

EVALUATION OF UNICEF'S RESPONSE TO THE LEVEL 2 CHOLERA AND CYCLONE FREDDY EMERGENCIES IN MOZAMBIQUE

FINAL REPORT

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This report is informed by the opinions and suggestions of various stakeholders; however, the evaluation team takes full responsibility for its contents.

ACRONYMS

AAP	Accountability to Affected Populations
AAR	After Action Review
AIDS	Acquired immunodeficiency syndrome
CATI	Case-area/case-cluster targeted interventions
CBO	Community-based organization
CCCs	Core Commitments for Children
CCRA	Child-Centred Risk Assessment
CFR	Case Fatality rate
CFSs	Child-Friendly Spaces
CLTS	Community-led total sanitation
CEAP	Corporate Emergency Activation Procedure
CP	Child protection
CPD	Country Programme Document
CRA	Community Rapid Assessment
CSO	Civil society organization
CTC	Cholera Treatment Centre
CUAMM	Doctors with Africa
DPOP	Provincial Directorate of Public Works (Direcção Provincial de Obras Públicas)
EMOPS	Emergency Operations
EMT	Emergency Management Team
EP	Emergency Procedures
EPF	Emergency Programme Funds
EPP	Emergency Preparedness Platform
EQ	Evaluation Question
ESAR	Eastern and Southern Africa Region
ESARO	Eastern and Southern Africa Regional Office
FGD	Focus group discussion
FO	Field Office (UNICEF)
GBV	Gender-based violence
GRIP	Guidance for Risk-Informed Programming
GoM	Government of Mozambique
GPE	Global Partnership for Education
HAC	Humanitarian Action for Children
HCT	Humanitarian Country Team
HDP	Humanitarian-development-peace nexus
HIV	Human immunodeficiency virus
HQ	Headquarters
HR	Human resources
HRP	Humanitarian Response Plan

IASC	Inter-Agency Standing Committee
ICG	International Coordinating Group
INGD	National Institute of Disaster Management and Risk Reduction
INGO	International non-government organization
IP	Implementing partner
IPC	Infection prevention and control
KEQ	Key Evaluation Question
KII	Key informant interview
L2	Level 2
LTA	Long-term agreement
MCO	Mozambique Country Office (UNICEF)
MHPSS	Mental health and psychosocial support
MIRA	Multi-cluster/Multisector Initial Rapid Needs Assessment
MoEHD	Ministry of Education and Human Development
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NFIs	Non-food Items
NGO	Non-government organization
OCAC	Operational Capacity Assessment and Certification
OCHA	Office for the Coordination of Humanitarian Affairs
OCV	Oral Cholera Vaccine
ORP	Oral Rehydration Points
PAMI	Priority areas for multisectoral interventions for cholera control
PD	Programme Document
PHE	Public health emergency
PHE-PR	Public health Emergency preparedness and response
PRC	Partnership Review Committee
PSEA	Protection from sexual exploitation and abuse
RCCE	Risk communication and community engagement
R-EMT	Regional Emergency Management Team
RO	Regional Office
RRM	Rapid Response Mechanism
SBC	Social and behavioural change
SDG	Sustainable Development Goal
SIMEX	Simulation Exercise
TLs	Temporary Learning Spaces
ToC	Theory of change
ToR	Terms of reference
UNCT	United Nations Country Team
UNICEF	United Nations International Children's Emergency Fund
UNSDCF	United Nations Sustainable Development Country Framework

USD	United States Dollar
VfM	Value for money
WASH	Water, Sanitation, and Hygiene
WFP	United Nations World Food Programme
WHO	World Health Organization

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EXECUTIVE SUMMARY

This report presents the results of the evaluation of UNICEF's Level 2 (L2) response to the cholera and Cyclone Freddy Emergencies in Mozambique. The following paragraphs present a brief narrative on the emergency itself and UNICEF's response to it.

A L2 Corporate Emergency Activation Procedure (CEAP) for the cholera outbreak was triggered on 10 March 2023. Tropical Cyclone Freddy made a record second landfall in Zambézia on 12 March (building on the first landfall that occurred on February 24 in Vilanculos district in Inhambane province). The cyclone exacerbated what was already a devastating cholera outbreak in Mozambique and compounded an already complex humanitarian situation where millions of people had been affected by armed conflict in the northern provinces. (It is also important to note the cyclical nature of extreme weather events in Mozambique: the last activation of the Emergency Procedures (EPs) in response to a natural disaster was in 2019, in response to Cyclone Idai.¹) On 23 March, UNICEF expanded the L2 CEAP scale-up for the cholera outbreak in Malawi to cover Mozambique and include: 1) response to floods and overall impact of Tropical Cyclone Freddy in both Malawi and Mozambique, and 2) response to ongoing cholera outbreak in Mozambique, until 9 September 2023 when the L2 CEAP scale-up was officially deactivated (for both countries).

The rights holders targeted by the L2 interventions were cholera- and cyclone-affected populations throughout Mozambique, in particular: children, women, children, persons with disabilities, refugees, cholera survivors, and students in Zambézia, Sofala, Tete, and Niassa provinces (this includes those living in urban, peri-urban, and rural settings). An assemblage of state and non-state actors worked together with UNICEF to assist the cholera- and cyclone affected populations.

As of July 2023, as a result of the L2 interventions, 470,000 persons were able to access health services, over 5,800 children had received treatment for Severe or Acute Malnutrition (SAM), close to 470,000 persons had access to safe water, more than 117,000 persons had access to Mental Health and Psychosocial Support (MHPSS) services, over 108,700 students had access to education, 3.1 million persons had been reached with Risk Communication messaging, and 1.5 million persons had received information and/ or services regarding the Prevention of Sexual Abuse and Exploitation (PSAE).²

The evaluation aims to strengthen UNICEF's accountability to affected populations, partners, and donors supporting the response to the L2 cholera and Cyclone Freddy emergencies in Mozambique. The evaluation will also support learning on how to improve preparedness for and response to future emergencies to contribute to building resilience and strengthening the humanitarian-development-peace (HDP) nexus.

The evaluation has three objectives:

1. Provide an assessment of UNICEF's response to the Level 2 cholera and cyclone Freddy emergencies in Mozambique vis-a-vis issues of appropriateness/relevance, effectiveness, efficiency, connectedness, and coordination/partnerships, with a specific focus on the adaptiveness/ responsiveness of the UNICEF response and how it has addressed issues for children, adolescents, and women, including those with disabilities, marginalization, or deprivation.
2. Assess the extent to which emergency preparedness and procedures enabled UNICEF to respond effectively. This should include reviewing the extent to which UNICEF has incorporated lessons

¹ Nb. The Emergency Procedures were activated in 2020 in the northern province of Cabo Del Gado; however, this was in response to the conflict in the area, not due to an extreme weather event.

² UNICEF. (2023) Southern Africa: Malawi and Mozambique cholera and cyclone response: July 2023.

<https://www.unicef.org/documents/malawi-and-mozambique-humanitarian-situation-and-response-dashboard-july-2023>. Accessed 19 May 2024.

learned from responses to previous emergencies; as well as whether and how the Emergency Preparedness Platform (EPP), Human Resources (HR)/surge capacities, Partnerships, L2 Emergency Procedures (EP), coordination mechanisms, supply prepositioning and distribution monitoring, data and monitoring systems, social protection/shock responsive systems that were established enabled a timely and effective UNICEF response.

3. Draw out key learning and specific sectoral, cross-sectoral, and operational recommendations to strengthen UNICEF's humanitarian-development-peace nexus bridging and preparedness for future emergencies through risk-informed country programmes.

The evaluation considers the span of UNICEF's emergency response, from the date the L2 CEAP was expanded (from Malawi) to Mozambique on 10 March 2023, with some reflections back to February when Cyclone Freddy first struck, through 9 September 2023, when the L2 was deactivated. The evaluation also considers preparedness plans and actions in place prior to emergencies.

The evaluation team retrospectively developed a theory of change (ToC) to examine the causal linkages between goals, objectives, and activities and reflect on what worked and what did not in each outcome pathway. Evaluation questions were structured around the core criteria of relevance, effectiveness, coverage and proportionality, efficiency, quality and coherence, coordination, and connectedness/sustainability.

Data collection was conducted between December 2023 and March 2024. The evaluation team applied a mixed methods approach including document review, key informant interviews (KII), focus group discussions (FGD), and a mobile phone survey (Community Rapid Assessment, or CRA).

The primary audience for this evaluation consists of UNICEF staff, management, and regional advisors who were responsible for leading the UNICEF response to the L2 cholera and cyclone emergencies in Mozambique. The evaluation's findings may also be shared with key counterparts, in addition to the main stakeholders involved in this evaluation at the community level.

Overview of findings

Response Area 1: Health and Nutrition (Effectiveness)

UNICEF Mozambique Country Office (MCO) contributed to a decrease in cholera incidence and mortality rates (main outcome) by improving the capacity of local health workers and providing essential emergency medical supplies to support an estimated 1.5 million people across 10 of 11 provinces. On top of the limited number (106) of Oral Rehydration Points (ORPs) (which were effective and inexpensive solutions), significant logistical support was given to the Ministry of Health's (MoH's) Oral Cholera Vaccine (OCV) campaigns, including transport and maintenance of the cold chain.

Response area 2: WASH (Effectiveness)

UNICEF MCO largely achieved its objective of providing appropriate life-saving prevention and response measures that contributed to controlling the spread of cholera. However, UNICEF could not cover all existing needs (particularly in terms of hard WASH components). Collaborations with district authorities and implementing partners (IPs) enhanced coverage and intervention effectiveness. Immediate solutions were scaled up across 7 provinces, with sanitation and environmental cleaning supported at the community level. Innovative approaches, like purchasing cards and start-up letters for infection prevention and control (IPC) material procurement, significantly contributed to the functionality of Cholera Treatment Centres (CTCs) and addressed critical gaps in community-based cholera prevention.

Response Area 3: Education (Effectiveness)

UNICEF MCO supported the Government of Mozambique (GoM) to ensure/re-establish access to education services in cyclone-affected schools (main outcome) by providing educational kits, tarps, tents, and supporting the rehabilitation and cleaning of schools. The installation of Temporary Learning Spaces (TLSs) and emergency WASH facilities helped create safe and secure learning environments for children and adolescents. Despite the significant damage caused by Cyclone Freddy, UNICEF's interventions mitigated many negative impacts on learning environments in Zambézia, Nampula, and Sofala provinces. Schools were also used as platforms for behavioral change, promoting WASH and hygiene practices focused on cholera prevention. However, the scale of UNICEF's educational support did not fully match the extensive needs.

Response Area 4: Child Protection (Effectiveness)

UNICEF MCO's support significantly strengthened child protection services in cyclone-affected areas (main outcome), but limited funding and a lack of experienced partners restricted these efforts to Sofala and Zambézia provinces. Sensitizing stakeholders on children's protection needs during emergencies increased demand for these services. However, the lack of experienced organizations and expertise among government and local authorities posed challenges. A key achievement was partnering with a competent IPs to establish Child-Friendly Spaces (CFSs) and community-based mental health and psychosocial support (MHPSS), marking a crucial step in system strengthening efforts.

Response Area 5: Risk Communication and Community Engagement (RCCE)/Social and Behavioural Change (SBC) (Effectiveness)

UNICEF MCO's technical assistance in designing and coordinating RCCE interventions helped minimize cholera spread and the impacts of Cyclone Freddy by increasing knowledge and promoting preventive behaviors in at-risk communities (main outcome). These efforts created an enabling environment for emergency preparedness and response, including cholera outbreaks. RCCE interventions mobilized tens of thousands of community actors and reached many people through various platforms and channels, supporting demand for OCV campaigns. Despite these successes, poor data collection practices hindered accurate assessment and the interventions often lacked focus due to insufficient context-specific data.

RELEVANCE

UNICEF-supported interventions were designed to address the emerging needs of cyclone- and cholera-affected communities. UNICEF's interventions were especially relevant to the needs and rights of children affected by Cyclone Freddy. The relevance of MCO's interventions and its ability to meet the specific needs of women affected by the cholera and Cyclone Freddy emergencies was mixed. UNICEF MCO's efforts to target, engage with and include adolescents in its response interventions were highly relevant.

UNICEF MCO's response plan specifically identified the need to support persons with disabilities as a cross-cutting approach common to all response areas. The evaluation finds support to persons with disabilities to be particularly relevant for the cyclone response as persons with disabilities are especially vulnerable in areas that are flooded, or in which houses are damaged or destroyed and where access to services and temporary accommodation is an issue, and their rights might be at stake. However, organizational commitments to prioritize persons with disabilities were not effectively put into practice.

EFFICIENCY

UNICEF MCO supported the responses to cholera and cyclone emergencies with significant quantities of in-kind goods; however, related supply chain management and logistical issues slowed operational response timelines. Mobilisation of HR to cover critical gaps remained a main challenge right through the L2 response. MCO's *modus operandi* via partnerships encountered difficulties and incurred delays, despite the availability of simplified L2 procedures and efforts to identify new partners. The extension of UNICEF's

CEAP L2 designation to include Mozambique's responses to the cholera emergency in Malawi came too late. The result was that MCO's cholera response was rolled out at scale too late in the epidemic curve to prevent the peak and was reactive (rather than proactive) in responding to the ongoing outbreak.

COVERAGE & PROPORTIONALITY

The responses to the cholera and Cyclone Freddy emergencies were marked by a paucity of accurate and timely data. UNICEF scaled up its emergency responses—increasing its coverage to a significant degree—and endeavoured to reach as many cholera- and cyclone-affected persons as possible. Access issues challenged coverage and proportionality; internal adaptations in coordination architecture increased operational flexibility and resulted in increased coverage. UNICEF (together with its civil society organization (CSO) IPs) had limited resources to respond to a multi-factor crisis of a large magnitude; nevertheless, UNICEF's planning and monitoring capabilities enabled UNICEF to prioritize and scale up its responses to both emergencies, despite the absence of national and subnational plans and the overall lack of accurate, reliable and timely data. The politicization of aid and the application of adequate criteria aligned with needs and vulnerability (e.g., to establish lists of beneficiaries) posed challenges for some humanitarian actors. For UNICEF, finding the right balance between adhering to its mandate to support the GoM's response while operating according to a principled approach remained a challenge throughout the emergency response.

QUALITY & COHERENCE

UNICEF's L2 responses to the cholera and Cyclone Freddy emergencies were guided by and adhered to its Core Commitments for Children (CCCs) in Humanitarian Action, its commitments related to Public Health Emergencies (PHEs)—*Children and their communities are protected from exposure to and the impacts of PHEs*—and to its corporate priorities regarding emergency response. UNICEF's response to the cholera emergency successfully met two out of the White Paper's three objectives and incorporated eight out of its nine recommendations.

CONNECTEDNESS/ SUSTAINABILITY

The extent to which UNICEF succeeded in incorporating longer-term considerations into its cholera and Cyclone Freddy responses was mixed, varying across interventions and response areas. Infrastructure rehabilitation/resilience building, and capacity building took place. Some WASH-related initiatives were designed to bring about long-term behavioural change and sustainable sanitation practices. There is no clear evidence that sufficient consideration was given to environmental sustainability.

COORDINATION

UNICEF MCO supported a multisectoral approach to cholera and Cyclone Freddy responses and supported the GoM's efforts to lead both responses at national, provincial and local levels. However, the cluster system did not align well with the eight pillars of the cholera response or with the National Institute of Disaster Management and Risk Reduction (INGD's) four pillars. UNICEF not only supported the MoH in coordinating and leading the health response but also provided critical coordination support to other government agencies and sectors in its leadership role. Overall, UNICEF's joint coordination efforts with WHO, and to a lesser extent with MSF, proved to be effective and productive. UNICEF supported the coordination of multiple clusters, played a pivotal role within the Humanitarian Country Team (HCT), and fulfilled a valuable intra-coordination role between local authorities. UNICEF's high level of involvement in coordination was greatly appreciated, but it came with challenges, requiring more resources, effort, and expertise. Though there were missed opportunities for a timely and adequate workflow in the initial stages of the response, internal coordination improved as the response progressed and more resources and experience became available (especially skilled HR). Overall, the UNICEF Eastern and Southern Africa Regional Office (ESARO) provided adequate levels of coordination to the MCO.

Overview of conclusions³

EFFECTIVENESS and EFFICIENCY

Conclusion 1:

Though MCO's interventions ensured the continuity of essential services (e.g., Health, Nutrition, WASH, Education) to cholera- and cyclone-affected populations, ongoing challenges related to funding, mobilisation of supplies and HR, the dearth of available IPs with relevant technical/emergency skills and physical presence across Mozambique, as well as limited data collection and analysis capabilities will potentially limit the extent to which sectoral objectives will be met during responses to future emergencies. Unless resolved, constraints (caused by lengthy international procurement processes with corresponding delays in delivery times, as well as challenges related to the distribution of supplies at the community level) may again produce significant delays in the delivery of needed supplies. MCO's adaptiveness and responsiveness, and its capability to improve its preparedness measures through drawing on internal reflection and learning stand out, along with its capabilities to mitigate operational constraints while scaling up. MCO's sustained involvement in RCCE/SBC and in child protection (CP)—crucial to raising cholera-awareness and in ensuring that children's needs were met—and its ability to scale up and collect and analyse data to judge the efficacy of its interventions will be crucial for the success of future PHE response operations.

Conclusion 2:

In the aggregate, MCO's interventions responded to the principal needs of the cholera- and Cyclone Freddy-affected populations. However, the response showed that MCO's capabilities to identify, target and meet the needs of specific vulnerable groups among the affected population groups (e.g., persons living with disabilities, girls, the elderly, or single-headed households, et al) are low. Unless addressed, MCO's capability to operationalise its institutional commitments to equity and inclusion in future emergency responses may prove to be problematic.

Conclusion 3:

Despite the absence of (sub)national plans and accurate epidemiological data, MCO's commitment to scaling-up response efforts using varying, context-specific response modalities (often based on the presence/proximity of Field Offices (Fos)) was key to ensuring adequate geographical coverage and in reaching both cholera- and cyclone-affected populations. Moving forward, MCO's adaptability and flexibility to address emergent needs will likely be tempered by its ability to identify IPs capable of implementing response activities in affected regions where MCO does not have an FO and in providing operational support to them.

Conclusion 4:

UNICEF MCO's emergency response interventions showed a high degree of alignment with UNICEF's CCCs and emergency response priorities, and ESARO capably supported MCO in the earliest phase of the L2 response (e.g., coordination⁴, HR), both of which leave MCO well placed as it prepares for future emergency response. However, the Regional Director's (RD) accountability for the L2 CEAP was not operationalised through directives, overt assumption of risk, or enhanced support to the CO to implement the Emergency Procedures (Eps)' "simplifications" on a "no regrets" basis (which CO staff are mandated to take to facilitate a timely response). Accordingly, the "specific simplifications that supersede global policies and procedures that would otherwise

³ Conclusions have been colour ranked, with red indicating that there were significant issues, delays, or problems with the intervention, amber indicating the existence of concerns or risks that need attention; and green indicating that progress went as planned and there were no major concerns or risks.

⁴ Provided to Mozambique and Malawi COs via RD-chaired Regional Emergency Management Team (REMT) meetings.

apply in non-emergency context⁵ were not applied to any significant extent. Unless this situation is addressed, MCO's capability to actualise the EP's intended gains in efficiency and timeliness in future L2 responses may remain aspirational (rather than operational).

Conclusion 5:

Though UNICEF MCO's response efforts underscored a commitment to addressing the immediate needs of the cholera- and cyclone-affected populations, MCO's capability to integrate longer-term considerations into its emergency interventions was uneven. However, continued focus on capacity-building, community engagement, and infrastructure rehabilitation presents opportunities for MCO to integrate sustainability and resilience across future response interventions. In the WASH and RCCE sectors, UNICEF-supported community initiatives targeting long-term behavioral change and sustainable practices show promise in addressing future needs. Until MCO pre-positions essential supplies (e.g., medical supplies, non-food items (NFIs) and WASH hardware components) in high-risk areas and successfully incorporates environmentally sustainable considerations, future emergency response activities may be less than optimally connected/sustainable.

Conclusion 6:

UNICEF MCO's support to coordination efforts at the subnational levels in affected provinces—where MCO served as a central point for intra-coordination among local authorities, sectors, and emergency response stakeholders—will likely be a key element to successful future emergency responses. MCO's active contributions to Cluster coordination ensured that Clusters under its leadership were active. However, not all clusters were adequately staffed and skilled during the L2 response, thereby there are opportunities to further operationalise UNICEF's institutional commitments to effective coordination. As was the case during the recent L2 response, this will require likely additional resources and expertise if MCO is to continue to navigate Mozambique's complex coordination dynamics effectively. The cross-border call between the Malawi and Mozambique COs was an example of good practice: fully exploring such opportunities for inter-CO coordination will likely be a key element of successful future regional responses.

Conclusion 7:

The extension of the L2 CEAP from Malawi to include the response to the cholera and Cyclone Freddy emergencies in Mozambique did not catalyse the required increase in funds needed to meet the needs of the cholera- and cyclone-affected populations, raising significant questions about the extent to which donors are committed to funding emergency responses in Mozambique. Given the likelihood of future multi-country emergencies in the Eastern and Southern Africa Region (ESAR), UNICEF's current protocols of splitting L2 Emergency Programme Funds (EPF) between COs will likely result in underfunded future responses, with corresponding impingements on MCOs coverage capabilities

Conclusion 8:

The L2 response included some longer-term and sustainability considerations, however, consistent and strategic linkages between humanitarian and development interventions and peacebuilding efforts will need to be made if future emergency responses are to demonstrate the required levels of cooperation, collaboration and coordination at the national level required to ensure collective outcomes based on joined up, coherent, complementary and risk-informed analysis, planning and action. The needs and gaps related to infrastructure and cyclone resilient construction, which require a holistic developmental approach and long-term resources and support present as an opportunity that MCO could explore in future emergency responses. The activation of MHPSS and Child Protection services during the L2 response played a crucial role in raising awareness among key stakeholders, including public services, about the pressing protection needs of children in emergencies. This

⁵ UNICEF. (2021) Guidance Handbook in L1, L2 and L3 Emergencies: Simplified and Streamlined for every Emergency (L1, L2, L3). UNICEF, NY, NY.

initial step catalysed a growing demand for such services, laying the foundation for broader Child Protection interventions within future emergency responses.

Recommendations

Recommendation 1: Strengthen preparedness for cholera and climate-related disasters.

Rationale: Cholera outbreaks and climate-related disasters are becoming more frequent and severe in the region, including in Mozambique. MCO was not sufficiently prepared for a timely and efficient response to an emergency of this scale.

Suggested actions: Develop a preparedness plan with appropriate scenarios (including multiple crises), that involves government stakeholders and United Nations agencies. Advocating for better surveillance systems for early detection of outbreaks and improving (internal) data management for planning and monitoring and response purposes, as well as identifying the EP simplifications will improve future response effectiveness. The development of early warning emergency trigger thresholds for PHEs, as well as an overhaul of existing internal and external global rosters will also improve MCO's future response ability.

Recommendation 2: Increase focus on placing persons with disabilities and other vulnerable groups (e.g., the elderly, women) at the centre of the emergency response.

Rationale: High-risk and vulnerable populations are disproportionately affected in crises. Efforts to identify and target these groups during the response were largely unsuccessful; organizational commitments could have been operationalized to a greater extent.

Suggested actions: Creating contingency Programme Documents (PDs) with organisations that can provide coverage to especially vulnerable groups rapidly after a disaster, particularly by involving local women's/girl's associations and those for persons living with disabilities, will improve MCO's abilities to meet their specific needs. This process should ensure the participation of persons with disabilities, and other identified vulnerable groups, in the planning and implementation processes. Scaling up child protection components across by strengthening community base protection structures will mitigate the impact of future emergencies on children and contribute to building stronger case management systems that will be adaptable for future emergency responses.

Recommendation 3: Ensure all required operational resources (e.g., human and material) are in place and known to all involved for efficient and timely implementation of an emergency response.

Rationale: Not all operational resources were fully integrated as part of the emergency preparedness, which is required to allow for timely and adequate implementation.

Suggested actions: Further enhance resource mobilization and funding mechanisms covering each pillar or area of the response, advocating for flexibility that allows for contingency planning, adjustment, and adequate emergency preparedness. Develop procedures for meaningful decentralization of specific activities to FOs during future emergency responses. Continue enhancing supply chain management to ensure the timely procurement of needed supplies: this will necessarily involve pre-positioning sufficient quantities of both medical, WASH hardware, and NFI supplies in high-risks areas and building local government capacity to manage and store these stocks.

Recommendation 4: Strengthen MCO's role and contributions in inter-agency coordination and ensure complementarity between key stakeholders.

Rationale: Emergency responses require a multisectoral approach and strong external and internal coordination, with clear roles and responsibilities for leading agencies and stakeholders supporting the GoM.

Suggested actions: Prioritize strengthening all UNICEF response areas within emergency response by coordinating closely with local authorities and humanitarian partners and by ensuring effective coordination between UNICEF and WHO for future PHE by clarifying delineation of mandates and roles.

Recommendation 5: Continue supporting the GoM in emergency preparedness.

Rationale: UNICEF is mandated to support the government in its efforts to prepare and respond to crises, including increasing their capacity to become more resilient and self-sufficient.

Suggested actions: Advocating for a child-centred agenda for future emergency responses following an inclusive (e.g., gender, persons with disabilities, the elderly, etc.), rights-based approach, and advocating for the activation of contingency plans from key GoM ministries will ensure a high level of involvement in future emergency responses.

Recommendation 6: Improve MCO's approach to ensure that HDP nexus/risk informed programming is implemented.

Rationale: UNICEF is well positioned to advocate for and prioritize addressing the complex challenges faced by children and communities affected by cholera and climate related crises that require more resilient, longer term, and durable solutions.

Suggested actions: Identify links between future humanitarian responses and anticipatory action in longer-term programming will ensure that HDP Nexus and resilience considerations are not only implemented in the north, but in all provinces supported by the MCO. Additionally, the Partnership Review Committee (PRC) should ensure that the HDP nexus is included in all PDs that go through them, and all MCO personnel should be trained on Guidance for Risk-Informed Programming (GRIP). Of especial importance is the need to develop focused advocacy efforts to ensure that the GoM includes cash transfers in future emergency responses. Lastly, ensuring that development activities (especially infrastructure) are risk/climate informed using the 2022 Child-Centred Risk Assessment (CCRA) as a guide (e.g., regarding location, materials, and maintenance) will bolster community resilience against recurrent emergencies.

1. INTRODUCTION

This report describes the results of the Evaluation of the United Nations Children Fund's (UNICEF) Response to the Level 2 (L2) Cholera and Cyclone Freddy Emergencies in Mozambique. UNICEF's responses aimed to provide life-saving assistance to children and women by facilitating timely action on a no-regrets basis through established multisectoral inter-agency partnerships, collaboration with national and local governments, and sustained presence by partners wherever possible.

The evaluation was led and implemented by a team of independent consultants from *hera – right to health and development*, a Belgium-based cooperative company that works with a network of experts, research organizations, governments, non-governmental organizations (NGOs) and public health institutions to promote the right to health and development for all. It was managed by UNICEF's Eastern and Southern Africa Regional Office (ESARO), in close collaboration with the UNICEF Mozambique Country Office (MCO). The evaluation covers the period between September 2022 and September 2023,⁶ and was conducted between October 2023 and June 2024.

The evaluation report consists of seven sections. This first section provides a very brief introduction to the evaluation. The second section presents the background and context. The third section presents the object of the evaluation. The fourth section describes the evaluation purpose, objectives, scope, and users. The fifth section provides information about the design, approach, methods, limitations, and ethical issues. The sixth section describes the evaluation findings. The seventh section presents the conclusions, lessons learned, and a set of recommendations. The annexes, compiled in a separate document, contain supporting data, documents, and evidence.

2. BACKGROUND AND CONTEXT

This section explores the context of cholera within the field of global health, the context of extreme weather events in the Eastern and Southern Africa Region (ESAR), UNICEF's regular programming in Mozambique, and UNICEF's multisectoral response to the cholera and tropical cyclone emergencies in Mozambique. It also provides a description of expected vulnerabilities during cholera outbreaks, with a focus on women and children. This section has been informed by a review of grey and academic literature.

2.1 Cholera

Cholera is an acute diarrhoeal infection caused by eating food or drinking water that is contaminated with the bacterium *Vibrio cholerae*. Cholera remains a global threat to public health and is an indicator of inequity and poverty, specifically inadequate safe water, and sanitation. According to World Health Organization (WHO) estimates, every year there are 1.3 to 4.0 million cases of cholera, and 21,000 to 143,000 deaths worldwide due to the infection.⁷ Despite being a relatively easy disease to manage, cholera can cause severe acute watery diarrhoea, with severe dehydration leading to hypovolemic shock due to fluid loss, and death if not treated in a timely manner or properly. It takes between 12 hours and five days for a person to show symptoms after exposure. Cholera affects both children and adults and can kill within hours if untreated. Most people infected with *Vibrio cholerae* do not develop any symptoms, although the bacteria

⁶ The period covered by the evaluation starts with the official declaration of the cholera outbreak in September 2022. The L2 was activated in March 2023, and deactivated in September 2023 (the end of the period covered by this evaluation). See also the timeline in Annex 1.

⁷ WHO. (2023) Cholera: Overview. https://www.who.int/health-topics/cholera#tab=tab_1. Accessed 30 November 2023.

are present in their faeces for one to 10 days after infection. This means the bacteria can be shed back into the environment, potentially infecting other people.

After a brief decline in cholera cases from 2019, which was largely related to lack of movement due to COVID-19 public health and social measures and anecdotally linked to better hand hygiene adopted as a COVID-19 preventive measure, cases of cholera started to increase again in mid-2021, doubling by 2022. By February 2024, twenty countries across three WHO regions reported cases.⁸ The proportion of people who die from reported cholera remains higher in Africa than elsewhere. This reflects the lack of timely access to treatment.⁹

Cholera is endemic in at least half of the 21 countries in ESAR. In highly endemic areas, a small number of specific geographic zones and populations are known as priority areas for multisectoral interventions (PAMIs).¹⁰ PAMIs with alternating seasonal outbreaks and lull periods are thought to be the source of epidemics that spread beyond their boundaries. For example, frequent outbreaks among the fishing communities of Lake Malawi seem to be the origin of cholera transmission in Malawi.¹¹ Cholera outbreaks have been on the rise in ESAR since January 2023, with widespread and extended transmission in Malawi and Mozambique and outbreaks reported in Tanzania, South Africa, Zimbabwe, Burundi, Zambia, and the Comoros.

Cholera prevention/elimination Cholera is preventable and can be eliminated where populations' access to clean water and sanitation facilities that facilitate the adherence to good hygiene practices is ensured and sustained for the whole population.¹²

Cholera response to reduce cholera-related mortality, contain and prevent major outbreaks and minimize the impact of cholera epidemics on communities, interventions must be implemented in a coordinated manner through a multidisciplinary response structure with five core components: coordination, collaborative surveillance, community protection, safe and scalable care, countermeasures, and research.

Oral Cholera Vaccine (OCV) The OCV has been successfully used in selected cholera hotspots and during cholera outbreaks. OCV is used in conjunction with other cholera prevention and control measures, such as case management and emergency water, water sanitation and hygiene (WASH) interventions. Since 2013, the International Coordinating Group¹³ (ICG) has managed the global stockpile of OCV that was created as an additional tool to help control cholera epidemics. The group is composed of members of WHO, Médecins Sans Frontières (MSF), UNICEF, and the International Federation of the Red Cross. Since the establishment of the cholera vaccine stockpile in 2013, 140 million doses of OCV have been shipped to 26 countries, of which 94 million (66 per cent) have been approved for use in emergency responses. Since January 2022, nearly 39 million vaccine doses have been shipped to 15 countries. The global surge in cholera cases has put a strain on the ICG OCV stockpile, and dose supply is not sufficient to meet demand. The strained global supply of cholera vaccines obliged the WHO to make the decision in October

⁸ <https://www.who.int/publications/m/item/multi-country-outbreak-of-cholera--external-situation-report--12---14-march-2024>. Accessed 17 April 2024.

⁹ Centres for Disease Control. (2023) Cholera in Africa. <https://www.cdc.gov/cholera/africa/index.html>. Accessed 30 November 2023.

¹⁰ Formerly known as 'hotspots'.

¹¹ Cholera Platform. (2023) Eastern and South Africa Regional Cholera Platform. <https://www.platemecholera.info/east-and-south-africa-regional-cholera-platform-0>. Accessed 30 November 2023.

¹² WHO. (2023) Cholera: Overview. https://www.who.int/health-topics/cholera#tab=tab_1. Accessed 30 November 2023.

¹³ The ICG is an international group that manages and coordinates the provision of emergency vaccine supplies and antibiotics to countries during major disease outbreaks, while the Global Task Force on Cholera Control coordinates the stockpile for preventive vaccines.

2022 to temporarily suspend the standard two-dose vaccination regimen in cholera outbreak response campaigns, using instead a single-dose approach, and to cease preventive campaigns in PAMIs.¹⁴

2.2 Extreme weather events in ESAR

Extreme weather events, such as cyclones, floods, landslides and droughts, occur regularly in the Southern Africa and Indian Ocean region and have become more frequent and severe due to climate change.¹⁵ Climate change poses serious threats and challenges to Eastern and Southern Africa, exacerbating existing risks such as water stress, the spread of infectious diseases, and food insecurity, all of which are negatively compounded by situations of conflict and economic degradation. Societal transformations, such as urbanization, land tenure changes and market reforms, in many cases undermine adaptive capacity and increase vulnerability.¹⁶ Despite a greater push for multi-hazard, people-centred climate risk reduction efforts across Africa, to date climate risk reduction efforts have been largely unsuccessful in reducing the vulnerability of those living in Eastern and Southern Africa to extreme weather events.

2.3 The impact of cholera outbreaks and Cyclone Freddy in Mozambique

This section outlines the impact of cholera outbreaks and Cyclone Freddy in Mozambique.

Mozambique is a low-income East African economy with a mostly rural labour force. It is rich in natural resources and has strong ties with South African. Islamist terrorism in the north endangers newly discovered sources of natural gas. Mozambique is currently in court over massive (and possibly unauthorized) debt. The Zambezi River flows north through the north-central and most fertile part of the country. Though it is 99% African (Makhuwa, Tsonga, Longwe, Sena and others) Mozambique is home to various ethnic groups: Mestizo: 0.8%, and Indian, Pakistani, Chinese and European 0.2%). Mozambique is a poor, sparsely populated country with high fertility and mortality rates and a rapidly growing youthful population – 45% of the population is younger than 15, as of 2020. Mozambique's high poverty rate is sustained by natural disasters (e.g., severe droughts, devastating cyclones, and floods), disease, high population growth, low agricultural productivity, and the unequal distribution of wealth. The country's birth rate is among the world's highest, averaging around 5 children per woman (and higher in rural areas) for at least the last three decades. Mozambique is predominantly a country of emigration, but internal, rural-urban migration has begun to grow. Mozambicans, primarily from the country's southern region, have been migrating to South Africa for work for more than a century. Increased migration of the population to urban and coastal areas has come with adverse environmental consequences such as desertification, soil erosion, and deforestation. Water pollution is caused by artisanal mining and wildlife preservation (elephant poaching for ivory) is a challenge. Mozambique is marked by severe localized food insecurity. Due to a shortfall in agricultural production and an economic downturn, the number of people in need of food assistance is expected to rise above the 1.86 million estimated in 2021-2022.¹⁷

¹⁴ WHO. Global Strategic Preparedness, Readiness and Response Plan for Cholera: April 2020–April 2024. https://cdn.who.int/media/docs/default-source/documents/emergencies/global-cholera-sprpp-v7-2023-05-19_cleared.pdf?sfvrsn=7b5f7ced_2&download=true. Accessed 14 December 2023.

¹⁵ International Federation of Red Cross Red Crescent Societies. (2023) A greater push for multi-hazard, people-centred climate risk reduction across Africa. <https://www.ifrc.org/article/greater-push-multi-hazard-people-centred-climate-risk-reduction-across-africa>. Accessed 1 December 2023.

¹⁶ Global Environmental Change and Human Security. (2008) Climate Change in Eastern and Southern Africa: Impacts, Vulnerability and Adaptation. https://www.ipcc.ch/apps/nj-lite/srex/nj-lite_download.php?id=5977. Accessed 1 December 2023.

¹⁷ CIA. (2024) The World Factbook: Mozambique. <https://www.cia.gov/the-world-factbook/countries/mozambique/#introduction>. Accessed 23 May 2024.

Extreme weather events have become cyclical in Mozambique, which is particularly prone to natural hazards. In the last three decades, Mozambique has suffered the impact of 35 hydro-meteorological disasters, affecting nearly 16 million people. This has included five cyclones and two tropical storms in the last decade that affected 3.8 million people. Statistics point to an upward trend in natural disaster occurrence in Mozambique due to climate change: extreme events are becoming more frequent, and tropical storms are bringing flooding, material destruction, and loss of lives. Mozambique's geographical location – next to the Indian Ocean and downstream from many of Africa's largest rivers – combined with low levels of socioeconomic development, makes the country particularly vulnerable to climate change. Natural disasters are particularly worrisome in Mozambique, where it is difficult to circulate information about extreme weather events to everyone that needs it, as a very large percentage of Mozambique's population live in rural areas that are without the infrastructure to allow for adequate communication. The combination of floods and drought makes many communities in Mozambique particularly vulnerable to the effects of extreme weather events. In times of drought people move closer to the rivers to farm because the land is more fertile, but when floods come, they do not have time to head for higher ground. Natural hazards compound other vectors of vulnerability present in Mozambique, such as food insecurity (1.1 million people affected) and internal displacement caused by the violence of armed insurgency (over 1 million people affected).

In Mozambique, which has about 32 million inhabitants, cholera follows a seasonal pattern and is endemic, with peaks during the rainy season, which generally lasts from November to April. Cholera was introduced to Mozambique from the Indian subcontinent in 1970, becoming a major cause of infectious diarrhoea in the country.¹⁸ Since then, the country has been faced with repeated outbreaks, particularly in Nampula province.¹⁹ The most severe outbreak happened during the 1990s, resulting in one-third of all cases in Africa in that period.²⁰ All diarrheic diseases taken together are the fourth major cause of death of children under the age of five in Mozambique, causing an average 13,000 deaths per annum. Mozambique's cholera epidemiological profile changes from epidemic to endemic due to the frequent outbreaks.²¹ In general, there is a virtually countrywide epidemic every five years; however, the cities of Nampula and Cuamba register cases each year,²² usually during the rainy season.

During the period 2022–2023 Mozambique faced a triple crisis of climate change, escalating armed conflict and the aftermath of the COVID-19 pandemic. In 2022, the humanitarian situation in Mozambique was both complex and challenging, with climate shocks, disease outbreaks and conflict in the northern provinces. Between January and March 2022, Mozambique experienced four tropical systems, one of which turned into Tropical Cyclone Gombé. The combined effects of these storms affected nearly 968,000 people in the central and northern regions of the country (Zambézia and Nampula provinces), of whom around 41,000 were temporarily displaced.²³ In addition to conflict, climate shocks, and previous cholera outbreaks, in 2022 the country also experienced polio outbreaks and other disease outbreaks. Earlier, in 2019, Cyclones Idai and Kenneth hit Mozambique, the first time in recorded history that two strong tropical cyclones had hit Mozambique and the region in the same season.

¹⁸ Marrufo T, Salomão C, Chicumbe S, Muianga C, Cardoso N, Baltazar C, et al. Avaliação de determinantes ambientais (água, saneamento e higiene) na cidade de Nampula em 2016. *Revista Moçambicana de Ciências de Saúde*. 2018;4:66

¹⁹ Victorino J, Savaio L, António M. Mitos e boatos da cólera na província de Nampula Janeiro-Março 2018. *Revista Moçambicana de Ciências de Saúde*. 2018;4:149

²⁰ Borges BV, Armando E, Missage E. Acesso à água, higiene, atitudes e práticas relacionadas com a prevenção da cólera em torno das comunidades do município de Metangula, província de Niassa, 2016. *Revista Moçambicana de Ciências de Saúde*. 2019;4:104.

²¹ Victorino J, Savaio L, António M. Mitos e boatos da cólera na província de Nampula Janeiro-Março 2018. *Revista Moçambicana de Ciências de Saúde*. 2018;4:149.

²² Mesa F, Simbine E, Faranguana AC. Análise de casos de diarreias agudas e óbitos no Hospital Distrital de Mocuba-Junho a Julho de 2015. *Revista Moçambicana de Saúde Pública*. 2018;4:190.

²³ National Institute of Disaster Management and Risk Reduction (INGD) (2022).

The scale of the outbreak that started in 2022 was more significant than those in previous years, occurring in more districts (80 in total)²⁴ and more urban locations, across 10 provinces, and had significant potential to continue to spread – especially considering flooding and infrastructure damages due to the rainy season, which was then followed by the effects of Cyclone Freddy. On 14 September 2022, the Ministry of Health (MoH) announced a cholera outbreak in Niassa province. Thereafter, cholera spread geographically: rising floodwaters resulting from Cyclone Freddy’s double landfall—along with the limited coverage of health and WASH services and high levels of food insecurity—contributed to the disease spreading further throughout the country. Cyclone Freddy, the longest-lasting cyclone in history, made landfall twice in Mozambique: once in late February 2023, affecting Inhambane, Gaza and Sofala provinces, and again in mid-March 2023, impacting the central zone (Zambézia, Sofala, Manica, Tete and Niassa provinces), including areas with high cholera caseloads.

Cyclonic flooding took a heavy toll on infrastructure and crops. The 2023 floods affected approximately 390,000 hectares of agricultural land (of which 40–50 per cent were considered lost) in areas already identified as being at a crisis level according to the Integrated Food Security Phase Classification (IPC3),²⁵ raising concerns of long-term food insecurity. Cyclone Freddy caused significant obstacles to education throughout Mozambique: in many instances storms and floods damaged school infrastructure or made them inaccessible and in other areas (a few), education was interrupted and, in some cases, classrooms served as temporary accommodation centres for displaced families. The damage to WASH and health facilities, and general infrastructure, in provinces already affected by cholera and with limited pre-storm/flood hygiene and health services, raised the alarm for the risk of a significant spread of the cholera outbreak. With the sudden escalation of the cholera outbreak, UNICEF redoubled its efforts to support affected communities through WASH, health, and social and behavioural change (SBC) activities via the provision of technical and financial support to the GoM and partners.²⁶

The cholera outbreak started in September 2022 and as of November 2023 over 36,000 cholera cases had been reported. By January 2024, cholera cases had been reported in 11 provinces and 80 of Mozambique’s 161 districts.²⁷ The case fatality rate (CFR) has remained below the critical threshold of 1 per cent (in October 2023 the CFR stood 0.4 per cent, or 146 deaths),²⁸ but it is believed that deaths are underreported. Some areas are known to have a higher CFR, especially at the start of a new outbreak cluster, and unreported community deaths persist.

While the incidence of other notifiable diseases has improved since September 2023, the cholera situation has been escalating. As at November 2023, 19 districts had announced new outbreaks (doubling the number as of two weeks prior), and two additional districts announced new outbreaks (also doubling the number as of two weeks prior). Furthermore, two additional districts were on high alert, with rising cases of acute watery diarrhoea.²⁹

Cholera and Cyclone Freddy: children, women and vulnerabilities

Women and children have faced many challenges in the aftermath of Cyclone Freddy and during the ongoing cholera outbreak. In total, Cyclone Freddy destroyed more than 100 health facilities and more than 1 650 schools, disrupting the learning of almost half a million children. Around 250 water points and six

²⁴ WHO Cholera Epidemiological update, 10 January 2024.

²⁵ Integrated Food Security Phase Classification. (2023) Mozambique: Acute Food Insecurity Situation November 2022 – March 2023. <https://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1155848/>. Accessed 2 January 2024.

²⁶ See Annex 2 for an outline of new cholera cases in Mozambique in 2023, and Annex 3 for a map showing the cholera- and flood-affected districts as at April 2023.

²⁷ WHO Cholera Epidemiological update, 10 January 2024.

²⁸ WHO. (2023) Weekly Situation Report #57, published on 20 October 2023.

²⁹ UNICEF. (2023) UNICEF & WHO Joint call for urgent and collective action to fight the cholera outbreak in Mozambique. [https://www.unicef.org/mozambique/en/reports/unicef-who-joint-call-urgent-and-collective-action-fight-cholera-outbreak-mozambique#:~:text=Highlights-.Mozambique%20is%20suffering%20from%20the%20deadliest%20cholera%20outbreak%20in%2025,in%20September%202023%2C%20escalated%20again](https://www.unicef.org/mozambique/en/reports/unicef-who-joint-call-urgent-and-collective-action-fight-cholera-outbreak-mozambique#:~:text=Highlights-.Mozambique%20is%20suffering%20from%20the%20deadliest%20cholera%20outbreak%20in%2025,in%20September%202023%2C%20escalated%20again.). Accessed 12 December 2023.

urban water systems were damaged or destroyed, cutting access to potable water for approximately 300,000 people. Food insecurity presented a major risk to children in the country: more than 390,000 hectares of land were affected by Cyclone Freddy and the floods that resulted. The education system also suffered major challenges. For over eight weeks some districts could not be accessed to assess and verify damage to school infrastructure. As noted above, even in instances where school infrastructure was undamaged, learning was interrupted as schools were not accessible or served (partially) as temporary accommodation centres for cyclone- and flood-affected families. Even though the floodwaters have now receded, education challenges persist, especially in Zambézia province, where many schools face limited access to clean water (which is needed to disinfect the premises after schools reopen) and hygiene materials. The disruption to health services caused by Cyclone Freddy and the resulting floods particularly impacted women and girls, via reduced access to antenatal and postnatal services, HIV, sexual and reproductive health services, and family planning. Gender-based violence (GBV) response services, particularly in Zambézia province, saw deteriorations to a system that was already structurally inadequate, with the result that displaced populations were not able to access information or referral services.

3.OBJECT OF THE EVALUATION

This section describes UNICEF's global recommendations to preparedness and response to public health emergency (PHEs),³⁰ and its position in Mozambique, both through its development programming as well as through its emergency response to the cholera outbreaks and Cyclone Freddy. The section also sets out a theory of change (ToC) that has been retroactively developed to comprehensively describe and illustrate how and why the emergency responses' desired changes were expected to happen.

3.1 UNICEF and PHEs

In its 2023 White Paper 'Putting the Best Interest of Children, Women and their Communities at the Centre of Public Health Emergency Preparedness and Response'³¹, UNICEF outlined nine recommendations in relation to PHE prevention and response (PHE-PR). UNICEF's programmatic and operational commitments in PHE-PR are guided by three objectives: 1) to ensure that the rights and needs of children are at the centre of all efforts: 2) to leverage the agency's recognized expertise on multisectoral preventive approaches to prevent and control outbreaks; and 3) to prevent and mitigate the humanitarian and socioeconomic consequences of PHEs on communities, with a whole-of-society focus. The nine essential recommendations for PHE-PR set out in the White Paper were informed by lessons learned through the COVID-19 pandemic response and UNICEF's response to previous PHEs. They support UNICEF's Core Commitments for

White Paper PHE-PR recommendations

1. Prioritize and invest in robust primary health-care systems.
2. Ensure WASH services for all.
3. Invest in strong immunization systems to reach the most marginalized.
4. Strengthen the capacities of first responders.
5. Ensure that no child misses out on their education.
6. Foster social cohesion and build trust through social protection systems.
7. Strengthen systems to care for and protect the most vulnerable children.
8. Invest in informed and better decision-making through data systems.
9. Make lifesaving countermeasures universally accessible, relevant, and acceptable to all.

³⁰ See Section 6.1.5 for an analysis of the extent to which UNICEF MCO's response incorporated these nine recommendations, and how aspects of the response either corresponded with or varied from UNICEF's response to prior PHE responses.

³¹ <https://www.unicef.org/reports/putting-best-interest-children-women-and-their-communities-centre>. Accessed 17 April 2024.

Children in Humanitarian Action (CCCs), the UNICEF Strategic Plan 2022–2026, UNICEF’s Guiding Principles,³² and other international frameworks.³³

3.2 UNICEF in Mozambique

UNICEF has been a key partner in Mozambique for almost five decades. During this time, the country has been faced with numerous significant challenges, including civil war, post-conflict recovery and peacebuilding, poverty, recurrent natural disasters, and the surge of HIV and AIDS. After Mozambique’s independence from Portugal, which took place on 25 June 1975, UNICEF opened its first office in Maputo. Currently, aside from the Country Office in Maputo, UNICEF has four field offices (FOs) (in Beira, Nampula, Quelimane, and Pemba), which were all active in responding to both the cholera outbreak and Cyclone Freddy.

The UNICEF Mozambique Country Programme Document (CPD) 2022–2026 outlines an indicative budget of United States dollars (USD) 107 million from regular resources, subject to the availability of funds, and USD 280 million in other resources, subject to the availability of specific-purpose contributions. The CPD is aligned with the country’s new United Nations Sustainable Development Country Framework (UNSDCF) and aimed for a convergence/ integration approach to HDP Nexus/resilience programming. Within the UNSDCF, UNICEF is uniquely positioned to support the achievement of national development targets and Sustainable Development Goals relating to children. The UNICEF Mozambique Country Office (MCO) contributes to UNSDCF strategic priorities on human development, climate resilience and sustainable use of natural resources, and on peacebuilding, human rights, and inclusive governance. MCO is also contributing to a lesser extent to strategic priorities on economic diversification, building resilience in institutions and communities, and sustainable livelihoods to address existing, structural weaknesses around basic service provision that make children and communities extremely vulnerable to any shock.

3.3 UNICEF’s response to the cholera and Cyclone Freddy emergencies

An L2 Corporate Emergency Activation Procedure (CEAP) for the cholera outbreak was triggered on 10 March 2023. Tropical Cyclone Freddy made a record second landfall in Zambezia, Mozambique on 12 March, affecting four provinces of Mozambique and southern Malawi, building on the first landfall that occurred on February 24 in Vilankulos district in Inhambane province. The cyclone exacerbated what was already a devastating cholera outbreak in both countries. This compounded an already complex humanitarian situation in Mozambique where millions of people had been affected by armed conflict in the northern provinces. On 23 March, UNICEF expanded the L2 CEAP scale-up for the cholera outbreak in Malawi to cover Mozambique and include: 1) response to floods and overall impact of Tropical Cyclone Freddy in both Malawi and Mozambique, and 2) response to ongoing cholera outbreak in Mozambique, until 9 September 2023 when the L2 CEAP scale-up was officially deactivated (for both countries).

The rights holders targeted by the L2 interventions were cholera- and cyclone-affected populations throughout Mozambique, in particular: children, women, children, persons with disabilities, refugees, cholera survivors, and students in Zambézia, Sofala, Tete, and Niassa provinces (this includes those living in urban, peri-urban, and rural settings). An assemblage of state and non-state actors worked together with

³² UNICEF’s Core Commitments for Children: human rights-based approach; do no harm; non-discrimination; child participation; the best interest of the child; environmental sustainability; environmental sustainability.

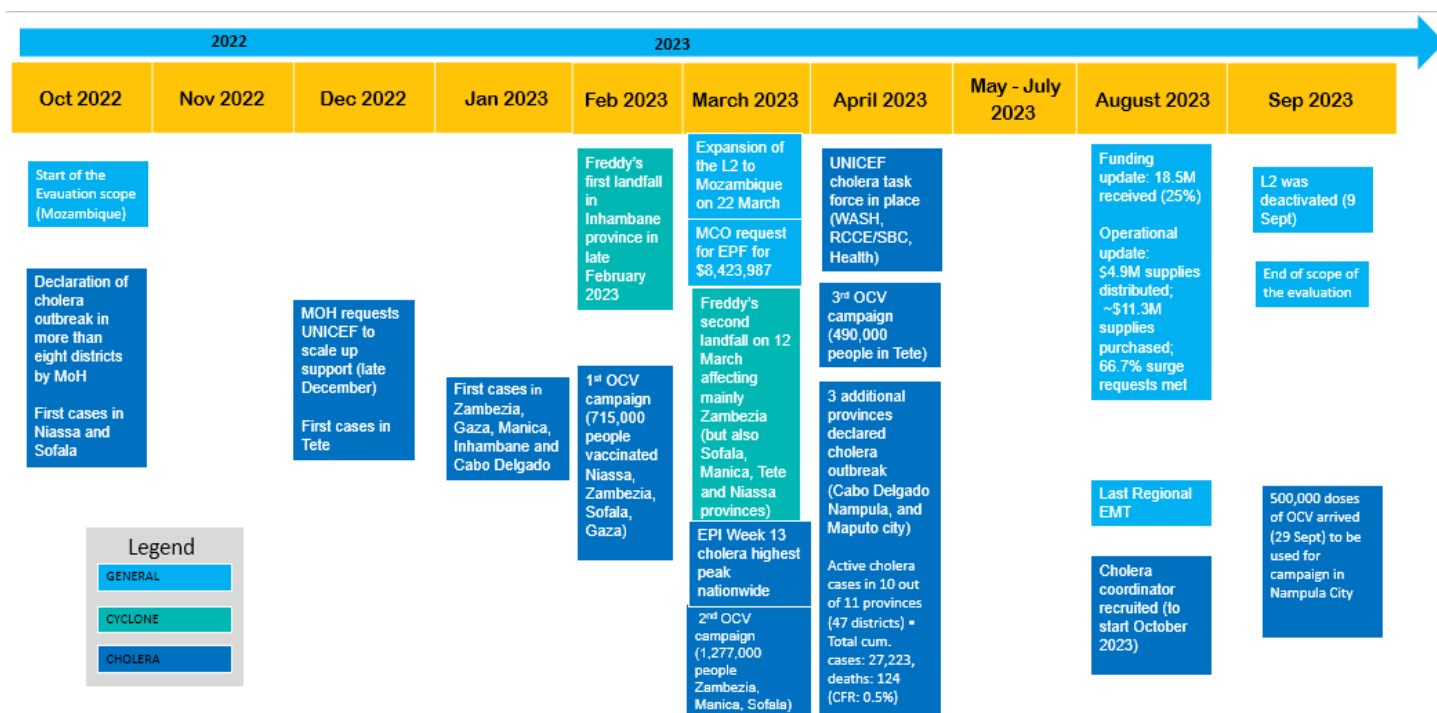
³³ These include the Convention on the Rights of the Child; UNICEF’s mission to respond to emergencies to protect the rights of children; UNICEF’s role in contributing to the implementation of the International Health Regulations (2005); and UNICEF’s response role in emergency settings as per the Inter-Agency Standing Committee (IASC) Humanitarian Systemwide Scale-Up Activation Protocol for the Control of Infectious Disease Events (April 2019).

UNICEF to assist the cholera- and cyclone affected populations. A list of the duty bearers (state and non-state actors with responsibilities to the rights holders) who participated in the response to the cholera and Cyclone Freddy emergencies can be found in Table 1 in Section 4.4 below.

As of July 2023, as a result of the L2 interventions 470,000 persons were able to access health services, 5,866 children had received treatment for Severe or Acute Malnutrition (SAM), 469,534 persons had access to safe water, 117,128 persons had access to Mental Health and Psychosocial Support (MHPSS) services, 108,753 students had access to education, 3.1 million persons had been reached with Risk Communication messaging, 1.5 million persons had received information and/ or services regarding the Prevention of Sexual Abuse and Exploitation (PSAE).³⁴ (As disaggregated data is not available, it is not possible to provide a more granular snapshot as to the numbers of children, men/ women, the elderly or persons with disabilities that the interventions reached.)

Following the declaration of the cholera outbreak (September 2022) in more than eight districts by the MoH, UNICEF MCO stepped up its response by activating a multisector response, responding to the MoH's request to scale up support in late December 2022; this was further extended after Cyclone Freddy hit in March 2023. UNICEF MCO's response to the cholera outbreak was based on an integrated life-saving approach, building on existing activities and partnerships—both with the GoM and NGOs—and applying community mobilization and participation. The health and WASH clusters, as part of the Humanitarian Response Plan (HRP) Addendum process, which took part during the emergency response, and in view of the increasing caseload after the cyclone, identified at least 16 million people at risk of cholera in Mozambique. In April 2023, three additional provinces declared a cholera outbreak: Cabo Delgado and Nampula in the north,³⁵ and the capital city of Maputo.

Figure 1. Timeline of Cyclone Freddy and cholera in Mozambique: 2022-2023³⁵



³⁴ UNICEF. (2023) Southern Africa: Malawi and Mozambique cholera and cyclone response: July 2023. <https://www.unicef.org/documents/malawi-and-mozambique-humanitarian-situation-and-response-dashboard-july-2023>. Accessed 19 May 2024.

³⁵ WHO Mozambique. (2023) WHO Cholera & Cyclone Emergency W16, 24/04/2023.

Between January and March 2023, UNICEF provided over USD 2.5 million in supplies to support responses to the flooding, Cyclone Freddy, and cholera, as well as to provide technical and financial support to the GoM and NGO partners. In addition to staff deployments to Niassa, Tete, Inhambane and Manica provinces, UNICEF's Field Office (FO) teams in Zambézia, Sofala, Nampula and Cabo Delgado provinces continued to support the GoM's response. Since the start of 2023, all 11 provinces in Mozambique have required support to the response to either cholera (10 provinces) and/or flooding/Cyclone Freddy (five provinces). The combination of these needs is taxing the response infrastructure in a country with inequitable access to resources and where 46 per cent of children are multidimensionally poor.

In 2023, UNICEF MCO prepared the Mozambique Multisector Cholera and Floods Response Plan, which is aligned with the GoM's Cholera Response Plan, the WASH and Health Cluster Response Plans, and the HRP Addendum. The UNICEF response plan targeted 2.1 million people affected by cholera and Cyclone Freddy and required funding support of USD 89 million for six months (March–September 2023). The response plan was informed by lessons learned from past cholera responses and was anchored in UNICEF's CCCs (more specifically, the CCCs relating to PHEs).³⁶ UNICEF stepped up its response by activating a multisector response through the CCCs core areas, such as WASH, health and nutrition, child protection, and education, incorporating cross-sectoral issues, such as adolescent engagement, GBV, and protection from sexual exploitation and abuse (PSEA). For the cholera response, activities were identified through the global 'pillars', including risk communication and community engagement (RCCE), case management, coordination, WASH, supplies and logistics, and vaccination, among others. The response plan detailed UNICEF's response and identified key gaps.

3.4 Theory of Change (ToC)

As per the requirements of the evaluation's terms of reference (ToR), the evaluation team retrospectively developed a ToC that outlines the intervention logic underlying how and why desired changes were expected to occur as a result of the emergency response activities. It was constructed based on UNICEF Mozambique's Multisectoral Cholera and Floods Response Plan, the Humanitarian Action for Children (HAC) benchmarks tracking system, and feedback received from UNICEF technical teams.³⁷

The theory behind UNICEF's response to the L2 cholera and Cyclone Freddy emergencies is as follows:

- **IF** the severity of the cholera outbreaks and damage brought by Cyclone Freddy exceeds the existing response capacities of UNICEF MCO,
- **AND** UNICEF activates an L2 emergency response, triggering the establishment of the emergency procedures (EPs), deployment of staff and supplies, and access to additional financial resources,
- **AND** UNICEF MCO contributes to the cholera and cyclone responses, by proactively coordinating the WASH pillar, funding and supporting the GoM, implementing partners (IPs) and affected populations, and implementing health and nutrition, WASH, education, child protection and RCCE/SBC interventions under the national response programmes, while upholding UNICEF's CCC's and adhering to UNICEF's EPs,
- **THEN** UNICEF MCO's efforts will contribute to national cholera and cyclone preparedness and responses to meet the increased needs of the affected populations in the relevant districts, save lives, and halt cholera transmission.

³⁶ UNICEF. (2023) Core Commitments for Children. <https://www.corecommitments.unicef.org/ccc-2-5-1>. Accessed 15 October 2023.

³⁷ The ToC was developed in close collaboration with the MCO: a remote ToC workshop was held on 18 January 2023, and was followed by continuous discussions, both online and during the data collection phase.

The ToC is based on the following eight assumptions:

- UNICEF (Country Office and ESARO) will apply EPs in a timely manner.
- UNICEF (Country Office and ESARO) has the required financial, supply and human resources to reach the population at risk and affected by cholera and by Cyclone Freddy.
- UNICEF MCO's response plan is adequate, in line with UNICEF corporate guidelines and Contingency Programme Document in Mozambique and aligned to the GoM's response plans.
- UNICEF MCO receives the required cooperation and support from the GoM.
- UNICEF MCO has sufficient partners to rapidly respond to the cholera outbreak in all targeted communities in the required locations with sufficient capacity and resources.
- UNICEF MCO's RCCE/SBC sections and teams provide information in the affected and at-risk communities that mitigate the impact of Cyclone Freddy and bring about the changes in the social behaviour necessary to contain the cholera outbreak.
- UNICEF ESARO capably supports the MCO.
- UNICEF and partners, including the GoM, have sufficient capacity and resources to transition from emergency response to longer-term response, ensuring there is continuation of the outcomes and objectives beyond UNICEF's support.

(See Annex 4 for a diagram showing the complete ToC.)

4. PURPOSE, OBJECTIVES, SCOPE AND USERS

This section starts by explaining the purpose and the objectives of the evaluation. This is then followed by a description of the evaluation's scope and the intended users.

4.1 Purpose

The evaluation was mandated by UNICEF's revised evaluation policy.³⁸ The evaluation serves two main purposes: 1) to strengthen UNICEF's accountability to affected populations (AAP) and to donors that supported the response, and 2) to support learning on how to improve preparedness for and response to future emergencies and to contribute to building resilience and strengthening the humanitarian-development-peace (HDP) nexus.

4.2 Objectives

The objectives of the evaluation are to do the following:

1. Provide an assessment of UNICEF's response to the L2 cholera and Cyclone Freddy emergencies in Mozambique vis-à-vis the issues of appropriateness/relevance, effectiveness, efficiency, connectedness, and coordination/partnerships, with a specific focus on the adaptiveness/responsiveness of UNICEF's response and how it has addressed issues for children, adolescents and women, including those with disabilities or facing marginalization or deprivation.
2. Assess the extent to which emergency preparedness and procedures enabled UNICEF to respond effectively. This should include reviewing the extent to which UNICEF has incorporated lessons

³⁸ UNICEF. (2018) Revised Evaluation Policy of UNICEF. <https://www.unicef.org/media/54816/file>. Accessed 30 March 2024.

learned from responses to previous emergencies as well as whether and how the Emergency Preparedness Platform, human resource (HR)/surge capacities, partnerships, L2 Emergency Procedures, coordination mechanisms, supply pre-positioning and distribution monitoring, data and monitoring systems, social protection/shock-responsive systems that were established enabled a timely and effective UNICEF response.

3. Draw out key learning and specific sectoral, cross-sectoral, and operational recommendations to strengthen UNICEF's HDP nexus bridging and preparedness for future emergencies through risk-informed country programmes.

The evaluation team has given priority to developing actionable recommendations that align with natural disaster and global disease outbreak preparedness and response priorities, as well as with UNICEF's White Paper on PHEs. The recommendations have been collaboratively created with UNICEF through a five-stage process. In the first phase, indicative recommendations were included in the first version of the Evaluation Report for UNICEF's review and comments. The evaluation team then incorporated all comments provided on the indicative recommendations and presented the revised recommendations to UNICEF in a recommendations workshop. These recommendations were then workshopped. The evaluation team again incorporated all comments to the recommendations they received and presented the next iteration of the revised recommendations to MCO senior emergency management for their review and comment. These comments and suggestions were then incorporated into the fourth iteration of the recommendations that appear in this report.³⁹ The evaluation team will then address all comments and suggestions that are received after UNICEF reviews this report (V2), into the final, approved report. The evaluation also paid particular attention to integrated responses for vulnerable and marginalized group or communities, including women and children, persons with disabilities, and those with other vulnerabilities.

As part of its desk review, the evaluation incorporated findings contained in the MCO After Action Review (AAR) and as a result ensured a strong focus on including the perspectives of affected communities and external stakeholders in this evaluation.

4.3 Scope

In line with the ToR, the evaluation encapsulates the span of the entire UNICEF emergency response to the cholera outbreak and Cyclone Freddy, starting from September 2022, through to the expansion of the L2 to Mozambique on 22 March 2023, and covering the ongoing response through to 9 September 2023.⁴⁰ Though the L2 CEAP was activated in December 2022, in order to better consider the L2 response within the entirety of the emergency, as per the ToR, the time-scope of evaluation extends back to September, when the cholera outbreak was first declared in Mozambique. The evaluation also includes reflections on preparedness and action plans in place prior to the emergencies. The programmatic scope of the evaluation included the emergency preparedness and response of integrated and multisectoral programming bringing together Health, Child Protection, WASH, Social Protection, Nutrition, Education, Community Development and Resilience, SBC/ RCCE, with PSEA and gender and disability as cross-cutting themes. It included an analysis of the effectiveness of mobilising partnerships, the contribution of internal/ external coordination/ partnerships to success or failure, the adaptiveness/ responsiveness of the response, the extent to which it was child-centric, how it addressed gender, disability, and age vulnerabilities. It extended to considering MCO's the responses' mid- to long-term risk-informed planning and its connection to the HDP nexus (using the criteria of the appropriateness, effectiveness, and connectedness/ coherence). The geographical scope of the evaluation was the entirety of both the cholera- and cyclone-affected areas in Mozambique. The evaluation assessed MCO's humanitarian action across crises-affected areas, including both rural and

³⁹ The recommendations cocreation workshop was held in early May 2024.

⁴⁰ See Annex 5 for the full ToR.

urban populations, areas of displacement, relocation and resettlement, and hard-to-reach areas. Primary data was collected in: Zambézia (Quelimane, Maganja de Costa, Sofala (Caia), and Niassa (remotely).

The evaluation did not consider value for money (VfM) or conduct any sort of cost analysis. The reason for this is that the appropriate benchmarks or metrics against which performance can be assessed to make a judgement as to whether efficiency/VfM was realised or not were not established by MCO *ex ante* during the design of the response, or subsequently during the monitoring stages. It was therefore not possible *ex post facto* to conduct a cost analysis to quantitatively consider the effectiveness (spending wisely), efficiency (spending well), or economy (spending less) of MCO's L2 programmes. It was only possible to provide key stakeholder's estimations as to the extent to which MCO's responses were cost-effective: this estimation appears in Section 6 (Findings) below.

(A more detailed description of the scope can be found in Annex 6.)

4.4 Stakeholder mapping and evaluation users (rights holders and duty bearers)

Table 1 below lists the different categories of stakeholders involved in the cholera and Cyclone Freddy emergencies. **Categories I-III** adumbrate the principal duty bearers that worked (directly and/ or indirectly (in the case of regional or global personnel)) alongside UNICEF to aid the rights holders.

Category I stakeholders provided support (both remotely and in-person, through surge deployments) to their in-country UNICEF colleagues.

Category II lists national and international duty holders who both directly and indirectly aided the rights bearers.

Category II.a contains a list of the international NGOs (INGOs) who supported the GoM to provide assistance to cholera- and cyclone-affected rights holders.

- MSF and CUAMM are both international medical charities that provided health assistance,
- Peace Winds, a Japanese NGO, in collaboration with local partners constructed water supply systems and wells in resettlement areas to provide safe water to those affected by Cyclone Freddy.
- The Mozambique Red Cross (supported by the International Federation of Red Cross and Red Crescent Societies (IFRC)) used its volunteers to disseminate cholera prevention messaging and provided essential non food items (NFIs) to cyclone-affected persons.
- Food for the Hungry provided nutrition support to affected persons,

Plan International provided support to the cholera- and cyclone-affected populations with sexual and reproductive health and rights, as well as supporting education and economic empowerment efforts.

Category II.b lists the United Nations agencies that with their implementing partners supported the GoM's emergency efforts and according to their expertise:

- **United Nations High Commissioner for Refugees (UNHCR):** provided multisectoral support to refugees affected by cholera and Cyclone Freddy,

- **World Health Organisation (WHO, UN):** provided health and care support to those affected by cholera,
- **United Nations Development Program (UNDP):** supports the GoM to try to achieve its sustainable development goals.

Category II.c lists the GoM’s ministries that oversaw and coordinated the emergency response:

- **Instituto Nacional de Gestão e Redução de Risco (National Institute of Disaster Management and Risk Reduction) (INGD):** Coordinated the national response to support to cyclone-affected populations (with significant cross over to cholera affected persons in some districts affected by both emergencies)
- **Instituto Nacional de Saúde (National Institute for Health):** Coordinated the national cholera response.
- **Instituto de Comunicação Social (Institute of Social Communication):** Coordinated the national dissemination of cholera risk messaging.

Donors (**Category II.d**) funded the institutions and agencies listed in **Categories II.a, and II.b**. **Category III.c** lists the various government ministries involved in the emergency response and who were supported by the rights holders listed in **Categories II.and II.b**.

Category III refers to NGOs that participated in the emergency response (in the aggregate), as well as to the variety of community-based organisations and authorities with which UNICEF (and other duty holders) worked throughout the emergency response.

Category IV outlines the categories and locations of the cholera- and cyclone-affected rights holders who the duty bearers endeavoured to assist.

These are also stakeholders that contributed to the evaluation. Rights bearers actively participated in developing the evaluation’s findings, and their input was incorporated in the development of the recommendations. The column on the right describes how each category of stakeholder could benefit from the evaluation results.

Table 1. Mapping of stakeholders involved in the cholera and Cyclone Freddy emergencies and those who contributed to the evaluation

Stakeholders	Primary users
<p>Category I: UNICEF staff in Mozambique, Headquarters (HQ), Emergency Operations (EMOPS), ESARO, and other country offices in countries at risk of cholera or who wish to learn from Mozambique’s response to natural disasters</p>	<p>Primary users will benefit from understanding response implementation, good practices, lessons learned, innovation and gaps, and UNICEF Emergency Procedures and their operationalisation.</p>
<p>Category II:</p> <p>a) INGOs: MSF, Peace Winds, Doctors with Africa (CUAMM), ActionAid, Food for the Hungry, Plan International, Mozambique Red Cross, IFRC.</p> <p>b) United Nations agencies: WHO, World Food Programme (WFP), International Organization for Migration, United Nations Development Programme, and United Nations High Commissioner for Refugees.</p> <p>c) GoM: <i>Instituto Nacional de Gestão e Redução de Risco</i> (National Institute of Disaster Management and Risk Reduction) (INGD), <i>Instituto</i></p>	

<p><i>de Comunicação Social</i> (Institute of Social Communication), <i>Instituto Nacional de Saúde</i> (National Institute for Health)</p> <p>d) Donors/development partners: United States Agency for International Development/Bureau of Humanitarian Affairs, Canadian High Commission, European Civil Protection and Humanitarian Aid Operations, Irish Aid, and development donors.</p>	
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Secondary users

<p>Category III:</p> <ul style="list-style-type: none"> Local NGOs and civil society organizations (CSOs). UNICEF-trained community volunteers, community health workers, community-based organizations, traditional leaders, traditional healers, faith-based organizations, village task forces, social workers, teachers. 	<p>Secondary users may learn from best practices, lessons, and gaps and benefit from the possibility of holding UNICEF accountable.</p>
<p>Category IV:</p> <p>Affected populations throughout Mozambique, in particular children, women, adolescents, persons with disabilities, refugees, cholera survivors, and students in Zambézia, Sofala, Tete, and Niassa (this includes those living in urban, peri-urban, and rural settings).</p>	

5 EVALUATION DESIGN, METHODS, SAMPLING, LIMITATIONS AND ETHICS

This section summarizes the evaluation design and the evaluation questions; it highlights the methodology, and sampling techniques used and notes limitations and compliance to United Nations ethical standards.

5.1 Design

Following the evaluation purpose and objectives, the evaluation was summative and formative, and the design was realist-based, use-focused, and allows for robust analysis.⁴¹ The evaluation was based on the three main evaluation questions proposed in the ToR. Those questions were plotted against the evaluation criteria of effectiveness, relevance, efficiency, coverage and proportionality, quality and coherence, coordination, connectedness/ sustainability, coordination and partnerships.⁴² The design⁴³ partitioned UNICEF’s L2 response into four streams:

- First, the L2 mechanism, which refers to the ‘whole-of-organization response’ processes and mechanisms needed to scale up a response. This provided data to assess whether the L2 mechanism and its processes at all levels were applied and fit for purpose to ensure timely and effective scale-up (for example, resource and partnership mobilization, procedure application, and support functions).

⁴¹ See Annex 7 for further details.
⁴² Developed by the Organisation for Economic Co-operation’s Development Assistance Committee; <https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.html> and the ALNAP Evaluation of Humanitarian Action (EHA) Guide: [https://www.humanitarianlibrary.org/resource/alnap-evaluating-humanitarian-action-0#:~:text=This%20guide%20was%20developed%20after,Assistance%20Committee%20\(DAC\)%20evaluationcriteria](https://www.humanitarianlibrary.org/resource/alnap-evaluating-humanitarian-action-0#:~:text=This%20guide%20was%20developed%20after,Assistance%20Committee%20(DAC)%20evaluationcriteria)
⁴³ See Annex 8 for a diagram depicting the evaluation logic.

- Second, UNICEF’s operational response, referring to the ‘**in-country response**’ and how response strategies across the eight response pillars were aligned to relevant policy/strategy, and how they were implemented. Here, the evaluation aimed to understand to what extent UNICEF embedded its mandate and corporate commitments to children in humanitarian response (for example, alignment and coherence with the inter-agency response, coordination, and leadership, and achieved results).
- Third, the evaluation assessed the response from the angle of the ‘**geographic focus**’, and whether and how UNICEF’s humanitarian action extended across the different areas affected by the crises (i.e., urban/rural, areas of displacement, relocation, resettlement, and hard-to-reach areas).
- Fourth, the evaluation assessed the response from the angle of the ‘**time frame**’ and considered the entire span of UNICEF’s emergency responses to the cholera outbreak and Cyclone Freddy, starting when cholera was declared in Mozambique in September 2022, the first time (24 February 2023) and the second time (11 March 2023) Cyclone Freddy made landfall in Mozambique, the expansion of the L2 to Mozambique on 22 March 2023, through to when the L2 was deactivated on 9 September 2023.

UNICEF’s organizational commitments to gender (inclusive of GBV/PSEA), human rights and equity (age, disability, other vulnerabilities) were assessed as cross-cutting themes throughout the four streams, using the UNICEF Guidance on Gender Integration in Evaluation.⁴⁴

5.2 Evaluation management

The evaluation was managed by a member of ESARO’s Evaluation Section, who worked with an in-country Evaluation Focal Point who was the primary liaison with the Evaluation Manager and the Evaluation Team Leader for in-country data collection efforts. An Evaluation Reference Group⁴⁵ (ERG) was established to ensure ownership from relevant stakeholder groups of the evaluation process, provide expert advice, inputs, and support to the evaluation as it unfolded.

The ERG had the following responsibilities:

- Provide inputs in the inception phase to influence the approach of the evaluation, and, where necessary,
- Provide information and institutional knowledge as key informants,
- Support the work of the evaluation team by facilitating connections with key informants and ensuring the team has relevant reference documents,
- Review selected evaluation products (inception report, draft and final reports, summary briefs) and provide written comments to the evaluation team through the evaluation manager; and,
- Contribute to the post-evaluation management response, action plan and dissemination strategy.

5.3 Evaluation questions

The evaluation was structured around a set of three overarching Key Evaluation Questions (KEQs) (which were then broken down into 18 sub-EQs) covering the eight evaluation criteria: 1) effectiveness, 2) relevance, 3) efficiency, 4) coverage and proportionality, 5) quality and coherence, 6) connectedness/sustainability, 7) coordination, and 8) partnerships.⁴⁶ The evaluation team slightly modified the sub-questions to better structure and clarify them.

⁴⁴ [https://www.unicef.org/evaluation/media/1226/file/UNICEF%20Guidance%20on%20Gender%20\(Full%20version\).pdf](https://www.unicef.org/evaluation/media/1226/file/UNICEF%20Guidance%20on%20Gender%20(Full%20version).pdf)

⁴⁵ The complete list of ERG members and their functions can be found in the Acknowledgments section.

⁴⁶ For further details, see the Evaluation Matrix in Annex 9.

Table 2. Main evaluation questions and evaluation criteria

MAIN EVALUATION QUESTIONS		EVALUATION CRITERIA
EQ.1.	How well did UNICEF respond during the L2 emergencies in Mozambique?	Criteria 1-7
EQ.2.	How well-prepared and well-equipped was UNICEF to respond to multiple concurrent emergencies?	Criteria 1-3
EQ.3.	What actions are required to strengthen the HDP nexus and preparedness for future emergencies through risk-informed country programmes?	Criteria 6-8

As part of its desk review, the evaluation incorporated data and findings from the AAR conducted by UNICEF. The evaluation also gave special consideration to the human rights of children, focusing on key principles such as non-discrimination, respect for the views of the child, addressing gender-based discrimination, and ensuring equal enjoyment of human rights for persons with disabilities. The evaluation used UNICEF’s human rights based CCCs as both guide and standard by which to evaluate the extent to which people’s rights were put at the centre of its L2 interventions. These CCC’s are specifically referenced, as relevant, throughout the finding’s section (6).

5.4 Evaluation methodology

The evaluation methodology is presented here in brief, having already been described in detail in the inception report.

The overall approach to the evaluation considered the following aspects:

- A context marked by volatility in geopolitical and security factors, which requires ongoing operational and programmatic adjustment to ensure the success of interventions.
- The use of results by UNICEF and its partners to support their decisions and adjust their actions, through regular feedback exercises.
- A constructive approach to data collection, applying the ‘light footprint’ concept and ‘appreciative enquiry’ methods to recognize efforts to strengthen learning for change.
- An approach based on mixed methods, combining qualitative and quantitative methods to gather comprehensive information from a diversity of sources to ensure maximum evidence through cross-referencing, validation, and triangulation.

In line with the purpose and objectives of the evaluation, this report adopted both a summative and formative approach. Data collection took place both in-country and online. A total of 1,281 stakeholders were consulted over the course of the evaluation: 83 key informants (Categories I and II, see Table 1 in Section 4.4 above) were consulted through semi-structured interviews (KIs), 40 percent of which were female,⁴⁷ 149 people (Category IV) participated in focus group discussions (FGDs), 48% of which were female,⁴⁸ and

⁴⁷ 31 women and 49 men.

⁴⁸ For a list of stakeholders consulted, please see Annex 10, and for a list of FGD conducted, please see Annex 11.

1,049 community members (Category IV) completed the Community Rapid Assessment (CRA) conducted via mobile phone (the target was 1,000; 5,496 people started the CRA survey) with a 19 percent survey completion rate.⁴⁹ The demographic breakdown shows that 48.3 percent of CRA respondents (507) were female. The CRA collected primary data from affected populations (Category IV). Through a series of 13 questions conducted via a mobile phone survey (designed by the *hera* evaluation team in collaboration with MCO's RCCE experts and implemented via Viamo⁵⁰), the CRA gathered information on respondents' knowledge, attitudes and practices related to cholera and their experiences with Cyclone Freddy. The CRA supplied insights into community perceptions and knowledge.

With input from and the approval of the HML ethics review⁵¹, the evaluation was able to ensure the inclusion of children's voices through FGDs. A total of 51 children between the ages of 10 and 17 participated in FGDs conducted in Maganja da Costa and Caia, comprising also other remote locations (Madal, Nessa, Tesse and Nhachueca)⁵². This included 51 percent girls. Children were recruited through schools or community leaders, ensuring a gender balance, and applying inclusion criteria. Accompanied by their teachers or guardians, children were invited to fill in a grid with the learning questions to be answered related to the cholera and Cyclone Freddy response and were encouraged to be transparent and to feel comfortable. The six questions were as follows:

1. Did the information you received about cholera and Cyclone Freddy make you feel safer coming to school?
2. Did your school have running water, soap, and a thermometer at all times?
3. Did someone come to your school to speak to you about your worries and stress?
4. Did you at any time stop attending school due to fear of cholera and Cyclone Freddy?
5. Did you always feel safe at home during the cholera outbreak and Cyclone Freddy?
6. Did you and your family always have enough food during the cholera outbreak?

Children were given colour pencils and paper and invited to make drawings depicting their memories of the cyclone and of the cholera outbreak⁵³ to conduct the evaluation team on a walk through/ guided tour of the drawing. Such simulated recall enabled members of the evaluation team to investigate situations as they occurred in the children's real world, without external influences or restraints.

Further, the evaluation used gender-responsive methods⁵⁴ particularly by including data collection techniques designed to collect data that reflected the experiences of all gender identities. Data collection processes and tools were designed to create an enabling environment where diverse women and girls could speak freely and openly (e.g., having FGD with only girls or boys, enhancing women and girls' participation in mixed FGDs, ensuring gender balance in KIs, and ensuring the evaluation framework included gender-specific questions and lines of inquiry).

The evaluation team also reviewed and analysed a total of 94 programme documents and 14 websites, including response planning documents, work plans, the AAR, studies, and monitoring data.⁵⁵

⁴⁹ Average response rates for completion of telephone surveys range between 20 to 40 percent. McGuckin, Nancy et al. (2024) Hang-ups: Looking at Non-Response in Telephone Surveys. https://www.fhwa.dot.gov/ohim/hang_ups.htm Accessed 20 May 2024.

⁵⁰ Viamo.it is a tech social enterprise that provides connection to information exchanges for all sectors involved in International Development: <https://viamo.io/about-us/>

⁵¹ See Annex 17.

⁵² See Annex 12 for the schedule of the field visit of the evaluation team (February 2023)

⁵³ See Annex 13

⁵⁴ UNICEF Guidance on Gender Integration in Evaluation, September 2019
[https://www.unicef.org/evaluation/media/1226/file/UNICEF%20Guidance%20on%20Gender%20\(Full%20version\).pdf](https://www.unicef.org/evaluation/media/1226/file/UNICEF%20Guidance%20on%20Gender%20(Full%20version).pdf)

⁵⁵ See Annex 15 for a comprehensive list of the documents that were reviewed and which are referred to in this report.

5.5 Sampling

The evaluation used a variety of purposive sampling strategies to yield information-rich cases for the most effective use of limited resources. Stratified purposive sampling was employed to capture major variations rather than identify a common core (although this did emerge in the analysis).

Key informants (from Categories I-IV) who were especially knowledgeable about/ experienced with the cholera and Cyclone Freddy emergencies and the humanitarian responses to them, and who were available, willing to participate and had the ability to communicate their experiences and opinions in an articulate, expressive, and reflective manner were identified by MCO personnel. As outlined in Table 1 in Section 4.4 above, after conducting a mapping of stakeholders (rights bearers and duty holders; according to the above-cited criteria), they were divided into homogeneous subgroups (or strata) that defined a collectively exhaustive and mutually exclusive stratum. Purposive sampling (by geography—the areas most affected by the cholera outbreaks and Cyclone Freddy; knowledge of/ experience with UNICEF’s humanitarian response and/ or the cholera and Cyclone Freddy emergencies) was then used to select representative members from each stratum (see Table 1 in Section 4.4).

Snowball sampling was applied during the first round of interviews to identify cases of interest from sampling people who knew people that had generally similar characteristics who, in turn knew people, also with similar characteristics. A theory-based sampling strategy using a realist approach⁵⁶ was also employed to find manifestations of the theoretical construct elaborated in the ToC and examine the construct and its variations. Additionally, a confirming and disconfirming case sampling strategy was employed to confirm the importance and meaning of possible patterns and to check out the viability of emergent findings with new data and additional cases.

The evaluation team employed quotas to ensure gender equity among KII and FGD participants. Separate FGDs were conducted to ensure the inclusion of children’s voices and experiences. Even though the evaluation team worked with MCO FO personnel to include persons with disabilities and the elderly in FGDs, the experiences of persons with disabilities is under-represented in this evaluation, a fact that, as the report strongly notes in the findings section below, may be strongly correlated to an inclusion gap/weakness inherent in the emergency response. Participants in the CRA survey were Viamo 3-2-1 platform subscribers who had given their consent to sharing their personal information and having information “pushed out” to them: n = 1,000.⁵⁷ Quantitative filters were applied to CRA respondents to ensure gender equity and that a statistically equivalent number of adults from each of six targeted districts completed the survey.

5.6 Analysis

Qualitative data from KIIs and FGDs was recorded (upon receiving informed consent), transcribed, coded, and analysed using Dedoose© software.⁵⁸ Questions were translated into Portuguese.⁵⁹ Notes from KIIs and FGDs were uploaded and analysed via Dedoose. The evaluation team developed a book of codes and sub-codes based on the evaluation questions and the response pillars and all notes were coded within Dedoose. Descriptors were assigned to categorize information sources, which allowed for subsequent disaggregation (e.g., categories of stakeholders, geographical location, gender, etc.) and comparison during the analysis phase. Quantitative data gathered during the CRA was quality assessed and analysed

⁵⁶<https://www.ncbi.nlm.nih.gov/books/NBK533089/#:~:text=Realist%20evaluation%20is%20concerned%20with,works%20and%20under%20what%20conditions>.

⁵⁷ Annex 12 contains the CRA questions. For information about the CRA methodology, please refer to the inception report. See Annex 16 for the CRA sampling table.

⁵⁸ Dedoose is a cross-platform app for analysing qualitative and mixed methods research: www.dedoose.com.

⁵⁹ The evaluation questionnaires and the evaluation matrix can be found in the Inception Report and its annexes.

in frequency tables and graphs/ pivot tables, and used to complement, supplement, and qualify qualitative data.⁶⁰ Where relevant, stratification across evaluation questions, pillars, and stakeholder categories was applied, taking into consideration the statistical power of each stratum. Evaluation criteria and evaluation questions were considered equally.

The evaluation team combined and triangulated all data and findings across the various sources of quantitative and qualitative evidence. Data from the document review served as the basis for comparison between data collected through KIIs, FGDs and the CRA. Comparing all data collected via each data collection method against each evaluation question and sub-evaluation question facilitated a uniform approach to collecting, triangulating, and analysing the validity of the gathered data. Our analysis identified reoccurring themes and subthemes, coding frequencies, comparisons, and contrasts, and established relationships between them that generated evidence to answer the evaluation questions.

“Emerging findings” were presented to MCO senior management at the conclusion of the field visit and a cocreation of recommendations workshop was conducted with MCO and ESARO personnel during the drafting of the final report, the results of which served to concretise and nuance the initial indicative conclusions and recommendations described in the first version of the draft report.

Conclusions are color-coded using a **Red-Amber-Green** designation to indicate the nature of the conclusion: **Green** = success; **Amber** = mixed or partial success; **Red** = failure, or negative conclusion. Recommendations are linked to relevant conclusions and lessons learned: they are evidence-based, context-aware, and practicable (action-oriented, time-bound and define who is responsible).

5.7 Limitations

Table 3 below lists the evaluation limitations, including the mitigation measures adopted to address these constraints.

Table 3. Constraints and mitigation measures

Constraints, challenges, limitations	Mitigation measures
Bias and validity	The number and variety of sources allowed for confirmation of findings via cross-checking and data triangulation: this significantly accounted for potential evaluator and respondent bias.
CRA shortcomings	To ensure statistical validity across the districts, target numbers were established per district proportionate to the percentage of the population per district as compared to the overall target population across all six districts (Quelimane, Caia, Lichinga, Nampula, Tete, and Beira). These hard targets (limits were set on the number and gender of persons per district who could respond to the survey via Viamo’s software) were meant to ensure inter-district sampling parity and gender equity. ⁶¹ The survey was translated into Portuguese, Sena, Ndau, and Changana. It was designed to reach a diverse audience across age, gender, location, and educational background, and, to the extent possible, ensure that people from hard-to-reach areas, and with diverse educational backgrounds, literacy levels and socioeconomic status, were given equal opportunity to participate.

⁶⁰ The full survey can be found here: https://lookerstudio.google.com/reporting/e1acc136-b3a4-4eaa-bcbc-aa098005240f/page/p_h35v0h79vc.

Constraints, challenges, limitations	Mitigation measures
Availability of FGD participants	Advance notice was given to communities through UNICEF and partners on the ground to ensure all key stakeholders were available on the date and time KIIs and FGDs were to be conducted and could be present at the required location. Special advanced attention was given notifying parents of children aged 10–14 who participated in FGDs, to ensure their participation.
Informants' knowledge of UNICEF programmes and availability	The evaluation team relied on the support and advice of UNICEF and partners on the ground to suggest relevant stakeholders. Interviews with pre-identified key informants were arranged in advance and outlined in a field visit schedule that was validated and shared in advance with all relevant parties. The evaluation team maintained a high degree of flexibility to meet key informants at a time and place that was convenient for them and proposed alternate dates and times that were convenient to the stakeholders' schedules, including the possibility of conducting remote interviews. The 'snowball technique' was used to identify additional key informants.
Limited performance and results data	The team had access to the UNICEF cholera and Cyclone Freddy response result and performance framework, but the availability of particularly (epidemiological) data on the cholera outbreak was limited. The evaluation team leader updated the evaluation manager during their fortnightly meetings on any challenges or knowledge gaps that the evaluation team faced, and they then assisted setting up meetings with well-placed UNICEF stakeholders to fill these knowledge gaps to the extent possible.
Insufficient inclusion of persons living with disabilities in field level data collection	Prior to commencing field level data collection, the evaluation team communicated to the UNICEF FO focal points the need to include persons with disabilities, as well as representatives of other especially vulnerable groups, when FGD groups were being arranged. Despite their endeavours, few persons with disabilities were interviewed for this evaluation.
Unexpected results	"Unexpected results" as an area of inquiry was included in the data collection tools (KII guide, probing question under EQ1.3. Annex 11.7, Inception Report); however, none were reported. This anomaly suggests that "unexpected results" was not given sufficient prominence among the panoply of sub EQs.

5.8 Ethical safeguarding

The evaluation was conducted in accordance with UNICEF's Procedures for Ethical Research Involving Children, the United Nations Evaluation Group Ethical Guidelines and Code of Conduct, as well as the United Nations Supplier Code of Conduct, ensuring compliance with these standards at every stage. The evaluation was also aligned with international ethical guidelines and best practice in quality assurance, evaluation conduct and research, respecting the following key principles. These principles include transparency, cultural diversity and inclusion, independence, informed consent, and confidentiality. In addition, the evaluation sought to do no harm, and ensure safety and anonymity.⁶² Ethical clearance was obtained from the Health Media Lab Institutional Review Board to conduct the evaluation in accordance with protocols for the protection of the human subjects involved in the evaluation.⁶³

⁶² Please refer to Annex 40 for a detailed description of the evaluation's ethical safeguarding approach.

⁶³ See Annex 17.

6 FINDINGS

The findings section presents the evaluation findings and consists of three subsections which correspond to each of the evaluation questions in the evaluation matrix (see Annex 9). The AAR and other internal reviews⁶⁴ have been used as part of the findings, with the evaluation complementing and triangulating these as part of the analysis. Linkages between emergency interventions and relevant Sustainable Development Goals (SDGs) and their targets have provided in footnotes, as applicable.

Measuring results during the L2 response

In terms of assessing the extent to which the L2 response achieved its intended objectives (effectiveness), the analysis undertaken by the evaluation team was based on planned outputs and outcomes. In the case of both cholera and Cyclone Freddy emergencies, these were adapted by MCO according to the evolving situation and considered their different geographical locations. For this, the HAC was adjusted in the form of a living “excel sheet” as the main monitoring tool to track planned targets across various pillars and funding requirements. This tracking tool included a set of outputs with relevant indicators monitoring the response. These outputs were mainly based on selected benchmarks from UNICEF's CCC. Aside from the five response areas (section 6.1.1), the tracking tool also considered social protection and cross-cutting issues (e.g., gender, disability inclusion, adolescent empowerment, and PSEA). MCO reported on these outputs in the humanitarian situation reports, which included also results from other humanitarian activities (e.g., the crisis in Cabo Delgado). Additional data sets were produced by MCO, including the AAP results data, funding trackers, and ESARO dashboards. A narrative plan, the UNICEF Mozambique Multisectoral Cholera and Floods Response Plan 1 March – 30 September 2023 (aka “the response plan”), was developed with the support of ESARO. This response plan, however, was not used to monitor progress by MCO or FO. Additionally, key L2 benchmarks were presented at the end of the response during the August 2023 meeting of the regional emergency management team (R-EMT).

One of UNICEF's most significant reporting weaknesses vis-à-vis mandatory evaluations (such as this one) for L2 and L3 CEAP responses is that UNICEF has not sufficiently developed an L2- or L3-specific comprehensive monitoring tool. Dashboards such as the monthly “Malawi and Mozambique Situation and Response Dashboard”⁶⁵ and situation reports provide important snapshots; however, the results of L2 specific interventions are mostly included within the overall response. The lack of a final L2-specific operations report with disaggregated L2 CEAP interventions (from HAC and other country programs) that reports back against indicators, targets and benchmarks established during the planning stage, impedes efforts to develop a precisely detailed analysis of all interventions. MCO's established monitoring system (an excel sheet) shows a few weaknesses. It is not comprehensive (only outputs are included, but not outcomes or results): this does not allow for identification of the expected changes as per the intervention logic outlined in the ToC. MCO did not build a ToC at any stage of the response: the ToC that appears in this report has been retrospectively reconstructed by the evaluation team to overtly identify the L2 operation's implicit logic. Even within an evolving and ever-changing emergency context, a ToC would have helped to identify the building blocks, expected change pathways, strategies, risks, and assumptions relevant to achieve substantive change during the emergency response. Such a ToC, furthermore, would have supported MCO, its partners and other relevant stakeholders to understand and monitor targets and achievements established for each response area. It would have also provided a clear overview of activities and outputs agreed upon as part of MCO's response to both the cholera and Cyclone Freddy emergencies.

⁶⁴ UNICEF. (2023) Multisectoral Response to a Nationwide Cholera Outbreak in Mozambique, WASH field note (UNICEF internal report).

⁶⁵ <https://www.unicef.org/documents/malawi-and-mozambique-humanitarian-situation-and-response-dashboard-july-2023>

Some targets were set at MCO level, with little input from the FOs.⁶⁶ Benchmarks and outputs were mixed without clear delineation, and there were about 250 benchmarks/ indicators for the entire L2 response, measured against quantitative indicators only (qualitative indicators were not included). Baseline data to estimate the People in Need (PIN) were based on the number of people affected by the cholera outbreak and Cyclone Freddy in the different provinces; however, details on the methods applied remained unclear (e.g. the HRP and UNICEF had different PIN estimations, (e.g., RCCE). Targets were set, but systematic reporting against targets did not take place. Neither was data disaggregated, which made it impossible to conduct an adequate Age, Gender, and Diversity (AGD) analysis. Lastly, both the excel sheet and the response plan do not differentiate between the cholera and Cyclone Freddy. As a result, and to measure effectiveness, the evaluation has placed less emphasis on merely analysing if and how targets in the excel sheet were met, but has assessed what worked, in which circumstances, and for whom for each of the response areas, as it is detailed in the next section.

6.1 How well did UNICEF respond during the L2 emergencies in Mozambique?

6.1.1 To what extent did the UNICEF L2 response achieve its stated objectives and Humanitarian Action for Children (HAC) targets? (Effectiveness)

*This section focuses on the effectiveness of UNICEF's cholera and Cyclone Freddy preparedness and response.*⁶⁷

UNICEF's response to the cholera and Cyclone Freddy emergencies covered five response areas: health and nutrition; WASH; education; child protection, and RCCE/SBC. These five response areas were supported by six support functions: administration and finance; supply and logistics; HR; communications; partnerships; and coordination and leadership (see Section 6.2.1 below). Though in some instances it was difficult to clearly distinguish the cholera and cyclone response areas given that some areas were common to both, in general WASH, and health and nutrition,⁶⁸ had dedicated outcomes for both cholera and the Cyclone Freddy responses; child protection and education primarily achieved outcomes related to the Cyclone Freddy response; RCCE primarily contributed to outcomes related to cholera. To the extent possible, this section differentiates which findings corresponded to which emergency,⁶⁹ noting that in some locations (i.e., Zambézia province) the cholera and Cyclone Freddy responses happened simultaneously, and UNICEF activities overlapped.

6.1.1.1 Response Area 1: **Health⁷⁰ and Nutrition⁷¹**

UNICEF MCO ensured the continuity of essential health services after the two Cyclone Freddy landfalls and integrated nutrition within the emergency health response, as per the ToC's Health Outcome: By the end of the L2 response, UNICEF has contributed to a decrease in incidences and

⁶⁶ Key informant interviews.

⁶⁷ See Annex 18 for discussion of how results and progress were measured across the response areas during the L2 response.

⁶⁸ Based on the suggestion from the MCO Chief of Health and Nutrition, health and nutrition have been merged as one response area.

⁶⁹ Cyclone Freddy response also refers to the consequences of the cyclone which in some cases and locations resulted in floods, roads cut, etc.

⁷⁰ SDG 3: Ensure health lives and promote well-being for all at all ages. Target 3.3: end the epidemics of ... water-borne diseases; Target 3.4 ... promote mental health and wellbeing; Target 3.d: Strengthen the capacity ... for early warning, risk reduction and management of national and global health risks. United Nations. (2024) Sustainable Development. https://sdgs.un.org/goals/goal3#targets_and_indicators Accessed 23 May 2024.

⁷¹ SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture. Target 2.2: ... end all forms of malnutrition including ... the internationally agreed targets on stunting and wasting in children under 5 years of age... United Nations. (2024) Sustainable Development. https://sdgs.un.org/goals/goal2#targets_and_indicators Accessed 23 May 2024.

cholera mortality rates (See Annex 4). This was accomplished through supporting the rehabilitation of damaged health facilities, the provision of medicines and health commodities, and the replacement of damaged equipment.⁷² By April 2023,⁷³ over 41,000 children were reached in affected areas with essential health services, including nutrition (e.g., acute malnutrition screening, provision of Vitamin A, deworming, counselling, essential medicines, promotion of infant and young child feeding protocols and advocacy for access to an adequate diet, ensuring infection prevention and control (IPC) measures were in place in nutrition points), in accommodation and resettlement sites. Additionally, as part of its cholera response, UNICEF provided updated guidance to health-care workers on wasting, breastfeeding management, and cholera case management protocols to support the stabilization of mothers immediately after childbirth, which were key contributions according to internal key informants, as without them, “cases of acute malnutrition in the context of cholera are usually fatal”.⁷⁴ However, significant funding gaps—compounded by the late arrival of expected funds⁷⁵—meant that a) the quantity of medical supplies UNICEF was able to supply was not commensurate with the scale of the needs, and b) there was an overall lack of adequate data on malnutrition status required to inform the response (e.g., through rapid SMART surveys).

During the cholera response, UNICEF successfully improved the capacity of local health workers and fulfilled its mandate to procure and pre-position essential emergency medical supplies,⁷⁶ supporting an estimated 1.5 million people.⁷⁷ In the initial stages of the response, limited medical and IPC supplies were delivered to Cholera Treatment Centres (CTCs); however, as the response progressed, supply levels increased.⁷⁸ Key informants indicated that the Mozambique health system (at both national and local levels) was insufficiently prepared to respond to the cholera outbreak, and in the first months of the response (until April 2023) UNICEF was only able to provide limited funding. Even though WHO’s mandate was to focus on the more technical elements regarding cholera treatment and supply and logistics were allocated to UNICEF,⁷⁹ several key informants indicated that UNICEF’s health response was overly supply-driven. These key informants highlighted the importance of active surveillance and community-based interventions to complement the supply of essential medical supplies; however, they noted that due to logistical challenges, UNICEF was unable to support the scale-up of these approaches.^{80,81}

Compared to the scale of the outbreak, the number (106) of Oral Rehydration Points (ORPs)⁸² was limited,⁸³ even though ORCs were recognized as being an effective and inexpensive solution for patients transiting to CTCs.⁸⁴ Key informants indicated that there were missed opportunities to scale up the number of ORCs and establish them in remote areas where access to CTCs was limited. These

⁷² UNICEF. (March 2023) Mozambique Cholera and Cyclone Flash update. UNICEF targeted 388,716 women and children (out of an estimated 740,000 people) who were in need of health and nutrition services in areas where Cyclone Freddy had damaged health facilities and equipment, and/or where medicine and health commodities were destroyed or spoiled; UNICEF. (2023) Mozambique Humanitarian Situation Report No. 12. To support the continuity of essential health services for almost 50,000 people, including 7,500 children under the age of five years, UNICEF supported the rehabilitation and respective equipment of five health facilities in Sofala and Zambézia that were partially or severely damaged by Cyclone Freddy.

⁷³ Technical Emergency team meeting 20 April 2023

⁷⁴ Key informant interviews.

⁷⁵ UNICEF. (2023) Technical Emergency Team meeting 20 April 2023: by April 2023, about half of the expected funds had not arrived.

⁷⁶ In 10 out of the 11 provinces.

⁷⁷ UNICEF (March 2023) Mozambique Cholera and Cyclone Flash update (e.g., Inter-agency Emergency Health Kits, acute watery diarrhea kits, 233 cholera beds, supplies for the installation of Oral Rehydration Corners (ORCs), and 109 tents to establish Cholera Treatment Units/CTCs were provided).

⁷⁸ Key informant interviews.

⁷⁹ Supply is further assessed in Section 6.2.1.2 below.

⁸⁰ UNICEF. (December 2022 – January 2023) *MOZAMBIQUE Humanitarian Situation Report No. 12*. That being said, it is important to note that in the first quarter of 2023, UNICEF trained 277 community actors and religious leaders in community surveillance, and 116 health professionals received training on cholera IPC and case management, as well as techniques to slow and stop cholera transmission and provide appropriate treatment to improve the capacity of local actors to recognize issues and provide support.

⁸¹ Supply-related issues are further discussed in Section 6.2.1.2 of this report.

⁸² L2 Regional Emergency Management Team (R-EMT) meeting August 2023.

⁸³ Key informant interviews.

⁸⁴ <https://www.mdpi.com/2414-6366/7/5/67>

informants also highlighted that several ORCs were underutilized; and that greater community engagement during the planning stages could have ensured that ORCs were established in high-use locations.

UNICEF provided significant logistical support to the MoH's OCV campaigns, including transport and maintenance of cold chain. Providing OCV in the quantities and dosages needed to halt the spread of cholera proved impossible due to the global supply shortage of OCV. UNICEF advocated that Gavi prioritize Mozambique and target high-risk areas in the country. 2.4 million people,⁸⁵ of whom 58 per cent were children aged one to 14 (52 per cent male, 48 per cent female), received one dose of OCV⁸⁶ to maximize the vaccine's impact.^{87,88} Only 2 per cent of respondents to the CRA mentioned OCV as a protection measure against cholera. Through its IPs, UNICEF MCO supported the vaccination campaigns with social mobilization and sensitization⁸⁹ activities, as well as with transport and ensuring the cold chain was not broken, which helped to ensure that the MoH met 100 per cent of its target.⁹⁰ That being said, key informants indicated that the "OCV campaign was done in a rush, with little time for building demands. [Contrary to the positive results produced] in Niassa and Quelimane, the campaign of Nampula did not manage to stop cholera."⁹¹ Though measuring the results of the OCV alone is complex, anecdotally, qualitative data indicates that in the areas reached by OCV the cholera caseload reduced significantly and contributed to stabilizing⁹² the outbreak nationwide from epidemiological week 15 onwards (9 April 2023).⁹³

6.1.1.2 Response Area 2: **WASH**⁹⁴

UNICEF MCO largely achieved its objective of providing appropriate life-saving prevention and response measures that contributed to controlling the spread of cholera (WASH ToC Outcome, see Annex 4); but not all existing needs could be covered (particularly in terms of hard WASH components). The provision of WASH supplies, WASH facilities and hygiene promotion activities in resettlement sites and temporary accommodation centres significantly contributed to efforts to ensure that those affected by Cyclone Freddy had access to potable water and sanitation facilities.⁹⁵ UNICEF MCO positively contributed to relevant coordination mechanisms at both national and local levels.

Cyclone Freddy negatively impacted pre-existing water supply and sanitation infrastructure, which negatively contributed to the cholera outbreak. Local authorities did not have the capacity to repair water infrastructure, conduct regular monitoring of water quality, and mitigate cholera-contaminated water

⁸⁵ Internal presentation at Country Office Technical Emergency Team meeting in April 2023.

⁸⁶ Rather than the recommended two doses, in order to double the number of persons reached with the vaccine, aligned with the global policy due to the international shortage.

⁸⁷ In addition to 719,000 OCV doses, 1,358,682 OCV doses were distributed to Manica, Zambézia, and Sofala to conduct a reactive vaccination campaign in Quelimane, Beira, Marromeu and Chimoio. UNICEF. (31 March 2023) Cholera and Cyclone Flash update.

⁸⁸ <https://www.who.int/news/item/19-10-2022-shortage-of-cholera-vaccines-leads-to-temporary-suspension-of-two-dose-strategy--as-cases-rise-worldwide>

⁸⁹ E.g., radio, theatre, including mitigation of negative rumours about the OCV.

⁹⁰ See Annex 19 (OCV results).

⁹¹ Key informant interviews.

⁹² WHO/MSF bilateral meeting June 2023.

⁹³ See Annex 20 (OCV and cholera cases). As the epidemiologic curve available for review by the evaluation team only shows the number of cases at national level, comparison with provinces in Mozambique where OCV took place is not possible. It was therefore beyond the evaluation's scope to corroborate the impact of the OCV campaign in order to measure UNICEF's contribution to it. This can be used as an indication that cases continued to be reported in peri-urban areas and rural areas, with new outbreaks in various locations within the same districts and that OCV needs to continue to be implemented with other components of cholera response for effectiveness purposes.

⁹⁴ SDG 6: Ensure availability and sustainable management of water and sanitation for all. Target 6.1: ...achieve universal and equitable access to safe and affordable drinking water for all; Target 6.2: achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situation; Target 6.b: Support and strengthen the participation of local communities in improving water and sanitation management. United Nations. (2024) Sustainable Development. https://sdgs.un.org/goals/goal6#targets_and_indicators. Accessed 23 May 2024.

⁹⁵ See Annex 21 (summary of UNICEF's WASH interventions).

sources. This led to a heavy reliance on household water purification products (i.e., Certeza)⁹⁶ **UNICEF's direct work with district authorities and collaboration with IPs already active in affected areas—** relating to the prioritization of disinfection, reinforcement of the chlorination of water sources,⁹⁷ and the rehabilitation of water sources—**successfully increased its coverage and enhanced the effectiveness of its interventions.** 73.5 per cent of CRA respondents mentioned they use Certeza to make their drinking water safe. UNICEF MCO also supported local authorities (e.g., FIPAG, AIAS) with bulk water treatment chemicals. Sanitation-related activities were largely neglected by water supply and sanitation authorities,⁹⁸ but **UNICEF MCO succeeded in assisting its NGO partners to support sanitation and environmental cleaning at the community level, alongside government partners and the communities themselves.**

Hardware WASH components were upscaled in seven provinces, mainly focusing on immediate solutions. **The WASH hardware support to CTCs helped to ensure their functioning.**⁹⁹ Initially, some CTCs were established with little to no access to adequate WASH and waste management facilities.¹⁰⁰

The establishment of purchasing cards (p-cards)¹⁰¹ as a petty cash modality and the use of start-up letters to transfer funds to partners were extremely useful in order to procure needed IPC materials for CTCs.¹⁰² However, despite the progress made in meeting most immediate WASH needs, the overall WASH infrastructure in most of the affected districts still does not adequately meet the needs of the communities it serves. Providing such solutions would be possible only through the implementation of a systemic development approach, which could not be applied during the emergency response.¹⁰³ (Nevertheless, technical assessments and targeting of communities based on cholera epidemiological data and low WASH services can still be done during an emergency response and used during the early recovery/development phase. This approach was started in late 2023, after the deactivation of the L2.)

UNICEF's implementation, adaptation and expansion of different community-based cholera prevention and control measures positively contributed to controlling the spread of cholera and contributed to covering communities' basic needs and critical gaps.¹⁰⁴ The case-area/case-cluster targeted interventions (CATI) approach was used to great effect in areas where cases were too low to be tracked.¹⁰⁵ In locations with high cholera caseloads,¹⁰⁶ UNICEF adapted its approach and supported 'blanket neighbourhood interventions' during the peak of the epidemic curve.¹⁰⁷ This was then followed by the CATI approach when the epidemiological situation became more manageable.¹⁰⁸ However, the dearth

⁹⁶ Certeza is a branded and socially marketed point-of-use water treatment product consisting of diluted sodium hypochlorite solution launched in Mozambique by Population Services International in 2004. Certeza is sold in 150-mL bottles at subsidized prices through the private sector and distributed for free during emergency situations.

⁹⁷ Complemented by bucket chlorination in affected communities and rapid interventions in high transmission areas (e.g., RCCE and environmental cleaning in markets and bus stations).

⁹⁸ Cholera was perceived to be a water-related disease, according to AAR and key informants.

⁹⁹ UNICEF MCO procured and delivered water purification products, partnering with government-owned public utilities to improve the quality of piped water and to deliver water by truck, particularly to health facilities and CTCs. UNICEF delivered about 16,450 kg of calcium hypochlorite (65–70 per cent), 8,200 kg of aluminium sulphate and 201,781 bottles of household water purification products between January–June 2023. UNICEF. 2023. Multi-sectoral Response to a Nationwide Cholera Outbreak in Mozambique, WASH field note (UNICEF internal report).

¹⁰⁰ This was particularly the case in locations affected by Cyclone Freddy.

¹⁰¹ A p-card is a type of pre-paid debit card that was put in place during the L2 response to make payments more agile. It allowed UNICEF staff to charge goods and services locally without the need for pre-approval and petty cash, yet with some restrictions regarding the type of supplies allowed to purchase.

¹⁰² The Quelimane FO procured 1,000 buckets and 3,000 soap bars for the CTC in less than 24 hours using the p-card.

¹⁰³ For further information, see Section 6.3 below.

¹⁰⁴ See Annex 22 (Delivery mechanisms used for cholera prevention and control in communities).

¹⁰⁵ E.g., in Niassa and Tete provinces, health workers and volunteers led by health technicians visited hospitalized patients' households and provided sensitization talks, distributed water purification products and other WASH items, and installed bucket chlorination.

¹⁰⁶ E.g., Quelimane and Beira cities.

¹⁰⁷ Depending on the situation, this included door-to-door or community sensitization, the blanket distribution of water purification products and the chlorination of water points.

¹⁰⁸ UNICEF. (20 April 2023) Mozambique CO Internal presentation. According to the AAR, about 1 million people were reached following the CATI approach, with seven provinces covered through 10 partners (INGOs, local NGOs and local authorities).

of trained staff¹⁰⁹ led to initial delays in implementing the CATI approach. This was compounded by a lack of prioritization of affected locations. Deviations from/differential implementation of CATI protocols, especially in the first stages of the response,¹¹⁰ limited the effectiveness of the CATI approach.¹¹¹ Partners, including government health authorities, also needed additional support and guidance with regards to other CATI-related interventions.¹¹² However, it should be noted that these points became standardized over the timeline of the response. The reliance on the (essentially) voluntary contributions of *activistas* (volunteers) to implement these activities¹¹³ provided mixed results: this approach produced an extensive workforce that facilitated reaching a high number of (remote) areas; however, issues related to incentives and workload impeded maximum operational effectiveness.¹¹⁴ While, overall, the CATI approach was found to be effective, key informants highlighted the need 1) to adopt the CATI approach at the earliest stages of an outbreak, 2) to complement it with preventive community outreach activities¹¹⁵ to better halt cholera transmission, and 3) ensure a higher level of multisectoral coordination between UNICEF and its IPs in terms of hygiene promotion, IPC and health interventions.

6.1.1.3 Response Area 3: Education¹¹⁶

UNICEF MCO supported the GoM to ensure/re-establish access to education services in cyclone-affected schools, (as per the ToC outcome for education, see Annex 4). The provision of primary learning and menstrual hygiene management kits, as well as tarpaulin sheets and tents, combined with support to rehabilitate and clean schools, the installation of Temporary Learning Spaces (TLSs) and emergency WASH facilities, all positively contributed to children and adolescents being able to access safe and secure learning environments.¹¹⁷ Despite the scale and significance of the damage Cyclone Freddy wrought on schools and classrooms,¹¹⁸ **UNICEF's interventions mitigated many of the cyclone's negative impacts on learning environments in Zambézia, Inhambane and Sofala provinces.** Behavioural change training and services and reproductive health support (Sofala province), as well as support to relocate children and teachers to safe places (Inhambane province), were noted by key informants as being well received.¹¹⁹

“The support with school materials was very important for the children because after the cyclone they had lost everything, and the support was useful for them to go back to school.”

FGD with local leaders,
Quelimane district

¹⁰⁹ Within both UNICEF and IPs.

¹¹⁰ UNICEF's guideline was to implement CATI within 48 hours after a patient was *admitted* to the CTCs, but this intervention initially was implemented differently by some partners, namely 48 hours *after discharge*, which increased the time lapse for successful implementation of IPC measures.

¹¹¹ Key informant interviews.

¹¹² E.g., disinfection, chlorination, and water quality testing as part of CATI.

¹¹³ CATI activities were implemented by so called *activistas* or volunteers from local implementing partners like PIRCOM, Nos Saúde, CUAMM, Kukumbi, and FHU.

¹¹⁴ KIIs.

¹¹⁵ E.g., access to potable water, sanitation and hygiene practices, and community-based surveillance activities.

¹¹⁶ SDG 4: Quality Education: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all. Target 4.1: ... ensure that all girls and boys complete free, equitable and quality primary and secondary education...; Target 4.5: ...eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including person with disabilities, indigenous peoples and children in vulnerable situations. United Nations. (2024) Sustainable Development. https://sdgs.un.org/goals/goal4#targets_and_indicators. Accessed 23 May 2024.

¹¹⁷ See for more education activities and achievements Annex 23.

¹¹⁸ Including the negative impact on education activities in schools used as transit centres, which UNICEF mitigated via advocacy efforts highlighting the importance of reopening schools.

¹¹⁹ SITREP Number 06 (Jan–Jun, 2023).

Nonetheless, **the scale and scope of UNICEF’s educational support was not commensurate with the scale of the needs.**¹²⁰ TLSs provided critical support to help ensure the continuity of education services post-Freddy; however, these buildings could not overcome teacher shortages reported in some districts¹²¹ or the overall need for safe classrooms across the countries to mitigate impact of future emergencies.

MCO’s interventions were not always timely: the USD 10 million grant by the Global Partnership for Education (GPE) was approved in August 2023; however, due to the prolonged approval process on the operational plan by the Ministry of Education and Human Development (MoEHD) related to infrastructure, global procurement procedures, delays in identifying IPs, and the realities of the academic calendar, implementation was delayed and education materials designed to be distributed post-Freddy arrived at their destination with considerable delays. Key informants also indicated delays on MCO’s side in supporting the MoEHD with additional UNICEF staff, especially at FO level. The UNICEF surge staff brought in to support the team in one of the provinces unfortunately did not speak Portuguese. MCO’s Education in emergency response goes beyond the immediate response of providing supplies and temporary learning spaces, and includes activities designed to enable children to catch up on lost time (in or out of school). As the Mozambique education system faces challenges in terms of staff retention and learning in school, the education interventions rolled out as part of the L2 response were intended to support Mozambique’s education sector, thereby linking humanitarian with development programming.

Although somewhat prepared for natural disasters,¹²² schools in Mozambique were generally unprepared to continue providing inclusive education opportunities (as per ToC education outcome) during a PHE; however, **schools were successfully used as behavioural change platforms¹²³ and MCO supported the MoEHD and the Direccção Provincial de Educação (Provincial Education Directorate) with WASH¹²⁴ and hygiene promotion materials focused on cholera prevention in schools.**¹²⁵ Lastly, UNICEF staff indicated the need to systematize the PHE response package, pre-position relevant supplies/materials and overcome challenges in identifying IPs with experience in the education sector.

6.1.1.4 Response Area 4: *Child Protection*

MCO’s support strengthened child protection services in cyclone-affected areas, (as per the ToC outcome for Education, see Annex 4); **however, due to limited funding and lack of experienced partners, system strengthening activities took place only on a small scale and response activities were limited principally to two prioritized provinces (Sofala and Zambézia). The sensitization of key stakeholders as to the protection needs and rights for children during emergencies positively contributed to creating demand for child protection services.**

To mitigate cyclone- (and to a lesser extent cholera-) induced risks of family separation, violence, exploitation, and abuse of the rights for children, UNICEF supported the GoM and other key stakeholders (at both national and local levels) to identify and address the needs and rights of children and adolescents. This was accomplished through support to scale up the provision of mental health and psychosocial support (MHPSS), provide information, preventive messaging, referral, and case management services, establish Child-Friendly Spaces (CFSs), and support family tracing and reunification of separated and

¹²⁰ The AAR noted that one of the measures that should be implemented in the future would be the expansion of the geographic coverage of the Programme Document (PD).

¹²¹ During fieldwork in Maganja da Costa district it was mentioned that TLSs were critical in the aftermath of the cyclone but there were many situations where one teacher alone was catering for 250 pupils.

¹²² Many valuable lessons were learned after Cyclone Idai.

¹²³ SITREP Number 06 (Jan–Jun, 2023). Using schools as a platform for behaviour change and information sharing 6,790 students received cholera prevention messages through sensitization campaigns.

¹²⁴ SITREP Number 08 (August 2023). In Sofala, work focused on the distribution of cholera response kits in schools to strengthen control and prevention measures. The distribution of 5,728 bars of soap and 1,432 buckets with taps supported appropriate hygiene measures for nearly 219,000 children (99,623 girls).

¹²⁵ SITREP Number 05 (1–31 May 2023).

unaccompanied children.¹²⁶ At the provincial level, UNICEF supported its partners to scale up capacity building of social workers and humanitarian actors in priority locations.¹²⁷

As identified by the AAR (and validated by key informants), **MCO's support for child protection systems strengthening interventions was challenged by the lack of organizations with experience in child protection in emergencies, and the general lack of expertise in the same on the part of government and local authorities.** This was partially mitigated by an increased focus on capacity building during the initial stages of the response, and the identification of a competent IP (ActionAid) that was operational in Sofala and Zambézia provinces (no partners were identified in Maputo). Limited funding and HR and logistical challenges, combined with poor coordination (initially), delayed the establishment of CFSs. Nevertheless, the fact that UNICEF support led to the establishment of child protection focal points in prioritized districts and the integration of child protection activities within cyclone- and cholera- response interventions is notable as this was a new approach for many local counterparts.

A partnership with a competent IP and training provided to establish and run CFSs and community based MHPSS led to the establishment of these services for the first time. These interventions proved to be a key element in MCO's support to child protection system strengthening efforts. CFSs became entry points for the identification and referral of child protection cases,¹²⁸ and UNICEF's IP, ActionAid, then worked to build the capacity of the social services managing those cases. Community child protection committees that were established (post-cyclone) in CFS sites mapped their respective communities for vulnerable children.¹²⁹ Key informants noted that, in part because of UNICEF's work, authorities at national, provincial, and local levels started to take ownership of the need to identify and manage child protection cases in emergencies, as well as to provide key messages. However, they also noted that further capacity building may be required to concretize the gains made. With the cessation of L2 interventions, key informants questioned whether the post-emergency capacity of provincial- and district-level child protection systems in Sofala and Zambézia provinces had been strengthened to the extent that they could autonomously prevent and respond to all forms of violence, exploitation, rights abuse, neglect and harmful practices to children, or whether further support would be needed.

6.1.1.4 Response Area 5: RCCE/ SBC

UNICEF MCO's technical assistance to the design and coordination of RCCE interventions contributed to minimizing the spread of cholera and the impacts of the Freddy cyclone by increasing the knowledge around cholera in at-risk communities, as well as in promoting the adoption of key preventive and care-

"We first heard about the cyclone in radio spots. After the announcement all the other relevant information we would get from the radio."

FGD Heads of Affected Families,
Caia District

seeking behaviours by affected communities (as per the ToC outcome for RCCE, see Annex 4). These interventions played a key role in facilitating an enabling community environment for preparedness and response to emergencies, including cholera outbreaks. UNICEF-supported RCCE interventions, which mobilized tens of thousands of community actors and reached a massive amount of people through diversified community platforms and communications channels¹³⁰ with

¹²⁶ Through screening of children in evacuation centres and affected communities.

¹²⁷ See Annex 24 for further information on child protection activities.

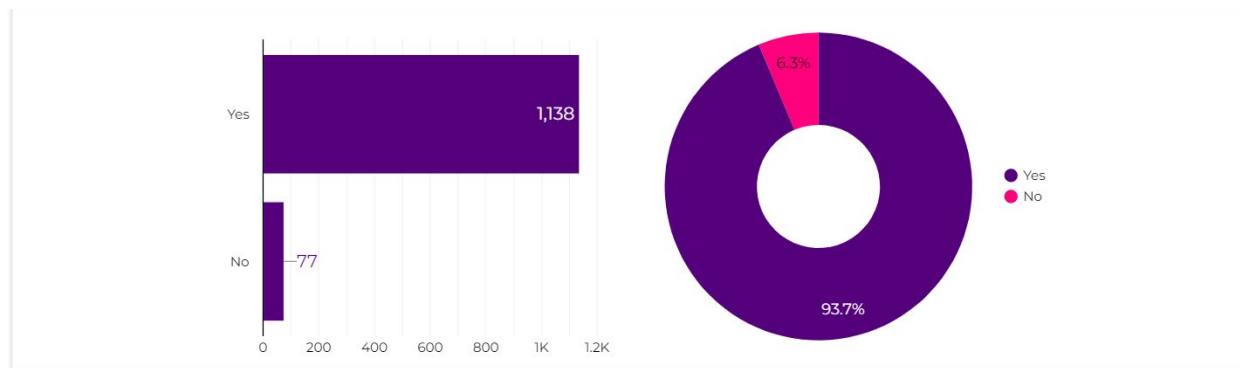
¹²⁸ E.g., children who suffered from protection issues, such as abuse, violence, exploitation, missing school, etc.

¹²⁹ 3,000 children were identified in Caia district alone (source: KII, NGO Sofala).

¹³⁰ Community theatre groups, multimedia mobile units, meetings, religious leaders, social media campaign, a page on the Internet of Good Things, radio and media

a variety of key messages,¹³¹ as well as the support provided to demand creation for OCV campaigns.¹³² PSEA and GBV were included as a core component of SBC activities and a number of technical staff and social mobilizers were trained in the CATI approach and SBC/RCCE in Emergencies, including activity reporting and case survey tools.¹³³

Figure 2. CRA survey results showing the reach of cholera messaging



Despite its notable successes, poor data collection practices made it difficult to accurately assess and quantify the relevance and effectiveness of the RCCE interventions. RCCE initiatives were largely blanket interventions and tended to be unfocused as they lacked granular data on context-specific drivers and perceptions of risks amongst populations at risk. This information gap extended to UNICEF’s partners’ limited capacity to collect behavioural data and community feedback, which problematized monitoring and evaluation efforts. The lack of PAMI-specific epidemiological data¹³⁴ meant that RCCE interventions could not be directed to specific at-risk communities or vulnerable groups within these communities. While most CRA respondents had heard about cholera (94 per cent), and over 65 per cent were able to identify main symptoms (vomiting, acute watery diarrhoea, dehydration), transmission

modes were still not extensively known: a cough was identified as a symptom by 18 per cent of respondents. Lastly, while this is in part due to the lack of community-level epidemiological data from which the whole response suffered (and the fact that cholera is not addressed as a routine health concern), key informants highlighted that RCCE

“We enjoyed the theatre plays. They were funny and taught many lessons on how to prevent cholera.”

FGD mothers of disabled children,
Quelimane District

activities commenced only after the outbreak was declared, and that timeliness (and thus effectiveness) could have been improved if RCCE activities had been rolled out when the first cases were reported.

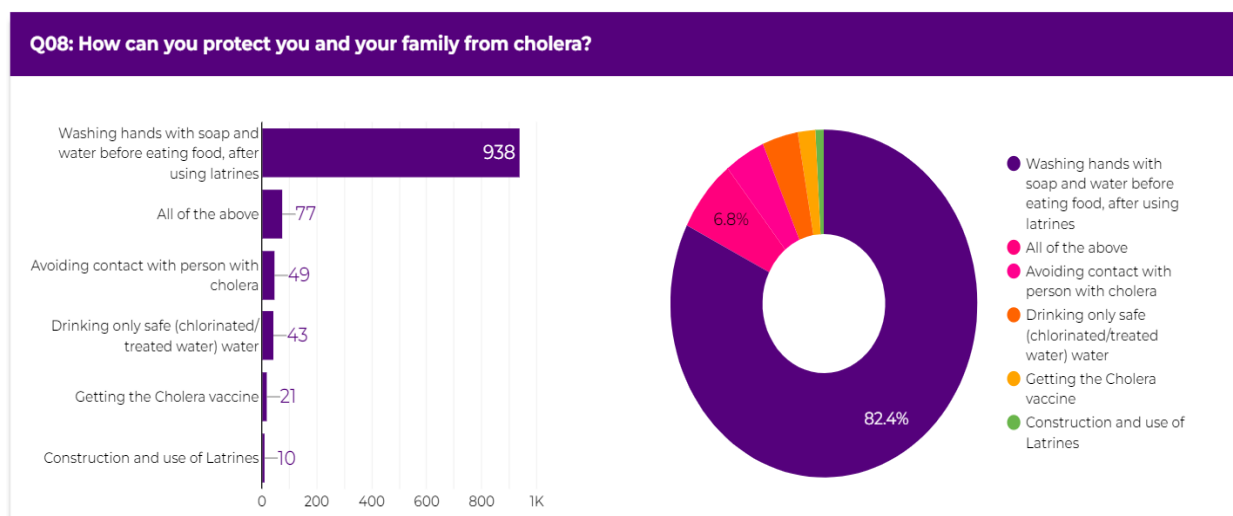
¹³¹ Messages contained information on cholera signs and symptoms, preventive practices, sensitization of boys and men on non-violent masculinity, information on assistance services, hygiene promotion and handwashing, malaria and PSEA prevention, GBV risks in emergency settings, and positive gender socialization.

¹³² See Annex 25 for a more complete list of messages, methods and numbers reached.

¹³³ SITREP Number 03 (1–31 Mar 2023).

¹³⁴ Nb. The lack of reliable data was an issue that affected many areas of the response, not just RCCE.

Figure 3: CRA survey showing results of cholera sensitization and prevention messaging



6.1.2 To what extent did the intervention objectives and design respond to the needs of the affected persons? And did they continue to do so as circumstances changed? (Relevance)

UNICEF-supported interventions were designed to address the emerging needs of cyclone- and cholera-affected communities. UNICEF-supported cholera interventions—such as RCCE preventive behaviours (almost 94 per cent of CRA participants reported receiving information about cholera; survey respondents showed a significant awareness of the importance of handwashing with soap as a preventive measure), WASH/IPC interventions, hygiene promotion, cluster support, and the OCV campaigns—were all well designed to respond to those (potentially) affected by cholera. UNICEF adapted its cholera interventions as the context evolved (i.e., CATI, CATI Light, to blanket approach) and key informants indicated that following the ‘house of the case’ approach, in many instances UNICEF-supported interventions were tailored so that “*people benefitted according to [their] specific needs*”¹³⁵ and that “*TB patients (who had been pre-identified by the health unit) received ‘certain kits’.*” In some instances, data collection led to coverage in new areas of need (e.g., Alto Molocue, islands in the Chire river, and Gorro, on the border between Morrumbala and Milange).

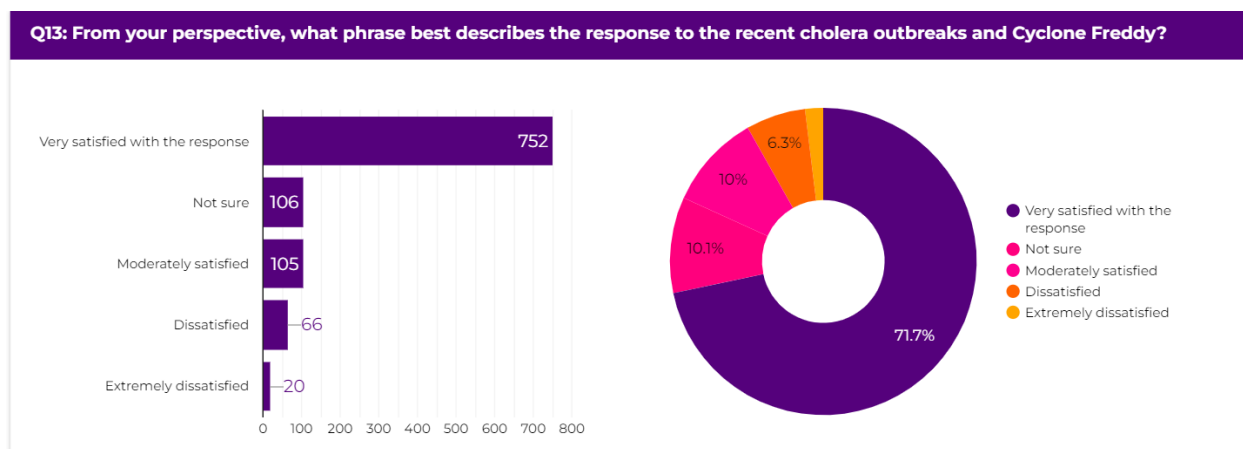
Interventions designed to mitigate the negative effects of Cyclone Freddy, such as educational assistance/ school learning materials, tents, TLSs, hygiene kits, dignity kits, evacuation assistance, cluster support, the provision of non-food items (NFIs) and information and assistance to repair/ rebuild latrines and to rehabilitate water sources, all corresponded to the needs of the cyclone-affected populations.¹³⁶

¹³⁵ Key informant interviews.

¹³⁶ Key informant interviews.

Nearly 82 per cent of CRA respondents indicated that they were either “very satisfied” (71.7 per cent) or “moderately satisfied” (10.1 per cent) with the response to cholera and Cyclone Freddy.¹³⁷

Figure 4. CRA survey results showing degree of appreciation of the cholera and Cyclone Freddy response



In alignment with the World Humanitarian Summit and the Sustainable Development Goals (SDGs), the aid sector, including UNICEF, has pledged to ‘leave no one behind’¹³⁸ and aims to address the rights and needs of marginalised and highly vulnerable populations, including persons with disabilities. The evaluation paid particular attention to the integration of persons with disabilities and people with other vulnerabilities and needs in the response (see also Section 6.2.1). The imperative to address the needs of vulnerable groups was highlighted in response plan documents. Key informants indicated that, as the indicators did not mention vulnerable groups *per se*, everyone was taken care of equally. However, as vulnerability targeting was being done by local leaders there is little visibility as to the extent to which the specific needs of vulnerable groups were met by the response interventions.

6.1.2.1 Children

UNICEF’s interventions were especially relevant to the needs and rights of children affected by Cyclone Freddy. UNICEF partnered with child-friendly organizations to create CFSs and provide needed MHPSS support. Tents, TLs, and educational materials (see above) directly targeted the need for children to continue their education with as little disruption as possible. Child protection (including children rights), GBV and PSEA identification, referral, case management, and tracing/reunifications services were all directed to address children’s needs/vulnerabilities in those areas.

6.1.2.2 Women and girls

The relevance of MCO’s interventions and its ability to meet the specific needs of women affected by the cholera and Cyclone Freddy emergencies was mixed. As co-chair of the gender working group, (and consistent with its Gender CCC #3 on gender responsive programming), MCO led the integration of gender into preparedness and response plans and INGD contingency plans, supported capacity building at cluster level and the development of dedicated gender tools. MCO developed a gender annex to the Multisector Initial Rapid Needs Assessment (MIRA) in the Maputo floods response, which captured the

¹³⁷ To see the full results from the survey, please use this link: https://lookerstudio.google.com/reporting/e1acc136-b3a4-4eaa-bcbc-aa098005240f/page/p_7eiwzffefd.And

¹³⁸ <https://www.unicef.org/media/102136/file/LNOB-in-WASH-Guidance-Note.pdf>

emergency's multi-sectoral gender repercussions.. While the MIRA exercise presented some challenges¹³⁹, the experience led to stronger awareness on the importance of integrating gender into the main tool. Gender analysis was integrated into programme development, and GBV risk mitigation was addressed as a cross-cutting issue across response areas (Gender CCC #1). In collaboration with child protection and PSEA, MCO strengthened IPs' capacities on GBV awareness raising and response.

While committed to the implementation of its CCCs, MCO struggled with engaging women and girls organisations in programme design, implementation and monitoring due to the (heavy) administrative procedures requiring a level of competencies that these organizations in the affected areas did not have.¹⁴⁰ Even though affected provinces had active networks of women-led organizations, their members' limited informatic literacy, lack of English competencies, unfamiliarity with UNICEF administrative procedures and portal, as well as limited financial management skills represented a barrier to the establishment of a PD with UNICEF.¹⁴¹ Nevertheless, a group of adolescents and young people were trained on GBV risk mitigation, positive masculinity and PSEA, which expanded the outreach of community mobilisations and awareness raising on these subjects, including in hard to reach areas. In a context where temporary shelters were not equipped to ensure protection for women and girls, the structural weakness of GBV referral systems and response services translated into gaps in coverage, while NGOs were also lacking capacities on GBV response. Against this background, efforts were made with MCO's child protection and PSEA teams to support the reactivation of the *Centro de Apoio Integrado* (Integrated Assistance Centres)¹⁴² by equipping the centres. To provide close and dedicated GBV capacity building and technical assistance and considering that UNICEF's in-country and regional (ESAR) HR capacity on GBV in emergencies, PSEA, and child protection (including their rights) was insufficient to meet the needs of the cholera and Cyclone Freddy emergencies, efforts were made to hire additional expertise. Various attempts were unsuccessful (e.g., due to a lack of Lusophone speakers), which hampered MCO's capabilities to achieve the desired results on PSEA and GBV.¹⁴³

6.1.2.3 Adolescents

UNICEF MCO's efforts to target, engage with and include adolescents in its response interventions were highly relevant. Content for interventions was tailored to their age. TV spots, music, music videos, media campaigns, the utilization of adolescent boys and girls as radio producers, and the inclusion of young artists and members of the Adolescent and Youth Platform speaking in person in resettlement centres about cholera and looking at risk behaviours they might face in their communities, were all tailored to address and utilize adolescents as agents of behavioural change. Videos with adolescents discussing unhygienic practices in markets, and the use of Flood Tutor, SMS Biz/U-report,¹⁴⁴ as well as SMS, social media, Facebook, and WhatsApp groups, were all extremely relevant to reaching and engaging adolescents.

6.1.2.4 Persons with disabilities

UNICEF MCO's response plan specifically identified the need to support persons with disabilities as a cross-cutting approach common to all response areas. The evaluation finds support to persons with disabilities to be particularly relevant for the cyclone response as persons with disabilities are

¹³⁹ KII. Not all assessment teams had a gender focal point, MIRA teams did not have enough time to do both MIRA and gender questions, and data analysis was delayed.

¹⁴⁰ KII.

¹⁴¹ KII.

¹⁴² *Centro de Apoio Integrado* is a one-stop-centre for reporting, services and referrals for GBV and violence against children.

<https://www.mgcas.gov.mz/index.php/imprensa/noticias/441-centros-de-atendimento-integrado-encorajam-denuncia-de-violencia>

¹⁴³ KII.

¹⁴⁴ SMS Biz utilizes the U-report platform, a free SMS social monitoring system that promotes participation and sensitization of youth and adolescents on sexual and reproductive health and HIV/AIDS prevention. SMS Biz was designed to support young people and adolescents to express problems faced in their communities.

especially vulnerable in areas that are flooded, or in which houses are damaged or destroyed and where access to services and temporary accommodation is an issue, and their rights might be at stake. However, it seems that organizational commitments¹⁴⁵ to prioritise persons with disabilities were not effectively put into practice. The evaluation team could find no data that quantified the extent to which persons with disabilities were able to access required services either post-Freddy or during the cholera outbreak. Key informants provided contradictory information: some indicated that no specific actions were taken to prioritize persons with disabilities as they were *de facto* included in blanket (cholera-specific) interventions; others indicated that “special attention” was directed towards persons with disabilities but could not provide concrete actions that had been taken. Additionally, the programme with Humanitarian and Inclusion to support a stronger approach to persons with disabilities was signed several months after the cyclone response. Overall, the evaluation could not find evidence that persons with disabilities were included to any significant degree in UNICEF’s responses to the Cyclone Freddy and cholera emergencies.

6.1.3 To what extent did the intervention deliver results in an economic and timely way? (Efficiency)

This section assesses the extent to which UNICEF’s interventions delivered results in an economic and timely way. A timeline has been added, setting out the key events, to complement this section (see Annex 1: Timeline).

Most partners and stakeholders appreciated the support provided by UNICEF. The fact that responses to cholera and cyclone emergencies were running simultaneously at an unplanned-for magnitude challenged UNICEF’s and its IPs’ response capacities, which had a corresponding impact on the timeliness of the responses. Most informants agreed that UNICEF did the best it could with the means at its disposal. However, from an emergency preparedness perspective, and given the pressing needs that developed after the crises, several critical points are raised below for consideration, some of which were beyond MCO’s control.

MCO supported the responses to the cholera and cyclone emergencies with significant quantities of in-kind goods;¹⁴⁶ however, related supply chain management and logistical issues slowed operational response timelines. The long-term agreements (LTAs) formalizing UNICEF’s business relationships with suppliers of goods and services that were in place prior to the L2 cholera and Cyclone Freddy emergencies proved to be inadequate to the task of ensuring a steady flow of the required goods and services in the required quantities, within the emergency timeframe, to the required locations.¹⁴⁷ As both emergency responses were heavily supply-dependent, this lack of preparedness impinged upon UNICEF’s ability to respond to the emergencies efficiently. Over time, some supply agreements were put in place that facilitated procurement and distribution processes. One of the principal response challenges related to the pre-positioning of stock. MCO had a quantity of various supplies pre-positioned in country prior to the emergencies; however, the quantities of in-country stock were not commensurate to the scale of the needs, and the supplies that were in-country had not been pre-positioned in cyclone-affected provinces. Flooding and the cutting of roads problematized and delayed the transport of supplies to the most affected areas in the initial stages of the emergency response. UNICEF’s FOs were able to procure and (through their IPs) distribute a limited amount of required goods in small amounts sufficient to kick-start the response. As the availability of supplies on local markets was insufficient to meet the scale of the needs,

¹⁴⁵ UNICEF (2022) UNICEF Disability Inclusion Policy and Strategy 2022–30.

¹⁴⁶ A list of goods and services, and their order and delivery dates, can be found at UNICEF’s internal spreadsheet: 24_03_26 SO Timeline.

¹⁴⁷ This point was also identified by the AAR. For a complete listing of MCO’s LTAs, please see the internal UNICEF Excel sheet 24_03_24 LTA.

it was necessary to procure and transport most response goods from Maputo, or import the items, both of which led to long(er) delivery times. International procurement was further challenged by delays in obtaining duty exemptions. Once stock started to arrive in the field, finding appropriate and safe storage spaces became a major challenge. Key informants reported that, as a result, some supplies were reportedly lost but the evaluation team did not find any further evidence on this issue.¹⁴⁸ Delivery to affected locations outside of provincial capitals was an issue. Despite logistical support provided by WFP, some supplies got stuck in provincial warehouses waiting for further distribution to districts, and onwards to communities.¹⁴⁹ The delays faced were exemplified by the arrival of (small quantities of) supplies in Nante, a district in Zambézia, only in June 2023.

Mobilisation of HR to cover critical gaps remained a main challenge right through the L2 response.

There were significant existing gaps in HR at the beginning of the L2 response, mainly caused by the ongoing recruitment process for the new Country Programme Management Plan.¹⁵⁰ Because there had been no cholera outbreaks over the previous five years, the natural levels of staff turnover during that time had led to a significant loss of relevant institutional memory. Even though many UNICEF staff members were 'double-hatted' and worked around the clock for months for the first stages of the response, UNICEF's overall staff capacity to implement a cholera response was low: this negatively impacted UNICEF's ability to efficiently respond to the cholera emergency in its initial stages. Despite receiving significant support from ESARO HR,¹⁵¹ and launching several recruitment processes for national and international experts, including surge deployment missions, and despite ESARO and HQ covering some HR gaps with Emergency Response Team members, challenges remained throughout the L2 response.¹⁵² Considering ESARO accountability in a L2 response, deployment of ESARO staff and members from the Rapid Response Mechanism (RRM) rosters should be the first resources to cover HR support needs. However, as the external roster had not been updated for five years at that time, it was found to be "*really not useful*" in sourcing the required HR positions through the roster (however, some internal staff members who were not on the roster were deployed after being vetted both by ESARO technical sections and the MCO.¹⁵³ Frontline, UNICEF's global surge platform, proved to be of little use: people were not vetted, some did not have emergency experience, and others who were Lusophones did not have the required profiles.¹⁵⁴ The practice of sending qualified English speakers who were helped by a local staff member proved to be only.¹⁵⁵ These challenges meant that available MCO staff, both in Maputo and in the FOs, had to cover the gaps as best they could, which overburdened them and stretched their capacities. Short-term missions were useful for advising and training, but caused challenges for coordination, partnership building, and monitoring of partners and interventions. UNICEF learned and adapted over the course of the response. However, by August 2023 only 67% of the surge requests were recruited¹⁵⁶. By the time the L2 was deactivated, UNICEF had recruited a cholera coordinator (October 2023) and, convinced that cholera/emergency positions are crucial, managed to cover many of the pre-existing gaps and made strides in developing a local roster, all of which contributed to increase the timeliness and agility of its ongoing cholera response and increased its current level of preparedness (for the next PHE).

¹⁴⁸ Key informant interviews.

¹⁴⁹ Key informant interviews.

¹⁵⁰ For example, the WASH department had lost nine positions. KII.

¹⁵¹ The deployment of approximately 70 people to the Malawi and Mozambique emergencies, orientations with the Country Office on emergency standard operating procedures, regular calls to the in-country HR specialist, the establishment of HR plans as part of preparedness, the promotion of technical assistance positions that can be filled for 729 days with single source recruitment, etc.

¹⁵² As noted in the AAR, finding Lusophone speaking experts with the required profiles, such as GBV in emergencies and child protection in emergencies, was a significant challenge (and often impossible).

¹⁵³ Key informant interviews.

¹⁵⁴ Key informant interviews.

¹⁵⁵ Key informant interviews.

¹⁵⁶ Annex 36, Progress against I2 Benchmarks

MCO's *modus operandi* via partnerships encountered difficulties and incurred delays, despite the availability of simplified emergency procedures¹⁵⁷ and efforts to identify new partners. These challenges are related to the fact that MCO worked solely through partnerships and largely did not do direct implementation, which in some instances may have been more efficient. Even though procedures for signing new PD theoretically become streamlined with an L2 activation, the actual process still took considerable time and effort.¹⁵⁸ Also, UNICEF encountered challenges in finding IPs with adequate experience in emergency response and in the required thematic areas (e.g., WASH, child protection, and cross-cutting issues, such as gender), and which were already on the ground in cholera- and cyclone-affected areas. Having some pre-identified partners with an active PD on cholera response proved helpful; however, as reported during the AAR, existing Contingency Programme Documents had either expired¹⁵⁹ or were not adequate to meet the response needs (i.e., partners did not include the required technical expertise or comply with the minimum PD required standards). UNICEF faced delays in identifying and contracting additional IPs because the new e-Programme Document platform (e-tools) was being inopportunistically rolled out concurrently with the height of the emergency responses. By the time new IPs were in place, the cholera caseload was very low or decreasing in affected areas, which affected the relevance of the activities foreseen to be implemented in the emergency response plan.¹⁶⁰ Start-up letters proved to have a less-than-hoped-for impact as in some instances it took UNICEF several weeks to transfer the initial tranche of resources to these partners, who could only immediately commence the required acute, life-saving interventions if they had a sufficient amount of their own cash on hand to cover the initial response costs.¹⁶¹

The extension of UNICEF's Corporate Emergency Activation Procedure (CEAP) L2 designation to include Mozambique's responses to the cholera emergency in Mozambique came too late. The result was that MCO's cholera response was rolled out at scale too late in the epidemic curve to prevent the peak and was reactive (rather than proactive) in responding to the ongoing outbreak.¹⁶² The cholera outbreak began in September 2022 in Niassa province. Lacking a FO in this province, UNICEF deployed one person (on a rotating basis) to Niassa to support the response. This support arrived after the cholera outbreak had peaked in the early weeks of 2023, despite numerous earlier appeals for assistance (e.g., WASH support). Cholera then expanded to other locations¹⁶³ (see Annex 27). Only after Cyclone Freddy hit in March 2023 did UNICEF scale up activities with the resources and focus necessary to address the cholera outbreak in Quelimane, the epicentre for both the cyclone and the cholera outbreak. The L2 was activated in Mozambique on 22 March 2023.

Overall, key informants reported that UNICEF was reactive and became operational only when the cholera caseload had peaked or started to decrease, rather than acting earlier in the outbreak at the critical time for curbing transmission. Response times varied between the sections: some UNICEF sections were quicker to respond in some provinces than other sections and key informants reported internal delays occurred in some sections (the WASH and child protection sections required more time than others to scale up response activities).¹⁶⁴

¹⁵⁷ UNICEF. (2021) *Guidance Handbook in L1, L2 and L2 Emergencies*, Ch. 12. 'CSO Implementing Partnerships'.

¹⁵⁸ Internal key informants indicated that they were still expected to use the same processes and procedures, but to do so in a compressed timeframe.

¹⁵⁹ An updated Contingency Programme Document needs to be in place that can be quickly activated when an emergency occurs. Country offices are encouraged to have preparedness plans with civil society organization partners in place in case of an emergency and that the CPDs are uploaded in the UNICEF e-tools platform.

¹⁶⁰ For further information see Section 6.2 on partnerships.

¹⁶¹ Key informant interviews.

¹⁶² Key informants indicated that the triggers for activating this L2 were too slow, and that it should have been declared in December.

¹⁶³ <https://www.who.int/emergencies/disease-outbreak-news/item/2023-DON443>

¹⁶⁴ Key informant interviews.

Due to the lack of specific, reliable and accurate epidemiological data relating to cholera outbreaks at the provincial level (a factor which certainly affected UNICEF's ability to gauge the scale of the outbreaks and assess where they were vis-à-vis the epidemic curve), the evaluation was not able to quantitatively ascertain the extent of the timeliness of UNICEF's response at provincial and district levels. However, qualitative data gathered across the various localities visited by the evaluation team during its field visit indicates that, overall, UNICEF's cholera response was not timely, but rather reactive, and was only substantively rolled out when the caseload had peaked or was decreasing. According to available data, nationwide the cholera outbreak peaked in epidemiological weeks 12–13 (around 12–26 March 2023), with most cases in Zambézia (see Annexes 27, 28, 29 and 30). Other outbreaks started in other locations simultaneously or following the cyclone, with reports from partners that there was a trend of fast peaks, with a quick decrease of cases and no plateau, which highlights even more the importance of achieving a timely response to avoid higher mortality and morbidity.

6.1.4 To what extent did UNICEF's response scale up for adequate coverage, reaching all demographic populations of vulnerability and marginalization (last-mile delivery)? (Coverage and Proportionality)

This section endeavours to assess the extent to which communities that faced life-threatening suffering were reached by humanitarian action.¹⁶⁵

The responses to the cholera and Cyclone Freddy emergencies were marked by a paucity of accurate and timely data. Though this affected UNICEF's response operations, it is important to note that this was not limited to UNICEF but applied globally to all actors responding to the Cyclone Freddy and cholera emergencies, whether they were governmental, national, international or United Nations. The responses were rolled out reactively—knowing that there was much that was unknown—based on reports coming in from personnel located in cholera- and cyclone-affected districts and provinces but without reliable numbers that indicated the actual need, either in numbers or geographical location. 'Progress' measured by tracking against target indicators does not speak to coverage against needs,¹⁶⁶ and therefore it is not possible to accurately assess to what extent UNICEF's humanitarian actions reached those in need, nor the extent to which UNICEF's response was equitable¹⁶⁷ or proportionate. However, **it is certain that UNICEF scaled up its emergency responses—increasing its coverage to a significant degree—and endeavoured to reach as many cholera- and cyclone-affected persons as possible.**

Regarding the cholera response: **epidemiological data is a critical factor in order to ensure appropriate coverage and access to the most needed populations.** However, in the case of Mozambique, reporting of cholera cases and deaths was based on cases registered in CTCs (i.e., admitted in-patient cases); these numbers, therefore, did not represent the reality either in terms of number of cases or the actual CFR. The case definition changed in March 2023, when mild cases started to be reported also; however, cases in remote health facilities and most communities were still not included. Incomplete epidemiological data did not allow for a proper tailoring of the response according transmission contexts or for the prioritization of geographic or response areas according to needs and availability of resources. Additionally, official outbreak declarations in affected zones were often delayed, with corresponding delays in the commencement of cholera response interventions.¹⁶⁸ As a result, as the response progressed, **UNICEF strengthened its coordination with MSF and WHO to facilitate epidemiological data sharing, analysis, and subsequent quick mobilization of resources** (including HR). **UNICEF also began**

¹⁶⁵UNICEF. (2022) *Core Commitments for Children in Humanitarian Action*. p. 105.

¹⁶⁶ The Sitreps do not report against targets.

¹⁶⁷ See the discussion of persons with disabilities, in Section 6.1.2 above.

¹⁶⁸ In Alto Molocue (Zambézia province) health authorities learned about a cholera outbreak in their district via one of the IPs through (early) data collection.

training IPs in the use of data to guide its response. However, WHO's capacity to forecast epidemiological trends was dependent on the MoH recognizing the magnitude of the cholera crisis (which did not possess this capability) and to declare outbreaks in a timely manner, which limited opportunities to expand community surveillance networks and at the same time highlighted the need to improve existing information sharing mechanisms.

Regarding the cholera and Cyclone Freddy responses, **UNICEF** (together with its CSO IPs) **had limited resources to respond to a multi-factor crisis of a large magnitude;**¹⁶⁹ nevertheless, **UNICEF's planning and monitoring capabilities enabled UNICEF to prioritize and scale up its responses to both emergencies, despite the absence of national and subnational plans and the overall lack of accurate, reliable and timely data.** As was highlighted in the AAR, in terms of the quality of information management, including timely data collection, the avoidance of duplication and conducting appropriate analysis that progressively informed response interventions was widely recognized as inadequate.¹⁷⁰ Planning and monitoring tools that were shared and used by different sections within UNICEF were not always interconnected or interoperable. Though field personnel occasionally participated in establishing targets, most were involved only in the reporting stage, with little time for reflection and re-prioritization according to the evolving needs of the emergency responses.¹⁷¹ UNICEF-led WASH and Health Clusters updated their common response plan twice; however, this was mainly for fundraising purposes (reviews of the Flash Appeal and the HRP). These updated cluster plans could not be used for planning and monitoring purposes, since results frameworks and detailed budgets were missing.¹⁷² UNICEF supported the establishment of regular cluster meetings at national, provincial and district levels, and the exchanges of information that occurred in those fora played a key role in the overall expansion of coverage and scale-up. UNICEF-supported WASH and Health Clusters contributed to the development of a joint Cholera Response Plan at national and provincial levels.¹⁷³ The National Cholera Response Plan was drafted by the GoM;¹⁷⁴ however, as it was neither finalized nor shared with partners, it did not enable a broader understanding of geographical priorities, or allow partners to respond to and evaluate identified needs and gaps, or align with government priorities. Joint needs assessments were conducted by UNICEF and other partners and the results were shared with relevant stakeholders for subsequent action: this occurred mainly via the clusters. UNICEF attempted to motivate provincial authorities to develop provincial/district response plans; however, this was not achieved for all provinces and districts. Further information on cluster leadership in page 44.

The lack of a UNICEF presence in some cyclone- and cholera-affected areas (no FOs), as well as the level of proximity of UNICEF's FOs to cholera- and cyclone-affected areas, both led to diverse response modalities, resulting in varying expansions of response activities with corresponding differentials in coverage. Prior to the cholera outbreaks and Cyclone Freddy's landfalls, UNICEF had staff on the ground and established networks in Zambézia, Sofala, Nampula and Cabo Delgado provinces (via its FOs). Despite occasional communication challenges between the Country Office and FOs,¹⁷⁵ this proximity proved to be particularly important in both Zambézia (the most heavily affected province, being affected by cholera and Cyclone Freddy) and Sofala province (principally cholera). Emergency response modalities included using CTCs and transit centres as both entry (CATI approach) and distribution points (for NFI distributions), as well as sites for spreading preventive messaging.¹⁷⁶ Accommodation centres and

¹⁶⁹ This point was articulated in the AAR as well.

¹⁷⁰ Key informant interviews and AAR.

¹⁷¹ Key informant interviews.

¹⁷² UNICEF. (2023) Multisectoral Response to a Nationwide Cholera Outbreak in Mozambique, WASH field note (UNICEF internal report).

¹⁷³ See Section 6.1.7 on coordination.

¹⁷⁴ <https://ins.gov.mz/este-ano-mocambique-conclui-elaboracao-do-plano-de-accao-para-eliminacao-da-colera/>

¹⁷⁵ Key informant interviews.

¹⁷⁶ Transit centres were mostly tents, schools, churches or other large buildings where people that had lost their housing were accommodated. These were dismantled relatively quickly due to the risk of cholera infection. In Sofala province alone, 60 transit centres were opened: 50 in Caia and 10 in Marromeu districts. Resettlement sites remained at the time of the evaluation, housing

resettlement sites (cyclone response) were also used, which ensured both a degree of relevance (that the NFIs being distributed were needed) and impartiality.

Challenges in finding qualified IPs in provinces where UNICEF did not have an FO (e.g., Inhambane and Niassa province, see Annex 30) caused delays in implementation, problematized decision-making regarding the prioritization of increasing coverage, and produced varying results in terms of targeting, coverage and proportionality. Geographical proximity/levels of presence were factors that affected UNICEF's operational response capabilities¹⁷⁷ and thus affected coverage in general. Although this was established with a greater-than-hoped-for delay, MCO managed to set up and utilize p-cards for staff travelling to provinces where UNICEF did not have an FO. Some FOs close to affected provinces provided critical support to staff deployed in the field (e.g., the Nampula FO supported UNICEF colleagues deployed to neighbouring Niassa province).

The politicization of aid and the application of adequate criteria aligned with needs and vulnerability (e.g., to establish lists of beneficiaries) were posed challenges for some humanitarian actors. For UNICEF, finding the right balance between adhering to its mandate to support the GoM's response while operating according to a principled approach remained a challenge throughout the emergency response. UNICEF staff and humanitarian cluster members took efforts to identify the most vulnerable groups in each region; however, the customary targeting systems that were in place did not include a proper vulnerability and needs analysis or allow for verification of the degree to which humanitarian assistance reached the most vulnerable groups of the affected population. Some IPs relied on *activistas* to be their *ears and eyes* in the communities; however, transport issues regarding travel to more remote areas and incidents related to incentives may have affected their motivation and impartiality. Additionally, multiple well-placed key informants indicated that, as was customary, lists of beneficiaries to receive humanitarian assistance were established in the field by community leaders “*who favoured the people they were politically aligned with,*”¹⁷⁸ or who were “*following directions of the local/provincial government*”.¹⁷⁹ In Zambézia province, lists were “*blatantly manipulated*”: key informants witnessed members of political families coming in their SUV 4x4s to evacuation centres for food distributions.¹⁸⁰ Some areas, such as Quelimane, posed specific challenges to coverage and proportionality in the sense that the crises became politicized (with opposing political parties controlling the municipality, provincial and central governments), which affected which side received assistance and added additional barriers to efforts to provide neutral assistance..

Access issues challenged coverage and proportionality: it took UNICEF and partners weeks to access some locations in Zambézia province due to roads being cut and water levels being too high; whereas other actors managed to gain access and deliver supplies in the first week after the cyclone hit and when cholera cases started to escalate and scaling up was most needed.¹⁸¹ Expertise, flexibility and the (fortuitous) presence of IPs in affected areas also impacted coverage and proportionality: for instance, UNICEF's IPs were able to expand the provision of needed WASH interventions to additional districts (Gurue and Alto

lower-income families that had no housing options. In Sofala province, there were three active resettlement sites: one in Mafambisse, Dondo district (with 55 families), one in Nhacuecha, Caia district (initially with 292 families, a number which had been falling until the current 30 families), and Nensa resettlement site in Marromeu district (with 45 families). In Zambézia, there is Namitangurine resettlement centre, located in Nicoadala district, which in April 2023 had 3,262 families and 16,335 people, including people displaced by past events and Cyclone Freddy; and Munguissa (which includes 2,683 families and 1,072 people) resettlement centres in Namacura district, which are the most affected districts with active resettlement centres.

¹⁷⁷ E.g., a lack of flexible disbursement procedures, LTAs for car rental and other services, petty cash, contracts with phone/internet service providers.

¹⁷⁸ Key informant interviews.

¹⁷⁹ Key informant interviews.

¹⁸⁰ Due to large groups of people demonstrating against this practice in front of their offices, WFP had to halt food distributions for several days in order to address this issue.

¹⁸¹ E.g., MSF negotiated with WFP to use their available means of transport, which made it possible to access the affected areas quickly after the cyclone hit.

Molocue)¹⁸² and 500 cyclone-displaced families relocated from Malawi to a rural and isolated location in the south of Niassa province. It took several weeks for a joint mission to reach and to assess the needs of this community, revealing the challenges to coverage posed both by remoteness of the location and the political dilemma relating to whether or not to aid foreigners.

Internal adaptations in coordination architecture increased operational flexibility and resulted in increased coverage. The establishment of a multisectoral (SBC, health, and WASH) cholera task force (in April 2023) leveraged UNICEF’s comparative advantage and expertise and ensured that the key sectors needed to prevent and respond to the cholera outbreaks were involved in all interventions. This task force worked to identify gaps and needs (via needs assessments) and provided relevant training and technical support to IPs.

6.1.5 To what extent was the response consistent with relevant UNICEF standards and policies (CCCs, PHE-PR)? (Quality and Coherence)

UNICEF’s CCCs and the White Paper for PHE-PR¹⁸³ have been used to inform this section, while the CCCs and other corporate guidelines have been used for other sections of this report for alignment. The evaluation examined the extent to which UNICEF’s cholera response operations corresponded to or differed from the nine recommendations put forward in the White Paper. (Annex 31: UNICEF and PHEs contains a more detailed analysis). Section 6.2.1 reviews the alignment of the responses to the Cyclone Freddy and cholera emergencies with L2 Emergency Procedures.

UNICEF’s L2 responses to the cholera and Cyclone Freddy emergencies were guided by and adhered to its CCCs in Humanitarian Action, its commitments related to PHEs—*Children and their communities are protected from exposure to and the impacts of PHEs*¹⁸⁴—and to its corporate priorities regarding emergency response. As previous sections have detailed, UNICEF’s response was guided by the global standards and principles, institutional responsibilities, overarching commitments, programmatic approaches, and sectoral, cross-sectoral, situation-specific and operational commitments outlined in its CCCs. UNICEF did not manage to include environmental sustainability and climate change, and humanitarian cash transfers in its programmatic approaches, and, as noted above, faced limitations in operationalizing its cross-sectoral commitments to gender equality and the empowerment of girls and women and disabilities inclusion. However, this was largely out of UNICEF’s control (i.e., the GoM’s refusal to implement humanitarian cash transfers as a response modality, challenges regarding targeting) and the evaluation found that UNICEF’s response was entirely consistent with its standards and policies.

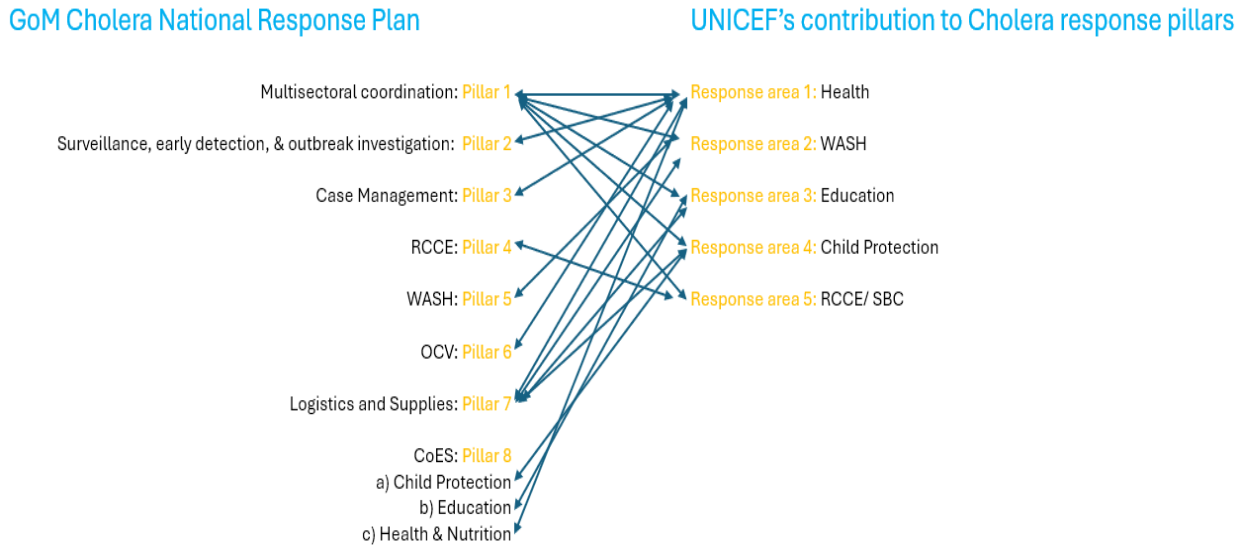
UNICEF’s response plans for both the cholera outbreak and Cyclone Freddy were in line with its CCCs and were based on a comprehensive, integrated, multisectoral approach. At the strategic level, there was no cyclone response plan developed by the GoM; however, UNICEF, in close collaboration with INGD at national, provincial and district levels, and the United Nations Country Team (UNCT), the Humanitarian Country Team (HCT) and cluster coordination structures, ensured programmatic alignment and consistency in response quality. UNICEF’s cholera response strategies were aligned with the GoM’s strategic pillars, as outlined in the GoM’s Cholera National Response plan (see Figure 4 below).

¹⁸² See Annex 30 (Example of Scale up in Sofala, Inhambane and Niassa), and Annex 18 (Summary of WASH interventions).

¹⁸³ UNICEF. (2023) Putting the Best Interest of Children, Women and their Communities at the Center of Public Health Emergency Preparedness and Response, UNICEF White Paper. <https://www.unicef.org/reports/putting-best-interest-children-women-and-their-communities-centre>

¹⁸⁴ UNICEF. (2024) Core Commitments for Children and Public Health Emergencies. 2.5.1 “Strategic Result”, p. 76. <https://www.corecommitments.unicef.org/ccc-2-5-1> accessed 4 April 2024.

Figure 5. UNICEF's response areas and their alignment with GoM cholera response pillars



Source: Developed by the evaluation team based on the GoM's Cholera National Response Plan and UNICEF's cholera and Cyclone Freddy response plans

UNICEF's response to the cholera emergency successfully met two out of the White Paper's three objectives and incorporated eight out of its nine recommendations (see Section 3.1 above). UNICEF's response was child-focused (Objective 1); its cholera responses closely linked health, WASH and SBC sectors together (both CATI and blanket interventions) and clearly showed that UNICEF leveraged its multisectoral expertise to control the cholera outbreak and prevent/reduce its spread (Objective 2). UNICEF ensured that expertise was available to the GoM and provided a great deal of capacity building to the GoM and its agencies. A good example is the measuring of water treatment chemicals: many water provision agencies relied on UNICEF's expertise to carry this out. However, as was noted above, UNICEF was unsuccessful in its efforts to implement cash distributions to mitigate the socioeconomic consequences of the cholera outbreak (Objective 3).

Though UNICEF successfully incorporated the White Paper's other eight recommendations, it did not *invest in informed and better decision-making through data systems (#8)* to any significant degree. Although UNICEF demonstrated flexibility in decision-making, and UNICEF's interventions demonstrated a high level of adaptability to (newly) identified needs, the evaluation team could not find evidence that UNICEF made any significant investment to increase the robustness of the data systems used to inform its response. It is important to highlight the fact that key informants interviewed by the evaluation team overwhelmingly indicated that the countrywide lack of clear and reliable data negatively impinged upon many aspects of the emergency responses at local, regional and national levels. Nevertheless, the fact that UNICEF's response incorporated the other eight recommendations for PHE-PR to a significant level is noteworthy.

6.1.6 To what extent were longer-term considerations incorporated into response interventions? (Connectedness/ Sustainability)

The extent to which UNICEF succeeded in incorporating longer-term considerations into its cholera and Cyclone Freddy responses was mixed, varying across interventions and response areas. Sustainability and/or longer-term considerations were not included as such in UNICEF's Multisectoral Cholera and Cyclone Response Plan. The primary focus of UNICEF's interventions in response to the

cholera and cyclone emergencies was addressing the immediate humanitarian needs. While several efforts to incorporate longer-term considerations were made, they remained a secondary focus. For instance, IPs indicated they did not have exit strategies and had not considered the long-term continuation of support beyond UNICEF's emergency funding. (Further analysis is provided in Section 6.3, on links with the HDP nexus.)

Infrastructure rehabilitation/resilience building, and capacity building took place. For education-, health- and WASH-related interventions, damaged infrastructure, health facilities, and water and sanitation infrastructure were repaired/rehabilitated. These interventions not only helped to meet immediate needs but also ensured continued access to essential services for affected populations. Capacity-building initiatives were conducted to enhance local expertise and sustainability in responding to future crises. This is not to say that all rehabilitation works were meant to be long-lasting. There were instances where quick and cost-effective repairs were made using local materials/techniques which were not designed to be durable over the long term (i.e., resistant to rain, floods and cyclonic winds). However, UNICEF, with its combination of architectural and engineering expertise, supported the implementation of many innovative interventions and improved the quality and resilience of infrastructure that was repaired/rehabilitated. While work may still need to be done to expand UNICEF's efforts beyond the education sector and to directly link them with climate change/ resilience work, properly utilized, the infrastructure-related work shows UNICEF's comparative advantage in incorporating longer-term considerations into future emergency response interventions.

Some WASH-related initiatives were designed to bring about long-term behavioural change and sustainable sanitation practices. Some WASH activities were reported to follow a community-led total sanitation (CLTS) model, including hygiene and health promotion activities undertaken in markets and other public spaces. Additionally, support provided to WASH authorities at provincial and district levels focused on strengthening coordination and preparedness for future PHEs. However, an overly high reliance on community 'resilience' (interpreted sometimes as community-led but without much guidance and support) was observed by the evaluation team during its field visit. This, together with sustaining the WASH initiatives, will require further support if the **WASH-related initiatives implemented** are to be sustained beyond UNICEF's emergency funding cycle.

There is no clear evidence that sufficient consideration was given to environmental sustainability. As was noted in the previous section, the CCCs highlight the importance of integrating environmental sustainability into UNICEF's humanitarian action to enhance community resilience to climate change.¹⁸⁵ UNICEF's Emergency Procedures do not mention climate change or environmental approaches, leaving uncertainty about the extent to which UNICEF at the corporate level prioritizes climate change and environmental approaches in emergency response. This is particularly relevant not only to the current climate change agenda and its links to global health security, but also to Mozambique geo-specifically, with its anticipated increase in vulnerability to emerging diseases and climate change-related extreme weather events.

6.1.7 To what extent was the response well-coordinated? (Coordination)

As guided by EMOPS¹⁸⁶ and outlined in its CCCs, UNICEF is expected to play its part in inter-agency and intersectoral coordination mechanisms for PHEs. Furthermore, UNICEF is mandated to take on the leadership and coordination role in the government pillar efforts as the primary organization responsible for

¹⁸⁵ The clause stating "whenever feasible and relevant" suggests that environmental considerations are not prioritized in emergency response.

¹⁸⁶ UNICEF, EMOPS Indicator Guidance for Public Health Emergencies.

responding to a public health crisis, regardless of whether the cluster approach is activated.¹⁸⁷ This section assesses UNICEF's coordination efforts in both the cyclone and cholera responses.¹⁸⁸

6.1.7.1 External coordination

6.1.7.1.1 Coordination with the GoM

UNICEF supported a multisectoral approach to cholera and Cyclone Freddy responses and supported the GoM's efforts to lead both responses at national, provincial and local levels. However, as Figure 4 in Section 6.1.5 above demonstrates, **the cluster system did not align well with the eight pillars of the cholera response¹⁸⁹ or with INGD's four pillars.¹⁹⁰** Under the overall coordination of the INGD, UNICEF participated in cyclone response coordination meetings held both at central and provincial levels. As the INGD is responsible for advising the activation of emergency contingency plans in each province but has limited response capacity, it relies heavily on partners such as UNICEF and the Office for the Coordination of Humanitarian Affairs (OCHA) to coordinate and implement response interventions. UNICEF was recognized for the critical support it provided to the INGD, which enhanced its capacity to coordinate and implement the cyclone response at national,¹⁹¹ provincial and local¹⁹² levels. Key informants highlighted that the INGD had a stronger presence and was better able to carry out its coordination role in provinces where UNICEF is present.

UNICEF not only supported the MoH in coordinating and leading the health response but also provided critical coordination support to other government agencies and sectors in its leadership role. The MoH took the lead on the cholera response, but emphasized health-related activities, despite the need for a multisectoral approach. A cholera Emergency Operating Centre was not activated at the beginning of the outbreak, nor was there a finalized National Cholera Plan, both of which were missed opportunities for the GoM to ensure adequate coordination with its non-governmental partners. However, a cholera incident manager was appointed by the MoH to support coordination and response efforts. UNICEF actively participated in cholera coordination meetings chaired by the MoH.¹⁹³

At the provincial level, multisectoral cholera task forces were activated and led by the MoH, with progressively greater involvement from WASH counterparts, as well as other non-health sector partners. To ensure the required multisectorality within the GoM's response, UNICEF coordinated its activities with the affected municipalities and the government entities overseeing different aspects of the response (the *Direcção Provincial de Obras Públicas* (DPOP) (Provincial Directorate of Public Works) and the *Direcção Provincial de Saúde* (DPS) (Provincial Directorate of Health)). In Quelimane and other districts, this coordination proved challenging as the DPOP was absent from most coordination meetings (despite the fact that the DPOP was responsible for key public works).¹⁹⁴ UNICEF also coordinated with the local WASH authority: it coordinated with the *Fundo de Investimento e Património do Abastecimento de Água* (FIPAG) (Water Supply Asset Holding and Investment Fund) for infrastructure works and to ensure the logistics were in place for water trucking. UNICEF continued its coordination support to the response by working¹⁹⁵ to

¹⁸⁷ Inter-Agency Standing Committee. (2018) Standard Operating Procedures, Humanitarian System-wide Scale-up Activation, Protocol 2: Empowered Leadership. <https://interagencystandingcommittee.org/sites/default/files/migrated/2020-09/Protocol%202.%20Empowered%20Leadership%20in%20a%20Humanitarian%20System-Wide%20Scale-Up%20Activation.pdf> Accessed 4 April 2024.

¹⁸⁸ See Annex 32 for more information on coordination activities.

¹⁸⁹ As per National Cholera Response plan pillars, see Section 6.1.5. For example, cholera indicators were not the same as WASH cluster indicators in terms of monitoring.

¹⁹⁰ The INGD response is organized according to four pillars: 1. information/planning, 2. social assistance, 3. infrastructure, and 4. communication.

¹⁹¹ Information management, funding, and capacity building.

¹⁹² Logistics, supplies, warehouse capacity, etc.

¹⁹³ Via the provincial and district health administrations.

¹⁹⁴ E.g., water trucking and rehabilitation of water points.

¹⁹⁵ Zambézia, Nampula.

ensure that all relevant non-health authorities (e.g., WASH, education) participated in existing cholera response coordination structures.¹⁹⁶ At the Maputo level, UNICEF supported the MoH's Health Promotion Department to organize coordination meetings with the participation of representatives from the affected provinces. Although these meetings were not regularly scheduled, key informants noted that over time the coordination with different actors improved (e.g., sharing of information, bilateral meetings).

Though it may have been useful for UNICEF to participate in existing cross-border coordination fora, given its integral involvement in both cyclone and cholera response interventions in both Mozambique and Malawi, UNICEF Mozambique's cross-border coordination work was limited.¹⁹⁷ In this case in Niassa province, coordination was under the aegis of provincial and district authorities.

6.1.7.1.2 Coordination with other stakeholders

Overall, UNICEF's joint coordination efforts with WHO, and to a lesser extent with MSF, proved to be effective and productive. An informal coordination group made up of representatives from WHO, UNICEF and MSF was created to prioritize, harmonize, and coordinate interventions at national level. This coordination was found to be useful, agile and relevant, with WHO working alongside the MoH to support most of the system-wide health components of the cholera response at national level. UNICEF and WHO actively contributed to joint coordination efforts in key response pillars, and maintained active communication and coordination lines with MSF in provinces where they were operational. UNICEF was the chair of the Health Partners Group¹⁹⁸ during the cholera response and was valued as an asset given its role as both a donor and implementing partner. While WHO was the technical lead supporting the MoH, as per its Inter-Agency Standing Committee (IASC) mandate, there were instances when the mandates of UNICEF overlapped with that of WHO and communication between the two organizations needed to be streamlined. Given WHO's leadership roles (cholera response, Health Cluster lead), high staff turnover led to loss of institutional memory and impinged upon WHO leadership and coordination capabilities. Key informants indicated that WHO was at times overly cooperative with the MoH, which limited the extent to which it could leverage its position to advocate for increased speed and further scale-up of the cholera response, as well as limiting the politicization of the response. Some key informants suggested that coordination between UNICEF and WHO in some instances needed to be improved, which was mainly the case in provinces where both organizations were present, though UNICEF and WHO advocated to maintain established coordination and surveillance at both Maputo and provincial level as the cholera outbreak subsided. Once the peak of the outbreak passed and OCV campaigns ended, coordination became more challenging due to a loss of momentum around the response.

UNICEF (co)led the coordination of multiple clusters, played a pivotal role within the HCT, and fulfilled a valuable intra-coordination role between local authorities. With the advent of the cholera and Cyclone Freddy emergencies, the HCT expanded coordination support services from Cabo Delgado to areas affected by Cyclone Freddy and cholera. As OCHA had no permanent Mozambique-based staff (from 2017 onwards), different agencies were assigned as HCT focal points in affected provinces. In Sofala and Zambézia provinces, UNICEF acted as the HCT focal point tasked with supporting provincial-level coordination of both the cholera and cyclone emergency responses and liaising with the GoM at the strategic level. UNICEF was already leading the WASH, nutrition, education and child protection Area of Operational Responsibility clusters at the national level,¹⁹⁹ co-chaired the gender working group and, as such, participated at inter-cluster and HCT coordination meetings. UNICEF co-chaired the gender working

¹⁹⁶ Technical Emergency team meeting, 12 July 2023 (internal).

¹⁹⁷ UNICEF MCO invested in coordination with local Malawian health counterparts from Tete and Zambezia provinces, especially with regard to cross-border cases registered in Doa-Chikwawa, Morrumbala-Nsanje, and the joint coordination between the two country surveillance teams.

¹⁹⁸ A group established with donors and agencies to organize health partners and standardize engagement with the MoH.

¹⁹⁹ As part of the cluster system activated for the Cabo Delgado conflict response but not officially activated for the cholera and Cyclone Freddy.

group. At the provincial level, especially in Zambézia province, UNICEF's role as HCT focal point was particularly appreciated by partners due to UNICEF's dedication to improving coordination, leadership, and dialogue with the GoM. This allowed United Nations agencies, NGOs, and the private sector to work as "one team with one voice" and request support from the government (e.g., the Secretary of State)²⁰⁰ when needed. Despite not being officially activated, the cluster system²⁰¹ was promptly rolled out to great effect²⁰² in cyclone- and cholera-affected provinces.²⁰³ UNICEF led the WASH Cluster at national and provincial levels, ensuring that dedicated staff were in place to oversee Cluster coordination responsibilities. With no permanent WHO staff in the field, UNICEF took on the lead of the Health (and Nutrition) Clusters in Zambézia and Sofala provinces, working closely with WHO on case management and OCV.²⁰⁴ UNICEF led the RCCE working group, ensuring coordination and collaboration with other key partners (such as the Mozambique Red Cross) and the consolidation of messaging (though the latter was reportedly delayed as priority was given to other topics).²⁰⁵ Frequent RCCE technical working group meetings were conducted at the provincial level; however, these meetings were not always well attended by relevant stakeholders.²⁰⁶

UNICEF's high level of involvement in coordination was greatly appreciated, but it came with challenges, requiring more resources, effort, and expertise. UNICEF's role as HCT focal points, especially in Zambézia province, improved coordination, leadership, and dialogue with the GoM; however, it was a significant time commitment for the Heads of Sections who filled these roles. Key informants indicated there were incidences of inter-cluster competition (as to who would take the lead, thematically, and for resources). At times the distinction between the roles of the WASH and Health Clusters and the coordination mechanism between these clusters was unclear. Mapping of actors/ gap analysis was not systematized²⁰⁷ and epidemiological trends were discussed monthly only, which affected planning and did not allow for adequate responsiveness. Also, the cluster structure's lack of coherence with pre-existing local coordination structures at the sector levels resulted occasional mis-communication and duplication of efforts (e.g., in the education sector). UNICEF encountered difficulties filling cluster coordinator positions, and some coordinators were considered "too junior" for their roles.²⁰⁸ Some cluster coordinators were double and triple hatted, and UNICEF was unable to fill the key Child Protection Cluster Coordinator position. Also, UNICEF's role managing the various clusters and supporting HCT focal points took a significant amount of effort and time and occurred at a moment when UNICEF was struggling to obtain sufficient field resources to implement emergency response interventions. Filling the Health Cluster Coordinator roles in the provinces required significant effort/resources and was reported as a missed

²⁰⁰ Key informant interviews.

²⁰¹ Which meant less financial and human resources, including funding for dedicated cluster coordinators and information managers, and less official responsibilities according to each agency's mandates and towards the Resident Coordinator, i.e., no ToRs in place or an initial activation period of six months.

²⁰² The clusters ensured a unique thematic space for humanitarian partners but also development partners, for updates and exchange of information, and, as such, were supported by each IASC thematic national clusters in Maputo/Cabo Delgado. According to most key informants, clusters helped to join key actors per sector, avoided duplication of interventions, and promoted synergies. Joint needs assessments took place and action followed, although with a variety of results. In those provinces where UNICEF was leading, partners saw good added value, especially in the most acute phase of the crises (the three months from February 2023 onwards, in most cases). For example, bi-weekly WASH cluster progress updates were developed and shared with all cluster members, and at the peak of the response, weekly cluster meetings were conducted at national and provincial levels. A WASH Cluster 5W matrix was established where all partners—both governmental and non-governmental—reported on weekly progress.

²⁰³ Despite the fact that IASC 'clusters' were not officially activated as such, coordination/'cluster' meetings for several response sectors, such as health and WASH, were regularly held in several of the affected provinces. For the purpose of this evaluation, they will be referred to as clusters, even though they were not 'officially' clusters in the IASC sense.

²⁰⁴ In some provinces, like Zambézia, which holds half of the cholera caseload, the health authorities (via the Provincial Directorate of Health and National Institute for Health) led the response at provincial level, so the Health Cluster's role was limited to data and information exchange.

²⁰⁵ Key informant interviews.

²⁰⁶ Key informant interviews.

²⁰⁷ Key informant interviews.

²⁰⁸ Key informant interviews.

opportunity for WHO to assume a more technical approach in health-related issues and advocate for accurate and timely epidemiological data (among others).

6.1.7.2 Internal coordination

Though there were missed opportunities for a timely and adequate workflow in the initial stages of the responses to the cholera and cyclone emergencies, internal coordination improved as the responses progressed and more resources and experience became available (especially skilled HR). Overall, ESARO provided adequate levels of coordination to the MCO. The Cholera Working Group that coordinated the cholera response in its first months proved to be unwieldy and lacked clear accountability and reporting lines.²⁰⁹ However, with the expansion of the L2 to Mozambique in March 2023, the experience of those first months led to the establishment of a cholera task force, under the aegis of the Emergency Section, with dedicated staff from the key sections involved in the response (health, WASH, SBC). Though initially it was unclear who would lead and manage the task force, this was resolved, and the task force successfully guided and coordinated the work of field teams.²¹⁰ However, all task force members were double-hatted and could not fully dedicate themselves to coordination activities, which led to the identification and recruitment of a dedicated cholera coordinator.²¹¹ Overall, the centralization of coordination and decision-making at the Maputo level worked well. Some FOs requested greater autonomy, especially when supporting the response in provinces with no FO. Some key informants highlighted the need for greater intersectoral coordination at Country Office, FO and implementation levels (with partners).²¹² ESARO coordination support (Regional Emergency Management Team (R-EMT) meetings, Technical Emergency Teams, one-on-one technical support (e.g., HR, WASH, SBC, etc) to the country was adequate and responded to MCO's needs.

6.2 How well-prepared and equipped was UNICEF to respond to multiple emergencies?

6.2.1 To what extent have the emergency preparedness and procedures been used and to what extent have they enabled UNICEF to scale up effectively? (Effectiveness)

UNICEF is expected to ensure that preparedness is integrated across the organization, and this includes mandatory Minimum Preparedness Actions for country offices, as part of the UNICEF Procedure on Preparedness for Emergency Response.²¹³ In this section, five key operational areas—administration and finance, supply and logistics, HR, communications, and partnerships—are assessed. Additionally, subsections 6.2.1.6 and 6.2.1.7 deal with cross-cutting issues and emergency procedures, complementing other important components for emergency preparedness.

²⁰⁹ KIs.

²¹⁰ According to analysis of available floods and epidemiological data, which was limited and of low quality.

²¹¹ October 2023, after the period covered by this evaluation.

²¹² For example, CATI approaches were implemented by both WASH- and SBC-led partnerships, using the CTCs as entry points (health) but there was some degree of disconnect between these partnerships and there were instances when leadership was not clear or standardized.

²¹³ UNICEF. (2022) UNICEF Emergency Preparedness Funding Initiatives: Fact Sheet. <https://www.unicef.org/documents/emergency-preparedness-unicef> Accessed 11 April 2024.

6.2.1.1 Administration and finance

6.2.1.1.1 Funding mobilization

Even with the Emergency Programme Funds (EPF)²¹⁴ loan that came with expansion of the L2 declaration to Mozambique, UNICEF was unable to mobilize the amount of funds required to meet all the needs of cholera- and Cyclone Freddy-affected populations within the required timeline. UNICEF actively endeavoured, through various channels and mechanisms, to mobilize the quantity of funds required to meet the humanitarian needs of the affected populations (~815,000 people).²¹⁵ However, UNICEF encountered challenges in mobilize funds to scale up the response and operated with significant funding gaps over the course of the L2 response timeline.

In February 2023, UNICEF MCO released USD 800,000 as contingency funds. Key donors were contacted with requests for additional funds and/ or approval to repurpose/reprogramme existing funds, which was allowed in some instances.²¹⁶ Several donors committed to providing additional funding; however, the amounts were small and some of this was earmarked (with reduced flexibility and increased reporting requirements). As the magnitude of the crises unfolded, it quickly became apparent that the funds initially mobilised as per the HAC for the cholera and cyclone responses in the early phase of the responses were not enough to meet the needs.

In March 2023, UNICEF had only managed to mobilize 12 per cent of the required funds: with the estimated requirement of USD 89 million, UNICEF had a funding gap of nearly USD 79 million. This disparity persisted across the duration of the response: in August 2023, with a revised requirement of USD 75.2 million, UNICEF had managed to mobilize only USD 18.5 million, just over 24 per cent of the funds required to meet the humanitarian needs.²¹⁷

UNICEF MCO released nearly USD 2.4 million (through March 2023)²¹⁸ but did not have the funds available to sustain this level of programme support. That same month, the MCO requested USD 8.4 million in additional EPF, as part of expansion of the L2 designation to include cholera and Cyclone Freddy response operations.²¹⁹ This request was added to the earlier request to HAC launched late in 2022 for USD 113 million.²²⁰ The EPF funds were expected to strengthen UNICEF's L2 response, allowing the procurement and provision of life-saving supplies. To support this EPF, the MCO, with the support of ESARO, developed the nine-month Response Plan.²²¹ However, even with the USD 11.2 million from HAC, UNICEF was still USD 73.5 million ²²² short of the required funds. Moreover, the EPF funds—designed to be used within the first 24-48 hours of a sudden-onset emergency—were not received in a timely manner.²²³

²¹⁴ Emergency Programme Fund (EPF) – Regular Resources is the 'first responder' in most emergency situations, used within the first 24–48 hours of a sudden-onset emergency in a country. The EPF is a revolving fund providing reimbursable loans to offices that require immediate financing of emergency programmes prior to receiving broader donor support.

²¹⁵ OCHA. (29 April 2023) Mozambique: Tropical Cyclone Freddy, Floods and Cholera – Situation Report 3. <https://reliefweb.int/report/mozambique/mozambique-tropical-cyclone-freddy-floods-and-cholera-situation-report-no3> Accessed 12 April 2024.

²¹⁶ For example, the European Union approved use of the crisis modifier attached to the multi-year stunting programme, but no other reprogramming was allowed. The Canadian High Commission allowed the reprogramming of USD 5.9 million earmarked supplies (KIs, desk review).

²¹⁷ See Annex 33 for further details.

²¹⁸ UNICEF MCO, request for EPF, Cyclone Freddy and Cholera, 29 March 2023.

²¹⁹ UNICEF committed to reimburse USD 4 million of EPF funds, to be obtained from other donor contributions or flexible funding.

²²⁰ The large part of which aimed to cover the needs of the conflict-affected populations in Cabo Delgado.

²²¹ Idem 84 above.

²²² See Annexes 33, 34 and 35.

²²³ Key informant interviews.

By June 2023, out of the required USD 89 million, UNICEF had received only USD 10 million (excluding the EPF loan, and Core Resources for Results (RR)²²⁴ and Other Resources Regular (ORR)²²⁵ funds that were reprogrammed): the funding gap was still high (80 per cent, or USD 75.1 million).²²⁶ Funding in the pipeline was approximately USD 2.6 million (USD 1.2 million for WASH through the Today and Tomorrow Initiative).²²⁷ By August 2023, there was still a 75 per cent funding gap.²²⁸ Both the delays and the extreme funding deficit negatively affected UNICEF's capabilities to meet the humanitarian needs of the affected populations.

Some of the challenges faced in coordination and implementation efforts (e.g., capacity to scale up, timeliness, and effectiveness, as detailed in Section 6.1) were due to limited funding and operational capacity, and a development focus in Mozambique. Despite attempts to enhance coordination, United Nations agencies' responses, including UNICEF's, were heavily dependent on their fundraising capabilities, leading to competition among agencies with similar objectives. This dynamic hampered efficient coordination and impeded overall effectiveness. Such challenges are common in other humanitarian operations, and they underscore the importance of having in place robust coordination mechanisms to ensure a coherent and effective response. Traditionally, aid in Mozambique has been mostly for development work. The crisis in Cabo Delgado is absorbing most of the humanitarian funds, expertise and IPs. These two factors significantly constrained the availability of funds, implementation capacity, presence of IPs in cholera- and Cyclone Freddy-affected areas, and overall attention paid to emergency preparedness and humanitarian action in other geographical areas, which compete for development funds. Most donors only activate emergency funds when certain thresholds or conditions are reached. In the case of the cholera response, because the epidemiological numbers were not accurate and timely, funds were not activated in time. Due to this, funding for preparedness, additional supplies, and response activities were not sufficient. Overall, there was limited capacity of partners and government in emergency preparedness and response. Additionally, the related absence/limited presence of I/NGOs further exacerbated the situation.

6.2.1.1.2 Funding expenditure

Though MCO only received a fraction of the required funds, it allocated those funds according to its CCCs and the priorities outlined in the Cholera, Cyclone and Floods Response Plan. However, despite being underfunded, MCO was not able to absorb all the funds it received²²⁹ and only achieved “medium” progress towards L2 financial benchmarks. Out of the USD 18.5 million MCO had received by August 2023, USD 7.1 million was allocated to WASH, USD 2.5 million to education²³⁰, USD 2.2 million to health, USD 2 million to RCCE/SBC, USD 1.5 million to nutrition, and USD 0.6 million to child

²²⁴ Core Resources for Results (RR): contributions without restrictions, to be used flexibly for children wherever and whenever the need is urgent.

²²⁵ Other Resources Regular (ORR): contributions that are earmarked by UNICEF partners for targeted interventions in development programming. These can include flexible thematic funding for a country and/or sector. These can also be further earmarked for specific programmes or projects.

²²⁶ USD 5.9 million had been mobilized and utilized through the UNICEF Supply Division to procure WASH supplies that had still not been received by June 2023 (source: presentation for R-EMT, 15 June 2023).

²²⁷ To address the growing climate and disaster risk finance gap for children, UNICEF has recently launched the Today & Tomorrow Initiative as the first integrated climate and disaster risk finance solution worldwide that is specifically targeted and designed for children.

²²⁸ See Annexes 33, 34 and 35. Nb. This amount was reported in the last R-EMT (August 2023) and considered a funding requirement of USD 75.2 million, of which USD 18.5 million was received and USD 56.7 million was missing. Note that amounts differ from the June 2023 reports.

²²⁹ Reasons for the limited absorption of available funds remain unclear as a more detailed overview on expenditure was not available to the evaluation team.

²³⁰ MCO's Education sector also received USD 10 million in GPE funding, and approximately USD 400,000 from Norway, USD 500,000 from Republic of Korea, and USD 76,000 from JCU (through reprogramming), however, much of this was only spent after the deactivation of the L2, which is beyond the scope of this evaluation. Information provided by key informants.

protection,²³¹ all of which were priority areas.²³² The MCO expected to receive USD 0.5 million from the EPF funds for PSEA-related activities, as per L2 standard operating procedures; however, ultimately it received only half this amount.²³³ As noted previously, as welcome as the funds were, the practice of earmarking funds for particular response areas according to donor priority areas limited UNICEF's flexibility to reallocate budget lines to priority interventions.

In terms of value for money, internal and external key informants estimated UNICEF's response to be relatively effective, efficient, and cost effective; however, challenges with timeliness (significant delays in receiving funding and supplies, as noted above) and equity (as noted above) reduced the relevance and effectiveness of the supported activities. The large funding gap for WASH-related activities (USD 40.4 million) resulted in a missed opportunity in terms of sustainability. Even though it only received a small portion of what it required, UNICEF was unable to absorb all the funds it received:²³⁴ by the end of August 2023, MCO had spent 67 per cent per cent of the funds received for the cholera and cyclone responses, which, according to its own review, denoted "medium" progress against L2 financial benchmarks.²³⁵ Reasons for the underspend are varied. MCO had a plan to spend the EPF, but, as the EPF is a loan, when funds from other donors came in quickly, MCO tried to ensure moderate repayment. At the advice of the RO, MCO used some of the EPF for the RUTF pipeline break in Cabo del Gado. For other EPF funds, the planned spending was delayed due to a variety of sectoral-specific issues. Flexible funds, or funds that came late, were rolled into 2024 to be of the most use.²³⁶ Overall, MCO did not promptly utilize emergency funds as they sought to ensure that staff/partnerships could be sustained for a longer period. The result was that instead of directly spending 100% of emergency funds received (and hoping more would come), MCO saved what they received and spent at a more cautious rate.²³⁷

6.2.1.2. Supply and logistics

Though supply chain management and logistical challenges reduced effectiveness (including timeliness) overall, UNICEF MCO's logistical and operational support positively facilitated response implementation across multiple pillars.²³⁸ Both the Cyclone Freddy and cholera responses were heavily supply-dependent and required substantial logistical support. UNICEF MCO supported existing GoM systems for procurement, distribution, and monitoring of supplies through the provision of in-kind donations and technical assistance. Partners and the GoM at national, provincial and district levels appreciated UNICEF's technical, logistical and procurement support.²³⁹ According to the AAR, good practices that should be retained were the use of LTAs to purchase emergencies supplies, pre-positioning of supplies in UNICEF warehouses, the development of a response plan, a contingency to support the roll-out of an End User Supply Monitoring system and an electronic poll for obtaining approval from UNICEF's Contract Review Committee.

²³¹ UNICEF EMT presentation, 31 August 2023.

²³² The total amount allocated to these priority areas is lower than the USD 18.5 million received, which may be relate to the funds in the pipeline, but this could not be confirmed by the MCO. A detailed overview was not available to the evaluation team.

²³³ UNICEF Country Office Malawi received the other half. This was only one of the areas where the expansion of the L2 designation to a second country did not produce the results as per the L2 standard operating procedures.

²³⁴ Even though the MCO received only half of the PSEA funds, a portion of this had to be returned as the MCO was unable to spend it due to HR issues, see above.

²³⁵ As opposed to high (76–100 per cent) or low (0–49 per cent). See Annex 36 (Progress against L2 benchmarks).

²³⁶ e.g., the GPE funds arrived relatively late, the agreement with the GoM took quite a long time, and then it made the most sense to distribute school kits in line with the new school year in January, rather than 75% of the way through the 2023 school year. The Today/Tomorrow (TTI) funds came largely after the initial response and are still being spent now for light reconstruction, preparedness, DRR. There were some changes of funding sources from TTI to other expiring grants at the end of 2023, that decreased the spend rate on that program in particular.

²³⁷ KII.

²³⁸ Section 6.3.1 discusses supply challenges in detail.

²³⁹ KIIs.

Delays in funding contributed to procurement and distribution delays. Despite the significant (and appreciated) support UNICEF’s logistics and supply sections provided to the cholera and Cyclone Freddy responses, UNICEF’s supply and procurement capabilities were not able to meet the scale of the demands, being rated from medium to low against relevant L2 benchmarks. By April 2023, after delays in procurement (mainly caused by the lack of funding), supplies (including OCV)²⁴⁰ worth USD 8.2 million were procured. Stock worth USD 2.7 million was distributed to affected areas for pre-positioning purposes and replenishment continued. In June 2023, USD 9 million of supplies were procured, and USD 3.9 million worth of supplies were distributed in 10 provinces for both cholera and cyclone responses. An expert from Supply Division in Copenhagen was deployed to MCO for four weeks to support the supply section. By the end of August 2023, a cumulative USD 11.3 million of in-kind supplies had been procured and USD 4 million had been distributed.²⁴¹ At the time of the deactivation of the L2, the execution rate (percentage) of the cholera and cyclone supply plan stood at 58 per cent (ranked medium), and only 40 per cent of supplies had been distributed (ranked low).²⁴² Though the Canadian High Commission allowed UNICEF to repurpose 5.9 million Canadian dollars from the COVID-19 appeal for the responses to the cholera and Cyclone Freddy emergencies, earmarking it for needed supplies, UNICEF was unable to use those funds for the emergency responses and is instead using that amount to pre-position supplies for the next outbreak/natural disaster. Similarly, due to factors both internal and external (e.g., GoM approval and consensus on specific activities particularly in the area of creating temporary learning spaces), implementation of the response under Freddy – USD 10 million received from the Global Partnership for Education was delayed and needed learning and teaching materials were only distributed materials at the start of the 2024 school year, after the deactivation of the L2.

The AAR highlighted measures to mitigate internal challenges, including pre-positioning of supplies and the use of partners’ facilities in affected regions. Local procurement was enhanced by, for example, conversion of offshore kits into locally assembled kits and assessing and expanding the national and local pools of suppliers. However, the lack of UNICEF-standard warehouse capacity at district and provincial levels (inclusive of warehousing facilities from IPs and the INGD) was a factor that significantly impinged upon UNICEF’s supply chain and pre-positioning capabilities during the cholera and Cyclone Freddy responses. The issue of where/how to pre-position supplies at the district level is crucial, yet it remains a ‘wicked’ problem²⁴³ that is difficult to solve because of incomplete, contradictory, and changing requirements that are hard to recognize. Most likely, there is no single solution to the problem and substantial further work is needed if UNICEF MCO is to identify and implement appropriate solutions that will provide it with the required supply chain capabilities so as to be well-placed to respond to the next PHE or natural disaster.

6.2.1.3 HR and surge team

Overall, UNICEF achieved a moderate level of success in regard to its capabilities to mobilize and recruit the personnel required to roll out and scale up the responses to the cholera and Cyclone Freddy emergencies. The deployment of surge personnel—emergency experts from HQ, ESARO, and MCO, as well as individuals recruited nationally and internationally—combined with the repurposing of MCO/ FO staff significantly contributed to initial operational efficiency. Considering multiple emergencies at the global level limiting availability of surge personnel and the language challenge in sourcing surge for MCO, the HR response strategy focused on sourcing surge to cover critical HR gaps in complement to ESARO deployments, internal refocusing of staff members, and emergency staffing already deployed to support other emergencies (e.g., Cabo Delgado armed conflict). By April 2023, MCO

²⁴⁰ Through Gavi.

²⁴¹ UNICEF EMT presentation, 31 August 2023.

²⁴² See Annex 36.

²⁴³ Potangaroa, R. (2016) “Unproblematizing” the Technical Complexity of Shelter in Post Disaster Reconstruction. In: Masys, A. (eds) Applications of Systems Thinking and Soft Operations Research in Managing Complexity. Advanced Sciences and Technologies for Security Applications. Springer, Cham. https://doi.org/10.1007/978-3-319-21106-0_8

HR, in coordination with ESARO HR, had identified 33 surge requests.²⁴⁴ An internal surge deployment roster was developed and operational, which was monitored on a weekly basis by the Emergency Management Team (EMT). Measured against the L2 benchmark of “% of surge requests recruited”, having recruited 67 per cent of the positions requested, UNICEF’s response level was “medium.”²⁴⁵

UNICEF considered various modalities, including temporary internal staff deployments, either from MCO or from one of their four FOs, complemented with the deployment of external HR (consultants and surge deployments). The initial repurposing of staff from Cabo Delgado was pivotal to cover emergency expertise and skills. Identification of expertise internationally was challenging due to the language requirement (Lusophone speakers). Significant effort was put into covering gaps. The UNICEF HR manager’s previous experience in emergencies proved helpful, as well as the fact that an HR tracker was put in place to identify resources via the UNICEF Geneva and New York HR pools. Monthly calls to ESARO, and weekly follow-up calls against the tracker for any new surge requests, established and improved overall management and oversight of the HR situation. Challenges presented by delays in/absence of surge deployment were to a certain extent offset by the support provided from HQ and ESARO. Over the course of the emergency responses, staff capacity to respond to emergencies was developed (notably so in the WASH section)²⁴⁶ so that in the future ‘regular’ programming staff can more easily switch to emergency mode.²⁴⁷

6.2.1.4 Communications

UNICEF MCO played a crucial role in sharing information, both to communities in at-risk areas as well as to the international media. One week prior to the landfall of Cyclone Freddy, UNICEF MCO launched a page on the Internet of Good Things²⁴⁸ to provide information on preparedness measures. Furthermore, a web page on UNICEF MCO’s website²⁴⁹ was set up providing up-to-date information on the damage caused by and impact of Cyclone Freddy. The voice of children and families affected by the cyclone appeared on this page, along with relevant human-interest stories and information on UNICEF’s response. On social media, more than 100 posts containing up-to-date information were shared before, during and after Cyclone Freddy’s landfalls, reaching more than 5 million people.

UNICEF was extremely visible in national and international media around Cyclone Freddy and the broader L2 emergency responses.²⁵⁰ UNICEF MCO communications staff on the ground demonstrated UNICEF’s comparative advantage as UNICEF was able to provide multimedia content from Quelimane during the first days following Cyclone Freddy’s second landfall. UNICEF was the source of the majority of photos and videos used by international media, which ensured accurate and focused messaging was disseminated throughout international media. This, in turn, generated high levels of engagement via social media: MCO received over 5 million impressions for articles shared via social media in the days following the cyclone. Efforts to sustain media coverage in the wake of Cyclone Freddy, focusing on the ongoing cholera outbreak, were also quite successful and, in April 2023, the MCO communications team briefed the Press Corps at the Palais des Nations in Geneva on this issue, securing additional high-level media coverage.

²⁴⁴ Out of which, nine positions were filled successfully, seven were in progress (sourcing from other offices), five were cancelled due to unsuccessful requests (office pursuing Temporary Appointments), and 12 have yet to be initiated (second priority).

²⁴⁵ See Annex 36.

²⁴⁶ KII.

²⁴⁷ For more information on HR see also Section 6.1.3 of this report.

²⁴⁸ <https://mz.ioqt.site/pt/sections/emergency-information/prepara%C3%A7%C3%A3o-ciclone-tropical-freddy>

²⁴⁹ <https://www.unicef.org/mozambique/ciclone-tropical-freddy-em-mocambique>

²⁵⁰ 43 interviews with international media before and after the cyclone, including CNN, BBC, Reuters, AP, AFP, Al Jazeera, NPR, the New York Times, France Inter, and various South African news outlets, resulting in exceptionally high levels of coverage for UNICEF’s response and fundraising calls in global media, according to the UNICEF communications team.

6.2.1.5 Partnerships

UNICEF's support to its IPs and the establishment of new partnerships during the responses to the cholera and Cyclone Freddy emergencies successfully enabled UNICEF MCO to play a leading role in the humanitarian response. The support UNICEF provided to its IPs was both appropriate (i.e., administrative and technical support) and pivotal, enabling IPs to undertake new tasks and work in new intervention areas (e.g., child protection, WASH, RCCE). However, UNICEF faced challenges in identifying and onboarding new partners in cholera- and cyclone-affected provinces and districts where it was not present, which negatively impacted operational efficiency in the initial phases of the response. In some instances, UNICEF's internal procedures (even emergency-specific modalities like the start-up letter),²⁵¹ and its preparedness measures (the establishment of CPDs and contingency clauses within PDs) did not function at the required speed or were not in place to successfully facilitate partners to undertake time-critical humanitarian activities.

Though UNICEF MCO successfully engaged with a wide range of IPs, including governmental agencies, INGOs and national NGOs, community-based organizations, CSOs and other United Nations agencies,²⁵² covering multiples sectors over a broad geographical swathe of Mozambique, UNICEF MCO encountered challenges in quickly identifying partners in some affected regions (e.g., Inhambane, Maputo).²⁵³ When the L2 declaration was expanded to include Mozambique, CPDs were not in place, which resulted in delays in commencing interventions with potential partners who had not yet undergone due diligence verification. UNICEF used start-up letters (for at least five WASH partners and one health partner) to kickstart humanitarian interventions (while the formal PD was being developed). However, on at least one occasion, even with the start-up letter modality, it took UNICEF MCO three to four weeks to transfer the funds to a partner, significantly undermining the timeliness the start-up modality was designed to ensure. Additionally, the new platform E-tools/E-PD²⁵⁴ module for partnership management and monitoring that was launched simultaneously with the L2 response caused difficulties (e.g., limited capacity of staff to support implementation of this new platform, partners facing challenges logging in).

UNICEF MCO's capabilities to facilitate dialogue and communication flows between their IP focal points and different UNICEF sections was mixed. New partners in provinces without an FO reported challenges in understanding UNICEF's partnership guidelines and processes, which led to delays in their application process. Others encountered delays created by UNICEF's administrative processes.²⁵⁵ Even after approval, some partners experienced significant delays, resulting in a prolonged period between application and starting activities, which coincided in some cases with the end of the cholera outbreak in their intervention areas. However, partners with established relations with UNICEF did not report such issues, highlighting the importance familiarity with UNICEF's procedures plays in enhancing efficient collaboration. At the onset of the response, IPs faced challenges in covering various districts and moving between locations, but UNICEF's support enhanced their flexibility and mobility over the course of the L2 responses.

A good practice that was identified was the extension of partnership agreements beyond 2023 to cover for the rainy season (up to March 2024, with the possibility of an extension) in case new climate-related disasters or cholera outbreaks developed during this higher-risk period. Partners, especially those with humanitarian capacity, indicated that longer-term forecasting of activities/availability

²⁵¹ This modality—a one-page start-up letter with a partner who has undergone due diligence verification and has a vendor record—allows UNICEF to transfer an initial tranche of resources (USD 25,000 as per L2 protocols) to meet acute, life-saving needs while a formal PD is being developed. UNICEF (2021) *Guidance Handbook in L1, L2 and L3 Emergencies*. p. 61.

²⁵² By August 2023, active partnerships (with CPDs) covered 36 districts nationwide, including selected at-risk districts in five provinces.

²⁵³ According to UNICEF Emergency Preparedness Procedures, Minimum Preparedness Standards.

²⁵⁴ <https://etools-demo.unicef.org/landing/>

²⁵⁵ Key informant interviews.

of programme funds would enable them to avoid the hassle of developing short-term PDs, which then require amendments/ extensions. Some partners indicated that they were required to advance their own funds (and supplies) to scale up emergency interventions pending the formalization of PDs. Partnerships with the GoM appear to require a more systemic and longer-term approach if long(er)-term goals are to be achieved (e.g., capacity building/ support to the INGD and WASH authorities).

The above notwithstanding, **the responses to the L2 cholera and Cyclone Freddy emergencies were marked by effective collaboration.**²⁵⁶ **Enhanced efficiency was achieved by applying different partnership modalities.** Collaboration with GoM counterparts, alongside other IPs, reduced bottlenecks, enhanced operational effectiveness, increased local ownership, and positively contributed to accessing affected communities in a timely manner. UNICEF's NGO partners relied on *activistas* and volunteers²⁵⁷ for interventions involving CATI, child protection and RCCE (among others), especially in remote and hard-to-reach areas. However, issues with fees and incentives, and the fact that policies differed between organizations, at times caused friction and conflict and decreased motivation levels.²⁵⁸

Operationalizing corporate commitments to localization²⁵⁹ **during emergency responses requires considerable effort that extends well past the cessation of emergency interventions.** National NGOs are key to fostering dialogue with local communities: their presence within communities is fundamental to the effectiveness of humanitarian programmes, especially in locations where UNICEF is not present. The longer-term commitment from national NGOs facilitates knowledge building through institutional learning and trust building with the local population, the GoM, and international donors. Training provided by UNICEF during the responses to the cholera and Cyclone Freddy emergencies successfully built the capacity of many of its partners and contributed to the professionalization of their interventions.²⁶⁰ However, continued training and support will be necessary if these gains are to be concretized. PSEA and gender-related aspects of humanitarian action, including GBV and AAP, were insufficiently mainstreamed across the responses, in part due to the limited capacity of local partners in these areas.

6.2.1.6 Cross-cutting issues

UNICEF incorporated AAP and PSEA across activities in its response plans for the cholera and Cyclone Freddy emergencies; however, implementation remained limited due to limited capacity and resources at all levels. UNICEF MCO endeavoured to mainstream cross-cutting issues across its activities; however, it encountered significant challenges in operationalizing its cross-cutting commitments in the Mozambique context. Knowledge, prioritization, implementation and reporting on these concepts remained low throughout the duration of the L2 responses, which might have been expected given the relative novelty of these approaches in Mozambique. AAP and PSEA were relatively new concepts in the responses to the cholera and Cyclone Freddy emergencies and were seen as being “donor-driven”.²⁶¹ UNICEF conducted trainings and made efforts to establish and reinforce feedback mechanisms

²⁵⁶ For example, the Institute of Social Communication managed to expand RCCE activities to rural areas with the support (capacity building and training) received from UNICEF.

²⁵⁷ Such as community health workers and health and education committees.

²⁵⁸ Key informant interviews.

²⁵⁹ Some of the national NGOs partners are branches of international NGOs. This means that the management is local but they receive varying levels of input from their ‘mother’ international organizations, including their name and mandate. Several of these organizations focus on development, and, particularly in the early days of the cholera and cyclone response, therefore did not have the adequate capacity for emergency response or a humanitarian mindset. In Cabo Delgado, a modality has been explored for adaptive peacebuilding with localized INGOs (L-INGOs). These L-INGOs have both an international dimension—benefitting from the lessons learned and experience in other conflict contexts—and are simultaneously fully localized: that is, the design, implementation and evaluation of their activities happen mostly at the local level and rely on local feedback. See Adaptive Peacebuilding in Mozambique: Examples of Localized International Non-Governmental Organizations (L-INGOs) in a Complex and Uncertain Environment https://link.springer.com/chapter/10.1007/978-3-031-18219-8_5

²⁶⁰ Such as case management and MHPSS for child protection, water treatment and testing for WASH.

²⁶¹ Key informant interviews

to ensure women and children's rights were respected (complaints boxes, *Linha Verde*,²⁶² *Linha fala criança*, the police and health lines). *Linha Verde* reported a spike in call numbers during the L2 responses;²⁶³ however, it is not possible to attribute this increase to UNICEF's AAP/PSEA/GBV activities, as other factors might have had an influence, and the complaints boxes were scarcely used.²⁶⁴

In terms of “GBV focal points within all UNICEF-led sectors and frontline workers identified and trained”, UNICEF ranked “high” in its GBV L2 Benchmark (96 per cent).²⁶⁵ However, as was previously discussed in Section 6.1.2, in the discussion on women) **despite the increase in the risks of GBV brought about by Cyclone Freddy-caused displacements,**²⁶⁶ **GBV was not mainstreamed to any significant degree due to limited internal and external capacities.** The incorporation of gender within the MIRA had limited results due to the challenges faced by the tool as a whole, which contributed to the lack of operational visibility vis-à-vis gender. UNICEF's attempt to establish risk mitigation initiatives was challenged by the limited capacity of IPs and weak and sparse referral services. Efforts to revive the *Centros de Apoio Integrado* in Quelimane, Zambézia, met with limited success (see Sections 6.1.2, in the discussion on women). Other United Nations agencies with GBV mandates and expertise had only a limited presence in the field. Opportunities to involve women's rights associations and women-led organizations were largely unfulfilled due to capacity limitations (see Section 6.1.2, in the discussion on women).

6.2.1.7 Emergency Procedures and exit strategy priorities

The expansion of the L2 designation to include the Mozambique responses to the cholera and Cyclone Freddy emergencies produced mixed results and, in many instances, did not produce the desired positive impacts in operational efficiency. Evaluated for its progress against the 10 categories attached to the six L2 benchmarks, overall, UNICEF ranked “medium” (70 per cent). Key informants indicated that they assumed that the L2 designation would come with what they believed to be automated responses; however, the expansion of the L2 to include a second country came with several significant wrinkles that the MCO was largely unaware of. Additionally, key informants indicated that the Emergency Procedures' (EP) split between accountability (resting with the Regional Director (RD) for L2 emergencies) and responsibility (resting at the CO-level), produced a situation where the RD's accountability for implementing the EP's “specific simplifications that supersede global policies and procedures that would otherwise apply in non-emergency contexts” and which CO staff “are mandated to take to facilitate a timely, predictable and efficient response” was unclear. The fact that this locus of this accountability (for implementing the EP's simplifications) was unclear, produced hesitancy²⁶⁷ on the part of CO-level staff to implement relevant EP simplifications and supersede global policies and procedures.²⁶⁸ The fact that the EPs simplifications were not applied to any significant extent negatively affected the timeliness of the emergency interventions implemented under the L2 response.

Several of the reasons why the expansion of the L2 designation to include Mozambique had less than optimal results pertain to the lack of clarity/knowledge in MCO around funding levels/timing for release of funds to Mozambique, as the second country. Key informants indicated that they did not know they had to

²⁶² *Linha Verde* 1458 is a toll-free inter-agency hotline that is used by the affected population and humanitarian actors to request information and assistance or raise concerns in relation to, or resulting from, humanitarian assistance. The hotline serves as a mechanism to report abuses in humanitarian assistance as well being one of the tools used to strengthen AAP in Mozambique. *Linha Verde* 1458 can also be used to disseminate accurate information about various issues on protection and to refer people to other services, both in protection and in other clusters. <https://reliefweb.int/report/mozambique/protection-flash-info-protection-cluster-briefing-linha-verde-operators-21-april-2023>

²⁶³ A key informant reported three to four PSEA cases per month.

²⁶⁴ Key informant interviews.

²⁶⁵ See Annex 36.

²⁶⁶ Protection Cluster, documents and Key informant interviews.

²⁶⁷ Key informant interviews.

²⁶⁸ UNICEF. (2021) Guidance Handbook in L1, L2 and L3 Emergencies: Simplified and Streamlined for every Emergency (L1, L2, L3). UNICEF, NY, NY.

make a specific request for EPF funds, as the assumption was that with the L2 designation would come the automatic release of EPF funds. This resulted in a multi-week delay in the reception of these funds. Secondly, it was unclear that because of the L2 being shared across two countries, the PSEA funding of USD 0.5 million would be split between the two countries. Most key informants interviewed by the evaluation team felt that the L2 was declared too late, and that as the triggers for the declaration of an L2 were set too high, the declaration of the L2 was overly delayed and was declared too late in the epidemic curve to prevent the peak in cholera cases. Bureaucratically and administratively, the declaration of the L2 produced no notable gains in time efficiency. Key informants indicated that instead of streamlining these processes, they were required to comply with the same processes, but were expected to do so in a more compressed timeframe, which was unrealistic. MCO expected that with the declaration of an L2 would come a significant bump in funding levels; however, the EPF monies were not as substantial as expected and arrived late and brought no noticeable increase in external funding. However, **HR and surge support from ESARO (and HQ) significantly contributed to operational effectiveness.**

6.2.2 To what extent has UNICEF incorporated lessons learned from responses to previous emergencies? (Effectiveness, Efficiency, Relevance)

This section discusses the extent to which the responses to the cholera and Cyclone Freddy emergencies incorporated learnings from previous cyclones and climate-related disasters. Annex 31 presents a point-by-point analysis of how UNICEF Mozambique's cholera response corresponded to/differed from UNICEF's responses to previous PHEs in Yemen (cholera), Latin America and the Caribbean (Zika), DRC (Ebola Virus Disease) and COVID-19.

Nb. Given the overlap between EQ. 2.3: What challenges and lessons for UNICEF's emergency preparedness planning have emerged? (Effectiveness, Efficiency, Relevance) and the subsequent lessons learned section, the two sections have been combined (see Section 7.2 Lessons learned, below).²⁶⁹

Lessons learned from previous responses to emergencies caused by cyclones prompted better preparedness and coping mechanisms; however, adequately addressing extreme weather events/ climate disasters requires a developmental approach. Prior to Cyclone Freddy's landfalls, early warning systems alerted Mozambicans to the approaching cyclone. After it hit, significant efforts were made to evacuate thousands of people from vulnerable areas. This initiative-taking approach, both on the side of the GoM and MCO, helped mitigate Cyclone Freddy's impact and facilitated a relatively organized response. Much of this came from learnings from the response to Cyclone Idai (e.g., enhancing preparedness measures, streamlining coordination mechanisms, prioritizing community engagement, more efficient supply procurement and distribution strategies, facilitating the establishment of early warning systems, and strengthened partnerships with local authorities and other humanitarian actors). Learnings from the CLTS protocol adaptations developed during the COVID-19 response were also absorbed (e.g., emphasizing community engagement, innovative sanitation practices and behaviour change communication to prevent disease transmission and promote hygiene practices).²⁷⁰ Based on previous lessons, other initiatives launched with UNICEF support within the scope of this evaluation included the climate change risk assessment for the WASH, health and education sectors; the development of ToR for the procurement and steering committee for the re-structuring of the National Monitoring System for WASH (SINAS); the development of ToR for the update to the WASH sector capacity assessment and plan; and

²⁶⁹Annex 37 sets out key lessons learned during the AAR.

²⁷⁰Munguambe, C. and Coultas, M. (2023) Adaptation of the Community-led Total Sanitation (CLTS) protocol during the COVID-19 response. [https://www.unicef.org/mozambique/media/5431/file/Adaptation%20of%20the%20Community-led%20Total%20Sanitation%20\(CLTS\)%20Protocol%20during%20the%20COVID-19%20Response.pdf](https://www.unicef.org/mozambique/media/5431/file/Adaptation%20of%20the%20Community-led%20Total%20Sanitation%20(CLTS)%20Protocol%20during%20the%20COVID-19%20Response.pdf) Accessed 13 April 2023.

the first Nationwide Rural WASH Sustainability Check in Mozambique.²⁷¹ However, despite the fact that the incorporation of learnings from previous responses improved UNICEF's preparedness for the Cyclone Freddy emergency, this evaluation shows that humanitarian endeavours cannot address development problems. The country's limited resources and basic and fragile infrastructure render it vulnerable to extreme weather events and problematise full recovery from them.

A comparison of the effectiveness of the overall response to the cholera and Cyclone Freddy emergencies with the response to Cyclone Idai (2019) shows that Mozambique has unevenly addressed the need for a wider use of anticipatory/early action triggers²⁷²: in terms of climate events, Mozambique has advanced in this regard; however, this the recent response showed this not to be the case for cholera. Additionally, an analysis of the cholera and Cyclone Freddy response showed that three significant factors that limited the effectiveness of the Cyclone Idai response were also factors that limited the effectiveness of the recent L2 response. They are: "the limited quantity of pre-positioned relief materials," "the limited scope for cash-based assistance due mainly to government restrictions" and the need "to develop a user-friendly system to collect, analyse, and communicate the assessment and monitoring data needed to guide decision-making during the successive phases of the response."²⁷³ Given that these unresolved limitations negatively affected the effectiveness of the recent L2 response, it raises the question whether, despite the introduction of the Emergency Procedures (EPs) in the intervening years (and the MCO's limited incorporation of the EP's simplifications), where UNICEF is more able to respond to these types of emergencies, especially when they repeatedly hit Mozambique over the course of a few years.

6.3. What actions are required to strengthen the HDP nexus and preparedness for future emergencies through risk-informed country programmes?

*UNICEF's 'Procedures Linking Humanitarian and Development Programming'*²⁷⁴ recommend that UNICEF's emergency interventions be linked with development and peacebuilding actions, while strengthening collaboration, coherence, and complementarity among key actors. This section examines the extent to which UNICEF's responses to the cholera and Cyclone Freddy emergencies were linked to the HDP nexus.²⁷⁵

Overall, integration of HDP nexus procedures into the L2 responses to the cholera and Cyclone Freddy emergencies was mixed; however, UNICEF MCO made various adjustments to its interventions over the course of the L2 responses that strengthened linkages between humanitarian and development programming.

²⁷¹UNICEF. (2023) "Factsheet Mozambique."

<https://www.unicef.org/mozambique/media/5496/file/Factsheet%20Mozambique:%20Water,%20Sanitation%20and%20Hygiene.pdf>. Accessed 7 May 2024.

²⁷² IAHE Steering Group. (2020) "Inter-Agency Humanitarian Evaluation of the Response to Cyclone Idai in Mozambique." <https://evaluationreports.unicef.org/GetDocument?documentID=16623&fileID=39193>. Accessed 10 July 2024.

²⁷³ Ibid. pp 3-4.

²⁷⁴ UNICEF. (2019) Procedures on Linking Humanitarian and Development Programming, PD/PROCEDURE/2019/001.

²⁷⁵ As EQs 3.1 and 3.2 solicited recommendations as to how to incorporate HDP-specific components (resilience—EQ 3.1, anticipatory action—EQ3.2, see the Evaluation Matrix in Annex 9) into the MCO's long-term programmes, these considerations have been folded into Section 7.3: Recommendations below, to avoid unnecessary repetition. Nb. Further analysis regarding sustainability can be found in Section 6.1.6.

Infrastructure needs and gaps could not be fully mitigated through the L2 emergency responses and require a development approach with multi-year resources and support. Damage caused by the impacts of Cyclone Freddy exacerbated pre-existing WASH infrastructure needs and brought about a partial collapse of WASH systems across Zambézia province. UNICEF MCO's repairs and rehabilitation to WASH infrastructure—needed and appreciated as this was—could not (and were not designed to) address the scale of pre-existing WASH deficits (prior to Cyclone Freddy, only 33 per cent of rural populations in Zambézia and 56 per cent in urban areas had access to potable water: these figures were similar for sanitation (see annex 38). As part of its 'build back better' approach, UNICEF supported the construction of TLSs that were designed to be more robust than previous classrooms, in order to ensure the continuity of education beyond the temporary/emergency phase of the response. However, the scale of this intervention was small, the needs enormous, and the materials and methods used for construction, while more substantial than pre-existing classrooms (and far more climate-resilient than tents), were not fully flood-/cyclone-resistant. The GoM is advancing the construction of *salas resilientes*—schools resilient to climate shocks—however, such initiatives require more robust materials (i.e., additional funds) and more advanced construction skills (time consumptive). Standardized health interventions were established during non-peak periods that will enhance the health system to respond to the ongoing cholera response. While attention was given to advancing age, gender, and diversity efforts to operationalize UNICEF's commitments in these areas, substantial strengthening is needed.²⁷⁶

“There is a huge investment in returning to classes, but the investment is not efficient. UNICEF tents are useful, but it has been proven that (in Mozambique) we are ‘in the way of the wind’.”
GoM official

Joint country analysis and planning took place. In collaboration with other stakeholders, UNICEF MCO conducted joint needs assessments and planning exercises to support the GoM's emergency preparedness and response efforts. Historically, external aid has followed a developmental approach, with planning and resource mobilization focused on long-term goals and durable solutions, particularly outside of Cabo Delgado province. The current CPD (2022 to 2026) includes specific priorities for both development and humanitarian contexts, aiming to strengthen the HDP nexus and to facilitate resource mobilization, reporting and implementation tasks for both humanitarian and development work. The inclusion of the cholera response as a standalone component in future planning was discussed among the UNCT. However, despite UNICEF's advocacy efforts, the Humanitarian Needs and Response Plan 2024²⁷⁷ did not allocate a specific budget for a multisectoral approach to cholera.²⁷⁸ Consequently, funding for preparedness and addressing longer-term cholera prevention and response needs remains limited.

The UNICEF MCO is well positioned to strengthen the HDP nexus. Based on knowledge and experience in multiple sectors developed over the years, the MCO is uniquely positioned to strengthen existing links between humanitarian and development work. Social protection is one of UNICEF's core humanitarian interventions; however, GoM resistance meant UNICEF MCO missed an opportunity to leverage its expertise and comparative advantage in this area in the cholera and Cyclone Freddy responses, with the result that vulnerable affected populations did not receive the financial assistance that would have enabled them not only to meet their basic needs, access essential services, and facilitate their

²⁷⁶ See Section 6.2.1.

²⁷⁷ Mozambique Humanitarian Needs and Response Plan 2024 (December 2023).

<https://reliefweb.int/report/mozambique/mozambique-humanitarian-needs-and-response-plan-2024-december-2023-enpt>

²⁷⁸ Aside for some budget for about 9,500 cholera cases to be treated under the health component.

<https://humanitarianaction.info/plan/1183/ge/7396>

recovery from the impacts of the cyclone and cholera outbreak, but also enhance their capabilities to address longer-term needs.

7. CONCLUSIONS, LESSONS LEARNED, AND RECOMMENDATIONS

7.1 Conclusions

*The conclusions listed below are based on the findings and are set out according to the three key evaluation questions. They have been colour ranked, with **red** indicating that there were significant issues, delays, or problems with the intervention, **amber** indicating that there were some concerns or risks that need attention; and **green** indicating that progress was as planned and there were no major concerns or risks.*

EQ1: How well did UNICEF respond during the L2 emergencies in Mozambique?

EFFECTIVENESS and EFFICIENCY

Conclusion 1:

Though MCO's interventions ensured the continuity of essential services (e.g., Health, Nutrition, WASH, Education) to cholera- and cyclone-affected populations, ongoing challenges related to funding, mobilisation of supplies and HR, the dearth of available IPs with relevant technical/emergency skills and physical presence across Mozambique, as well as limited data collection and analysis capabilities will potentially limit the extent to which sectoral objectives will be met during responses to future emergencies. Unless resolved, constraints (caused by lengthy international procurement processes with corresponding delays in delivery times, as well as challenges related to the distribution of supplies at the community level) may again produce significant delays in the delivery of needed supplies. MCO's adaptiveness and responsiveness, and its capability to improve its preparedness measures through drawing on internal reflection and learning stand out, along with its capabilities to mitigate operational constraints while scaling up. MCO's sustained involvement in RCCE/SBC and in CP—crucial to raising cholera-awareness and in ensuring that children's needs were met—and its ability to scale up and collect and analyse data to judge the efficacy of its interventions will be crucial for the success of future PHE response operations.

RELEVANCE

Conclusion 2:

In the aggregate, MCO's interventions responded to the principal needs of the cholera- and Cyclone Freddy-affected populations. However, the response showed that MCO's capabilities to identify, target, and meet the needs of specific vulnerable groups among the affected population groups (e.g., persons living with disabilities, girls, the elderly, or single-headed households, et al) are low. Unless addressed, MCO's capability to operationalise its institutional commitments to equity and inclusion in future emergency responses may prove to be problematic. MCO's continued employment of a "blanket" approach runs the risk of not actively targeting and meeting the needs of vulnerable groups among disaster- and crises-affected populations and thus ensuring the realisation of their rights. Two areas that MCO may wish to focus on are: a) the lag in MCO's response in regards to UNICEF's second CCC on Gender ("to engage women and girls in programme design, implementation and monitoring"); and b) MCO's capabilities to identify and support persons living with disabilities.

COVERAGE and PROPORTIONALITY

Conclusion 3:

Despite the absence of (sub)national plans and accurate epidemiological data, **MCO's commitment to scaling-up response efforts using varying, context-specific response modalities** (often based on the presence/proximity of FOs) **was key to ensuring adequate geographical coverage and in reaching both cholera- and cyclone-affected populations.** **Moving forward, MCO's adaptability and flexibility to address emergent needs will likely be tempered by its ability to identify IPs capable of implementing response activities in affected regions where MCO does not have an FO and in providing operational support to them.**

COHERENCE

Conclusion 4:

MCO's emergency response interventions showed a high degree of alignment with UNICEF's CCCs and emergency response priorities, and ESARO capably supported MCO in the earliest phase of the L2 response (e.g., coordination²⁷⁹, HR), both of which leave MCO well placed as it prepares for future emergency response. However, the Regional Director's (RD) accountability for the L2 CEAP was not operationalised through directives, overt assumption of risk, or enhanced support to the CO to implement the Emergency Procedures' "simplifications" on a "no regrets" basis (which CO staff are mandated to take to facilitate a timely response). Accordingly, the "specific simplifications that supersede global policies and procedures that would otherwise apply in non-emergency context²⁸⁰" were not applied to any significant extent. Unless this situation is addressed, MCO's capability to actualise the EP's intended gains in efficiency and timeliness in future L2 responses may remain aspirational (rather than operational).

CONNECTEDNESS and SUSTAINABILITY

Conclusion 5:

Though MCO's response efforts underscored a commitment to addressing the immediate needs of the cholera- and cyclone-affected populations, MCO's capability to integrate longer-term considerations into its emergency interventions was uneven. However, continued focus on capacity-building, community engagement, and infrastructure rehabilitation present opportunities for MCO to integrate sustainability and resilience across future response interventions. In the WASH and RCCE sectors, UNICEF-supported community initiatives targeting long-term behavioural change and sustainable practices show promise in addressing future needs. Until MCO pre-positions essential supplies (e.g., medical supplies, NFIs and WASH hardware components) in high-risks areas and successfully incorporates environmental sustainable considerations, future emergency response activities may be less than optimally connected/sustainable.

COORDINATION

Conclusion 6:

²⁷⁹ Provided to Mozambique and Malawi COs via RD-chaired Regional Emergency Management Team (REMT) meetings.

²⁸⁰ UNICEF. (2021) Guidance Handbook in L1, L2 and L3 Emergencies: Simplified and Streamlined for every Emergency (L1, L2, L3). UNICEF, NY, NY.

MCO's support to coordination efforts at the subnational levels in affected provinces—where MCO served as a central point for intra-coordination among local authorities, sectors, and emergency response stakeholders—will likely be a key element to successful future emergency responses. MCO's active contributions to Cluster coordination ensured that Clusters under its leadership were active. However, not all clusters were adequately staffed and skilled during the L2 response, thereby there are opportunities to further operationalise UNICEF's institutional commitments to effective coordination. As was the case during the recent L2 response, this will require likely additional resources and expertise if MCO is to continue to navigate Mozambique's complex coordination dynamics effectively. The cross-border call between the Malawi and Mozambique COs was an example of good practice: fully exploring such opportunities for inter-CO coordination will likely be a key elements of successful future regional responses.

EQ2: Emergency preparedness and procedures

Conclusion 7:

The extension of the L2 CEAP from Malawi to include the response to the cholera and Cyclone Freddy emergencies in Mozambique did not catalyse the required increase in funds needed to meet the needs of the cholera- and cyclone-affected populations, raising significant questions about the extent to which donors are committed to funding emergency responses in Mozambique. Given the likelihood of future multi-country emergencies in the ESAR, UNICEF's current protocols of splitting L2 EPF funds between COs will likely result in underfunded future responses, with corresponding impingements on MCOs coverage capabilities. Increased resource mobilization capabilities (at both CO- and RO-levels), enhanced partnership modalities, and capacity strengthening in key operational areas are all required to ensure adequate emergency response capacity. UNICEF successfully mobilized local and international HR to support the response but faced challenges in covering certain technical areas (e.g., PSEA, WASH, Child Protection in Emergencies) and engaging qualified Lusophone staff. These challenges underscore the need for improved emergency preparedness to address similar crises in the future. Communication and partnership building were vital components of the response, with MCO forging new partnerships and mainstreaming cross-cutting issues (e.g., AAP, PSEA, and to a lesser degree GBV risk mitigation), but further investment in emergency response partnerships is required for MCO to fully realise its future operational potential.

EQ3: HDP nexus

Conclusion 8:

The L2 response included some longer-term and sustainability considerations, however, consistent and strategic linkages between humanitarian and development interventions and peacebuilding efforts will need to be made if future emergency responses are to demonstrate the required levels of cooperation, collaboration and coordination at the national level required to ensure collective outcomes based on joined up, coherent, complementary and risk-informed analysis, planning and action. The needs and gaps related to infrastructure and cyclone resilient construction, which require a holistic developmental approach and long-term resources and support present as an opportunity that MCO could explore in future emergency responses. The activation of MHPSS and Child Protection services during the L2 response played a crucial role in raising awareness among key stakeholders, including public services, about the pressing protection needs of children in emergencies. This initial step catalysed a growing demand for such services, laying the foundation for broader Child Protection interventions within future emergency responses.

7.2 Lessons learned

This section provides an overview of the key lessons learned that derived from KII's, FGDs and document review²⁸¹. Some of these proved successful and should be considered for possible replication and adaptation by UNICEF and other stakeholders in future cholera and cyclone response.

- 1. The integration of various response interventions delivers more efficient results.** A key example is the different modalities of CATI, which provided a successful model for merging the activities of multiple sectors (health, WASH, RCCE) into a common approach, with tangible results regarding successful interventions for infection control. Also, active, and adaptive RCCE practices allow to focus and adjust community-level messaging to dispel myths, rumours and misperceptions (including related to OCV) and are a valuable tool in cholera prevention and control, and increased acceptance of OCV. RCCE combined with certain “hard” WASH interventions (e.g. latrine construction) results in increased use of latrines; however, the behaviour changes necessary to change common open defecation practices require long-term hygiene messaging (not just during an active cholera outbreak).
- 2. Additional efforts to identify partners, enhance skills, and maintain established partnerships is key to build technical capacity required during emergency response.** New UNICEF IPs require additional initial administrative support to facilitate rapid mobilization and timely commencement of emergency interventions in remote areas, and areas without UNICEF representation. Investments in capacity building on both technical and operational components relevant to emergency response (e.g., how to develop a PD, how to comply with UNICEF operational standards) for all IPs (e.g., government counterparts, CBOs, CSOs, NGOs) produces positive results for a timely and adequate implementation of response interventions. Flexibility in planning as well as continuous coaching and monitoring of partners by MCO and FO makes it possible to adapt interventions and geographical coverage to the dynamic emergency context, which contributes to positive and visible results. Operationalizing corporate commitments to localization during emergency responses requires considerable effort that extends well past the cessation of emergency interventions.
- 3. Safeguarding the rights of children by strengthening child protection services during emergencies is feasible and should be prioritised as a practice.** The identification of needs for, and the implementation of, case management for children motivates local authorities to prioritize child protection during emergencies (e.g., cyclones), and it creates demand for services from relevant public institutions (e.g., police, social services), even if in small scale and for short-term.
- 4. Adequate and timely data collection and analysis at community and district levels directly results in a higher level of preparedness and response.** Health facility-based epidemiological cholera data (e.g., CFR, confirmed cases) do not accurately capture the scale of cholera outbreaks in communities with barriers to accessing medical care and health facilities (e.g., distance, low literacy rates, poverty, prevalence of/ preference for traditional medical practices). Even though epidemiological data is not produced by UNICEF, it is used for planning and monitoring purposes so advocating to MoH (and WHO) to have more accurate and timely data is key for emergency preparedness.
- 5. Strategic supply planning before emergencies emerge is key for a speedy response.** Pre-positioning of critical supplies in high-risk areas and the development of consolidated supply plans enhance preparedness and are a significant step towards ensuring that communities living in high-risk areas have timely access to essential commodities in future emergencies. Also, rapid fund

²⁸¹ Annex 39 contains a list of lessons learned identified by UNICEF sections led by the WASH team, both for the preparedness and response phases of the cholera response.

disbursement mechanisms (e.g., petty cash, LTAs, P-cards) facilitate transactions for local supply purchase and related administration.

6. **Early development of an HR plan for the response helps with HR planning and facilitates communication with ESARO/HQ.** Development of international and local surge rosters to speed up deployment of skilled Lusophone personnel when needed is critical to ensuring timely, appropriate, technical support during emergency responses.

7.3 Recommendations

Table 4 below lists the evaluations recommendations, rationale, and the suggested actions. The table also includes the priority for each of the actions (short-, medium-, or long-term), and entity responsible for implementation. In the table, EQ refers to evaluation question, C refers to conclusion (as per Section 7.1 above).

Table 4. Recommendations

Recommendations and suggested actions	Priority	Responsible
Recommendation 1: Strengthen preparedness for cholera and climate-related disasters. <i>Linked to EQ2, and C1 and C8.</i>		
Rationale: Cholera outbreaks and climate-related disasters are becoming more frequent and severe in the region, including in Mozambique. MCO was not sufficiently prepared for a timely and efficient response to an emergency of this scale.		
Suggested actions		
1.1 Develop a preparedness plan with appropriate scenarios (including multiple crises), risk-informed programming, incorporating lessons learned and a SIMEX with partners, government stakeholders and United Nations agencies	Short-term	MCO, with support from ESARO
1.2 Advocate for better surveillance systems for early detection of outbreaks and improve (internal) data management for planning and monitoring and response purposes	Short-term	MCO, in collaboration WHO/GoM/ RO Health section
1.3 As part of the localisation agenda, MCO to build internal capacity needed to support the development and updating of partners' contingency plans tailored to high-risk emergencies and ensuring sufficient capacity building to be able to better respond to emergencies	Short-term	MCO
1.4 MCO sectors to review emergency procedures and identify simplified procedures and condensed processes per relevant business area, as well as potential challenges or gaps (to inform ongoing EP review).	Short-term	MCO
1.5 UNICEF HQ to establish funding protocols for multi-country L2s, disseminate L2/L3 multi-country guidance notes to Country Representatives and Deputy Representatives.	Short-term	UNICEF HQ/ EMOPS

Recommendations and suggested actions	Priority	Responsible
<p>1.6 ESARO Deputy Regional Director to lead discussions with MCO establishing L2 & L3 emergency trigger thresholds for PHEs and natural disasters, identify challenges at the execution level, highlight the shared responsibilities, and address CO-level hesitations to take risks (given the RO's assumption of risk).</p>	Short-term	ESARO Deputy Regional Director MCO Rep and Dep Rep
<p>1.7 UNICEF HQ to develop CO-level emergency procedures readiness Operational Capacity Assessment and Certification (OCAC) process (based on standard CEAP criteria, e.g., scale, severity, complexity, capacity).</p>	Short-term	UNICEF HQ/ EMOPS
<p>1.8 MCO to conduct OCAC of emergency procedures. Results of OCAC to be reviewed, with gaps/ limitations identified and subsequently addressed.</p>	Short-term Mid-term	ESARO sector leads MCO Dep Rep MCO sector leads
<p>1.9 UNICEF HQ (in coordination ROs) to review and overhaul existing internal and external global rosters ensuring all profiles are up to date and vetted and key emergency profiles (e.g., GBV in Emergencies, CP in Emergencies, Lusophones) are filled.</p>	Short-term Mid-term	UNICEF HQ/ EMOPS ESARO
<p>1.10 UNICEF HQ (in coordination with ROs) to explore innovative means to guarantee this Lusophone surge expertise by providing <i>intensive in situ</i> Portuguese language courses (in peace time) for enough qualified personnel, with promise/ incentive to deploy when needed; establish working group of all COs in Lusophone countries to identify and pool HR resources.</p>	Mid-term	UNICEF HQ/ EMOPS ESARO
<p>1.11 Implement a key set of agreed recommendations from the AAR and ensure all UNICEF sections are informed and committed to taking necessary key actions.</p>	Short-term	MCO
<p>1.12 Ensure strong internal coordination, with adequate resources, workflow, communication channels, clear leadership roles, and delegation of authority to FOs.</p>	Short-term	MCO
<p>Recommendation 2: Increase focus on placing persons with disabilities and other vulnerable groups (e.g., the elderly, women) at the centre of the emergency response. <i>Linked to EQ1, and C1 and C2</i></p>		
<p>Rationale: High-risk and vulnerable populations are disproportionately affected in crises. Efforts to identify and target these groups during the response were largely unsuccessful; organizational commitments could have been operationalized to a greater extent.</p>		
<p>Suggested actions</p>		
<p>2.1 Continue creating contingency PDs with agencies who can assist in providing coverage for cross-cutting issues (e.g., child protection, PSEA,</p>	Mid-term	MCO

Recommendations and suggested actions	Priority	Responsible
GBV) rapidly after a disaster, particularly involving local women's/girl's and persons with disabilities associations.		
2.2 Scale up child protection components across both development and emergency programming by strengthening community base protection structures to mitigate the impact in children of future emergencies and first response and building stronger case management systems adaptable to emergency response (nexus)	Mid-term	MCO
2.3 Ensure GBV/ PSEA risk mitigation and response at early onset in every response.	Short-term	MCO
2.4 Ensure that persons with disabilities, and other identified vulnerable groups, are specifically targeted in future emergency response and can participate in planning and implementation processes by identifying key relevant government agencies and CSOs to partner with.	Short-term	MCO
<p>Recommendation 3: Ensure all required operational resources (e.g., human and material) are in place and known to all involved for efficient and timely implementation of an emergency response. <i>Linked to EQ2, and C1 and C6</i></p>		
<p>Rationale: Not all operational resources were fully integrated as part of the emergency preparedness, which is required to allow for timely and adequate implementation of the response.</p>		
<p>Suggested actions</p>		
3.1 Further enhance resource mobilization and funding mechanisms covering each pillar or area of the response, advocating for flexibility that allows for contingency planning and adjustment, and adequate emergency preparedness (including funding for contingency supplies to cover various scenarios)	Short-term	MCO, with support from ESARO and HQ
3.2 Ensure that Lusophone/Hispanophone sectoral experts are on ESARO Emergency Roster, and that the national roster has all required emergency profiles.	Short-term	MCO, ESARO and HQ
3.3 Develop procedures for meaningful decentralization on specific activities (EPP) to FOs during emergency response	Mid-term	MCO
3.4 Continue enhancing supply chain management by addressing timely procurement, with supply pre-positioning in high-risks areas and building government capacity	Short-term	MCO
<p>Recommendation 4: Strengthen MCO's role and contributions in inter-agency coordination and ensure complementarity between key stakeholders. <i>Linked to EQ1, and C4 and C5</i></p>		

Recommendations and suggested actions	Priority	Responsible
Rationale: Emergency responses require a multisectoral approach and strong external and internal coordination, with clear roles and responsibilities for leading agencies and stakeholders supporting the GoM.		
Suggested actions		
4.1 Prioritize strengthening all UNICEF response areas within emergency response by coordinating closely with local authorities and humanitarian partners and by ensuring effective coordination between UNICEF and WHO for future PHE by clarifying delineation of mandates and roles	Short-term	MCO, in collaboration with other stakeholders
Recommendation 5: Continue supporting the GoM in emergency preparedness. <i>Linked to EQ1-2, and C3-5 and C8</i>		
Rationale: UNICEF is mandated to support the government in its efforts to prepare and respond to crises, including increasing their capacity to become more resilient and self-sufficient.		
Suggested actions		
5.1 Advocate for a people- (children-) centred agenda for emergency response following an inclusive (e.g., gender, persons with disabilities, the elderly, etc.) rights-based approach.	Short-term	MCO, in collaboration with GoM
5.2 UNICEF to advocate for a higher budget and activation of contingency plans from key agencies (e.g., INGD, MoH, MoE and any other relevant line ministers or governmental bodies) to ensure greater involvement and responsibility in emergency response	Short-term	MCO, in collaboration with GoM
Recommendation 6: Improve MCO's approach to ensure that HDP nexus/risk informed programming is implemented. <i>Linked to EQ3, and C5 and C6</i>		
Rationale: Considering its unique position as a humanitarian and developmental actor with a strong operational presence in Mozambique, UNICEF is well positioned to advocate for and prioritize addressing the complex challenges faced by children and communities affected by cholera and climate related crises that require more resilient, longer term, and durable solutions.		
Suggested actions		
<p>6.1 Identify better links between humanitarian and anticipatory action in longer-term programming by ensuring that HDP Nexus and resilience considerations are not only implemented in the north, but in all MCO provinces and FOs.</p> <p>6.2 PRC to ensure that nexus is included in all PDs that go through them.</p> <p>6.3 Ensure that MCO (i.e., Maputo office and FOs) are trained on Guidance for Risk-Informed Programming.</p> <p>6.4 Develop focused advocacy efforts to ensure the GoM includes cash transfers in future emergency responses.</p> <p>6.5 Include adequate sustainability, exit strategies and longer-term solutions in emergency</p>	Medium-term	MCO, in collaboration with GoM

Recommendations and suggested actions	Priority	Responsible
<p>programming (e.g., IPs to include interventions enhancing sustainability, and exit strategies).</p> <p>6.6 Integrate early warning systems and risk analysis into decision-making processes, facilitating pre-positioning of essential supplies in high-risk areas, and fostering community-based preparedness initiatives.</p>		
<p>6.7 Identify opportunities to enhance resilience post-L2 emergency phase by prioritizing capacity-building initiatives, particularly focusing on local partners to strengthen preparedness and response mechanisms for emergencies.</p> <p>6.8 Ensure that development activities (infrastructure) are risk/climate informed using the 2022 CCRA as a guide (e.g., in regard to location, materials, and maintenance).</p> <p>6.9 Work with GoM to promote community-based disaster risk reduction strategies that can further bolster resilience against recurrent emergencies.</p>	Mid- to long-term	MCO, in collaboration with GoM

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