing schools as safe and dignified temporary evacuation centres in high risk areas;[22] flexible water pumping rates at water sources; available superstructures for toilets to be readily installed; appointment of emergency focal points for activation of schools as temporary refuges, etc.).
   - Increase the **efficiency of PCA processes**, including i) concluding longer-term PCAs with partners to facilitate longer-term planning; ii) outcome indicators; iii) flexibility in geographical coverage, budget and type of interventions.
   - More systematic consideration of **disability and gender** when planning and implementing interventions.
   - Determining **optimal office and staffing configurations** for UNICEF in affected provinces based on priority needs and UNICEF's comparative advantage. This should include 'do no harm' perspectives relating to the lack of recruitment of staff from Sofala or Manica provinces which has resulted in gaps in understanding the local context and could eventually lead to resentment.
2. Improving **information management and coordination** at different levels.
3. Improving **M&E systems**, notably in capturing **outcomes**.

[22] See, for example, APCSS (2017), Limiting and planning for schools as temporary evacuation centres in emergencies and Asean, School Disaster Risk Management Guidelines (page 10, number 1 under "Three Pillars of Comprehensive School Safety").

Based on the above list of immediate actions, suggested ways forward are listed below.

Immediate follow-up actions
1. Recovery planning & implementation
• Organize **workshops involving partners**, initially in the hubs, which would then feed into a workshop in Maputo that would result in clear guidance for recovery. The advantage of such an approach is that it could be done relatively quickly (within 1-2 weeks) and at the same time facilitate implementation through joint ownership.[23] Discussion questions (in a working group format?) should include related conclusions listed above.
2. Updating assessments, information management and coordination
• Hub Team Leaders could lead an updating of assessment to ensure that UNICEF is using its comparative advantages in specific sectors both as an implementor and coordinator to meet needs of the most vulnerable. • Plan regular (quarterly?) coordination meetings to address the gap between Maputo and the hubs. Consider holding alternate meetings in different hubs that would include visits to intervention sites. • Solicit feedback and suggestions from users of UNICEF-generated information products and UNICEF-led coordination services (IPs, cluster members) to identify ways of improving their efficiency and effectiveness.
3. Improve M&E systems
• Make use of outcome data collected by partners, while harmonizing tools and procedures through PCAs; ensure that **monitoring tools are fit for purpose (e.g., 4Ws as coordination tools + outputs and targets monitoring tools; KAP surveys and post distribution monitoring for outcome monitoring)**. • **UNICEF cluster coordinators should be conversant with new 2018 Sphere standards**,[24] which include the Core Humanitarian Standard (CHS), since this will be a key reference for cluster members. Online training is available and Sphere training can be requested.

[23] To expedite the process further, a 'writeshop' approach could be used - see http://www.kstoolkit.org/Writeshops and https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7229.pdf.

[24] https://www.spherestandards.org/handbook-2018/.

UNICEF RTE – Action Planning for Zimbabwe

July 12, 2019

RTE Team – Follow-up actions

- Following a week of data collection efforts in **Zimbabwe**, the RTE team presented preliminary findings and emerging conclusions to UNICEF **Zimbabwe** country office on July 12th.
- The next milestone for the RTE will be the **debrief in Nairobi 16th July** when the team aims to have another presentation that includes a synthesis for the three countries along with draft recommendations targeted both at headquarters/regional level and individual countries.
- After the draft report is circulated, probably during the latter part of August, it may be useful **to have a call to have a high-level review of findings, conclusions and recommendations.**
- As described in the Inception Report, the **structure of evaluation report** will depend on how much commonality is found between countries.
- It was agreed that **additional documents to inform the evidence base** for the RTE team will be forwarded to Blessing Zindi who will, in turn, share with the evaluation team.

UNICEF Zimbabwe – Areas identified for immediate follow-up

The draft RTE report will be shared for comments in August – in the meantime, building on the conclusions and recommendations discussed during the debriefing session, the following **immediate actions were identified for the UNICEF Zimbabwe country office to consider,** while waiting for the report to be finalized:

1. **Planning and accelerating implementation for the recovery phase**. Follow-up on related conclusions would include:
   - Strengthening **accountability to affected populations** (AAP) by promoting greater information flows about incoming assistance/entitlements and enabling systematic complaints and feedback systems.
   - Using **opportunities to raise standards** in affected communities, operationalizing 'building back better' approaches to include aspects of flexibility in the design of infrastructure-related services.
   - Increasing systematic consideration of **gender** when planning and implementing recovery interventions.
   - Building on damage assessments conducted, plan for further **hazard mapping,** which can constitute baselines for recovery; also, in areas outside of UNICEF's mandate (e.g., shelter/livelihoods) advocate for hazard mapping as a driver of safer siting of infrastructures (new shelters and schools).
   - Incorporating **early action** into the recovery phase to mitigate the effects of the impending rainy season and drought.

UNICEF Zimbabwe – Areas identified for immediate follow-up continued

- Continuing **humanitarian assistance to bridge** the transition phase into recovery, while resources are secured for implementing the recovery plan.

2. Improve resilience by reviewing/revising **capacity-building approaches for affected communities**, including participatory approaches to empower community members and coaching/accompanying local government staff to enable them to take on effective lead coordination roles.
3. Further improve **monitoring systems**, notably to better capture **outcomes** in certain sectors (e.g., C4D, social protection). Make use of outcome-level reporting produced by implementing partners and agree with them on approaches for **harmonizing** related efforts.
4. Address gaps in PSEA awareness raising and training for **military and other government officials involved in humanitarian responses**. Explore use of **U-Report** for capturing trends and rumours about PSEA incidents in communities.
5. **Advocacy to address unmet needs** in sectors where UNICEF does not have a lead role and which have an adverse impact on children, including psychosocial support for parents and shelter.
6. UNICEF **Zimbabwe**'s emergency focal points could be strengthened further through a more systematic approach, including incorporation into the **staff development strategy**.

Based on the above list of immediate actions, suggested ways forward are listed below.

Immediate follow-up actions
1. Recovery planning & implementation
• Organize and facilitate **After Action Review workshops for UNICEF staff and partners**, initially at the provincial level and subsequently in Harare.[25] Key inputs to these workshops could be the draft RTE report and lessons learned from the drought as a way of addressing several areas identified for immediate follow-up including: » A chance to take stock and reflect on lessons learned and build ownership among key stakeholders to both **support the recovery phase and strengthen preparedness** for the impending raining season and likely impacts of the drought during the lean season. » Share good practices and identify joint actions to **improve accountability to affected populations**.[26] » Advocacy strategies to **fill gaps in critical sectors** where UNICEF does not have a lead role but which nevertheless have a direct impact on children.

[25] To expedite the process further, a 'writeshop' approach could be used - see http://www.kstoolkit.org/Writeshops and https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7229.pdf

[26] See, for example, the Good Enough Guide and resources on UNICEF's website relating to Accountability to Affected Populations (AAP) and Prevention of Sexual Abuse and Exploitation (PSEA).

continued

Immediate follow-up actions
» Improve monitoring systems of UNICEF and partners to more effectively and consistently measure outcomes[27] at a community level. » Capacity-building approaches that empower local government and community leadership.
2. Support PSEA awareness raising and training of government officials and the military.
• Supporting PSEA awareness-raising and training sessions through advocacy with senior level officials from the military, police, Programmes Coordination Units and local government officials.
3. Strengthen UNICEF Zimbabwe's emergency team.
• Strengthen UNICEF **Zimbabwe**'s emergency team by including emergency training/focal point roles in UNICEF **Zimbabwe**'s staff development strategy.

[27] This could include collecting feedback and suggestions from users of UNICEF-generated information products and UNICEF-led coordination services (IPs, cluster members) to identify ways of improving their efficiency and effectiveness.

ANNEX 3:
HAC Targets by Country

MOZAMBIQUE HAC targets[28]	March	September (Rev.)
Total people in need (Cyclones Idai and Kenneth)	1,850,000	2,500,000
Total children (<18) in need	1,000,000	1,300,000
Total people to be reached	965,000	990,000
Total children to be reached	500,000	786,000
People provided with access to safe water[29]/sufficient quantity of safe water	965,000	978,000
People benefitting from sanitation and hygiene promotion activities/with access to appropriate sanitation facilities and receiving hygiene messages	267,500	364,000
Children aged 6 months to 15 years vaccinated	500,000	833,614
Children under 5 receiving a consultation	229,500	761,796
Pregnant women (15-49) years living with HIV receiving antiretroviral therapy	n/a	24,400
Children under 5 screened for acute malnutrition/and receiving vitamin A	328,000	993,082
Pregnant and lactating women reached with IYCF services/ messages on IYCF	100,000	270,947
Children aged 6-15 years old (in humanitarian situations) accessing education	380,000	239,497
Children 3-5 years old (in humanitarian situations) accessing play-based learning	76,000	38,344
Children receiving psychosocial support through Safe Spaces and schools	20,000	44,725
Children (re)issued birth registration	n/a	131,924
People receiving information on prevention of and response to violence, abuse and exploitation	n/a	160,000
Separated and unaccompanied children identified and in family-based care/alternative care	1,000	n/a

[28] UNICEF Mozambique country office issued a revised HAC in September 2019.
[29] 7.5-15 litres per person per day.

continued

MOZAMBIQUE HAC targets	March	September (Rev.)
People reached with key life-saving/behaviour change messages	700,000	990,000
Households supported through joint multipurpose value vouchers	n/a	23,000
Households with children under 5 supported with shock-responsive child grant	n/a	10,000

MALAWI – HAC targets	March
Total people in need	3,300,000
Total children (<18) in need	1,700,000
Total people to be reached	1,200,000
Total children to be reached	710,000
People affected by drought, floods and cholera provided access to safe water per agreed standards	495,960
People affected by cholera and floods provided access to emergency sanitation facilities	40,000
Children and women affected by humanitarian situations provided access to health care services	424,071
Children under 5 vaccinated against measles	379,195
Women in disaster affected areas retained on HIV treatment for 6 months	10,000
Children under 5 with SAM admitted for treatment in therapeutic feeding programme	58,421
Children aged 5-59 months provided with vitamin A supplementation	400,075
School-aged children in disaster affected areas including adolescents provided access to quality education services	95,500
Adolescents in disaster-affected areas, in and out of school, provided access to relevant alternative education services	2,000
Number of children receiving psychosocial support (PSS) through Safe Spaces	150,000
People reached by GBV prevention and response services	7,000
People affected by disasters reached with key messages and call to action on life-saving practices	495,960
Vulnerable households receive cash emergency top ups	14,500

ZIMBABWE - HAC Targets[30]	March	August (Rev.)
Total people in need	5,300,000	5,500,000
Total children (<18) in need	2,500,000	2,600,000
Total people to be reached	1,500,000	3,200,000
Total children to be reached	696,000	1,600,000
People provided with a sufficient quantity of water of appropriate quality for drinking, cooking and personal hygiene/with access to safe water and hygiene	325,000	1,000,000
People provided with WASH-related information to prevent water-borne diseases	500,000	1,500,000
Children and women accessing lifesaving interventions	100,000	n/a
Children aged 6-59 months (in humanitarian situations) who have been immunized/ vaccinated against measles	100,000	1,484,685[31]
People in humanitarian situations reached with key life-saving and behaviour change messages on public health risks	n/a	231,986
Pregnant and breastfeeding women, children and adolescents living with HIV continue to receive PMTCT and treatment services	28,700	32,000
Community members in affected districts are reached with information on HIV prevention, care and treatment.	40,000	n/a
Children 6-59 months with SAM admitted to community-based treatment	27,000	33,394
Children aged 6-59 months receiving vitamin A supplementation	136,000	575,195
Children and adolescents in humanitarian situations accessing formal or non-formal basic education	225,000	120,000
Vulnerable boys, girls and adolescents in humanitarian situations provided with critical child protection services	80,000	100,000
Unaccompanied and separated children affected by humanitarian situations accessing appropriate care and child protection services	3,000	5,000
Vulnerable households receiving cash transfers to support access to basic services/Households affected by floods supported with expanded social cash transfers	19,000	10,500
People reached with behaviour change or life-saving messages	n/a	3,200,000

[30] UNICEF Zimbabwe country office issued a revised HAC in August 2019.
[31] This figure combines two different indicators in this version of the HAC.

ANNEX 4:
Programme Achievements vs. Targets

SECTOR	COUNTRY	Indicators	Targets[32]	Revised HAC targets[33]	Achievements[34]	%
EDUCATION	Mozambique	Children aged 6-15 years old (in humanitarian situations) accessing education - Idai	380,000	239,497	60,825	16%
		Children aged 6-15 years old (in humanitarian situations) accessing education - Kenneth	n/a	n/a	11,672	
		Children aged 3-5 years old in humanitarian situations accessing play-based learning - Idai	76,000	38,344	5,344	7%
		Children aged 3-5 years old in humanitarian situations accessing play-based learning - Kenneth	n/a	n/a	n/a	
	Malawi	School-age children in disaster-affected areas, including adolescents, provided access to quality education services	95,500	n/a	47,930	50%
		Adolescents in disaster-affected areas, in and out of school, provided access to relevant alternative education services	2,000	n/a	0[35]	
	Zimbabwe	School-age children in humanitarian situations accessing formal or non-formal basic education	225,000	120,000	70,666	31%
		# of schools in targeted areas who receive NFIs	60	n/a	58	97%

[32] Sources: Mozambique SitRep Mid-year report July 2019; Malawi SitRep July 2019; Zimbabwe SitRep Mid-Year report June 2019. There are a few cases of discrepancies between the original targets reported in the SitReps and the HACs.

[33] Sources: HAC August 2019 (Zimb) and HAC September 2019 (Moz) (no revised HAC for Malawi).

[34] Data sourced from mid-year reports referenced above. Percentage achieved is based on original targets.

[35] 'No alternative education centres were set up as earlier planned because the required education services could be provided to the affected children through the formal system by enhancing its capacity with the deployment of volunteer teachers and provision of material support.' (Malawi SitRep July 2019).

continued

SECTOR	COUNTRY	Indicators	Targets[32]	Revised HAC targets[33]	Achievements[34]	%
WASH	Mozambique	People provided with access to safe water/sufficient quantity of safe water - Idai	965,000	978,000	1,150,669	119%
		People provided with access to safe water/sufficient quantity of safe water - Kenneth	n/a	n/a	371,035	
		People benefitting from sanitation and hygiene promotion activities - Idai	267,500	364,000	628,045	235%
		People benefitting from sanitation and hygiene promotion activities - Kenneth	n/a	n/a	191,300	
	Malawi	People affected by drought, floods and cholera provided access to safe water per agreed standards	495,960	n/a	191,977	39%
		People affected by drought, floods and cholera provided with sanitation services per agreed standards	40,000	n/a	56,041	140%
	Zimbabwe	People provided with access to safe water and personal hygiene	325,000	1,000,000	856,061	263%
		People provided with critical WASH-related information to prevent waterborne diseases	500,000	1,500,000	1,270,704	254%

continued

SECTOR	COUNTRY	Indicators	Targets[32]	Revised HAC targets[33]	Achievements[34]	%
HEALTH	Mozambique	Children aged 6 months to 15 years vaccinated - Idai	500,000	833,614	330,890[36] 673,614[37]	197%
		Children aged 6 months to 15 years vaccinated - Kenneth	n/a	n/a	104,009	
		Children under 5 receiving a consultation - Idai	229,500	761,796	212,206	92%
		Children under 5 receiving a consultation - Kenneth	n/a	n/a	67,090	
	Malawi	Children and women in humanitarian situations provided with access to health care services	424,071	n/a	287,218	68%
		Children immunized against measles	379,195	n/a	159,217	42%
	Zimbabwe	Children aged 6-59 months in humanitarian situations who are vaccinated against measles	73,640[38]	1,484,685	61,162	83%

[36] The total number of people vaccinated against cholera with UNICEF support is nearly 900,000. Children aged 1-14 years are estimated to be 41.2% of the population. This proportion was used to calculate the result achieved.

[37] Includes the number of children under 5 vaccinated with measles – rubella vaccine during the Health Week (SSRE) in 21 affected districts of Cyclone Idai and flood.

[38] HAC target (March 2019) was 100,000.

continued

SECTOR	COUNTRY	Indicators	Targets[32]	Revised HAC targets[33]	Achievements[34]	%
NUTRITION	Mozambique	Children under 5 screened for acute malnutrition - Idai	328,000	993,082	735,589	224%
		Children under 5 screened for acute malnutrition - Kenneth	n/a	n/a	24,685	
		Pregnant and lactating women reached with IYCF services/messages on IYCF - Idai	100,000	270,947	82,822	83%
		Pregnant and lactating women reached with IYCF services/messages on IYCF - Kenneth	n/a	n/a	15,625	
	Malawi	Children under 5 with SAM admitted for treatment in therapeutic feeding programme	58,421	n/a	22,114	38%
		Children aged 6-59 months provided with vitamin A supplementation	400,075	n/a	59,949	15%
	Zimbabwe	Children aged 6-59 months with SAM who are admitted for treatment	27,000	33,894	7,888	29%
		Children aged 6-59 months receiving vitamin A supplementation	136,000	575,195	207,451	153%

continued

SECTOR	COUNTRY	Indicators	Targets[32]	Revised HAC targets[33]	Achievements[34]	%
CHILD PROTECTION	Mozambique	Children receiving psychosocial support through Safe Spaces - Idai	20,000	44,725	13,518	68%
		Children receiving psychosocial support through Safe Spaces - Kenneth	n/a	n/a	207	
		Separated and unaccompanied children are identified and are in family-based care or alternative care - Idai	400[39]	n/a	10	3%
	Malawi	Number of children receiving psychosocial support (PSS) through Safe Spaces	150,000	n/a	19,579	13%
		People reached by GBV prevention and response services	7,000	n/a	967	14%
	Zimbabwe	Vulnerable boys, girls and adolescents in humanitarian situations provided with critical child protection services	40,000	100,000	49,238	123%
		Unaccompanied and separated children affected by humanitarian situations accessing appropriate care and child protection services	1,500	5,000	682	45%
HIV/AIDS	Malawi	10,000 women in disaster affected areas retained on HIV treatment for 6 months	10,000	n/a	647	6%
	Zimbabwe	Pregnant and breast-feeding women, children and adolescents living with HIV that continue to receive PMTCT and treatment	28,700	32,000	9,547	33%

[39] HAC target (March 2019) was 1,000.

continued

SECTOR	COUNTRY	Indicators	Targets[32]	Revised HAC targets[33]	Achievements[34]	%
SOCIAL PROTECTION	**Malawi**	Vulnerable households receiving cash emergency top ups	14,500	n/a	29,277	202%
	Zimbabwe	Households affected by floods supported with expanded social cash transfers	19,000	10,500	0	0%
C4D	**Mozambique**	Number of people reached with key life-saving and behaviour change messages on health, nutrition and safe and appropriate sanitation and hygiene practices - Idai	700,000	990,000	871,814	125%
		Number of people reached with key life-saving and behaviour change messages on health, nutrition and safe and appropriate sanitation and hygiene practices - Kenneth	n/a	n/a	115,962	
	Malawi	Disaster-affected people reached with key messages and call to action on life-saving practices	495,960	n/a	150,000	30%
	Zimbabwe	People in humanitarian situations reached with key life-saving and behaviour change messages on public health risks	216,000	231,986	257,074	119%

ANNEX 5:
Achievements based on CCC Commitments

Qualitative assessments for selected CCC Commitments and Benchmarks are shown below based on an analysis of data from community focus group discussions, key informant interviews, field observations and secondary data. Relevant Key Questions from the Evaluation Matrix are also shown. Various constraints, including technical capacities in the RTE team, meant that there was insufficient data to provide an assessment for all CCCs in all countries. The RTE team's overall assessment was that targets for each country aligned well with the CCCs.

NUTRITION COMPONENTS AGAINST CCCs

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 1 Effective leadership is established for nutrition cluster inter-agency coordination, with links to other cluster/sector coordination mechanisms on critical inter-sectoral issues.	**Benchmark 1** Coordination mechanism provides guidance to all partners regarding common standards, strategies and approaches, ensuring that all critical nutrition gaps and vulnerabilities are identified; also provides information on roles, responsibilities and accountability to ensure that all gaps are addressed without duplication	**Common to all countries** Coordination at national and provincial levels was commendable, with some gaps at the district level. Nutrition was well integrated with other sectors such as WASH, health and child protection. Key nutrition messages that were harmonized, consistent and accurate were disseminated through these sectors. As nutrition sector lead, UNICEF co-chaired Nutrition Cluster meetings with MOH and ensured smooth implementation of nutrition interventions through coordination of all implementing partners. UNICEF used the 4W matrix to ensure adequate coverage, fill in gaps and avoid duplication in the affected areas. At the early phase of the response, UNICEF established Nutrition Cluster structures at the district level which enhanced the flow of information from the district, provincial up to national level. Data reporting was also improved through cluster meetings that were held weekly at the beginning of the crisis. The coordinated response enabled the Nutrition Cluster to administer critical roles such as monitoring the code of marketing of breast milk substitutes. **Mozambique**: The government's Secretariado Técnico de Segurança Alimentar e Nutricional (SETSAN) was a key technical lead and worked very closely with UNICEF to produce timely information that informed decision making for nutrition and food security interventions.	KQ2 KQ5

NUTRITION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 1 continued		**Malawi:** Through partnership and collaboration with government, proper targeting was done and rightful beneficiaries were reached and supported. Planning was coordinated to share roles and responsibilities. Weekly cluster meetings were very influential in ensuring that all critical nutrition gaps and vulnerabilities were identified and addressed accordingly. However, cluster coordination both among cluster partners and with government was inadequate; this resulted in some affected communities receiving little support during the response. One of the main challenges was low turnout for the meetings. DoDMA handled food security, Ministry of Health handled nutrition, and Ministry of Agriculture handled agriculture. There was no integration of these services and this led to limited coordination or information sharing during the emergency. **Zimbabwe:** As nutrition sector lead, UNICEF co-chaired Nutrition Cluster meetings with MOHCC and ensured smooth implementation of nutrition interventions through coordination of all implementing partners. At the early phase of the response, UNICEF established Nutrition Cluster structures at the district level which enhanced the flow of information from the district, provincial up to national level. Data reporting was also improved through cluster meetings that were held weekly at the beginning of the crisis. The coordinated response enabled the Nutrition Cluster to administer critical roles such as monitoring the code of marketing of breast milk substitutes. The Nutrition Cluster managed to stop distributions of approximately 20 MT of BMS including 5 metric tons of expired supplies. There were Gaps in data management during the early phase when there was underreporting from almost all facilities. However, reporting rate had increased to 62% (by 9 July 2019) when it was done through the RapidPro platform. Increased frequency in reporting helped to identify hot spots and channel appropriate resources to manage identified cases.	

NUTRITION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 2 Timely nutritional assessment and surveillance systems are established and/or reinforced.	**Benchmark 2** Quality assessments are reported on in a timely fashion and provide sufficient information for decision making, including the scope and severity of the nutritional situation, the underlying causes of malnutrition and contextual factors.	**Common to all countries** There were no rapid assessments for nutrition. However, UNICEF participated in subsequent government-led inter-agency assessment. **Mozambique**: UNICEF response to nutrition & food security information systems was timely and strong. UNICEF promptly supported the SETSAN for data collection and produced timely information needed for decision making in Sofala, Manica and Cabo Delgado. Key results achieved with UNICEF support in this area have been mainly in producing quarterly and timely information during the emergency for decision making at the technical up to level of Council of Ministers. The level of the emergency was devastating and no one would be prepared for such calamity. UNICEF was a key partner to the Ministry of Health and to the Nutrition Department in particular for many years. Given this mandate, UNICEF provided adequate and prompt response to the emergency since the beginning of the cyclone. **Malawi:** Institutionalized active case finding for acute malnutrition, supported by UNICEF, enabled early identification and prompt treatment of acute malnutrition. However, it was not consistent such that in other areas like Chikwawa it was done just at the very beginning of the floods and never continued through the emergency period, while in Zomba it was never conducted. The reasons for this were that there were no lunch allowances given to people involved in the screening as compared to what happened in 2015; and transportation challenges (lack of fuel, bicycles or vehicles) led to poor coverage, especially in hard-to-reach areas. UNICEF also supported a SMART survey between June and July 2019 to provide updates on prevalence of global acute malnutrition (GAM) to inform decision making, especially for SAM treatment. Based on the 2019 national SMART survey, the GAM rates dropped from 1.3% in 2018 to 0.5% in July 2019. Underweight prevalence reduced to 8.9% from about 11%. Overweight and obesity rates increased to 3.7% from 2.5% in 2018.	KQ3 KQ5

NUTRITION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 2 continued		**Zimbabwe**: Projection of the target population (i.e. malnourished children under 5 and pregnant and lactating women) was derived from a nutrition survey (2018) and ZimVac assessment that was conducted in May. The ZimVac results were not yet published; however, they were used as the latest data to estimate the magnitude of the problems in the affected districts (Chimanimani and Chipinge). The success in reaching target population was enhanced by screening of children that was conducted by trained village health workers at the community level. UNICEF strengthened surveillance through facilitating the recruitment of ward nutrition coordinators (a cadre that supervised nutrition activities at the ward level and provided the link between the health facility and district level) as well as deployment of surge staff to support nutrition interventions in the two affected districts.	
Commitment 3 Protect, promote and support optimal breastfeeding practices for infants and young children 0-23 months old to ensure that children don't fall sick with diarrhoea or pneumonia and grow and develop to their full potential.	**Benchmark 3** All emergency-affected areas have adequate numbers of skilled IYCF-E counsellors and/or functioning support groups	**Mozambique**: Concrete actions taken by UNICEF include early preparedness for the drought in Mozambique through technical assistance. Additionally, UNICEF provided prompt support to update guidelines and disseminate them to other key stakeholders in nutrition. UNICEF also supported the Ministry of Health at the provincial level in Sofala, Manica and Cabo Delgado in printing and distribution of technical materials, and in providing nutritional supplementation activities in the accommodation areas as well as resettlement locations. UNICEF support was extended to the Ministry at the provincial and district levels in Manica, Sofala, Zambezia and Cabo Delgado, in the surveillance of nutritional disorders such as pellagra in Nhamatanda (Sofala Province), where cases were reported. **Malawi:** Existing platforms and systems like child health days (CHDs), integrated community case management (ICCM) and care groups were used. UNICEF initiated integration and ensured that women were involved and at the centre of the support. With UNICEF's intervention, women and government staff were empowered with health and nutrition activities. UNICEF promoted protective practices in camps for internally displaced people by engaging them through health talks with integrated messages about nutrition, child protection, education, health and WASH.	KQ1 KQ2 KQ6

NUTRITION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 3 continued		**Zimbabwe:** Support for appropriate infant and young child feeding was commendable as evidenced by several activities that were undertaken in order to protect, promote and support optimal IYCF feeding practices in emergencies including: Establishment of IYCF support groups in the camps (Arboretum and Nhamatanda) in Chimanimani. Reinforcing the joint statement on infant and young child feeding that UNICEF, WHO, WFP and MOHCC issued to protect breastfeeding during emergencies. Monitoring and identification of breastmilk substitutes (BMS) donations and stopping the distribution of approximately 5MT of expired supplies. Approximately 20MT of BMS and other inappropriate baby food donations were identified, and their distribution stopped. The IYCF-E messages were provided during routine health services provision, mothers' care groups and by village health workers conducting health promotion at the community level. Promotion of appropriate infant and young child feeding (IYCF) and care practices was ongoing with support of nutrition partners ADRA, GOAL, Save the Children, NAZ and World Vision. However, "The Nutrition Cluster was closely monitoring the distribution of donations and working with the organizations donating to the BMS to ensure they do no harm to the community". (Sit Rep no. 5, 30, April 2019). The cluster should not accept donations but rather allow partners to procure for the needy using the emergency budget.	

NUTRITION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 4 Provide therapeutic feeding and care for children 6-59 months old with severe acute malnutrition (SAM) to protect their lives and bring them back to healthy growth and development.	**Benchmark 4** Effective management of acute malnutrition (recovery rate is >75%, and mortality rates are <10% in therapeutic care and <3% in supplementary care) reaches the majority of the target population (coverage >50% rural area, >70% urban area, >90% camp)	**Common to all countries** UNICEF facilitated access to appropriate management of acute malnutrition among children by working closely with their respective MOH and providing continuous technical support in case management and surveillance. Children that were already admitted into nutrition programmes for management of severe acute malnutrition continued to receive therapeutic feed and essential medicines. Expanded protocols for management of moderate acute malnutrition were activated at the onset of the emergency. Factors that contributed to success include provision of essential medicines and therapeutic feeds required for treatment of severe acute malnutrition at the affected facilities, setting up treatment centre and deploying nutrition staff to manage the centres. **Mozambique**: Comparable to **Malawi**. **Malawi**: The integration of therapeutic nutrition supplies within the national supply chain management system increased ownership by the Government, resulting in improved accountability and management of health facility stocks by the Pharmacy Department. Nutrition supplies were frequently monitored and replenished through the integrated system. However, this needs continuous monitoring to reallocate supplies to health facilities that do not have them from facilities that have much UNICEF support. Also required is timely and consistent distribution of nutrition therapeutic supplies including RUTF, F75 and F100 to ensure availability and access to these commodities. Between January and June 2019, more than 1.3 million children (612,421 boys and 718,930 girls) were screened for acute malnutrition and a total of 22,114 children (10,196 boys and 11,918 girls) with severe acute malnutrition (SAM) were admitted and treated through the community-based management of acute malnutrition (CMAM) programme against an annual target of 58,421. From January to August 2019, 27,673 were admitted for SAM treatment, a 31% decrease from the 31,840 admitted in 2018 during the same period. Between July 2018 and July 2019, the SAM cure rate was 93%, the MAM cure rate was 91.2%, and the SAM and MAM death rates were 2.1% and 0.2%, respectively. The default rate for SAM was 3.7% and for MAM 3.9%. These programme performance indicators were within internationally agreed minimum SPHERE standards. Affected populations were adequately identified but targeting seemed to be problematic with some districts (e.g., Chikwawa, Nsanje) traditionally 'favoured' by the broader international community over others (e.g., Zomba) which had very minimal support. In addition, not all affected populations in all affected districts were reached. This could be improved through conducting a timely needs assessment.	KQ1 KQ2

NUTRITION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 4 continued		**Zimbabwe**: Children who were already admitted into nutrition programmes for management of severe acute malnutrition (24 children in Chimanimani and 49 in Chipinge) continued to receive therapeutic feed and essential medicines. The number of children screened for acute malnutrition had exceeded targets by the first week of July 2019 (126%). The programme reached the majority of the target population with coverage > 80%. However, the proportion of children admitted for SAM and MAM was low (21% and 20%, respectively). The recovery rate reported in Chipinge was below the standard sphere target at 71.2% in the first quarter and 65% in the second quarter of 2019.	
Commitment 5 Ensure that all children aged 6-59 months have access to vitamin A supplements and deworming tablets, while pregnant women have access to iron and folic acid	**Benchmark 5** Micronutrient needs of targeted populations are met: >90% coverage of supplementation activities, or >90% of the affected population has access to additional sources of micronutrients for women and children	**Common to all countries** The micronutrient needs of the affected population were provided through provision of multiple micronutrient powders. The use of multiple micronutrient supplements (MNPs) to control micronutrient deficiencies was extended to include all children aged 6 to 59 months. **Mozambique**: Comparable to **Malawi**. **Malawi**: 153,221 children aged 6-59 months were provided with vitamin A supplementation out of 400,075 (38% of the annual target). Not much was documented on deworming tablets for children and iron and folic acid tablets for pregnant mothers. **Zimbabwe**: Prior to the crisis, MNPs were distributed to children aged 6-23 months. The proportion of children that had received MNPs by July 2019 was above the target (111%), while the percentage who had received vitamin A supplementation also the exceeded target and was at 95% by the first week of July 2019.	KQ1 KQ2 KQ3

NUTRITION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 6 Ensure that a comprehensive communication strategy is rolled out to protect, promote and support optimal maternal, infant and young child feeding, nutrition and care in the context of the emergency response	**Benchmark 6** Communication activities providing information on nutrition services (including how and where to access them) and entitlements are conducted in all emergency affected areas	**Common to all countries** UNICEF provided various platforms to ensure children and women had relevant information about nutrition programme activities. Nutrition was well integrated with other sectors. For example, WASH, health, child protection, education as well as and disseminated essential nutrition information. A majority of the target population received information during road shows that were conducted by C4D, while WASH disseminated the information during participatory health and hygiene education (PHHE). The partners that were working in the affected areas also disseminated vital nutrition information within the communities through trained village health workers and at the health facility level through health workers and extension health workers who were trained in nutrition interventions. **Mozambique**: Comparable to **Malawi**. **Malawi:** UNICEF promoted protective practices in camps for displaced persons by engaging them with integrated messages around nutrition, child protection, education, health and WASH through health talks. About 150,000 people have so far been reached with key messages using various methods (radio, drama, health talks, road shows and community dialogues). Additionally, UNICEF partner Centre for Development Communication, established radio listening groups in 36 displacement sites. Community radios also broadcast key messages, reaching more than 100,000 people every day. **Zimbabwe**: By the first week of July 2019, the percentage of people reached with IYCF messaging was 174% of the target.	KQ4 KQ5

HEALTH COMPONENTS AGAINST CCCs

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 1 Inter-agency coordination mechanisms in the health sector (e.g., cluster coordination) are supported and enhanced with links to other cluster/ sector coordination mechanisms on critical intersectoral issues	**Benchmark 1** Health programme initiated by UNICEF and its partners contributes to the development of inter-agency strategy and implementation plans and ensures that activities are in line with these.	**Mozambique:** Coordination was commendable. All government, national and international counterparts interviewed during the RTE exercise expressed deep appreciation for the way UNICEF coordinated their response, involving relevant stakeholders and partners from the start. It is worth noting that the major outcome of the health response was the containment of cholera outbreaks, which in and of itself was a clear indication of a successful intervention. UNICEF engaged government and counterparts in microplanning; joint review of key national guidelines for health and nutrition response; training of provincial districts stakeholders; integrating coordination mechanisms; and aligning UNICEF's intervention standards and strategy on development in resettlement area with the government's. **Malawi:** UNICEF led the Health Cluster well, filling gaps in WHO leadership. Although they had a strong, efficient health team at the UNICEF office in Blantyre, their coordination was undermined by a weak DoDMA office in Blantyre. In terms of inter-agency coordination, UNICEF had challenges coordinating data collection tools and coordinating district-level partner agencies. Furthermore, some partners observed that UNICEF's heavy focus on children overshadowed other vulnerable groups. UNICEF was strengthening district health systems and will do well to co-design contingency and recovery plans for each district at risk. Additionally, funding government activities through intermediaries had challenges with timeliness and negatively affected government staff morale. **Zimbabwe:** UNICEF coordinated well with the provincial administration and, from there, with the district level and affected facilities, initially with daily meetings to adapt to changing targets. UNICEF helped establish emergency operation centres that regularly reported to the provincial level regarding needs, such as the status of medical stocks. UNICEF's partners felt coordination was very good, which helped to ensure that there was no double dipping and that assistance was distributed equitably to affected communities.	KQ1 KQ4

HEALTH COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 2 Children and women access life-saving interventions through population- and community-based activities (e.g., campaigns and child health days)	**Benchmark 2** 95% coverage with measles vaccine, vitamin A and deworming medication in the relevant age group of the affected population. All families in the affected area receive two insecticide-treated bed nets in malaria-endemic areas	**Mozambique:** The successful containment of cholera and other communicable diseases was a result that was commended by all our respondents, including the communities visited. Measles vaccine achieved more than 95%of its target. Vitamin A, deworming and insecticide-treated mosquito nets distribution achieved more the 95% of the targets. Health interventions supported by UNICEF had very good coverage of most affected populations, particularly in Beira. The emergency health week and the cholera immunization campaign and social health mobilization for hygiene handwashing for cholera prevention were the key interventions with highest coverage. Nevertheless, delays in the response were evident in Cabo Delgado (due to security/access issues), some areas of Sofala Province (especially Buzi District, which was reached only after 2 months from the onset of the emergency) and Manica Province (where issues of accessibility delayed the response in Chenete, Macate District). **Malawi:** Only 38.4% of children targeted were immunized for measles. Adequate number of insecticide-treated mosquito nets were distributed, although their use was low. There were no mentions of deworming and vitamin A in the documents and interviews collected in the RTE. Nevertheless, respondents reported that protection for children and coverage of the most vulnerable people within the camps were adequate. There was also good participation of affected population in implementation. However, some affected districts and populations outside camps were not reached, and there were inadequate accountability mechanisms to assess the life-saving interventions. **Zimbabwe:** Achieved vaccination targets (90% vaccinated, 61,160 people). Health targets included essential health services for 75,000 people (EPI vaccines/procurement and distribution of essential medicines) and support vaccination services to the affected population.	KQ2 KQ4 KQ5

HEALTH COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 3 Children, adolescents and women equitably access essential health services with sustained coverage of high-impact preventive and curative interventions	**Benchmark 3** 90% of children aged 12-23 months fully covered with routine EPI vaccine doses; no stockouts of antibiotics (tracer for health), oxytocin (tracer for basic emergency obstetric and newborn care services), iron/folic acid (tracer for antenatal care) and antiretrovirals (tracer for prevention of mother-to-child transmission) in health centres in affected areas; at least one basic emergency obstetric care facility per 100,000 people	**Mozambique:** Across all assessed locations, 63 per cent were reported to have access to nearby health services, i.e. access to a health post, health centre, hospital, cholera treatment centre, or emergency medical team. Nevertheless, affected population interviewed at the camps reported health services provided were adequate. Mobile clinics provided comprehensive health services. **Malawi:** Access to health care services was provided to 58.9% of children and women in the humanitarian situation. There was no collection of data on tracer drugs. Nevertheless, affected population interviewed at the camps reported health services provided were adequate. Mobile clinics provided adequate health services, although their frequency was irregular. However, UNICEF's response arrived relatively late. **Zimbabwe:** The response was informed by the assessments. C4D for 37,500 people and improving health and feeding practices for 100,000 people (community mobilization and referral through the village health workers). Factors for success: prepositioning of supplies and pre-existing PCAs and coordination mechanisms. Village health workers system already in place due to cholera so allowed for good coordination mechanism; flexibility and reprogramming of donor funds; recruitment of health emergency specialists; HR ready to be sent to field; surge; response very timely; damage to health structures (but less damaged than schools – no big damages so no need for tents); mobile clinics immediately activated after the response. WASH and health integration with C4D achieved the major outcome of the response, cholera containment. Very timely response. Emergency coordination lead by Ministry of Health with the support of UNICEF immediately 3 days after the cyclone. Support from partners arrived immediately afterwards (within 1 week).	KQ3

HEALTH COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 4 Women and children access behaviour-change communication interventions to improve health-care and feeding practices	**Benchmark 4** All affected populations are exposed to key health education/ promotion messages through multiple channels	**Mozambique:** Health services were integrated with communication for development (C4D). There was adequate messaging on nutrition and WASH. The successful containment of cholera and other communicable diseases was a result that was commended by all our respondents, including the communities visited. This achievement was the result of strong multisectoral coordination and collaboration and UNICEF particularly, with health, WASH and C4D sectors and being recognized as key players in the overall emergency phase, including the administration and good coverage of oral cholera vaccine. **Malawi:** Health services were integrated with communication for development (C4D). There was adequate messaging on nutrition and WASH, but not on gender (please see their sector reports). UNICEF established a gender office, which then needed to aim at gender integration. For instance, this sector needs to overcome poor linkages between different services for GBV victims. In terms of health, there were gender disparities in accessing vaccinations and contraceptives. **Zimbabwe:** PETCO (provincial epidemiological and disease control officer) & PEO (provincial environmental health officer) carried out training on integrated disease surveillance and response (learning objective included how to formulate emergency response plans). Within the Environmental Health Department, partners such as Save the Children, Oxfam and IRC helped the Health Directorate in facilitating a training for community members (local leaders) on the issue of participatory hygiene education and hygiene clubs formation, plus a training for schools head masters in nine schools – in the 13 most affected wards.	KQ1 KQ6

HEALTH COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 5 Women and children have access to essential household items	**Benchmark 5** 90% of affected population has access to essential household items	**Mozambique:** Similar to Malawi. **Malawi:** There was a significant match between affected populations' needs and the response led by UNICEF. The response was provided with other organizations such that household needs were covered, even with some duplications. There was good preparation, but there was room for improvement. UNICEF must partner with government health staff in assessing affected populations' needs, and not just leave the exercise to government staff, to ensure that all essential household items are accessible. **Zimbabwe:** Gender integration was to a limited extent. For inaccessible areas (accessible after a month: Chiququa Ward 10, and Muchuazi, Ward 22) insecticide-treated mosquito nets were distributed together with sanitary pads for girls/women. Expectant mothers were air-lifted to more accessible areas near highway to be assisted by UNFPA (who gave dignity kits).	KQ1

WASH COMPONENTS AGAINST CCCs

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 1 Effective leadership is established for WASH Cluster/inter-agency coordination, with links to other cluster/sector coordination mechanisms on critical inter-sectorial issues	**Benchmark 1** Coordination mechanism provides guidance to all partners on common approaches and standards; ensures that all critical WASH gaps and vulnerabilities are identified; and provides information on who is doing what, where, when and how, to ensure that all gaps are addressed without duplication	**Mozambique:** WASH Internal and external coordination commendable, all Governmental counterparts expressed deep appreciation on the way UNICEF coordinated the WASH response, involving relevant stakeholders and partners from the start. Coordination tools (e.g. 4W matrix) have been adapted so to monitor interventions and retrieve operational presence, outputs, targets and achievements. Technical tools and standards developed for the sector. Contingency PCAs in place. It is worth noting that the major outcome of the WASH response was the containment of cholera outbreaks, which in and of itself was a clear indication of a successful intervention. Besides, remarkable cross-sectorial coordination between WASH and health allowed for rapid cholera containment and alignment of waterborne diseases with the previous year's EPI data. Clear intervention criteria set up at national level using a phased approach from emergency to recovery, from the onset of the emergency response. WASH Response Strategic Plan developed and agreed among partners, coupled with elements of preparedness, greatly contributed to the success of the WASH response. PDMs/KAP survey/outcomes monitoring were not systematically embedded within UNICEF monitoring system (partners were collecting outcomes on their own agenda).	KQ5

WASH COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 1 continued		'Double-hatting' of UNICEF WASH Chiefs/WASH Team Leaders and WASH Cluster Coordinators had to be managed carefully as it risked breeching principles of the cluster system vis-à-vis conflict of interest for monitoring and funding mechanisms. WASH coordination and action were linked to recovery. **Malawi:** Effective internal coordination from country office to field level. External coordination with other humanitarian actors was done through the establishment of the WASH Cluster coordination platform lead by DODMA and co-lead by UNICEF one week after the cyclone in Lilongwe and one week later in Blantyre: 5W matrix developed (though not always up to date, especially on UNICEF's achievements); GAPs analysis matrix developed; resource funding matrix developed; weekly coordination meetings carried out systematically. This allowed for minimal overlapping and an effective response in the most affected areas. Most important outcome of the integrated WASH/HEALTH/C4D response was the containment of cholera. Minimal information sharing internally across sectors within UNICEF and with districts. Some of UNICEF's partners' interventions not aligned with districts' priorities (in Chikwawa and Nsanje Districts). PDMs/KAP survey/ outcomes monitoring not embedded within UNICEF monitoring system. WASH coordination and action were linked to recovery and long-term development phases. **Zimbabwe**: WASH internal and external coordination remarkable. Coordination platform in place prior the cyclone: joint monitoring team composed of Ministry of Water, ETC, PWSSC, DWSSC. Active PCAs and contingency PCAs in place. UNICEF secondee at Provincial level in place to backstop the government performance and support disaster management, including the definition of the Emergency Response Plan. Coordination tool at cluster level and internally within UNICEF was the 4W matrix (updated online by partners), including indicators and progress against targets; WASH cluster strategy developed; WASH partners mapping provided. In terms of outcomes monitoring, Goal and Oxfam were carrying out PDM. WASH inter-agency PDM lead by Oxfam ongoing. Major outcome of the WASH response was the containment of cholera outbreaks, through remarkable cross-sectorial coordination between WASH, C4D and health. Dedicated IM for the sector. Internal coordination worked well from the capital down to district level. Overall good coordination at cluster level. Standardization of PDM tools not done. KAP baseline survey not carried out - waiting for the WB funding to start the cross-sectorial baseline survey for Idai-affected districts only. Double-hatting issues at district level and double coordination platforms (CPU & clusters).	

WASH COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 2 Children and women access sufficient water of appropriate quality and quantity for drinking, cooking and maintaining personal hygiene	**Benchmark 2** Children and women have access to at least 7.5-15 litres each of clean water per day	**Mozambique:** All water-related temporary solutions in accommodation centres have been completed within the planned timeframe. Recovery interventions in resettlement areas were ongoing. Response was very slow in Buzi District (Sofala Province), Makomia (Cabo Delgado Province) and Makate District (Manica Province) – 2-month delay (due to access and security issues). As per the HAC/HRP UNICEF WASH targets, 100% achieved for temporary solutions, though cleaning of data for double counting was still ongoing (e.g., people receiving water through water trucking at temporary sites were also provided with permanent water systems in resettlement areas). 1.5 million people reached on water achieving, 155% of the water target. Focus on outputs and people coverage rather than outcomes (some PDM and ad-hoc monitoring by partners but not systematically embedded in UNICEF systems) hampered the alignment with the CCCs benchmark on water access. FIPAG (Mozambique's water-supply funding arm) private sector (parastatal) water quality monitoring platform developed by CDC (seconded to FIPAG through UNICEF) in urban areas to systematically check and modify water quality parameters. Prior the the cyclones, WASH service coverage was already low (e.g., 60% water coverage in Sofala): the emergency worsened the situation, exacerbating vulnerabilities; in this respect WASH interventions have been used as an opportunity to raise standards, as unintended consequence. **Malawi:** Targets changed with time and due to high fluidity in affected population figures. HAC needed to be revised as targets were oversized. Almost all temporary solutions in WASH have been completed within the planned timeframe. CERF fund used for WASH, therefore deployment and interventions happened rapidly. Initial assumption was that all affected population was in camps. Out of camps UNICEF WASH implementation carried out through supporting districts, using LTAs with contractors for 13 solar water reticulation systems in four affected districts. All planned (direct implementation) interventions have been achieved or are near completion, especially in Machinga District, where two solar water reticulation systems have been completed. In Nsanje District, two out of four solar reticulation interventions were ongoing, while the remaining two were completed. In Chikwawa district almost all the four solar reticulation systems were completed. In Phalombe, two out of the planned three solar water reticulation systems wre completed.	KQ2

WASH COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 3 Children and women access toilets and washing facilities that are culturally appropriate, secure, sanitary, user-friendly and gender-appropriate	**Benchmark 3** A maximum ratio of 20 people per hygienic toilet or latrine squat hole; users should have a means to wash their hands after defecation with soap or alternative (such as ash)	A total of 153,836 people (out of whom 36,000 were reached by solar water reticulation systems) have been reached, meaning 31% of water targets achieved (496,000 people targeted for water supply as per revised 9-month HAC, April 2019). The overall target will be reached by end of 2019. However, some districts were prioritized over others (e.g. Chikwawa and Nsanje) due to high population figures, initial cholera cases and size of camps. Not clear on the total targeted figures, therefore difficult to estimate achievements versus targets and overall alignment with the CCCs benchmark. Information management missing.	KQ2 KQ3 KQ6
Commitment 4 Children and women receive critical WASH-related information to prevent childhood illness, especially diarrhoea	**Benchmark 4** Hygiene education and information pertaining to safe and hygienic childcare and feeding practices are provided to 70% of women and child caregivers Note: in the Response Plan, CCC expected result/outcome was "Appropriate hygiene practices in place"	**Zimbabwe:** Alignment with the CCCs benchmark on water in terms of coverage and relevance of the intervention, however, no outcomes monitoring provided therefore difficult to compare with the benchmark. HAC revised so to include cholera, drought and cyclone. In terms of achievements, UNICEF exceeded its water target of 325,000 people by June 30, 2019 (263% of the target). Main WASH services provided in Chipinge District included restoration of the town council main water supply (covering 25,000 people), which experienced disruption for 3 weeks. UNICEF supported through emergency water trucking up to when UNICEF/partners restored the urban water network. In town, UNICEF also supported repair of 15 handpumps, most of the works perceived as outstanding. UNICEF was also providing technical advice. Across the five most critically affected wards, UNICEF and partners provided springs rehabilitation and soft interventions (training on hygiene). In camps, all WASH emergency packages provided. One of the main unintended consequences of the humanitarian response was the rehabilitation of low-quality (in terms of construction standards) water sources in affected districts. Delays on the rehabilitation of the water distribution network in Chipinge urban area.	KQ2 KQ3 KQ6

WASH COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 5 Children access safe WASH facilities in their learning environment and in child-friendly spaces	**Benchmark 5** In learning facilities and child-friendly spaces, 1-2 litres of drinking water per child per day (depending on climate and individual physiology); 50 children per hygienic toilet or latrine squat hole at school; users have a means to wash their hands after defecation with soap or an alternative; and appropriate hygiene education and information are provided to children, guardians and teachers	**Mozambique:** Many children have been displaced from their homes and schools and many schools were initially used as collective centres for the displaced, rendering them non-functional for educational purposes. Although school has resumed in most of the affected areas, WASH facilities needed rehabilitation. Immediate WASH interventions for school resumption included ensuring functional WASH facilities for schools, distribution of dignity kits and hygiene promotion activities. **Malawi:** Targets set as per the CCCs, though benchmark alignment not verifiable due to the lack of outcomes monitoring. Extensive WASH in schools interventions have been carried out in the seven most affected districts during the response, including toilets and bathing facilities disaggregated by sex, age and disability, improved water services to ensure safety and easier access, and hygiene interventions targeting adolescent girls in schools to address MHM issues. **Zimbabwe:** Targets as per the CCCs. Immediate needs for temporary latrines were met in schools and camps. Low achievement on sanitation was due to several factors notably underreporting on sanitation, delays in the approval process of the standard latrine block design for schools from the MoH and no available resources to fund permanent latrines (especially for schools during the immediate response). With the approval of the recovery funds for Cyclone Idai-affected districts (some of which cover latrine construction), UNICEF will record most of the achievements during the last quarter of 2019. Ngangu Primary schools were provided with toilets for people with disability. In Chimanimani District partners perception on targeting/coverage was positive: vulnerable groups were considered (e.g., disabled, school children, people living with HIV and AIDS). These toilets have been built in all schools where the new latrines have been planned. In the community, IRC was building 56 single VIP (ward 21, ward 10 and 11) disability-friendly toilets. In schools, they were also including child-friendly toilets.	KQ2 KQ3

CHILD PROTECTION COMPONENTS AGAINST CCCs

Note that Commitments 7 and 8 are not covered because they are not applicable to this disaster scenario.

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 1 Effective leadership was established for both the child protection and gender-based violence (GBV) cluster areas of responsibility, with links to other cluster/sector coordination mechanisms on critical inter-sectoral issues. Support is provided for the establishment of a mental health and psychosocial support (MHPSS) coordination mechanism	**Benchmark 1** Both child protection and GBV coordination mechanisms provide guidance to all partners on common standards, strategies and approaches, ensuring that all critical child protection/GBV gaps and vulnerabilities are identified; information is provided on roles, responsibilities and accountability to ensure that all gaps are addressed without duplication. MHPSS coordination mechanisms are established, with linkages to relevant clusters	**Mozambique**: Coordination was a challenge; cluster problem, a challenge on who is doing what, duplication could have been a problem in some of the clusters, especially WASH and child protection). A challenge within cluster and with other clusters. Disconnect between child protection and GBV cluster to what extent Beira, Maputo, coordination issues. Beira team were doing a lot of work (so was Maputo) but there was a bit of mismatch. Strengthening case management system well-coordinated and working with government at national and district levels. Also supporting Ministry of Education so that they have meetings with other partners, for better coordination. Gaps in intersectoral coordination within UNICEF due to short duration of deployments, confusion about reporting lines, so that UNICEF sections ended up working in silos. **Malawi:** UNICEF's internal coordination needs strengthening, especially between Lilongwe and Blantyre. UNICEF operating in silos, staff in other sections not necessarily aware of child protection issues. UNICEF planned with district stakeholders, including Ministry of Gender and Child Welfare. UNICEF has involved various partners in planning. Gaps in intersectoral coordination within UNICEF due to short duration of deployments, confusion about reporting lines, so that UNICEF sections ended up working in silos. **Zimbabwe:** Internal coordination between the UNICEF country office and the operational hub was good. External coordination was also good. The PSEA network, the psychosocial support committee and child support committee were set up and operational within two weeks of the cyclone.	KQ5

CHILD PROTECTION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 2 Monitoring and reporting of grave violations and other serious protection concerns regarding children and women are undertaken and systematically trigger response (including advocacy)	**Benchmark 2** Periodic reports on grave violations and other serious protection concerns for children and women are available and utilized	**Mozambique:** The U-Report tool was used as an assessment tool and a complement to monitoring. Monitoring in general was not strong for child protection. **Malawi:** In **Malawi**, there was a WhatsApp group for communication with teachers and the UNICEF education section and used for monitoring and sharing real-time information, including assessments and visual reports. The teachers also reported for other sections including child protection. There were two helplines supported by YONECO, one was for GBV and the other was for child protection. Sexual and gender-based violence and child protection issues were reported through the helplines, which therefore acted as a data source. **Zimbabwe:** The U-Report tool was used as an assessment tool and a complement to monitoring. Increased awareness, provided information on the use of child hot line, 116 hotline, launched a mobile telephone booth, procured mobile phones to operate like public phone booths in camps and some schools.	KQ1 KQ2
Commitment 3 Key child protection mechanisms are strengthened in emergency-affected areas	**Benchmark 3** A plan is in place for preventing and responding to major child protection risks, building on existing systems; safe environments are established for the most vulnerable children	**Mozambique:** Child protection worked with government to put in place a referral system, alternative care and harmonization of case management. At the time of this RTE, this had been finalized but was not yet operational. Case management PCAs for PLAN and World Vision signed late and this affected implementation. **Malawi:** Training on PSEA provided prior to deployment of staff and voluntary teachers. Delays in dealing with cases of GBV or PSEA. UNICEF provided funds to social welfare to strengthen community-based response systems. **Zimbabwe:** Played an important role setting up the PSEA network. The role of the army during initial phase of the emergency until road access was restored raised concerns about PSEA that were reflected in the Early Recovery Plan (July 2019 version). Case management officers coming from other districts were supported by UNICEF to mainstream child protection; UNICEF surge supported efforts by setting up psychosocial support committee and child support committee, which were operational within 2 weeks. UNICEF played an important role advocating for an inter-agency approach in terms of mapping service providers. Strengthened coordination structures. Cooperated/complemented the work of UNFPA, UNHCR, several CSOs, NGOs and government. Rapid orientation of partners responding in the field and sector focal persons, supported by PSEA focal point from regional offices. Due to limited capacity of the government, UNICEF had partners offering child protection. Developed a dedicated indicator for disability. Identified short-, medium- and long-term needs (Early Recovery Plan July 2019).	KQ1 KQ2 KQ6

CHILD PROTECTION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 4 Separation of children from families is prevented and addressed, and family-based care is promoted	**Benchmark 4** All separated and unaccompanied children are identified and are in family-based care or an appropriate alternative	**Mozambique:** UNICEF worked with partners to identify and support separated and unaccompanied minors. The response had appropriate focus on separated and unaccompanied minors, most minors turned out to be separated and were reunited with families or relatives. At the time of the time of the RTE, 403 separated and 103 unaccompanied minors had been identified. 36 minors could not be found anymore, and it was suspected that they had parents and that they could have been using their status as unaccompanied to get more food supplies. **Malawi:** UNICEF supported minors separated from families who were quickly reunited, some were already child-headed households before the floods, they were given necessary support during the response. **Zimbabwe:** Identification, documentation, tracing, assessment and reunification was done relatively well. UNICEF was clear on the numbers of unaccompanied and separated minors, 656 for Chimanimani; placed in extended family 317 boys and 277 girls; made alternative care arrangement for 40 boys and 22 girls (in foster care have parents missing). The majority of the minors were placed in extended families. It was difficult to find foster homes for boys compared to girls. Assessments were done for every minor separated, before placed in foster family.	KQ2 KQ3
Commitment 5 Violence, exploitation and abuse of children and women, including GBV, are prevented and addressed	**Benchmark 5** Affected communities are mobilized to prevent and address violence, exploitation and abuse of children and women; existing systems to respond to the needs of GBV survivors are improved	**Mozambique:** Established focal points on safety in the camps and community police. **Malawi:** An **interagency complaints mechanism** with two helplines set up by UNICEF's partner Youth Net and Counselling (YONECO) provided a means for communities to report cases of PSEA and sexual and gender-based violence. Cases were referred to respective services, though gaps were reported in follow-up. UNICEF also worked with the **Malawi** Police Service to enhance community policing in flood-affected areas. **Zimbabwe:** Conducted training on referral pathways, trained on how to communicate with children, how to ensure confidentiality and protection so children were not exposed to more risk, and on making use of existing case management tools, case opening, case planning and referral. Training ensured ability to identify and process cases with social welfare and consideration to refer cases	KQ6 KQ3

CHILD PROTECTION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 6 Psychosocial support is provided to children and their caregivers	**Benchmark 6** All child protection programmes integrate psychosocial support in their work, in line with the IASC MHPSS guidelines	**Mozambique:** Interviews with UNICEF child protection staff indicated that psychosocial support (psychosocial support, child-friendly spaces) was integrated into programming. However, on the ground it was not evident. The only reference to psychological/psychosocial support mentioned was being offered by Oxfam in Guara Guara camp in Buzi, Sofala Province and World Vision International in Muwawa in Dombe. **Malawi:** Psychosocial support and child-friendly centres were set up in camps for children aged 5-18 years; however this was not evident in the camps visited. **Zimbabwe:** Child-friendly spaces: social workers identify specific issues coming from both boys and girls, disaggregated by gender and provide space to discuss issues and offer psychosocial support.	KQ3
Commitment 7 Child recruitment and use, as well as illegal and arbitrary detention, are addressed and prevented for conflict- affected children	**Benchmark 7** An inter-agency plan is developed and implemented for prevention of and response to child recruitment; advocacy against illegal and arbitrary detention for conflict-affected children is conducted	**Not applicable to this disaster scenario.**	
Commitment 8 The use of landmines and other indiscriminate or illicit weapons by State and non-state actors is prevented, and their impact is addressed	**Benchmark 8** Children and communities in affected areas have access to mine/ unexploded ordinance risk education and are better protected from the effects of landmines and other indiscriminate and/or illicit weapons	**Not applicable to this disaster scenario.**	

EDUCATION COMPONENTS AGAINST CCCs

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 1 Set up temporary learning spaces with minimal infrastructure	**Benchmark 1** Create conditions for a quick return of children to school activities through the distribution of school tents and tarpaulin to cover damaged roofs in schools affected	**Mozambique**: Response to cyclones Idai and Kenneth achieved different results in **Mozambique,** with many lessons learned from Idai improving results of the response to Kenneth. Overall the country office planned the distribution of 108 tents (all delivered); 8,428 tarpaulin sheets (only 4,103 delivered); and 25 tarpaulin rolls (only 18 delivered)(according to the Situação Actual do Procurement 02072019). For Idai, response was much centred in Beira, and other areas had less support and response was more delayed. Kids went to school after a month, school already existed, but helped with tents by UNICEF. In Pemba the response to Kenneth was more successful, and despite access and communication problems in affected areas such as Macomia, Quissanga and Ibo the material (including learning materials) arrived 1 week after the cyclone. (Before any assessment, which was done only in the second week). For education, despite initial challenges with data, access and supply, staff focused their initial response in coordination and planning and started to respond as soon as other priorities were met and conditions of accessibility and supply allowed. UNICEF support, both monetary and material, was directly given to the government; in some cases, although they had already received it, had not yet delivered to the most remote areas by the time of the evaluation (as was the case with the island of Matemo). **Malawi:** Main issues were lack of classrooms (because displaced people sheltered in schools), infrastructure damages or destruction, loss of education materials, food shortage. UNICEF focused the response in these (tents, schools reconstruction, materials supply, school feeding and support to cluster system at the district level). Tents from 2015 ruined; reportedly no education provision. Several assessments were done (DoDMA Assessment report in March, inter-agency assessment, real-time monitoring reports by volunteer teachers offered comprehensive emergency assessments before and after monitoring by UNICEF data teams/ cluster assessment and agency-specific assessments).	KQ1 KQ2

EDUCATION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 1 continued		Post-disaster damage assessment of education facilities affected by cyclone Idai (May 2019) mostly described damage and quantified only affected schools and children, and needs in general were not quantified. 50 tents (temporary learning spaces and shelters) in addition to 7 tents for ECD were distributed, but there was no information about the number needed or planned. In Namicheni village/Chikwawa district: Assistance came in late, generally speaking (i.e., WFP tents in Namicheni camp arrived 3 weeks late). The use of classrooms while waiting for tents to arrive had detrimental effects on education (kids had to be taught outdoors). In Nakhombe village, Zomba district: Response generally viewed as not very timely – affected population had to sleep in classrooms and church for 1 month prior to arrival of tents and this had negative consequences on schooling (noise and when it rained teachers could not teach outdoors). Overall, the response came 2 weeks after the cyclone, though in Namicheni (Chikwawa District) the response was late (1 to 2 months after the cyclone). **Zimbabwe:** UNICEF support was in line with needs assessments. UNICEF provided for the setup of temporary learning spaces using tents, teaching and learning materials (School-in-a-Box kits, ECD kits and recreational kits), school grants for repairs of damaged infrastructures, teaching and learning materials and other basic needs. Two days prior to the cyclone, organizations were prepositioned (tents and vehicles were ready). There was a 5-day warning notice – and 2 days of preparing. At the beginning, everyone was doing what they do best. CPU meetings in Chimanimani helped to organize the response at the beginning. First week was more chaotic. Priority given to WASH, health, shelter and food. According to the UNICEF **Zimbabwe** Cyclone IDAI response plan (March 2019), 190 temporary learning spaces (tents) should have been distributed. 120 tents were in fact distributed in the affected areas (**Zimbabwe** Humanitarian SitRep – June 2019). Education achievements went much beyond the targets previously set for the emergency and the response was timely and effective.	

EDUCATION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 2 Resume schooling by reopening schools and starting the reintegration of teachers and children by providing teaching and learning materials and organizing semi-structured recreational activities	**Benchmark 2** Supply schools with materials for students and teachers to restart education and recreational activities as soon as possible	**Mozambique:** Funded education department with money for fuel and for DSA, tents and school kits and ECD kits. This support was given directly to the government. Big gaps between the agreed plan with government and materials received, according to interviews and Situação Actual Procurement 020719 (e.g., planned 167,000 students kits, only 28,865 received; 1,648 teacher kits planned and only 618 received). Timely response in Cabo Delgado (after Cyclone Kenneth). Transfer of experience and supply in stock or pipeline. Better achievements for Kenneth (78%), but low achievements for Idai (16%). Preparedness not well established. Too much time to prepare PCAs and agreements with standby partners. Too much time for supply, centralized in health and WASH. Some affected areas still without support by the time of the evaluation field work. **Malawi:** According to UNICEF **Malawi** Flood Emergency 2019: RESPONSE – Packages of Sectoral Interventions in a Camp Setting, the following should have been distributed: 1. Provide School-in-a-Box materials. Each box supports at least 40 pupils with exercise books, pens, rulers, rubbers. 2. Provide chalkboards to be used in temporary spaces. Two chalkboards will be provided to a class of 60 pupils. 3. Provide at least one box of chalk per class of 60 pupils per month. 4. Provide Sports-in-a-Box kit. Each box contains nine balls of different types, and games to be used by both displaced children and the schools hosting them. Each kit supports up to 70 children. 5. Provide at least one waterproof UNICEF-branded school bag to be given to each pupil receiving learning materials. 6. Provide at least two volunteer teachers (At least two per school, male and female, to provide psychosocial support pupils.	KQ2

EDUCATION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 2 continued		Distribution data was not complete, but indications were that targets were not met. According to different sources, UNICEF targeted 174 schools and provided teaching and learning materials to all of them (143 school in a box kits, 247 kits of extra materials. 193 recreation kits, 50 tents (temporary learning spaces and shelters). They also provided school feeding in all 174 schools -UNICEF Emergency Education response from May. These numbers contradict the UNICEF **Malawi** flood sitrep and the Education Newsletter from May 2019, where UNICEF targeted 99,500 students (out of 135,000 targeted by the cluster) and in May had reached 24,376 students (26%) in only 36 schools. The HAC also targets 2000 adolescents in or out of school with access to alternative education services but there were no details. **Zimbabwe:** Education achievements largely exceeded targets set for the emergency and the response was timely and effective. Children discontinued going to school in most affected districts (4-6 weeks); also some schools used as collective centres; our response included children going back to school – by the second term, 100% of affected school were opened, so success; UNICEF Zimbabwe distributed teaching and learning materials (School-in-a-Box kits, ECD kits and recreational kits), school grants for repairs of damaged infrastructure, teaching and learning materials and other basic needs (700 School-in-a-Box kits, 200 ECD kits and 250 recreational kits). The supplies reached a total of 70,666 learners in both Chimanimani District (22,732 learners in 39 schools) and Chipinge District (47,934 learners in 63 schools). Of the 70,666 learners reached, 34,726 are girls while 35,940 are boys, with 322 of them children living with disabilities. School grants to 27 schools for repairs of damaged infrastructure, teaching and learning materials for and other basic needs (12,000 textbooks).	

EDUCATION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Beyond Initial Response **Commitment 3** Re-establish and/or sustain primary education. Provide education and recreation kits and basic learning materials and teacher training	**Benchmark 3** Primary schools have reopened and are well equipped with basic learning materials, and teachers are trained	**Mozambique:** According to the HAC, the targets set were 60,000 children aged 6-15 year accessing school (Idai) and 12,000 children aged 6-15 accessing school (Kenneth). They achieved 16% of the former and 78% of the latter. (Data from UNICEF targets and achievements, July 2019). The country office also set a target of 76,000 children aged 3-5 years accessing play-based learning (Idai), but there was no information on results. The resettlement camps used tents to provide first and second-grade classrooms and ECD. Teacher training not applicable in Mozambique. **Malawi:** HAC targeted 2,000 adolescents in or out of schools to be involved in education activities. Children reached by the response was only 26% of this target. Difficulty in setting targets and baselines. Late response (2 weeks to 2 months after the cyclone, depending on the affected area). Many children were having classes outside because schools were being used by people who had been displaced. ECD results unclear. Volunteers Teachers Programme trained in EiE and PSS, and there were at least two volunteer teachers in each school hosting the displaced. **Zimbabwe:** The section targeted 45,000 students (reaching 70,666) and targeted support at 62 (reaching 102). UNICEF was by far the main supporter among the partners, achieving alone almost two thirds of the cluster targets for the affected areas. According to EMIS there was a 1.7% increase in enrolment upon return to school, which UNICEF cannot explain yet (new population in the area, distribution of materials etc.). Targeted trainings and provision of psychosocial support for affected learners and teachers in affected districts (35,000 learners and 500 teachers). PSS support was done through payment of education department staff (gov) who were in the affected areas most of April and May, but there was no outcome data made available.	KQ2

EDUCATION COMPONENTS AGAINST CCCs continued

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 4 Promote the resumption of quality educational activities in literacy, numeracy and life skills issues such as HIV and AIDS, prevention of sexual exploitation and abuse, conflict resolution and hygiene	**Benchmark 4** Schools are offering quality education activities in literacy, numeracy and life skills	**Note on scoring of Benchmark 4**: There was insufficient baseline data to evaluate the quality of education in literacy and numeracy. Scores were based on life skills, and only then for primary education. **Mozambique:** PSEA training targeted development partners, not students and teachers. The longer-term plan of the Education Cluster is teacher training in EiE (including PSEA) in the future. There were no targets beyond primary education. **Malawi:** The Volunteer programme already includes several themes on life skills such as PSEA. The Flood Emergency 2019: RESPONSE - Packages of Sectoral Interventions in a Camp Setting set as a target the provision of HIV and life skills to adolescent girls (both in school and in non-school camps), although there no specific numbers were provided. **Zimbabwe:** PSS support targeted at 35,000 students included some life skills issues that were referred to by students, such as PSEA, hygiene (especially menstrual hygiene). There were no targets set beyond primary education.	
Commitment 5 Establish community services around schools (such as water supply and sanitation), where appropriate	**Benchmark 5** Schools benefit from services such as water supply and sanitation	**Mozambique:** There was a programme for rebuilding schools in partnership with UNHABITAT (not yet started by the time of the evaluation) in a Building Back Better model that already considers water and sanitation. Ministry of Education and Culture strategy for the future includes distribution of dignity kits, collecting age-disaggregated data on girls, building gender-sensitive WASH facilities and teacher training on EiE that includes gender issues and prevention of sexual and gender-based violence. **Malawi:** Permanent water distribution points and latrines constructed for 11,949 school children at schools that hosted displaced people. Distribution of hygiene supplies to schoolgirls. Urgent WASH needs remained in schools 2 months following the floods. **Zimbabwe:** According to UNICEF's Early Recovery Plan (July 2019), the short-term needs within 3 months after the cyclone were the provision of temporary latrines; rehabilitation of toilets/latrines; and provision of safe water sources, along with hygiene kits, soap & purification tablets. In the medium term (within 6 months) it required the construction of damaged WASH infrastructure (latrines, boreholes, handwashing facilities) and in the longer term (within 1 year) advocacy for the adoption of resilient, gender-sensitive and disability-responsive designs and structures in line with the concept of 'building back better'.	KQ2 KQ4 KQ6

HIV AND AIDS COMPONENTS AGAINST CCCs

COMMITMENTS	BENCHMARK	NARRATIVE/FINDINGS	KQ
Commitment 1 Children, young people and women have access to information regarding prevention, care and treatment	**Benchmark 1** 90% of affected population is reached and provided with information on prevention, care and treatment	**Mozambique:** Government of Mozambique covers HIV, gender and disability under cross-cutting issues, cluster chairs by National AIDS Council. Within UNICEF, HIV was under health clusters. To address low retention on HIV treatment, UNICEF worked with partners to systematize the use of BP5 biscuits as an incentive for pregnant and lactating women with HIV to seek regular consultation during/after pregnancy and adhere to treatment. UNICEF supported the training of MCH nurses and HIV staff and ensured awareness on sexual reproductive health, HIV prevention and distribution of condoms. **Malawi:** The Government of Malawi covers HIV under gender and disability clusters,[40] while UNICEF covers HIV under health and education clusters.[41] More women than men were coming out and declaring their HIV or AIDS status.[42] There was a need to continue with awareness raising on issues of SRH and HIV prevention, including distribution of condoms.[43]	KQ2 KQ3 KQ5 KQ6
Commitment 2 Children, young people and women access HIV and AIDS prevention, care and treatment during crisis	**Benchmark 2** 80% of emergency-affected population has access to relevant HIV and AIDS prevention, care and treatment services, e.g., post-rape care including post-exposure prophylaxis, sexually transmitted infection treatment, prevention of mother-to-child transmission of HIV (PMTCT) and antiretroviral treatment (ART)	**Mozambique:** Sofala and Manica provinces in the central region of **Mozambique is** in the main corridor for the landlocked countries. HIV transmission was highest in this region. Youth-friendly and comprehensive HIV services were well integrated into all health facilities of the national health system. During the cyclone emergency response, these services were provided by mobile brigades and outreach teams in all accommodation camps. UNICEF supported individual counselling sessions for pregnant and lactating women on infant and young child feeding (IYCF) and distributed boxes of BP5 fortified biscuits for more than 300 people living with HIV. PLWs with HIV. Maternal health nurses also received mentoring on antenatal consultations and child risk consultations. **Malawi:** Chikwawa has the second highest rates of teen pregnancy and HIV infection rate and unsafe abortion – after Mulanje. The affected population in Nsanje was 2,328 people (1,187 female and 1,140 males), of whom 354 people were living with HIV or AIDS.[44] However, lack of privacy affected provision of reproductive health (ANC/family planning) and HIV services.[45] Most of those under treatment were not able to continue taking their HIV medication … as it was washed away by the floods; for those who have the medication, [they] cannot take them … on empty stomachs [as that would pose] serious challenges to their health.[46]	KQ1 KQ2 KQ4

40 190531 Final Floods PDNA Report.
41 UNICEF Minimum Package of Intervention for flood-affected IDP camps and host communities.
42 Interagency Flood Assessment Report PE, NE and CK.
43 Final Interagency Flood Assessment Report_ZA_MG_MHG_BLK four districts.
44 Interagency Flood Assessment Report PE, NE and CK.
45 Challenges and lessons learnt during emergency response Idai 6.24.2019.
46 Interagency Flood Assessment Report PE, NE and CK.

ANNEX 6:
WORKSHOP AGENDA

Real-Time Evaluation of UNICEF's response to Cyclone Idai in **Mozambique**

Provisional Agenda for the Workshop on 4 July 2019 *(ver. 190619)*

Introduction

This workshop is designed to give participants a chance to review and discuss preliminary findings and emerging conclusions (which may end up as recommendations in the report) in a plenary session before breaking into small groups to assess the relevance and feasibility of the emerging conclusions and provide participants with an opportunity to suggest actionable recommendations. Group work will be followed by another plenary session where groups will present the results of their discussions.

Objectives

- Review and validate provisional findings and emerging conclusions;
- Provide team members with perspectives from UNICEF and their partners on priorities, gaps in the findings and how the outputs of this review can be made more useful to different categories of key stakeholders; and
- Help ensure that the recommendations in the report, once the report is drafted, are relevant and practical.

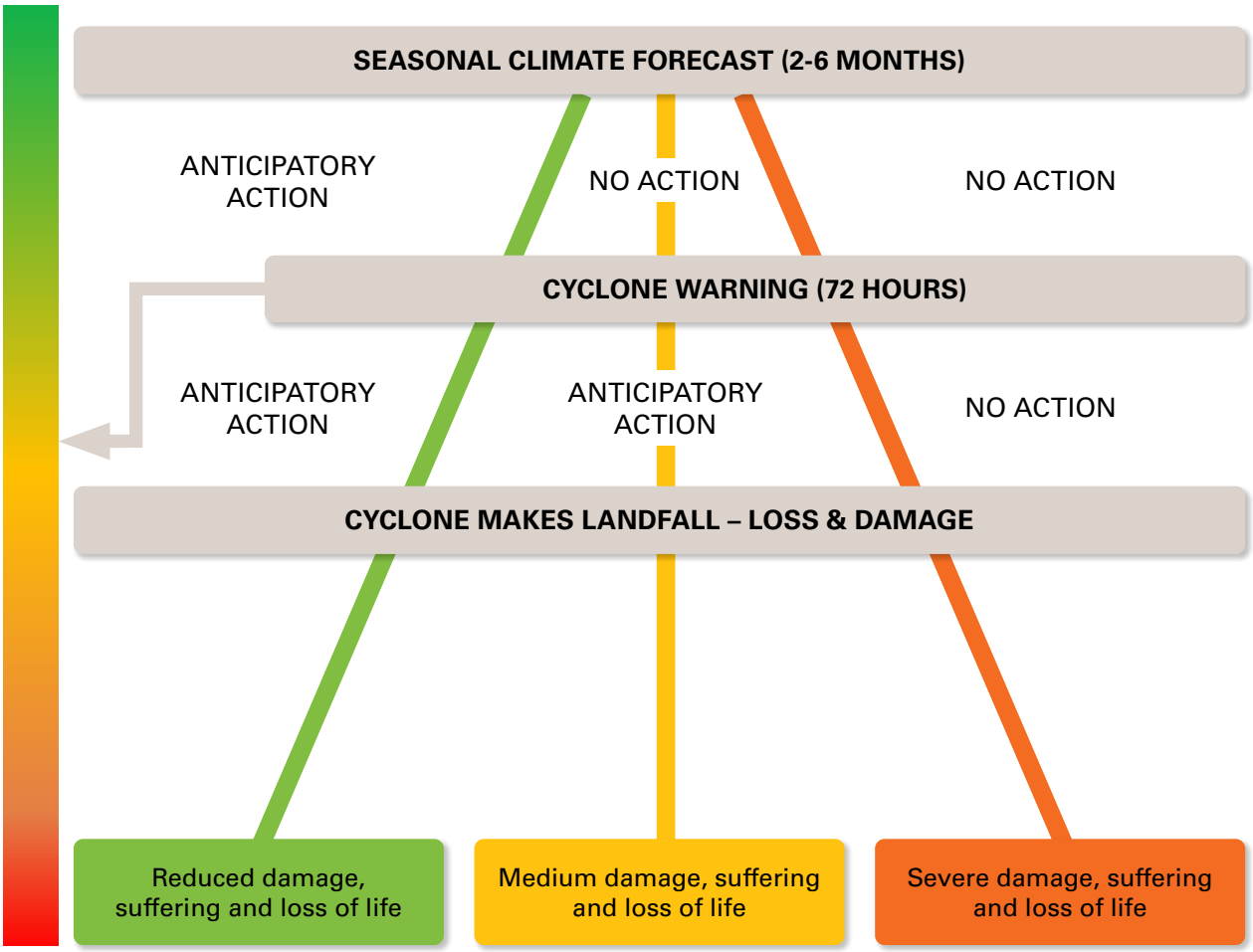
Agenda

Time	Topic	Format
09:00-09:30	Workshop open and introduction of participants	Plenary
09:30- 10:30	Introductory session: • Objectives of the review • Presentation of provisional findings and emerging conclusions • High-level feedback and questions of clarification	Plenary
10:30-11:00	**Break**	
11:00-12:00	Instructions for the Working Groups. Participants will fill in the templates provided to respond to the following questions: • Are the emerging conclusions relevant? • Are there any important emerging conclusions that appear to be missing that are of a higher priority than one of the existing ones? • Can you suggest recommendations and operational guidance to make your suggested recommendations relevant and achievable (realistic)?	Working Groups
12:00-13:00	**Lunch Break**	
13:00-14:00	Working Groups (continued)	WG
14:00-14:30	Report back from selected groups	Plenary
14:30-15:00	**Break**	
15:00-16:00	Report back from selected groups (continued)	Plenary
16:00-16:30	Workshop close and participant evaluations	Plenary

ANNEX 7:
ANTICIPATORY ACTION: CYCLONES

The term 'anticipatory action' is used here based on a concept paper published by the secretariat of the Central Emergency Response Fund (CERF) which defines this as "...an activity taking place between an early warning trigger or a high-probability forecast and the actual occurrence of the corresponding disaster in order to mitigate or prevent the humanitarian impact of the anticipated disaster". The diagram below suggests that anticipatory actions can usefully be triggered at two critical points in time. The first 'trigger' is if seasonal forecasts predict higher than usual cyclonic activity and the second is typically 3-5 days before the cyclone makes landfall, when it becomes clear where and with what force it is likely to strike.

Anticipatory action timeline[47]



[47] Adapted from Wilkinson, E. and L. Weingartner (2018) 'FbA, early response and late response in the case of droughts and cyclones', March 2018, ODI.

ANNEX 8:
VALUE FOR MONEY CHECKLIST[48]

Criteria	VFM Questions	VFM Indicators
Economy	Is UNICEF paying competitive prices for inputs?	1. Identification of key cost drivers and awareness of market prices. 2. Key cost drivers are managed so as to reduce costs.
	Is UNICEF integrating economic good practice into its project cycle?	3. Timely preparation of programme support plans (procurement, financial, staffing, security, etc.). 4. Support functions consulted throughout project cycle (planning, implementation, monitoring and evaluation).
Efficiency	How well is UNICEF converting inputs into outputs?	5. Timely delivery of outputs. 6. Administrative cost ratios. 7. Costs per key output consistent with benchmarks[49] (peer agencies, UNICEF 's own standards).
	Is UNICEF integrating efficiency considerations into its project cycle?	8. Identification and management of efficiency drivers. 9. Systems for measuring outputs in a way that can be linked to costs. 10. Tracking and reporting on timeliness of expenditures and outputs. 11. Detailed cost per activity and output recorded.
Effectiveness	How well are UNICEF 's outputs achieving desired outcomes? At the lowest possible cost?	12. Assistance reaches recipients in a timely way. 13. Systems for measuring outcomes that can be linked to investment of resources.[50]
	Is UNICEF integrating effectiveness and cost-effectiveness considerations into its project cycle?	14. Identification and management of cost-effectiveness drivers.[51] 15. Systems for measuring quality of outcomes and, in the longer term, impact. 16. Application of accountability to affected populations (AAP) commitments, notably participation, complaints & feedback, transparency, etc., helps to improve VFM.
Equity	Is UNICEF delivering assistance equitably and can any resulting higher costs be justified?	17. Selected intervention options take account of equity-related costs (e.g., additional costs to target vulnerable groups, hard-to-reach areas, host communities[52]).
	Is UNICEF integrating equity into its project cycle?	18. Consideration of gender, age and vulnerability and their influence on household dynamics during design, implementation and monitoring.

[48] Adapted from Baker, J. et al. (2016) Danish Refugee Council Value for Money Study.

[49] Benchmarking involves comparing UNICEF's own costs, performance, etc. with industry standards and/or with comparable peer agencies.

[50] Since UNICEF contributes to outcomes together with others, investments may include financial and in-kind contributions from other stakeholders.

[51] Examples of cost-effectiveness drivers could be targeting (% of recipients not in target group, % of transfers reaching target group, etc.) and implementation systems (costs of registration, use of beneficiary feedback systems, etc.).

[52] Host community members are normally less vulnerable than the displaced people living among them. However, learning has demonstrated the importance of equitable approaches towards host communities to mitigate conflicts.

ANNEX 9:
REFERENCE DOCUMENTS

The following bibliography presents the list of documents consulted that contributed to the evidence base and analysis when drafting of the evaluation report. These are presented by order of author (alphabetical) and then year (ascending).

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In addition to the above list, a range of relevant partner reports and other documents have also been consulted during the evaluation process.

ANNEX 10:
LIST OF PERSONS INTERVIEWED

UNICEF Interviewees – Mozambique

Name	Org. and function	♂	♀	Date	Location
Jesus Trelles	UNICEF WASH Specialist - Acting Chief of WASH and WASH Cluster Coordinator at National Level	1		24-Jun-19	Maputo
Emma Brigham	Chief, Planning and Monitoring		1	24-Jun-19	Maputo
Michel Le Pechoux	Deputy Representative	1		24-Jun-19	Maputo
Mariana Palavra	C4D		1	25-Jun-19	Beira
Ana Laylo	Education in Emergency Specialist		1	25-Jun-19	Beira
May Muñoz	Information Management Specialist		1	19-Jun-19	Beira
Hatem Grissa & Juan Lopez Frechilla	UNICEF WASH Specialist & Wash Cluster Coordinator (standby deployment by Action Contre la Faim)	2		25-Jun-19	Beira
Jean Luc Tonglet	OCHA TL	1		29-Jun-19	Pemba
Manuel Freitas & Albino	UNICEF WASH TL & Cluster Coordinator; UNICEF WASH Specialist	2		29-Jun-19	Pemba
Santiago Crespo	UNICEF TL Cabo Delgado (standby deployment from CANADEM)	1		29-Jun-19	Pemba
Jose Vallejo, Elsabete Caterian, Nazira Nangy	UNICEF Health & HIV Coord; UNICEF Nutrition Specialist; C4D Specialist	1	2	29-Jun-19	Pemba
Edith Morch-Binnema	UNICEF Child Protection, Section Chief		1	24-Jun-19	Maputo
Zamzam Billow	UNICEF Gender Advisor		1	24-Jun-19	Maputo
Bartholomeus Vrolijk (Bart), Efrain Chacon	UNICEF Beira EiE specialist (surge), EiE Education Section (newly arrived)	2		24-Jun-19	Maputo
Pieter Potter	National Education Cluster Coordinator	1		24-Jun-19	Maputo
Teresa Castilho Dias Machado	UNICEF CP specialist (standby deployment by CANADEM)		2	25-Jun-19	Beira
Sofia de Almeida	UNICEF C4D Specialist/Coordinator		1	5-Jul-19	Maputo
Damien Hazard	UNICEF Expert Disability (standby deployment by CANADEM)	1		25-Jun-19	Beira
Joanna Karlson	UNICEF PSEA specialist, CP specialist (?)		1	25-Jun-19	Beira
Adriana Alfaia Joia Dos Santis	UNICEF Education Consultant	1		26-Jun-19	Chimoio
Anna Sanchuz	UNICEF, CED Consultant		1	26-Jun-19	Chimoio

UNICEF Interviewees – Mozambique continued

Name	Org. and function	♂	♀	Date	Location
Massimo Lucania	Team leader in Chimoio (standby deployment by CANADEM)	1		26-Jun-19	Chimoio
Camile Baudot; Kenji Ohira; Efrain Chacon	UNICEF, Chief Education; Education Specialist; Education Specialist	2	1	3-Jul-19	Maputo
Brandao Co	UNICEF, Coordination	1		3-Jul-19	Maputo
Marcoluigi Corsi	UNICEF Representative and acting Humanitarian Coordinator	1		5-Jun-19	Maputo (Skype)
Ketan Chitnis	UNICEF Chief of Communication, Adolescence Public Advocacy	1		6-Jul-19	Maputo
Maki Keto	UNICEF Chief of Social Policy	1		6-Jul-19	Maputo
James McQuen-Patterson	Chief, Health and Nutrition Section	1		24-Jun-19	Maputo
Javier Rodrigues	Nutrition Emergency Specialist	1		25-Jun-19	Beira
Domingos Chiconela	Consultant Emergency WASH Chimoio	1		27-Jun-19	Chimoio

Other Interviewees – Mozambique

Name	Org. and function	♂	♀	FGD	Date	Location
Carla Ganhao (WFP), Webster Rice (WV), Suzana Lardies (Oxfam), Tom Skitt (Oxfam), Jeremiah Kaiuki (Save the Children), Fred Kana (Save the Children), Juan Luis Lopez (Wash Cluster)	Nutrition, WASH, Health actors	5	2	1	25-Jun-19	Beira
Save the Children, WorldVision, Care International, Oxfam, Cossaca	Education	6	2	1	25-Jun-19	Beira
Carlos Antonio Gonzalos (DPOPH), Garibaldino Da Silva Canote Zeca (FIPAG), Castigo Alvaro Cossa (FIPAG)	Director DPOPH, Director & Commercial Chief of FIPAG	3			26-Jun-19	Beira
Nadia	Oxfam, PHP and acting head		1		27-Jun-19	Guara Guara, Buzi
Mr. Djairosse and Mr. George	Education Director; General Education Chief (Buzi District Administration)	2			28-Jun-19	Buzi

Other Interviewees – Mozambique continued

Name	Org. and function	♂	♀	FGD	Date	Location
Armando Mambunguisse	Director of DSPI, Buzi District	1			28-Jun-19	Buzi
Hassani Director of Health Department, & Helton Americano Medical Chief Doctor - Buzi District	Health Directorate, Buzi District	2			28-Jun-19	Buzi
Dr. Anastasia	Director, Health Directorate, Pemba, Cabo Delgado		1		2-Jul-19	Pemba
Tania Miorin and Caterina Grilli	Oikos, Team Leader and WASH expert		2		1-Jul-19	Ibo Island, Cabo Delgado
Hasan Marcel; Faustino Loaquelia	General Secretary; Chief of Cabinet; Chief of Planning; Ibo Island; Cabo Delgado	3			1-Jul-19	Hasan Marcel; Faustino Loaquelia; x
Samuel Tinho, Taiwo Adesina, Luc Edema	Food for the Hungry Office Manager and Emergency Response Manager; Technical Advisor; Response Manager	2	1		2-Jul-19	Samuel Tinho, Taiwo Adesina, Luc Edema
Venancio Taimo, Antonio Filipe	DPOPH. Provincial Director; Water and Sanitation Director	2			2-Jul-19	Venancio Taimo, Antonio Filipe
Luis Pedro Marques	Pedagogic Director (school EP2 Guara Guara)	1			26-Jun-19	Luis Pedro Marques
Betinha Ribeiro	Caritas Program Manager		1		29-Jun-19	Betinha Ribeiro
Helene Nelsen, Julião Novela	Education UNV, CP emergency Specialist	1	1		29-Jun-19	Helene Nelsen, Julião Novela
Mario Jonas	Emergency Focal Point Province Education administration - Planning and research department	1			2-Jul-19	Mario Jonas
Deolinda Alberto	Children Department Chief - Ministry of Gender, Children and Social Action	1			2-Jul-19	Deolinda Alberto
Sejio Quembo and David Jacob	Ministry of Education Director Education, Youth & Technology Chief Planning	2			26-Jun-19	Nhematanda
Paciencia Rufino,	Nhhematanda District, Social Action and Women officer		1		26-Jun-19	Nematanda
Assane Ernestos; Jose Forte; Piuza Fransisca	Child Protection, Head of Child Department; Technician; Technician	3			27-Jun-19	Chimoi Province

Other Interviewees – Mozambique continued

Name	Org. and function	♂	♀	FGD	Date	Location
Ivaldo Quincardete; Pedro Cossa; Judite Sambo	Ministry of Education Director responsible for cross-cussting issues, Co-chair Education Cluster; Head of Community Engagement; Head of Gender	2	1		1-Jul-19	Maputo
Leovigildo Pechem	Light for the World Program Manager	1			1-Jul-19	Skype
Rui Maquene; Ali Cossing; Claudia Bonzi	Handicap International, Disability Technical Advisor; M&E Officer; Finance Officer	2	1		1-Jul-19	Maputo
Helga Gunnel; Penelope Muteteli	WFP, Gender Advisor; Protection	2			2-Jul-19	Maputo
Juan Hurtada-Martinez; Wild Rosario	UN Habitat, DRR/DRM/ ER Coordinator; Head of Programme	2			2-Jul-19	Maputo
Shelby Stapleton	World Vision International; Programme Manager		1		2-Jul-19	Skype
FGD Protection Cluster	Partners Protection Cluster	5	4	1	25-Jun-19	Beira
FGD Partners	Partners	7	6	1	27-Jun-19	Chimoio
Augusta Maita, Antonio Jose Beleza	Director General, Deputy National Director of CENOE	1	1		3-Jul-19	Maputo
Corinne Kreidler, Venetia Bellers, Nicolene Oudwater	Humanitarian Adviser/Team Leader, Humanitarian Adviser, Nutritional Livelihood Adviser, DFID Mozambique		3		3-Jul-19	Maputo
John Grabowski	Regional Advisor, USAID	1			1-Jul-19	Maputo
Susanna Lardis	WASH Coordinator, Oxfam representing COSACA		1		25-Jun-19	Beira
Elidio Cossa	Regional Director, FIPAG	1			2-Jul-19	Maputo
Cyntia Baltazar	Instituto Nacional de Saude INS		1		2-Jul-19	Marracuene
Lisa Rudge	Basic Services Deliver Advisor - DFID		1		1-Jul-19	Maputo
Nilton Trindade	National Director DNAAS Water & Sanitation	1			1-Jul-19	Maputo
Renato Solomone	Emergency Focal Point, DNAAS	1			1-Jul-19	Maputo
Hilario Ussene Isse	National Director	1			2-Jul-19	Maputo
Lindsey Wise	World Food Programme - Nutrition		1		2-Jul-19	Maputo
Helda	Head Nutrition Department at MISAU		1		3-Jul-19	Maputo

Other Interviewees – Mozambique continued

Name	Org. and function	♂	♀	FGD	Date	Location
Israel	Emergency programme officer	1			3-Jul-19	Maputo
Jose Tomas Nhaboa	Community member	6		1	28-Jun-19	Dombe
Felizarda Domingos Tomas	Director Dombe Health Centre		1		28-Jun-19	Dombe
Antonio Pacheco	Director Information System at SETSAN	1			8-Jul-19	Maputo
Saquina Jovem Felix	Head, Chenete Health Centre		1		29-Jun-19	Chenete, Macate
Nelson Nascimento	Director Health, Nhamatanda District	1			26-Jun-19	Nhamatanda
Maria da Conceicao Soberano	Head, WASH, DPOPH, Chimoio		1		27-Jun-19	Chimoio
Tomas Gemusse	Director, DDPOPH WASH, Sussundenga	1			28-Jun-19	Sussundenga
Dalte Felizardo	Clinical Director, Macate Health Centre	1			29-Jun-19	Macate
Xavier Isidoro	Head, Public Health Department at DPS Manica	1			28-Jun-19	Chimoio

Community Focus Group Discussions – Mozambique

Focus Group	♂	♀	Date	Location
Girls		6	26-Jun-19	Mutua, Dondo
Women		6	26-Jun-19	Mutua, Dondo
Men	7		26-Jun-19	Mutua, Dondo
Boys	6		26-Jun-19	Mutua, Dondo
Women		6	27-Jun-19	Guara Guara, Buzi
Boys	6		27-Jun-19	Guara Guara, Buzi
Girls		6	1-Jul-19	Ibo Island, Cabo Delgado
Women		6	2-Jul-19	Chuiba camp, Cabo Delgado
Women		5	1-Jul-19	Ibo Island, Cabo Delgado
Men	7		2-Jul-19	Chiuba Accommodation Centre, Pemba, Cabo Delgado
Men	6		26-Jun-19	Guara Guara, Buzi
Girls		6	26-Jun-19	Guara Guara, Buzi
Men	5		1-Jul-19	Ibo Island, Cabo Delgado
Girls		7	26-Jun-19	Nhematanda
Women		8	26-Jun-19	Nhematanda
Girls		6	28-Jun-19	Dombe
Women		6	28-Jun-19	Dombe
Women		6	28-Jun-19	Dombe

Community Focus Group Discussions – Mozambique continued

Focus Group	♂	♀	Date	Location
Men	6		29-Jun-19	Macate
Women		6	29-Jun-19	Macate

UNICEF Interviewees – Malawi

Name	Org. and function	♂	♀	Date	Location
Kristine Haldorsen, Miriam Kaluwa	UNICEF, Child Protection sub-cluster coordinator; Emergency Child Protection and GBV Consultant		2	20-Jun-19	Blantyre
Michele Paba, Patrick Okuni, Chimwemwe Nyimba	UNICEF, WASH (Chief of Wash, WASH Specialist; WASH Cluster Co-lead Lilongwe)	3		17-Jun-19	Lilongwe
Alan Kumwenda	UNICEF, WASH Emergency Specialist	1		18-Jun-19	Nsanje
Afrooz Kaviani Johnson, Martin Nkuna	Chief, Child Protection, Child Protection Officer	1	1	19-Jun-19	Lilongwe
Kimanzi Muthegi, Amilu Chilingolo,	Chief Education and Adolescents, Emergency Consultant	2		19-Jun-19	Lilongwe
Roisin de Burca	Deputy Representative		1	4-Jun-19	Lilongwe (Skype)
Guillermo Burns	Chief of Operations	1		17-Jun-19	Lilongwe
Johannes Wedenig	Representative	1		20-Jun-19	Lilongwe
Tedla M Damte	Chief of Health		1	17-Jun-19	Lilongwe
Victor Nyange, Kemish Kenneth, Steve Macheso	Health Specialist, Health Officer on SAG, Health Specialist		3	19-Jun-19	Blantyre
Johan Edler	Emergency Field Coordinator		1	19-Jun-19	Blantyre

Other Interviewees – Malawi

Name	Org. and function	♂	♀	Date	Location
Felix Kalimame Chisale	DODMA, District Social Welfare Officer	1		19-Jun-19	Nsanje
Kent Y G Mhepo; Blessings Nkata; Given Chichitike; Doubd Njerengwa	Story Workshop, Executive Director; Manager Programmes; Project Officer; Project Officer	3	1	20-Jun-19	Blantyre
Irene Banda; Hard Chatsika	Save the Children, Project Manager; Project Coordinator	1	1	20-Jun-19	Blantyre
Smorden Tomoka; Chifundo Mandara; Gomisani Nkosi	United Purpose, Wash Programme Manager; Logistics and monitoring coordinator; Project manager emergency WASH project	3		20-Jun-19	Blantyre

Other Interviewees – Malawi continued

Name	Org. and function	♂	♀	Date	Location
Civil Protection Committee	Civil Protection Committee	5	5	19-Jun-19	Chikuse Camp, Chikwawa District
Ms. Christian Kapscla	Save the Children, Child Protection Project Coordinator		1	19-Jun-19	Chikwawa district
Mr. Patrick Maconde	Yoneco District Coordinator	1		19-Jun-19	Chikwawa district
Mr x	Acting District Commissioner (Health Director)	1		20-Jun-19	Zomba district
Prince Malema	Red Cross Zomba District Manager		1	20-Jun-19	Zomba district
Luis Amaya Ortiz	Programme Officer, FAO		1	2-Jul-19	Lilongwe
Emma Mbalame	Director of Water Supply and Sanitation in the Ministry of Agriculture, Irrigation and Water Development	1		3-Jul-19	Lilongwe
Dorothy Nyasulu	Assistant Country Representative, UNFPA	1		4-Jul-19	Lilongwe
Allone Ganizani	Deputy Director of Preventive Health Services, Ministry of Health		1	13-Jul-19	Lilongwe
George Mbotwa	Nsanje Environmental Health Officer		1	18-Jun-19	Nsanje
Matts Wernaler, Laura Hastings, Veronica Mhango	Head of Office a.i., HAO, HAO, UN RCO	1	2	20-Jun-19	Lilongwe
Benoit Thiry	WFP Country Representative	1		20-Jun-19	Lilongwe
Felix Kalimame Chisale	Principal Social Welfare Officer, DODMA, Govt. of Malawi	1		20-Jun-19	Lilongwe

Community Focus Group Discussions – Malawi

Foc us Group	♂	♀	Date	Location
MEN	6		18-Jun-19	Butilinyo Camp, Nsnaje District
WOMEN		8	18-Jun-19	Butilinyo Camp, Nsnaje District
ADOLESCENT GIRLS		5	19-Jun-19	Chikuse Camp, Chikwawa District
Civil Protection Committee	5	5	19-Jun-19	Chikuse Camp, Chikwawa District
MEN	6		19-Jun-19	Chikuse Camp, Chikwawa District
ADOLESCENT GIRLS		6	19-Jun-19	Namichemi Village, Chikwawa District
ADOLESCENT BOYS	6		20-Jun-19	Mileme Village, Phalombe District
MEN	6		20-Jun-19	Mileme Village, Phalombe District
Disability/Elderly		1	18-Jun-19	Bitilinyo Camp, Nsanje District
Women		8	18-Jun-19	Bitilinyo Camp, Nsanje District

Community Focus Group Discussions – Malawi continued

Foc us Group	♂	♀	Date	Location
Disability	3	2	19-Jun-19	Namichemi Village, Chikwawa District
Men	6		19-Jun-19	Namichemi Village, Chikwawa District
Men	6		20-Jun-19	Nakhombe village, Zomba district
Girls		6	19-Jun-19	Bitilinyu, Nsanje Distirct
Women		6	19-Jun-19	Mileme Village, Phalombe District
Girls	6	1	19-Jun-19	Mileme Village, Phalombe District
Boys	4	1	20-Jun-19	Zomba district

UNICEF Interviewees – Zimbabwe

Name	Org. and function	♂	♀	Date	Location
Aiden Cronin; Kwanayi Meki; Mltsuaki Hirai; Rosewita Mazivota Susan Nsangi	WASH Sector (Chief of WASH, WASH Emergency Focal point); WASH Officer JPO; Emergency Consultant; WASH Cluster Coordinator	3	2	8-Jul-19	Harare
Dr Paul Ngwakum	Health Sector Chief	1		8-Jul-19	Harare
Cassandra Siwela,Annastancia Chineka	UNICEF, M&E Officer-Nutrition, Nutrition Officer		2	8-Jul-19	Harare
Nakai Munikwa	UNICEF Nutrition Consultant		1	8-Jul-19	UNICEF Offices
Catherine Makoni	UNICEF Gender Specialist		1	8-Jul-19	Harare
Chris Ngwerume; Allet Sibanda	UNICEF Child Protection in Emergency Consultant; Child Protection Specialist	1	1	8-Jul-19	Harare
Tawanda Chinembiri	UNICEF, Chief Social Policy & Research	1		8-Jul-19	Harare
Niki Abrishamian	UNICEF, Chief Education		1	8-Jul-19	Harare
Presila Kusena	UNICEF, C4D Officer		1	8-Jul-19	Harare
Emergency Focal points	UNICEF (HR, Health, WASH, HIV, Nutrition, Education, CP, C4D, Logistics)	5	5	11-Jul-19	Harare
Niels Balzer	WFP - Deputy Country Director	1		11-Jul-19	Harare
Getrude Matsika, Oscar Tapera, Alessia Aturo:	UNICEF Zimbabwe-M&E Specialist, UNICEF- Zimbabwe Humanitarian Performance Monitoring Consultant, UNICEF Zimbabwe Chief of Policy Planning and Monitoring	1	2	8-Jul-19	UNICEF Offices
Sabrie Ali-Salad, Tabinda Syed, Emely Muchochomi, Bayoudh Feker, Nishanatha Jayasekera	Deputy Representative Ops, HR Officer, Finance & Admin Manager, Supply & Logistics Manager, ICT Specialist	3	2	8-Jul-19	Harare

Other Interviewees – Zimbabwe

Name	Org. and function	♂	♀	Date	Location
APDC	Acting Provincial Development Coordinator	1		8-Jul-19	Mutare
John Misi	District Administrator, Chimanimani District	1		6-Jul-19	Chimanimani
Mr Chipfuwa (District Social Welfare Officer); Ms. Audrey (Case Management Officer) and Mr. Jairoz (Case Management Officer)	District Social Welfare Team	2	1	9-Jul-19	Chimanimani
Mr. Munyaradzi Mukuzunga	MOHCC, Manicaland Directorate Provincial Epidemiology & Disease Control Officer (PEDCO) & Malaria Focal Person	1		10-Jul-19	Mutare
Ms.Charity Ndadzungira	Provincial Social Welfare Officer		1	10-Jul-19	Mutare
Dr. Mafaune	Provincial Medical Director		1	10-Jul-19	Mutare
Mr. Norman Tinarwo	DFID, WASH Lead	1		11-Jul-19	Harare
George	District Administrator	1		9-Jul-19	Chimanimani
Clautias Vhumiso	District Health Promotion Officer	1		9-Jul-19	Chimanimani
Samuel Sithole	District HIV Coordinator	1		9-Jul-19	Chimanimani
Sister Bingura	District Nursing Officer		1	9-Jul-19	Chimanimani
Blessing Mamvosha and Agnes Nyanhite	CEO of Rural District Council & Community Services Officer	1	1	10-Jul-19	Chipinge Urban
Mr. Mashava & Mr Beto	District Administrator and Deputy	2		10-Jul-19	Chipinge Urban
Susan Dube; Paul Mulaeozi; Pikirai Kochiwe	Town Secretary (CEO); Urban Town Engineer; Urban Water Engineer	2	1	10-Jul-19	Chipinge Urban
Daniel Chinoiaowa; Svongwa Fungai	Provincial water management member of the PWSSC; Provincial water and sanitation committee secretary PWSSC	2		11-Jul-19	Mutare
Shylet Jonga	MOHCC, District Nutritionist Provincial Epidemiology & Disease Control Officer (PEDCO) & Malaria Focal Person		1	9-Jul-19	Chimanimani
Samukeliso Masikati	MOHCC, District Nutritionist		1	9-Jul-19	Chimanimani
Men	FGD	6		10-Jul-19	Chipinge
Caroline Chipinduro	MOHCC, Provincial Nutritionist		1	11-Jul-19	Mutare
C. Kanoerera	Deputy Education Director		1	10-Jul-19	Mutare

Other Interviewees – Zimbabwe continued

Name	Org. and function	♂	♀	Date	Location
UNICEF Partners	Goal, CPSociety, Child Line, Vuka Africa, WHH, Mercy Corps, Ministry of Health, Ministry of primary and secondary education, Africaid, REPSSI	5	5	11-Jul-19	Harare
Mr Zongoro	District Social Welfare Officer Chipinge	1		9-Jul-19	Chipinge Urban
Implementing partners in Chimanimani, Welthungerlife, Mercy Corps, Child Protection Society, REPSSI, Childline, Apostolic Trust, JF Kapnek, Africad	Implementing focal persons	4	6	11-Jul-19	Chimanimani
Taurayi Maja	Min Lands, Agriculture, Water Climate & Rural Settlement WASH (NCU) WASH Officer	1		15-Jul-19	Harare
Handrea Njovo	MOHCC Deputy Director Nutrition Services	1		16-Jul-19	Harare
Thuso Maphala	(Director, Social Welfare) Ministry of Public Service, Labour and Social Welfare	1		16-Jul-19	Harare
Dr. Mangazira	(Director Epidemology and Disease Control) (Ministry of Health and Child Care, Epidemology and Disease Control)		1	16-Jul-19	Harare
Margaret Madzinga and Chinyowa Enock	Acting Director: Strategic Policy Planning, Research and Statistics	1	1	16-Jul-19	Harare
Patrick	OCHA Consultant/Humanitarian Advisor to RC	1		11-Jul-19	Harare
Mr. Muhlanga	District Accountant	1		9-Jul-19	Chimanimani
Ms. Verena Bruno	UNFPA, GBV technical specialist		1	11-Jul-19	UNFPA Offices Harare
Ms. Marie	IOM, Emergency Specialist		1	11-Jul-19	IOM Offices Harare
Dr. Kimani	WHO, Team Leader for Incident Management Team		1	8-Jul-19	PMD Manicaland

Community Focus Group Discussions – Zimbabwe

Focus Group	♂	♀	Date	Location
Women		7	9-Jul-19	Ngangu (St John Church), Chimanimani
Girls		6	9-Jul-19	Ngangu (Primary school), Chimanimani
Boys	6		9-Jul-19	Ngangu, Chimanimani
Women		6	10-Jul-19	Chipinge Rural
Men	6		10-Jul-19	Chipinge
Community Camp Management Committee	4	2	9-Jul-19	Chimanimani
Men	5		9-Jul-19	Ngangu (St John Church), Chimanimani
Boys and youths	6		10-Jul-19	Mt Selinda, Chipinge
Village Health Workers and Child Care Workers	1	5	10-Jul-19	Mt Selinda, Chipinge
Village Health Workers and Child Care Workers	1	7	9-Jul-19	Ngangu, Chimanimani

UNICEF Interviewees – Headquarters and Regional

Name	Org. and function	♂	♀	Date	Location
Ms. Priscilla Ofori-Amanfo	Communications Specialist - Emergency, UNICEF ESARO		1	15-Jul-19	Nairobi
Mr. Akshay Sinha	HPM Specialist, HARP, UNICEF ESARO	1		15-Jul-19	Nairobi
Ms. Isabel Burchard and Mr Nicola dell'Arciprete	Partnership Manager Private and Public, PPP section UNICEF ESARO	1	1	15-Jul-19	Nairobi
Ms. Shareen Jelani and Ms. Linda Kawira	HR Specialist and HR Officer, UNICEF ESARO		2	15-Jul-19	Nairobi
Ms. Gemma Connell	Head of regional office for Southern and Eastern Africa, OCHA		1	15-Jul-19	Nairobi
Sahr Kemoh	UNICEF RO WASH Specialist	1		16-Jul-19	Nairobi
Laurie Gulaid	UNICEF RO HIV/AIDS Advisor		1	16-Jul-19	Nairobi
Nathalie Fol & Charles Kakaire	UNICEF RO C4D Specialists	1	1	16-Jul-19	Nairobi
Bo Viktor Nylund	ESARO Regional Director ai, UNICEF	1		6-Jun-19	Nairobi (Skype)
Anne Laure Maiola	Logistics Manager, Supply Division Transport Centre		1	25-Jul-19	Copenhagen (Skype)
Justus Olielo	Emergency Specialist - AAP, ERT	1		25-Jul-19	Geneva (Skype)
Rosangela Berman Biela	Senior Adviser, Children with Disability		1	8-Aug-19	Skype

UNICEF Interviewees – Headquarters and Regional continued

Name	Org. and function	♂	♀	Date	Location
Ms. Joan Matji, Marjaree and Mara	Nutrition regional advisor, UNICEF ESARO, and team		3	16-Jul-19	Nairobi
Mr. Raoul Kamadjeu and team	Health Specialist, Health Section, UNICEF ESARO	1	1	16-Jul-19	Nairobi
Soledad Herrero	Emergency Specialist, HARP, UNICEF ESARO		1	16-Jul-19	Nairobi
Manuel Fontaine, Geoff Wiffin, Tsedeye Girma	Director, Senior Adviser, Emergency Specialist	2	1	19-Aug-19	New York

Other Interviewees – Headquarters and Regional

Name	Org. and function	♂	♀	Date	Location
Gemma Connell	OCHA Regional Director and former OCHA Head of Office Mozambique during the Idai response		1	15-Jul-19	Nairobi
Sebastian Rhodes Stampa	Former Deputy HC based in Beira during the idai response	1		22-Jul-19	Geneva

ANNEX 11:
EVALUATION ETHICS

Principle	Explanation	Considered in the RTE design
Independence	Evidence that is objective and credible. Independent from programme design, management and implementation. Evaluations carried out by knowledgeable experts with high integrity who are independent of those responsible for the design, planning and implementation of the intervention.	The Team Leader is an independent consultant and with full overall editorial control within the parameters of quality standards. The transparency and traceability of evidence will be ensured - within the boundaries of ethical standards, below. Stakeholder engagement to promote utility will be balanced with maintaining independence.
Optimize transaction costs	To reduce pressures on busy staff, the evaluation needs to maximize coordination and information sharing.	The design makes efforts to ensure that data is shared/made maximum use of, and that field time spent with busy field staff adds value.
Transparency	Evaluations will be made publicly available for sharing lessons more widely and for accountability purposes. Disclosure will also allow review and test of the analysis and the methodologies used by other evaluators and researchers.	The evaluation team will develop a communication plan for the evaluation and will engage in its implementation as required.
Participation	Where possible the evaluation and the evaluation process must be designed to ensure that direct beneficiaries (women, girls, boys and men) of the intervention being evaluated are consulted and have opportunity to bring forward views and suggestions for improvements.	Different categories of affected populations will be engaged in the evaluation process, principally through focus group discussions.

Interviews/Discussions with children/ minors

The evaluation team used the following approach when interviewing children:

- With support from UNICEF & partners, modalities for engagement with children were agreed prior to any discussions or meetings with the children themselves;
- The evaluators complied with national legislation regarding age of a child and any other circumstances that allow for informed consent;
- Assent from the child and consent from his/her parents, guardians or teachers was sought. The child/minor was given a choice to agree or disagree to participate; and
- The data collection tools were reflective of the children's capacities and were clearly explained.

ANNEX 12:
INTERVIEW GUIDES

The interview guide below is based on the Evaluation Matrix in the Inception Report.

Guidance for team members: This interview guide is not intended to be a questionnaire, rather to be used as a '**checklist**' during semi-structured interviews and focus group discussions to ensure that we are collecting relevant data as we will need this to build an evidence base to support our conclusions and recommendations under each key question. It is often useful to ask high level questions such as "tell me about the evolution of the response? What were the key events/milestones?" and "what have been the particular achievements and challenges with interventions supported by UNICEF?" and guide the discussion by probing with relevant subquestions.

We should not expect that key informants will be able to respond to all subquestions. The main reasons for first trying to understand the background and experience of the key informant is to give you an idea of which subquestions that they should be able to answer.

It is of course important to respect evaluation norms, ethics and standards and clarify our commitments at the start of each interview and focus group discussion with regard to our independence, respect of confidentiality, etc. and ensure that those being interviewed understand the purpose of the RTE, how we propose to use the data we collect and where they will be able to see the report once it is finalized. Please review the United Nations Evaluation Group (UNEG) Norms and Standards at www.uneg.org, particularly those sections directly relevant to evaluators.

The following interview guides, one for key informants and another for community focus group discussions, are based on the questions in the TOR.

Key Informant Interviews

Key Question	Subquestion
Key Question 1: How appropriate is UNICEF's response strategy (present and planned) in reaching the most affected populations?	Assessment 1.1 To what extent is UNICEF's response aligned with and tailored to the needs of affected populations? 1.2 What tools (i.e., methodologies, situation analysis, needs assessments, data systems, etc.) were used to gauge these needs? What was the quality/appropriateness of these tools? 1.3 To what extent have affected populations been involved in and influenced needs assessments, delivery and monitoring of humanitarian assistance?

Key Informant Interviews continued

Key Question	Subquestion
Key Question 1: continued	Response 1.4 To what extent was the initial response by the CO and RO informed and enabled by elements of preparedness in place prior to the crisis? To what extent did the emergency preparedness planning influence CO capacity to respond? 1.5 How internally coherent/consistent has the response been between the various sectors of UNICEF's response? How integrated was UNICEF's approach across key sectors when addressing key priorities (e.g., WASH, C4D on cholera, etc.)? 1.6 To what extent was the response designed to complement activities of other humanitarian partners operating in the three countries? 1.7 How coherent is UNICEF's response with the priorities/responses of affected governments?
Key Question 2: 2. To what extent has UNICEF achieved/is UNICEF achieving its intended results, and within the planned time-frame? (consider HAC, response plans, adherence to CCCs, etc.)?	2.1 How realistic/feasible are planned targets (e.g., in the HAC) and to what extent are they based on situation analysis and updated as new information becomes available? To what extent has UNICEF been able to adapt its response to the changing needs on the ground (e.g., transition from drought to flood; Cyclone Kenneth etc.)? 2.2 What factors contributed to success and what factors constrained UNICEF's success? (e.g., Cyclone Kenneth; surge deployments; fund-raising; communication w/donors and NatComs)? What role have COs, the RO and HQ had in this? 2.3 How timely was the response? 2.4 What role has 'principled' innovation played in needs assessment and the response? 2.5 Were there any unintended consequences of the humanitarian assistance (positive and negative)?
Key Question 3: 3. To what extent was the affected population, including persons with disability, adequately identified, targeted and reached by UNICEF and its partners?	3.1 How successful has UNICEF been in reaching the most vulnerable groups (communities in hard-to-reach areas; people with disability; unaccompanied/ separated children; pregnant women, etc.)? 3.2 How effective were identification and referral systems for child protection? 3.3 Were activities and practices (including assessments, innovations, etc.) implemented based on ethical principles (respect for autonomy, beneficence, non-maleficence, justice)? 3.4 To what extent have UNICEF and its partners promoted participation by vulnerable groups in the design, implementation and monitoring of their interventions?

Key Informant Interviews continued

Key Question	Subquestion
Key Question 4: 4. To what extent is UNICEF's response contributing to longer-term goals of enhancing prevention of future emergencies, mitigation of negative effects of future natural hazards (resilience/sustainable solutions) and preparedness?	4.1 How successfully have recovery considerations been incorporated into planning and relief interventions? 4.2 To what extent is UNICEF's response specifically contributing to improving the resilience of local government systems and their capacity to prepare, respond and mitigate the effects of an emergency? (Explore effects on governments' new 5-year plans and UNICEF business-as-usual projects and partnerships.)
Key Question 5: 5. How effectively and efficiently has UNICEF coordinated its response both internally and externally (with key actors such as other UN Agencies, CSOs and developing partners, national and local governments)?	5.1 How effectively has UNICEF balanced its 'internal' operations with cluster coordination/leadership responsibilities? 5.2 To what extent are considerations of comparative advantage applied in designing and implementing the response and, as applicable, recovery efforts? 5.3 How well did UNICEF support the governments at different levels (districts, city, provincial, central) in coordinating the response? And clusters/national non-governmental partners? 5.4 How effective was the CO in coordinating the setup of and delivery of new stations at the heart of crisis?
Key Question 6: 6. To what extent have gender been integrated in the needs assessment, planning, implementation, monitoring and reporting of the response, as well as in recovery planning? 7. Can you suggest any other people to speak to? Are there any documents you can share that are particularly relevant to this RTE?	6.1 What are/were the specific gender and equity dimensions of the emergency? 6.2 Evidence that gender was integrated into UNICEF interventions 6.3 What were the main differences among women, men, boys, girls and vulnerable groups?

Interview Guide – Focus Group Discussions with Affected Communities

General Questions:

- Age and whether they are still displaced, returnees or resettled
- How far is your village of origin from the camp/temporary accommodation site?
- How long have you been here?

KEQ1:
How appropriate was UNICEF's response?

- Appropriateness/Relevance:
  - » Provision of basic services
    - — What type of assistance have you received from UNICEF during the emergency? (probe NFIs & services)
    - — What type of assistance have you received from other organizations?
    - — What was most relevant and least relevant assistance for you?
  - » Any organizations asked about your needs? (If yes, ask who and how it was done)
  - » How do you communicate with UNICEF and/or other organizations? (e.g., complaints mechanism)

KEQ2:
To what extent has UNICEF achieved/is UNICEF achieving its intended results, and within the planned timeframe?

- Effectiveness:
  - » How timely was the response? (by sector WASH, HEALTH, NUTRITION, EDUCATION, CHILD PROTECTION)
  - » Were there any problems?
- Sectorial effectiveness:
  - » WASH:
    - — What type of assistance did you receive to prevent waterborne disease (e.g. cholera)?
    - — What are the hygiene/health education services in your camp/village, if any?
    - — Water and sanitation infrastructures enough/timely? Ask for details.
  - » HEALTH:
    - — Main health issues during the emergency?
    - — What health services were provided during the response?

- EDUCATION:
  - Were there any interventions specifically on education?
  - Any disruption of schooling?
  - Was there school feeding program?
- NUTRITION
  - Are you aware of any cases of malnourished children during the emergency? If so, what was done?
  - Were kids screened for malnutrition? How often? By whom?
- PROTECTION
  - Did you and the community feel safe? What problems did you face and how were they solved?
  - Where there any unaccompanied kids? If so, what type of assistance have they received?
  - What services targeted children beyond education & health (e.g., child friendly space, psychological support)?
  - What measures were put in place by UNICEF to protect populations against sexual abuse/violence?

KEQ3:
To what extent was the affected population adequately identified, targeted and reached by UNICEF and its partners?

- Coverage:
  - Who decides who gets what?
  - How fair was the assistance provided (Anyone left out? Or included and not supposed to)?

KEQ4:
To what extent is UNICEF's response contributing to longer-term goals of enhancing prevention of future emergencies, mitigation of negative effects of future natural hazards?

- Resilience:
  - Among the assistance received, what will help you to be better prepared for the next emergency?

KEQ5:
How effectively and efficiently has UNICEF coordinated its response both internally and externally?

- Coordination:
  - Duplication?
  - Gaps?

KEQ6:
To what extent has gender been integrated in the needs assessment, planning, implementation, monitoring and reporting of the response, as well as in recovery planning?

- Inclusion (gender and vulnerable groups, including people with disabilities):
  - Were you involved in any phase of the response: from needs assessment, to intervention and/or monitoring?
  - Are you aware of any interventions tailored to the specific needs of women/girls, men/boys, children, elderly, people with disability, people living with HIV or AIDS, etc.?

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EVALUATION OFFICE

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