CARE's Fast and Fair COVID-19 campaign:
Comprehensive local-to-global impact

September 2023

Photo Credit: Achuoth Deng

Executive summary

CARE's systems-level impact: 21.2 million people fully vaccinated against COVID-19

In November 2020, CARE launched the Fast and Fair campaign to push for fairness and efficiency in the global COVID-19 vaccination effort. With approved vaccines becoming more widely available, CARE, with its decades of experience in supporting health systems around the world, recognized that a concerted redirection of resources and effort would be needed to ensure last mile access and delivery, especially in places affected by poverty, fragility and violence. Unless the vaccines reached everyone — including the world's most marginalized communities — quickly and efficiently, no one was safe.

As infection rates soared worldwide, CARE worked swiftly. We skillfully leveraged our global reach and influence to build and maintain support for more comprehensive funding for vaccine delivery while working hand-in-hand with national and local governments in 34 countries to get the vaccines into the arms of those most in need. Our Fast and Fair campaign effectively ensured that millions of vulnerable people living in places where healthcare systems were hard hit by the crisis were not forgotten. Our advocacy and influencing of US and global policy, along with our deep engagement in communities and years of programming investments drove systems-level change that contributed to **21.2 million people getting fully vaccinated in 29 countries**.[1] The Fast and Fair campaign achieved this by:

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- **Advocating**: CARE influenced US and global policy to ensure *equitable vaccine availability and distribution*. Our work helped secure $19 billion in global COVID-19 funding from the US government, including direct support to combat the pandemic, and humanitarian and developmental assistance to address its secondary impacts. We engaged the US government, multilateral partners (e.g., the World Health Organization (WHO), UNICEF, and the World Bank) and donors to mobilize vaccine donations and greater funding for supply and distribution in difficult contexts through the COVID-19 Vaccines Global Access (COVAX) facility. Armed with real-time data, we led the call for prioritization

[1] We measure our impact in 29 of the 34 countries where CARE contributed significantly to people getting fully vaccinated against COVID-19.

of women, girls, healthcare workers and other at-risk groups, including refugees and internally displaced persons. Importantly, CARE's advocacy on the true cost of vaccine delivery resulted in the removal of the cap on the COVAX humanitarian buffer.

- **Facilitating:** We assisted governments (at district, state/provincial, and national levels) in 34 countries to prioritize at-risk groups. We did this by actively participating in national strategic committees and engaging in micro planning, mapping, digital tracking and rapid training at district and provincial levels. CARE also helped governments *remove "last mile" logistical bottlenecks and embrace digital platforms and innovations*.

- **Protecting**: As most (70%) *frontline health workers* are women, equipping them was a significant component of addressing gender inequality in the COVID-19 response. CARE facilitated vaccination of clinical and non-clinical frontline health workers, provided them with protective equipment, ensured they were safe from harassment and/or violence in the line of duty, and that they were represented in decision-making. CARE also helped to maintain sexual and reproductive health services, along with other critical local health services during the crisis.

- **Mobilizing**: We engaged communities and provided them with accurate information to counter misperceptions and fake news, combat stigma, *reduce vaccine hesitancy*, build trust and set the stage for long-term increases in other health-seeking behavior, such as prenatal checkups and other recommended vaccinations.

This study is the first comprehensive evaluation that has attempted to quantify the number of lives impacted by positively changing local-to-global *systems*. To determine the comprehensive impact of the Fast and Fair campaign, we utilized country case studies, internal program data, and an external evaluation. These sources all affirmed CARE's advocacy and influencing contributions to the global vaccination effort, resulting in millions of vaccinations at the last mile.

In addition to saving lives, our local-to-global presence, advocacy, and data from local programming swayed global discourse towards the true cost of vaccine delivery, strengthened local health systems, and resulted in large numbers of frontline workers being recognized, protected and paid. CARE contributed to 21.2 million people getting fully vaccinated for COVID-19 because of our focus on *systems-level change*: we simultaneously worked at several levels—such as last mile delivery, local health systems, national and global advocacy—and with multiple communities and governments to combat the pandemic. We learned that long-term focus on health systems strengthening and advocacy all the way to local implementation is essential to prepare for future health crises. Although the global response to COVID-19 was ultimately considered inequitable, our results demonstrate CARE's clear success reaching the 'last mile' especially in areas where we have long term programming, infrastructure, relationships and trust.

The Fast and Fair campaign contributed to 21.2 million people getting fully vaccinated in 29 countries through:

Advocacy: securing funding for vaccine distribution

Facilitating: figuring out who needed the vaccine and where

Protecting: ensuring that frontline health workers could do their jobs safely

Mobilizing: encouraging demand for vaccination and other health services

Report

I. Local-to-global systems-level impact: CARE's unique contributions to COVID-19 vaccinations

While approved COVID-19 vaccines became more widely available, infection rates continued to rise with developing countries struggling to obtain enough doses for their people. Even as the COVID-19 Vaccines Global Access (COVAX) facility assisted vaccine rollout in the Global South, the logistics of getting the vaccines into the arms of the poorest and most marginalized was a major hurdle. In the contexts where CARE works health systems were under-resourced and overstretched; essential infrastructure such as roads and cold chain facilities were lacking; and few countries had clear plans on last mile delivery or social engagement strategies to encourage people to get vaccinated.

The Fast and Fair campaign's ultimate goal was to ensure *equitable access and delivery* of COVID-19 vaccines by leaning into CARE's local infrastructure, programming expertise and networks of influence. Achieving equitable vaccine access and delivery in fragile and severely under-resourced contexts often required a **combination** of *facilitating* vaccination of the "last mile" mainly by assisting governments and the private sector in finding innovative ways to remove logistical and structural bottlenecks; *protecting* frontline health workers (mostly women); *mobilizing* and engaging communities with correct information to counter misconceptions and reduce vaccine hesitancy; and *advocating* for equitable vaccine access and delivery at multiple levels. In the country examples that follow, we showcase how CARE engaged locally across these four pillars in several contexts.

In **Guatemala**, CARE prioritized support for Fast and Fair programming in municipalities with large rural and indigenous populations. These groups had among the lowest vaccination rates in the country primarily due to mistrust and lack of COVID-19 awareness. To address this, CARE mobilized its local partner, the Association of Community Health Services (ASECSA), a non-profit network of 58 community health organizations. CARE and ASECA partnered with local leaders and influencers to lead community dialogues; developed targeted information campaigns in indigenous languages; and trained community-based midwives and health promoters in vaccine delivery. Additionally, CARE launched a nation-wide communications campaign (reaching 750,000 people); built alliances and partnerships with key actors from national to local levels (including: the Association of Community Health Services, National Roundtable for the Rights of Girls and Adolescents/Mesa Niña, National Movement of Nim Alaxik Midwives, and Girls not Brides); hired a health specialist to implement an Integrated Health Strategy; and strengthened the capacities of community health personnel in COVID-19 case management. Frequent natural disasters have severely set back Guatemala's healthcare system. Recognizing that communities without the vaccine also lacked access to essential health services, CARE combined its COVID-19 response with sexual and reproductive health-related information and services.

In **Honduras**, misinformation and logistics proved major challenges to reaching communities living within its mountainous interior. CARE worked with partner organizations, including the Regional Network of Women of the South (RRMSur), the Pespirense Development Association (ADEPES), and Sur en Acción (South in Action) to directly address these barriers by: training over 600 mostly female health volunteers and health workers; protecting frontline health workers with biosafety kits and protective equipment and providing psychosocial support; running multi-channel/multi-layered information and awareness campaigns that included community dialogue and TV and radio programs; supporting a digital vaccination database in target communities; and advocating and coordinating to ensure that gender needs were reflected in the national vaccination plan. Consequently, there was significant improvement within the communities, and even nationally, with some areas achieving 100% vaccination.

In **Zambia**, one of the world's poorest countries, the high cost of vaccine delivery (CARE estimates that in Zambia, vaccine delivery costs at least $17.18 per fully vaccinated person — 7.2 times more than the global estimate of $2.38 per person) was a major roadblock at the last mile. CARE supported Fast and Fair programming in three districts (Mpika, Chinsali and Isoka) of Muchinga province by: influencing policy makers

at national, provincial and district levels; prioritizing important risk groups such as health care providers, refugees, and other vulnerable populations; and striving to combat stigma and build trust to reduce vaccine hesitancy.

At the district level, CARE Zambia worked with partners to pinpoint areas with low vaccine coverage, covered transportation costs, and supported data recording. CARE also rallied local leaders and influencers (such as village chiefs and the clergy) to promote vaccination. With these efforts Muchinga Province became the fourth province in the country to achieve the 70% vaccination coverage target (with 89% coverage as of December 2022).

Working against a backdrop of violent conflict, flooding and extreme poverty, CARE helped the government of **South Sudan** secure funding, train health workers and educate communities on the need for vaccination. As an active participant in the planning and direction of the national health response, CARE influenced the government's COVID-19 plans by providing regular and timely insights on the operational gaps and challenges hindering vaccine delivery. For example, CARE noted that more men than women were being vaccinated even though most healthcare workers were women, and women had higher infection rates. We explored and documented factors driving the gender gap, shared these insights, and advocated for better targeting of women and girls. Not only were we able to influence the national COVID-19 response, but our data and insights from South Sudan were used to bring widespread attention to the need for gender equity in vaccine delivery and helped galvanize global support for frontline healthcare workers.[2]

Alongside its guiding of national policy, CARE worked at the grassroots level within state and county-level response committees. CARE advocated for the use of mobile clinics and facilitated transportation (by boat and other means) for vaccinators to very remote areas in eight counties. We also partnered with religious and community leaders to dispel myths and counter vaccine hesitancy. Since radio is the primary source of information in South Sudan, CARE sponsored several local call-in shows to enable listeners to have their concerns addressed by health experts.

How a 10-year-old nation beat the odds to deliver the COVID-19 vaccine

In May 2021, when COVAX donated 132,000 doses of the COVID-19 vaccine to South Sudan, every single vial had to be returned. The 10-year-old nation (at the time) lacked the capacity to get the vaccines from the capital city Juba into the arms of the people across the country who needed them most.

Undaunted, CARE South Sudan's Dr. Emmanuel Ojwang and Dr. Kawa Tong solicited urgent investment in the country's healthcare system. With surge funding from CARE's Fast and Fair campaign (among other donors) South Sudan increased the capacity of its healthcare workers, filled gaps within its vaccine delivery system, and improved awareness among target communities. As a result, all of the 60,000 vaccines that arrived in the following COVAX shipment in July that year were successfully administered.

As South Sudan is a low-income country still in its infancy, rather than set up a temporary system specifically for COVID-19 vaccinations, CARE worked to address long-term healthcare staffing gaps and build the capacity of health workers to also support other essential services (such as sexual and reproductive services and

[2] In April 2022, CARE South Sudan's head of health and nutrition programming, Dr. Emmanuel Ojwang, was invited to address the UN Security Council on the challenges to equitable global vaccine delivery and how these could be resolved.

childhood immunizations). The nearly 200 additional staff hired by CARE have been retained, and our team in South Sudan continues to document best practices on last mile delivery to enable the system to sustainably meet future health needs.

CARE's adaptations of existing programming in response to the pandemic

Photo Credit: Asafuzzaman Captain

Country Highlight: Closing the gap at the last mile: The case of Bangladeshi factory workers

- CARE successfully pivoted its HALOW+ platform (an extension of the Health Access and Linkage Opportunities for Workers project) to respond to COVID-19. The platform (a partnership by CARE, GlaxoSmithKline and Marks and Spencer), is esteemed locally for its long-standing support of Bangladeshi low-income factory workers.

- On the strength of its impactful programming and deep public and private partnerships, CARE obtained UK Foreign, Commonwealth and Development Office funding to assist workers from 41 garment factories and their communities; effectively reaching more than 1.2 million people.

In the five years before the pandemic, CARE Bangladesh's HALOW and HALOW+ programmes delivered programming that improved the lives of more than 90,000 garment workers and amassed valuable expertise in meeting the needs of an otherwise underserved population. The HALOW+ program improved social protection within factories; enabled access to telemedicine for patients in very remote areas; and facilitated provision of menstrual hygiene products, nutrition education, and eye exams at low or no cost to factory workers.

When the pandemic reached Bangladesh in March 2020, these activities contributed to greater emergency response preparedness. HALOW+ quickly mobilized its community support groups into Coronavirus Awareness Committees to disseminate disease prevention messaging and protective equipment. Due to its long-standing relationship with CARE, the district-level Civil Surgeon Office requested HALOW+ staff and the committees to coordinate emergency response logistics and resource distribution. CARE Bangladesh also led a coalition of NGOs and government agencies in emergency resource mobilization for the local administration of Gazipur, a major industrial city in Bangladesh.

Country Highlight: Women savings group members turned frontline health workers in Myanmar

- In Myanmar, during a military coup, CARE pivoted its Village Savings and Loans Associations (VSLA) network and its Frontline Health Workers Initiative (in partnership with GlaxoSmithKline) to lead the COVID-19 response in Lashio district.
- Women in the VSLAs used their own savings to become first responders and midwives so they could still access health services during curfews and lockdowns.

Following the coup d'etat in Myanmar in February 2021, the military imposed a state of emergency and clamped down on NGOs, restricting their funding and limiting them to emergency activities only. Despite these challenges, CARE Myanmar mounted a COVID-19 response in Lashio district that emphasized its unique relationship with the community. The VSLAs — created by CARE as savings platforms — became important vehicles for COVID-19 prevention efforts. VSLA members even redirected some of their funds to train as vaccinators. They supplemented the COVID-19 prevention efforts of community health workers and government staff by serving as an additional workforce for health messaging, first aid and vaccine provision within their communities.

To ensure uninterrupted access to reproductive healthcare during the pandemic, a number of VSLA members completed a CARE/GSK Frontline Health Workers Initiative midwifery training so they could provide essential maternal and child health services including antenatal care, delivery, and postnatal care. They helped reduce the load on already overburdened health facilities by identifying and referring only high-risk pregnancies for case management.

To facilitate sustained funding and support for health services in the long term, communities in Lashio district went further and created a Village Emergency Response fund. Such innovative community-driven approaches during a military coup and a raging pandemic were only possible because of CARE Myanmar's trusted presence, its existing VSLA and training infrastructure, and the GSK's flexibility and willingness to reallocate programme funding.

Photo Credit: César López Balan

As in Guatemala, Honduras, Zambia, South Sudan, Bangladesh and Myanmar, CARE provided the same multi-faced and multi-level pattern of support across the other Fast and Fair participating countries. Working across local-to-global systems, we advocated, facilitated, protected and mobilized in our quest to ensure fair and fast access and delivery at the last mile. The manner in which we were able to achieve this was very context-specific, practical, and ultimately successful due to CARE's long-standing presence and partnerships on the ground and around the world.

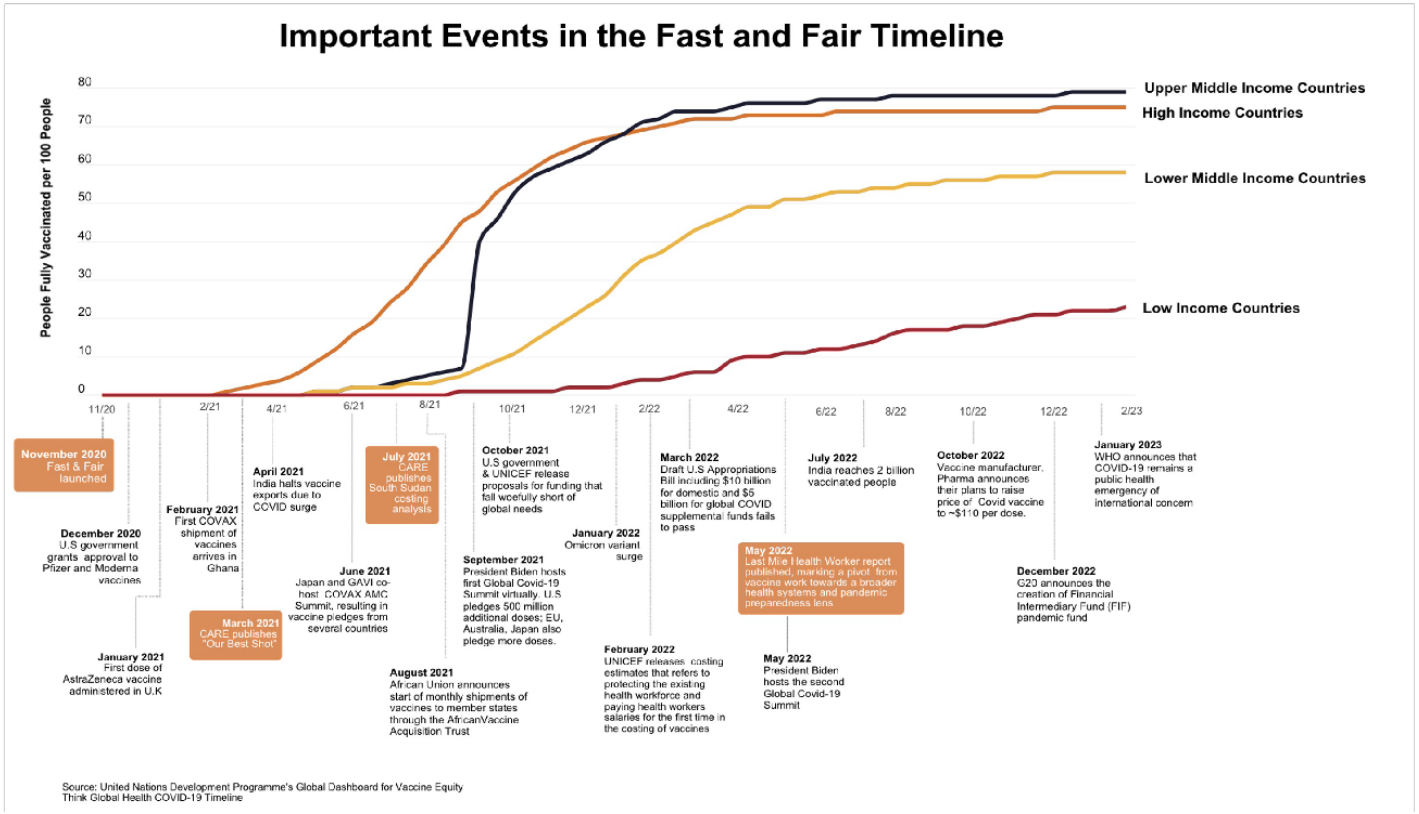
II. CARE's US and global influence: Insights for future efforts

CARE's advocacy and thought leadership has legitimacy because it is anchored deeply in concrete evidence from our programming. By skillfully leveraging CARE's local-to-global presence and real-time data from our programs on the ground, the Fast and Fair campaign was able to successfully influence practices, commitments and policies of duty-bearers such as the US government, the World Bank, COVAX, and the donor community. With data that included costing studies from South Sudan, Nepal, and Zambia, we swayed the global conversation and cemented our position as "the leader in drawing attention and resources" for vaccine delivery and access at the last mile.[3]

A number of wins were particularly significant for our Fast and Fair advocacy, including:

1. $19 billion in global COVID-19 response funding from the US government as a result of joint lobbying by CARE and its partners.
2. Shifting of the global conversation to the real cost of vaccine delivery. Alongside this, we amplified the need to protect and pay frontline healthcare workers (70% of whom are women).
3. Lifting of the $3-per-dose delivery cap on the COVAX humanitarian buffer due to CARE's thought leadership on the true cost of vaccine delivery to the last mile.
4. Positioning gender at the center of the global conversation on vaccine delivery and access.

[3] P. 13, Fighting for the least vaccinated: Independent evaluation of systems-level outcomes of CARE's COVID-19 Fast Initiative and Campaign, Ignited Word, June 2023.



How did CARE achieve these significant advocacy wins?

1. Achieving $19 billion in emergency funding from the US government for the COVID-19 response

Between March 2020 and March 2021, CARE worked closely with coalition partners and allies, US Congressional champions and leaders, and with members of the Biden administration to secure approximately $19 billion in global COVID-19 response funding from the US government, including direct support to combat the pandemic as well as humanitarian and development assistance to address the secondary impacts of the emergency.

Why is this important? This funding was in *addition* to current US investments in foreign assistance and represented a one time increase of approximately 30% over the usual foreign assistance budget. CARE's work to highlight the needs of women and girls in the pandemic is most clearly reflected in the latter tranches of funding in this process when the Biden administration made it clear that efforts to address gender-based violence and sexual and reproductive health and rights must be part of the global COVID-19 response and requested funds for that purpose.

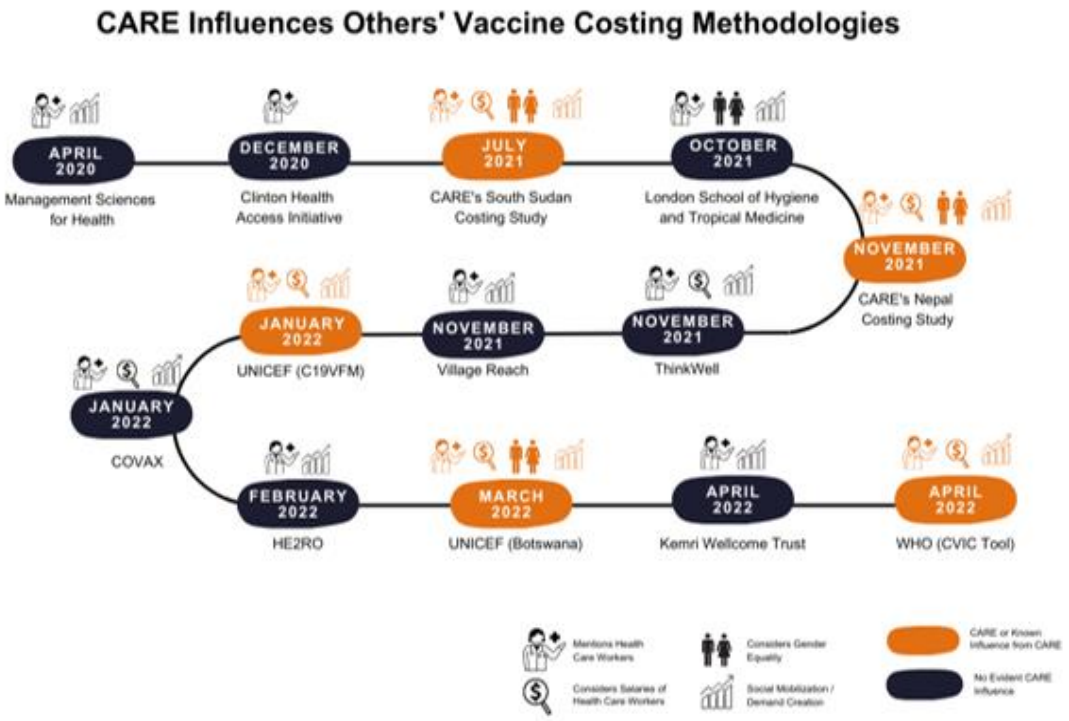
2. Shifting the global conversation to the true cost of inclusive last mile delivery

As vaccines became available, CARE began drawing attention of multilateral and global health institutions to the need for more robust costing of vaccination, inclusive of delivery in difficult environments and the often-unaccounted costs of recruiting, training and protecting frontline healthcare workers. Leveraging costing analyses from CARE's local programming in multiple countries, Fast and Fair advocacy influenced the costing methodologies of UNICEF, WHO and the World Bank as well as the vaccination positions of The Bill and Melinda Gates Foundation.

Alongside this awareness-raising, CARE actively lobbied the US government for greater resource allocation for global COVID-19 relief, specifically to support vaccine delivery and frontline health workers.[4] Between

[4] For example, see the CARE and Booz Allen Hamilton policy paper; "Our Best Shot" policy report and the need for additional global investments in the delivery support necessary for vaccines.

December 2021 and late March 2022, CARE and five close allies led an ad hoc coalition advocating for US government approval of $17B in supplemental funding.



Why is this important? Although the $17 billion global supplemental funding was not made available, CARE and its allies were successful in raising awareness and building support among key target policymakers[5] in Congress and within the presidential administration on priority issues — particularly the need for additional resources for frontline health workers. USAID, the White House, and key members of Congress all took concrete actions to support global COVID-19 funding, and there is evidence to show that the coalition's advocacy led to these results. USAID requested $17 billion in supplemental funding for global COVID-19 relief in its fiscal year 2022 budget request and included in its COVID-19 plan explicit support for frontline health workers in line with the coalition's asks. The US Office of Management and Budget made an informal request to Congress for global COVID-19 funding in fiscal year 2022 and a formal budget request in fiscal year 2023. Congress itself included $5 billion for global COVID-19 relief in the draft fiscal year 2022 Omnibus bill, and key members of Congress took action to support and defend this funding.

3. Influencing the removal of a cap on the COVAX humanitarian buffer

The COVAX humanitarian buffer[6] — a safety net designed to fill gaps where standard national COVID-19 vaccine procurement and distribution processes could not or would not reach vulnerable populations — initially capped delivery funding at $3 per dose. UNICEF's 2022 global costing models estimated that it cost between $3.70 and $4.45 to fully vaccinate someone. However, CARE clearly demonstrated that the real cost of delivery could go significantly higher, depending on the country and context. Using data and evidence from its programming in Nepal, a country with a relatively strong health system, CARE revealed that the real cost of last mile COVID-19 vaccine delivery there was $18.17, and that in South Sudan, the true cost of delivery was as high as $22 per fully vaccinated person. As a result of CARE's advocacy, the humanitarian buffer cap was removed. As shown below in a quote from an anonymous high-level stakeholder in an interview conducted by the external evaluator, CARE's costing studies directly influenced the decision to remove the cap on the UN humanitarian buffer.

[5] For more details on the outcomes and CARE's work in the global COVID-19 Supplemental Campaign, see an independently produced case study about CARE's Global COVID-19 Supplemental Campaign.

[6] https://www.kff.org/global-health-policy/issue-brief/the-covax-humanitarian-buffer-for-covid-19-vaccines-review-and-assessment-of-policy-implications/#:~:text=The%20Buffer%20was%20designed%20to,that%20were%20facing%20humanitarian%20emergencies.

Why is this important? The humanitarian buffer was established in 2021 to prioritize vaccine delivery and access to those most vulnerable and at risk of being neglected by national vaccination efforts, such as refugees and those who have been displaced. The humanitarian buffer had the potential to assist as many as 167 million most vulnerable people in need of the COVID-19 vaccine. However, the end result was disappointing. As of November 2022, only 1.6 million doses for Afghan refugees in Iran and 840,000 doses for refugees in Uganda were distributed.

Setting New Standards on the Cost of Vaccine Delivery

"I really think that [CARE's] technical paper on the cost of vaccine delivery was really powerful and it enabled us to point repeatedly at the additional cost of vaccines and that actually influenced the humanitarian buffer financing decisions [with the U.N. Security Council] because initially they were providing, I think it was like two or three dollars a dose. Ans we managed to get that up significantly higher, get the cap removed."

4. Putting gender at the center of discussions on vaccine delivery and access

In his address to the UN Security Council in April 2022, Dr. Emmanuel Ojwang, CARE South Sudan's Health and Nutrition Coordinator, presented data from CARE's local programming that clearly demonstrated gender-related inequalities in vaccine delivery and access. Prior to Dr. Ojwang's presentation of CARE's analysis, gender had been missing in the global conversation on vaccine equity. As a result of its close relationship with CARE South Sudan, the South Sudan government co-sponsored an NGO briefing on vaccine equity. This was indicative of South Sudan wanting CARE's messages on gender equity in vaccine access and the true cost of vaccine delivery to have wider reach within the international community. Consequently, CARE's analysis and messages were carried forward by other NGOs who attended the briefing.

Why is this important? CARE's analysis shows that in times of crisis, women and girls — especially those in development or humanitarian contexts — are the hardest hit. They shoulder the burden of unpaid care and make up 70% of the world's health workers. Not only are they on the frontline of infection risk but even after an outbreak has been contained, they continue to suffer long-term effects on their education, food security and nutrition, health, livelihoods, and protection.

Photo Credit: Ollivier Girard

The impact of the Fast and Fair campaign on the global vaccine response

The above examples highlight how CARE successfully exerted influence at local and global levels to ensure fast and fair access and delivery of the COVID-19 vaccines. CARE's global advocacy wins — having the US government allocate $19 billion in emergency funding for the pandemic response; redirecting the global conversation to the true cost of last mile delivery; influencing the UN to remove the humanitarian buffer financing cap; and emphasizing the importance of gender equity — were critical to improving vaccination outcomes for some of the most vulnerable people and communities in the world. These wins were also only possible because of CARE's deep local programming, partnerships, and expertise.

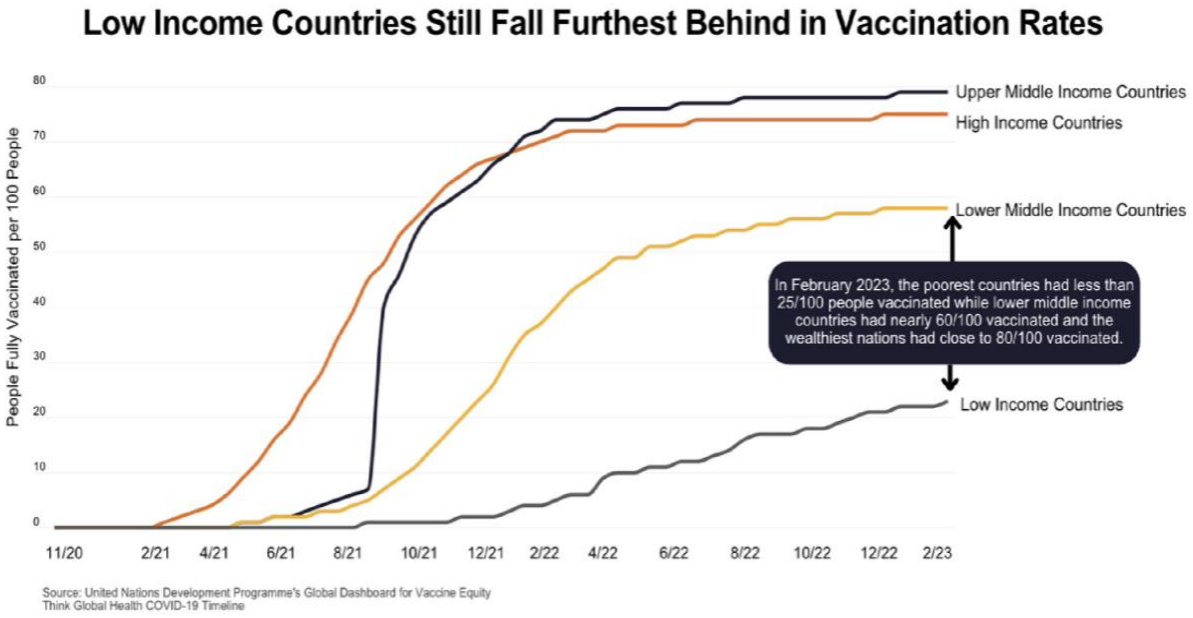
However, even with these significant efforts and achievements, the overall global vaccine response was inadequate. Despite CARE having successfully influenced duty-bearers (such as the United States Government, the World Bank, COVAX, and the donor community), these wins did not deliver on their potential for reasons beyond CARE's control. WHO, with widespread support from the international community, set a goal of 70% global COVID-19 vaccine coverage by September 2022. Yet in March 2023, three years after the WHO had declared COVID-19 a pandemic, only seven of the 34 Fast and Fair campaign countries had achieved 70% full vaccination. The external assessment of CARE's influence states "...in February 2023, less than 25 out of 100 people had been fully vaccinated in low-income countries, as compared to close to 80 out of 100 in high income countries."[7]

Nevertheless, CARE's overall contribution to the COVID-19 response *supported* 143 million people globally through awareness-raising, distribution of masks, and vaccine registration — far surpassing the Fast and Fair campaign target of 100 million people. Through this comprehensive local-to-global evaluation, we then determined that CARE contributed to **21.2 million people being fully vaccinated at the last mile**, which is the ultimate impact this campaign sought to achieve. This was attained despite a considerable shortfall in funding, and against the broader global context that included vaccine shortages, high delivery costs, rampant misinformation, and widespread hesitancy. At the start of the campaign, CARE set a fundraising target of $100 million to impact 100 million people. The amount secured by CARE for COVID-19 vaccinations was $4.7 million. The remarkable feat achieved by CARE was thus borne largely out of our strong relationships and influence

[7] P.7: Fighting for the least vaccinated: Independent evaluation of systems-level outcomes of CARE's COVID-19 Fast Initiative and Campaign, Ignited Word, June 2023.

at both local and global levels.

With adequate funding and/or scenario-planning, however, CARE would have been better placed to extend its advocacy beyond initial policy approvals, all the way through to implementation. This would have better ensured that CARE's support impacted even larger numbers of those who needed it most. For example, US government funding for the global COVID-19 emergency response was an important win, but additional advocacy at the local level was required to ensure that the funds reached communities most in need. USAID's implementation plan for the COVID-19 global response and recovery had a strong emphasis on delivery, with language about gender inequality lifted directly from talking points prepared by CARE. However, we were unable to trace how USAID's implementation plans were translated and implemented in the countries and contexts where we worked. We did not find strong evidence that USAID's COVID-19 activities and funding were fundamentally more gender-sensitive. A key learning from the Fast and Fair campaign is the importance of advocacy all the way to local implementation, and better scenario-planning in case funding goals are not fully met.



Significant systems-level changes that are not immediately quantifiable

Aside from the impacts mentioned above, the Fast and Fair campaign brought about a number of systems-level changes whose effects will likely only become clearer in the long term. They included:

- Strengthened local health systems;
- Maintenance and protection of sexual reproductive health and other life-saving health services during the pandemic, resulting in improved health outcomes for people in the long term;
- Changes in social norms that led to greater trust and deeper relationships between communities and health care providers;
- Improved capacity for more sophisticated advocacy by CARE and its partners at local and national levels, increasing their scope of impact; and
- A new global narrative that recognized the needs and contributions of frontline health workers and the challenges and real costs of getting vaccines from "tarmac to arm(s)".

While the precise value of these long-term structural changes cannot be determined as yet, the implications include:

- The importance of leveraging real-time programming data to inform advocacy asks;
- Stronger, more resilient systems, structures and communities that can better weather future crises;
- Elevation of global support for investment in frontline healthcare workers, the majority of whom are women; and
- Setting of new standards on the cost of vaccine delivery.

Photo Credit: Paul Assaker

How did we comprehensively measure our local-to-global impact?

The ultimate measure of the Fast and Fair Campaign's quantifiable impact is the *number of people fully vaccinated against COVID-19.* As CARE and the Fast and Fair campaign did not directly put shots in people's arms, we estimated the campaign's impact by following CARE's theory of action: CARE operated at different levels — local-to-national-to-global — to influence systems via advocacy, facilitation, protection, and mobilization to ensure fast and fair vaccination at the last mile. Our assessment therefore measures the combined impact of CARE's efforts at all levels and is based on CARE's substantial contribution, not attribution. We believe that systems are influenced by multiple actors and forces. While CARE's internal reporting systems estimated that 143.1 million people were vaccinated in areas where CARE had promoted vaccination rollout, we wanted to quantify CARE's specific contribution through advocating, facilitating, protecting, and mobilizing. We do not claim that CARE's influence alone led to people being vaccinated against COVID-19. Rather, our impact measurement approach seeks to reflect the complex reality of how systems change happens simultaneously at multiple levels.

We assessed CARE's impact on the COVID-19 vaccine roll-out in three ways:

1. Qualitative assessment of CARE's work in each Fast and Fair country to determine whether it met the threshold for significantly contributing to COVID-19 vaccination targets (internal analysis using existing programmatic and evaluation data; *see full country case study summary here*).
2. Independent assessment of CARE's global advocacy and thought leadership (external evaluation using multiple data sources, including bellwether interviews with high-level officials involved in the COVID-19 response; *see Fighting for the least vaccinated*).
3. Quantitative calculation of the number of people who were fully vaccinated against COVID-19 as at March 11, 2023 in places where CARE did significant work (internal analysis using secondary data from other sources; *spreadsheet is available upon request*).

We explain each of these methodologies in more detail below.

1. Qualitative assessment in each Fast and Fair participating country

To determine whether CARE was a primary contributor to people being fully vaccinated for COVID-19 in a particular country, we used a modified version of CARE's Advocacy and Influencing Impact Reporting (AIIR) tool. CARE measures advocacy and influencing by collecting information and evidence on an advocacy and influencing win. We determine the significance of the win, CARE's level of contribution, those who benefited,

and the evidence we have to support our claim of change or impact. For the Fast and Fair campaign, we assessed whether, and to what extent, CARE made substantial contributions in each participating country. The key analysis included: geographic focus of CARE's efforts; the meaningful change or win that was achieved by CARE and CARE's partners; the contextual importance of the change or win; CARE's contribution; and the evidence sources that underpinned CARE's work across the four Fast and Fair pillars of advocacy, facilitation, protection, and mobilization.

Of the 34 countries where CARE implemented Fast and Fair programming, our analysis found that five countries (Colombia, Ghana, Jordan, Philippines, and Sierra Leone) did not meet our evidence threshold to claim impact. For example, in the Philippines, Fast and Fair activities included radio advertisements that urged people to take the COVID-19 vaccine. While this was an important vaccine promotion and awareness raising activity, CARE does not have evidence that these radio advertisements directly led to people getting vaccinated against COVID-19, so we do not include the Philippines in our impact calculations.

Beyond determining whether there was evidence at the country level to potentially claim impact, we also identified the specific geographical areas in each country where CARE engaged in COVID-19 related programming. With the exception of three cases where CARE did significant work at the national level (Bangladesh, Rwanda, and South Sudan), CARE typically operated in a discrete set of provinces, municipalities, or districts. We used this geographic information to reasonably estimate the number of people who were fully vaccinated in the places where CARE had deep engagement. (See the *Fast and Fair country case studies* for the modified AIIR Tool analysis for all 34 countries).

2. Independent assessment of CARE's influence on COVID-19 vaccination

To affirm CARE's Fast and Fair global contributions beyond our internal analysis, we commissioned a comprehensive independent assessment by Ignited Word, an external agency. Their methodology included:

- Repeat of CARE's *Our Best Shot* analysis
- Costing methodology comparison
- Timeline creation
- Keyword web search of the phrase "tarmac to arm(s)", used by CARE and others to draw attention to the challenges of COVID-19 vaccine delivery to the last mile
- Literature and background document review
- Twelve bellwether interviews with high-level officials involved in the COVID-19 response
- Outcome tracking and rating

The external evaluation found that CARE's advocacy and influencing shaped commitments and contributions towards the global vaccination effort, including "large numbers of vaccinations and more compensation of frontline health workers that would otherwise not have happened."[8] While CARE was ultimately unable to single-handedly redirect the uneven and unequal course of the global response, the external assessment notes that we successfully catalyzed material support for the true cost of vaccine delivery and influenced norms around the obligations of richer nations to poorer nations. *The full external evaluation report is available on CARE Evaluations*.

3. Quantitative calculation of the number of people fully vaccinated

With the qualitative assessments by country and the independent assessment of CARE's global advocacy and thought leadership giving clear indication of CARE's contribution to getting people fully vaccinated at the last mile, we proceeded to quantify the campaign's impact.

[8] P.3, Fighting for the least vaccinated: Independent evaluation of systems-level outcomes of CARE's COVID-19 Fast Initiative and Campaign, Ignited Word, June 2023.

In the 29 countries where there is evidence of CARE's contribution to people getting fully vaccinated against COVID-19, we projected our impact using the impact metric: *number of people who are fully vaccinated against COVID-19*. We calculated this using the following steps and formula:

1) We acquired secondary data on the vaccines shipped by COVAX to a recipient country[9] (*a*). We estimated the wastage rate by country using the WHO's Vaccine Wastage Rates Calculator[10] (*b*). We then calculated the number of COVAX-donated vaccines used by taking out the estimated number of vaccines that went to waste (*c = 1-b*).
2) We used the number of fully vaccinated people (i.e., those who received the complete initial protocol) and the number of people partially vaccinated for each country from WHO's COVID-19 data and used these to estimate the proportion of fully vaccinated (*d*) versus the number of people partially vaccinated amongst those who received the COVAX-donated vaccines.
3) We then used these variables to estimate how many people were fully vaccinated (*f*) versus only partially vaccinated *(e*) at the country level.
4) We then discounted and limited the final impact number to a geographic scope where the qualitative data suggested significant contribution from CARE, using the calculated share of the population from that geographic area[11] (*g*), to arrive at the final impact number estimate by country (*f x g*).

For example: In **Benin**, where CARE worked at multiple levels but most profoundly in Abomey-Calavi/So-Ava commune, our calculations were as follows:

- COVAX-donated vaccines to Benin (*a*) = 2,082,390;
- Modeled COVID-19 vaccine wastage rate in Benin (*b*) = 45% (or 0.45)
- Thus, estimated number of COVAX vaccines used (*c*): 2,082,390 * (1-0.45) = 1,145,315
- Among those who received the COVID-19 vaccine, 74% were fully vaccinated (*d*); and 26% were only partially vaccinated (*e*);
- Such that, of the estimated 657,520 people who received the 1,145,315 vaccines, we estimate that 487,795 are fully vaccinated or received two doses (*f*) while 169,725 people were only partially vaccinated.
- Finally, this translates to *at least 48,816 fully vaccinated women and men in Abomey-Calavi/So-Ava commune in Benin* where CARE and partners engaged most profoundly and significantly in the face of severe strain on government health systems. We did this by: a) strategically empowering frontline healthcare workers with adequate knowledge through a comprehensive training program; b) *mobilizing* greater public awareness using radio programs, community engagement and dialogue; c) *protecting* frontline health workers by providing them with protective equipment; and d) *facilitating* acquisition of essential equipment and resources of hospitals and health centers within the Abomey-Calavi/So-Ava commune.

For Bangladesh, India, Rwanda and South Sudan, we determined CARE's contributions at the national level.

[9] We primarily used the underlying database of the UNICEF dashboard: https://www.unicef.org/supply/covid-19-market-dashboard and crossed-checked against data from https://www.kff.org/coronavirus-covid-19/issue-brief/u-s-international-covid-19-vaccine-donations-tracker/#table01

[10] The WHO Vaccine Wastage Rates Calculator can be downloaded here: https://www.who.int/publications/m/item/vaccine-wastage-rates-calculator . The parameters we used can be provided upon request.

[11] Most recent population data varies country by country. Some are from the 2010 and 2012 census, some are from 2015 and the most recent are from 2018. Projections to estimate the latest local population data were calculated using:
(Total population)*(1+growth rate [%])^nb year (how many years has it been since the census)

It should be noted that where possible, the calculations are based on secondary data, rather than through the calculation model used above. For example, in India, where we have data on the number of people CARE's project supported and who got fully vaccinated, the team conservatively estimated that CARE can claim impact for just half of all the people who were fully vaccinated in each project area, taking into account that CARE is not the sole actor in these areas. In the state of Bihar, where one of CARE's most robust COVID-19 interventions benefitted from years of health systems strengthening in collaboration with the state government and multiple partners (see previous evaluations here), CARE conservatively estimated its contribution to full vaccination to be 10% of those vaccinated. This is because CARE's most recent direct capacity strengthening in Bihar involved training of around 10% of the state's nurses, and nurses are the primary vaccinators in India. Since the estimated fully vaccinated population in Bihar is 53 million, our impact contribution is estimated at 5.3 million in this state.

In total, we quantified the impact of the Fast and Fair Campaign from 29 out of 34 participant countries at: 21,205,123 women and men who were fully vaccinated against COVID-19. (*Detailed calculations for each country are available upon request.*)

Learnings and recommendations

Like the global pandemic that led to it, CARE's Fast and Fair campaign was the first of its kind. It brought about a novel set of programming and funding considerations that present several learnings. Reflecting on the successes and shortcomings of the campaign is an opportunistic investment to potentially increase our systems-level impact in the future: from tens of millions to hundreds of millions of people around the world.

What went well:

- *Leveraging local infrastructure and relationships* to work in tandem with our broader advocacy agenda facilitated our ability to launch localized responses quickly and effectively. Additionally, our reputation in the development space eased our ability to lean on a wide range of private sector organizations, multilateral agencies, and national governments.
- CARE's decades-long work across sectors enabled us to easily pivot our programming and deliver *an integrated response.*
- *CARE's confederation and CARE member partner-country office structure* allowed CARE USA to institute practices to greatly reduce the programming and measurement burden for country offices.
- *Open collaboration* within CARE USA among the Health, Equity and Rights (HER), Impact, Learning, Knowledge, and Accountability (ILKA), and Advocacy teams was crucial for data-informed decision-making via rapid gender analyses, costing analyses, and evidence for programming approaches.

Areas for growth:

- Local-to-global influencing requires *campaigning and advocacy at all levels and ensuring that resulting policies are implemented.* For our influencing of global or US policy changes to translate into impact, we need clear advocacy strategies that guide and support implementation on the ground. Influencing of implementation does not always have to be led by CARE but can be done by our allies and partners locally.
- There were several instances of incredible collaboration across teams and offices that led to major wins during the Fast and Fair campaign. However, due to the unprecedented nature of the COVID-19 emergency, multiple groups arose across CARE addressing similar (or the same) issues but for different audiences. While there may be value in having different groups for coordination, evaluation, or programming a *more streamlined response* would likely have been more fruitful.
- *Disciplined prioritization.* The pandemic response was added to existing roles, requiring staff to expend additional effort without surge support. Programming, especially at the height of the pandemic, was made more challenging by the loss of several key staff members (and their positions) without additional investment.

- *Forecasting and contingency planning.* CARE's Fast and Fair advocacy efforts were intended as a launchpad for further investment in CARE's COVID-19 vaccination and other disease prevention infrastructure. However, this did not materialize when internal surge funding was depleted and the U.S. government supplemental bill did not pass. The lack of an in-built process that allows for inter-departmental reprioritization or realignment when original funding has ended or programmatic goals need to shift, makes it challenging for country teams to create or sustain new programs, or to capitalize on other gains made.

Five recommendations for future campaigns:

1. CARE's campaigns need to be responsive to rapidly changing circumstances. Scenario planning, an approach that considers multiple possible future events, would be a better approach versus traditional planning which tries to predict the most probable future. Having a strategy that anticipates a wide range of possible impacts and outcomes would enable us to be more agile and responsive to unexpected events.
2. Continuously improving the links between on-the-ground programming, local advocacy campaigning, and our US and global influencing is key to cementing our position as a leader in this space. Adapting our structures to make our internal processes (from communications to flexible teams) as seamless as possible would better ensure that our advocacy wins are followed through to implementation.
3. Continue building our capacity to form ad hoc multi-departmental teams to jointly strategize, set targets, execute, change tactics, streamline responses and mobilize support and capacity for country offices in the event of a similar campaign or crisis.
4. Capitalizing on, and collaborating with, peer organizations can be more effective than competing with them. By engaging in forecasting and relationship management, CARE can continue to anticipate when to leverage its existing expertise, infrastructure, and relationships to move a campaign forward with the right collaborators.
5. Ensure agreement on impact and resource metrics, and how they will be measured, at the very beginning of the campaign. Include "leading indicators" and incorporate mid-action reviews and/or frequent reflection points (using the leading indicators) into the project or campaign cycle so the team is better able to determine when adjustments or pivots may be necessary.

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