Fighting for the Least Vaccinated

(and those who vaccinate them)

Independent Evaluation of Systems-Level Outcomes of CARE's COVID-19 Fast and Fair Initiative and Campaign

June 2023

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Executive Summary

The global vaccination effort was generally considered inequitable and ineffective. Vaccination rates mostly followed an income-based pattern both in terms of onset of large-scale vaccination efforts and numbers of people vaccinated. Despite global efforts to address vaccine inequity, vaccination coverage in low-income countries has remained low, though the gap is shrinking.

CARE USA, an international poverty fighting and human rights organization, began its Fast and Fair COVID vaccine initiative and advocacy campaign in late 2020 –relatively early in the pandemic period. As the campaign's name suggests, CARE wanted to help steer the global vaccination effort down the path of fairness and efficiency. This evaluation is an assessment of whether and to what extent CARE, in collaboration with its partners, achieved its objectives.

At the end of 2020, the global conversation around COVID-19 vaccines centered on production and donations of vaccines, with little talk of the conditions required to actually administer the shots or the vital role of the predominantly female frontline health workers. CARE noticed this gap and, through various publications, outlined the need for more comprehensive funding dedicated to vaccine delivery, in order to limit the social and economic fallout of the pandemic in all countries. Specifically, CARE argued that for every $1 invested in vaccine doses, another $5 is required for delivering the vaccine, with $2.50 dedicated solely to paying, training and protecting formal and informal health care workers, 70% of whom are women.

In addition, within the U.S. and starting in the initial months of the pandemic, CARE along with coalition partners, mounted an ambitious advocacy effort to the U.S. government to request funding for global vaccination efforts. This work helped secure $11 bn in global COVID-19 funding from the U.S. Government, including direct support to combat the pandemic and humanitarian and developmental assistance to address its secondary impacts. A coalition-based effort to secure a further $17 bn in supplemental funding was unsuccessful.

Using the contribution ranking method, we conclude that CARE was largely successful in leveraging its experience, data, advocacy prowess, and local-to-global presence in achieving systemic impact, particularly in catalyzing material support for the true cost of vaccine delivery (HIGH contribution). To a lesser extent CARE also catalyzed global support for frontline health workers (MEDIUM contribution). CARE's efforts no doubt resulted in large numbers of vaccinations as well as frontline workers that were protected and paid – events that would otherwise not have happened. Nonetheless, perhaps few non-state actors were in a position to bend the inequitable trajectory of the response. Thus, CARE's contribution to the overall result is additive rather than transformative (LOW contribution).

A path to greater impact could also involve addressing more fundamental factors that crippled the global vaccine response, including the financing of global health–an area in which systems-focused international NGOs like CARE could have substantial sway in influencing relevant norms and discourse.

Ultimately, we can say with confidence that CARE's advocacy and influencing work, informed by its on-the-ground experience, shaped commitments and contributions towards the global vaccination effort.

Introduction

The COVID-19 pandemic tested the human rights principles of fairness and equity like no other emergency. In its early stages, it set up a breathtakingly suspenseful plot with high stakes – would the world collaborate and share resources so that everyone would have a fair chance at being vaccinated, thus reducing the deadly effects of the virus? Or would the richer nations be first in line to get their populations vaccinated at the expense of others?

CARE USA, an international poverty fighting and human rights organization, began its Fast and Fair COVID vaccine initiative and advocacy campaign in late 2020 –relatively early in the pandemic period. As the campaign's name suggests, CARE wanted to help steer the global vaccination effort down the path of fairness and efficiency. The basic mechanisms to do so were clear – use the organization's global reach and reputation to influence the actions of larger actors – state and non-state – that were in a position to make investments in vaccines and their delivery.

This evaluation is an assessment of whether and to what extent CARE, in collaboration with its partners, achieved its objectives. More broadly, it is an attempt to learn from a fascinating and highly significant stress test of our collective ideals, mechanisms and systems for global collaboration, humanitarian assistance and human rights.

The three guiding questions for this evaluation are as follows:

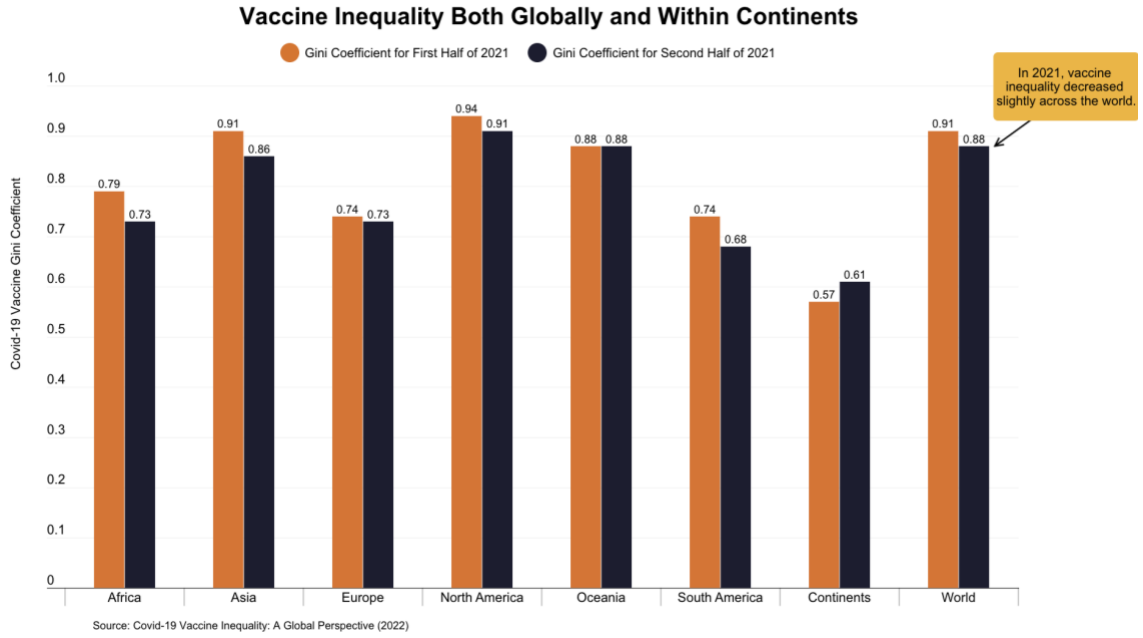
1. Did CARE make high-leverage changes within the global-local system that are relevant to Fast and Fair? What are those outcomes?
2. Did CARE have influence in multiple domains of systems change? What are those outcomes?
3. What is the fidelity between intended theories of change and action, and actual outcomes/impacts?

Background

An Inequitable Global Vaccination Response

The global vaccination effort was generally considered inequitable and ineffective. Vaccination rates mostly followed an income-based pattern both in terms of onset of large-scale vaccination efforts and numbers of people vaccinated. Using two comparison points of June 7, 2021 and December 7, 2021, Tatar et al. measured the degree of COVID-19 vaccine inequality globally using the Gini coefficient, a well-known measure of inequality.[1] Using a range of 0 to 1, with 0 as a perfectly equal distribution and 1 as perfectly unequal distribution, the findings revealed "World" COVID-19 vaccine inequality at 0.91 on June 7, 2021 and 0.88 on December 7, 2021, representing severe inequality. The findings were consistent with prior research which found extreme disparities and inequality during the COVID-19 pandemic.

The figure below shows vaccine inequality at three levels: within each continent, between the six continents, and at the global level (World). The figure reveals the continued severity of unequal distribution by December 2021. Although a slight decrease is recorded at the global level and within continents, a slight increase in inequality is seen between continents. This denotes the severity of inequality for vaccine distribution across all three levels.



[1] Tatar, M., Shoorekchali, J. M., Faraji, M. R., Seyyedkolaee, M. A., Pagan, J. A., & Wilson, F. A. (2022, October 14). *COVID-19 vaccine inequality: A global perspective - PMC.* Retrieved June 1, 2023, from NCBI: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9559176/#R2

COVID-19 vaccine inequality was made severe by several factors including “vaccine nationalism.” The term describes a situation where countries push to get first access to a supply of vaccines and potentially hoard key inputs for vaccine production. With national governments focusing on securing vaccines for their own populations, this approach left many people around the world without access to the lifesaving vaccine.[2] Furthermore, vaccine nationalism undermines global solidarity, as countries prioritize their own interests over the collective good of humanity and the human right principle of equality.[2]

Other drivers of inequality were the unwillingness of high-income countries to share their vaccine technology[2] and an intellectual property system which “grants monopolies to transnational pharmaceutical corporations and restricts the distribution of affordable generic products.”[3]

As experiments in global cooperation, vaccine hubs such as COVAX and the African Vaccine Acquisition Trust (AVAT) were set up in 2021 to promote global equity in vaccination through the mechanism of dose-sharing. Large numbers of doses were delivered through these mechanisms; for example, as of February 2022, 53.3% of the total doses in low-income countries had been obtained via COVAX.[4] Nonetheless, COVAX has been roundly criticized for failing to live up to its own targets of doses delivered, and, more broadly, its principles of equity.[5, 6] de Bengy Puyvalle and Storeng conclude that, “Although dose-sharing helped COVAX's vaccine delivery, its impact was undermined by donors' and industry's pursuit of national security, diplomatic and commercial interests, which COVAX largely accommodated.”[7]

Describing an increasing trend toward the financialization of global health, Stein and Fajber posit that this trend embedded a market—rather than human rights-oriented focus—into the design of the Access to COVID-19 Tools Accelerator (Act-A) in June 2020, of which COVAX is

[2] Hafner, M., Yerushalmi, E., Fays, C., Dufresne, E., & Stolk, C. V. (2022, August 31). *COVID-19 and the Cost of Vaccine Nationalism.* Retrieved June 1, 2023, from NCBI: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9519117/

[3] Silva, A. R., Silva, C. A., Borges da Fonseca, F., Villardi, P., & van der Ploeg, S. (2021). INTELLECTUAL PROPERTY AND GLOBAL INEQUALITY IN THE COVID-19 PANDEMIC. *Sur: International Journal on Human Rights, 18*(31), 107-117.

[4] Das, J. K., Chee, H. Y., Lakani, S., Khan, M. H., Isllam, M., Muhammad, S., & Bhutta, Z. A. (2023). COVID-19 Vaccines: How Efficient and Equitable Was the Initial Vaccination Process? *Vaccines, 11*(1), 11, 12.

[5] de Bengy Puyvallee, A., & Storeng, K. T. (2022). COVAX, vaccine donations and the politics of global vaccine inequity. *Globalization and Health, 18*(1), 1-14.

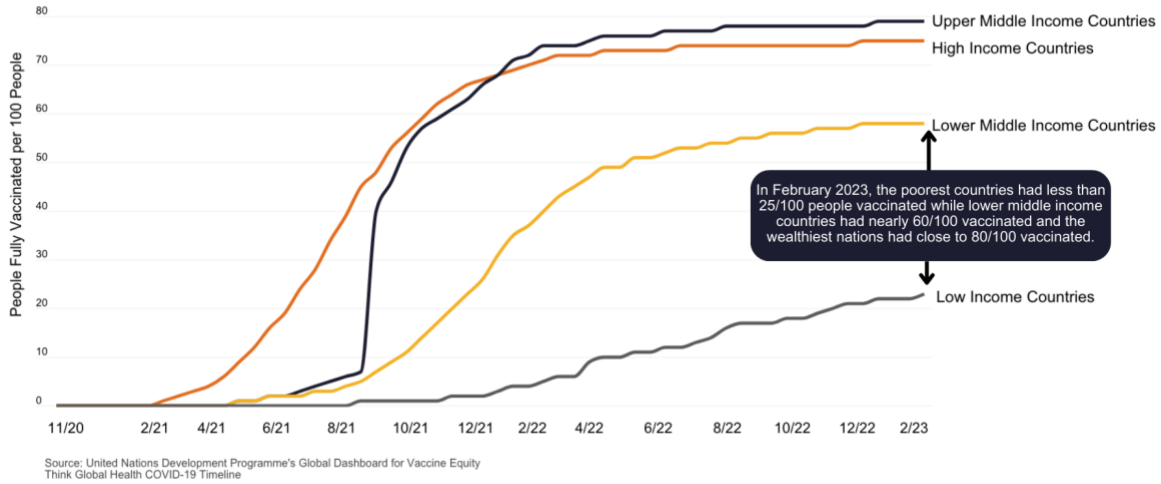
[6] Arbeiter, J., & Bucar, M. (2022). GLOBAL PARTNERSHIP IN RESPONSE TO COVID-19. *Annals for Istrian & Mediterranean Studies, 32*(3), 481-497.

[7] de Bengy Puyvallee, A., & Storeng, K. T. (2022). COVAX, vaccine donations and the politics of global vaccine inequity. *Globalization and Health, 18*(1), 1-14.

the vaccine pillar.[8,9] “As Act-A largely precludes engagement with the structural causes and catalysts of COVID-19 [[6]], it instead focuses the fight against the pandemic around three sets of technologies, namely diagnostics, treatments and vaccines.”[10] Citing other authors, Stein further notes that this prioritization of health technologies and market solutions undercuts a focus on health systems: “Together these technologies constituted 75% ($28,6bn) of Act-A's initial target budget of $38,1bn [[7]], greatly outweighing work on health systems, which originally also lacked an investment case [[9]].”[11]

Despite global efforts to address vaccine inequity, vaccination coverage in low-income countries has remained low, though the gap is shrinking. For example, 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.[12] At the same time, the steep disparity in the cost of vaccination in low-income countries versus higher income countries must be acknowledged. An estimate by the WHO, UNDP and UNICEF notes that high income countries would have to increase their spending on health care by 0.8% to cover the costs of vaccinating 70% of their populations, versus a whopping 56.6% for low-income countries.[10]

Low Income Countries Still Fall Furthest Behind in Vaccination Rates



Source: United Nations Development Programme's Global Dashboard for Vaccine Equity
Think Global Health COVID-19 Timeline

[8] Stein, F. (2022, December). Risky business: COVAX and the financialization of global vaccine equity. *Globalization and Health, 17*(1), 1-11.

[9] Fajber, K. (2022, December). Business as Usual? Centering Human Rights to Advance Global COVID-19 Vaccine Equity Through COVAX. *Health & Human Rights: An International Journal, 24*(2), 219-228.

[10] Stein, F. (2022, December). Risky business: COVAX and the financialization of global vaccine equity. *Globalization and Health, 17*(1), 1-11.

[11] Ibid.

[12] United Nations Development Programme. (n.d.). Vaccine Equity. UNDP Data. Retrieved from https://data.undp.org/vaccine-equity/

CARE's Fast and Fair Campaign

At the end of 2020, the global conversation around COVID-19 vaccines centered on production and donations of vaccines, with little talk of the conditions required to actually administer the shots or the vital role of the predominantly female frontline health workers. CARE noticed this gap and responded by publishing *Policy Report - Our Best Shot: Women Frontline Health Workers in other countries are keeping you safe from COVID-19* in March 2021. Within it they outlined the need for more comprehensive funding dedicated to vaccine delivery, in order to limit the social and economic fallout of the pandemic in all countries. Specifically, CARE argued that for every $1 invested in vaccine doses, another $5 is required for delivering the vaccine, with $2.50 dedicated solely to paying, training and protecting formal and informal health care workers, 70% of whom are women.

This, and subsequent publications and public positions on the true cost – and female faces behind – vaccine delivery, were part of a broad advocacy campaign and initiative by CARE USA named Fast and Fair. Fast and Fair had four pillars: Advocate, Facilitate, Protect and Mobilize. The **Advocate** pillar represents CARE's commitment to stand for accountability to communities and be a voice for structural improvements in the health systems at all levels. The **Facilitate** pillar represents CARE's support to government health systems and multilateral partners for preparing for and rolling out vaccine delivery within the existing immunization service infrastructure. The **Protect** pillar represents a particular focus on investing in the predominantly female frontline health workforce's capacity and leadership to improve access to vaccination and build a stronger, more resilient health system. The **Mobilize** pillar represents CARE's deep engagement with communities to provide safe, accurate information, facilitate dialogue to understand perceptions, address barriers to uptake, and partner with community leaders and influencers to lead these dialogues.

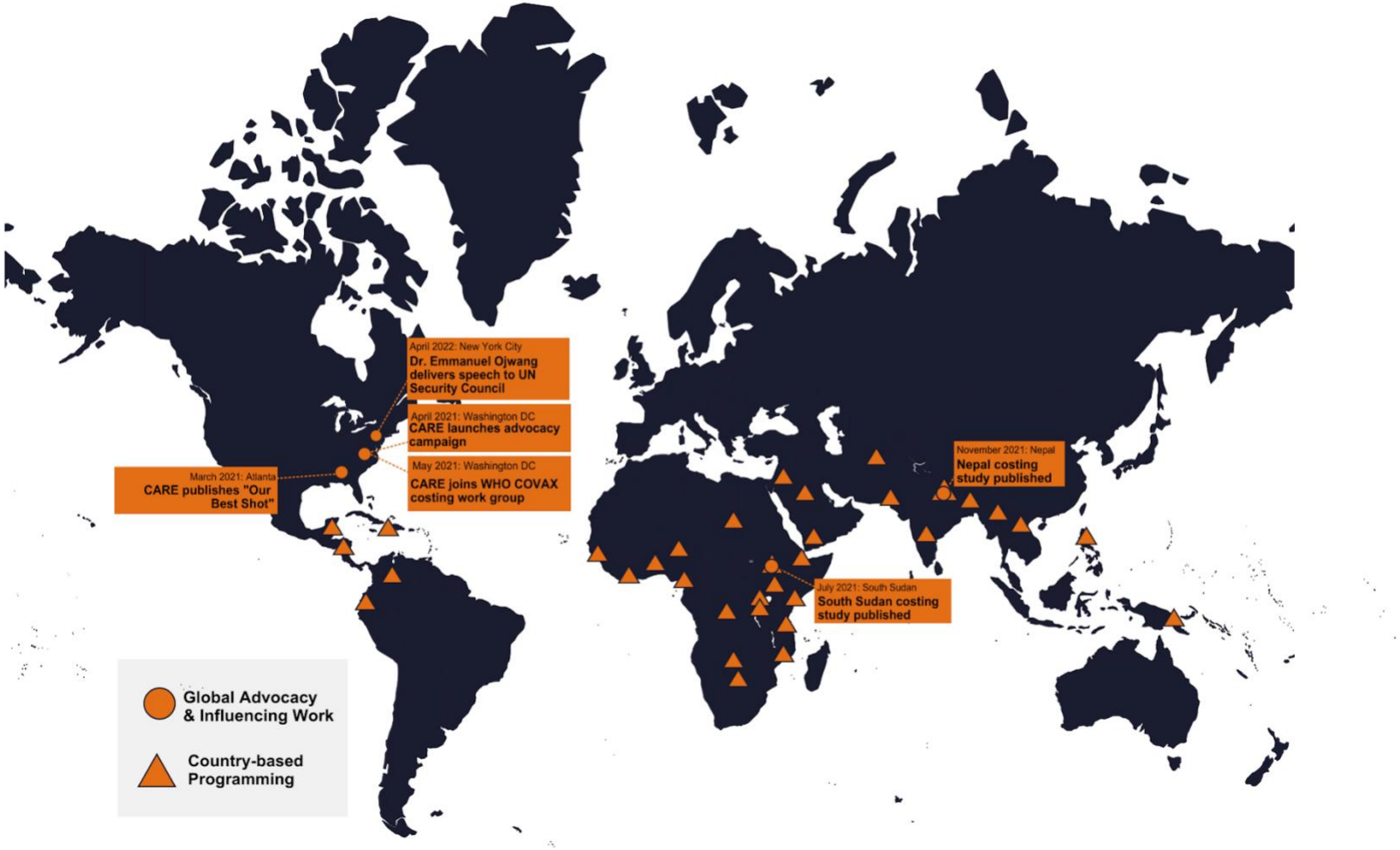
Using its own country-based calculations, including from the crisis-stricken nation of South Sudan, CARE urged multilateral and global health institutions to modify their costing methodology to include coverage for last mile delivery (with a particular focus on frontline health workers), and to increase their focus on women's leadership and on strengthening health systems.

In addition, within the U.S. and starting in the initial months of the pandemic, CARE along with coalition partners, mounted an ambitious advocacy effort to the U.S. government to request funding for global vaccination efforts. This work helped secure $11 bn in global COVID-19 funding from the U.S. Government, including direct support to combat the pandemic and humanitarian and developmental assistance to address its secondary impacts.

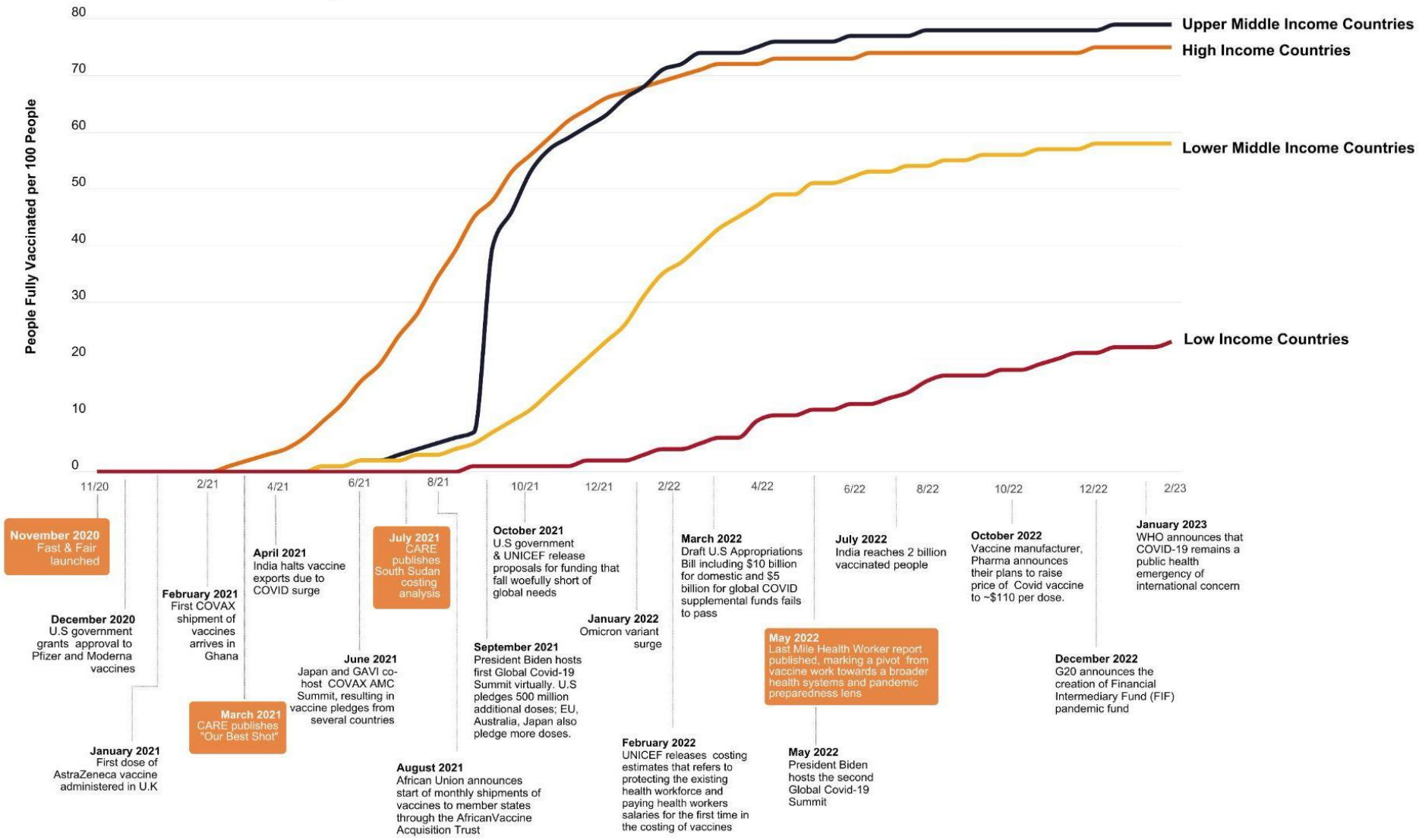
Other advocacy efforts included lobbying the U.S. Government to donate its fair share of COVID-19 vaccines to countries in the Global South; testifying to the United Nations Security Council on the challenges of vaccine delivery within difficult contexts; advocating for vaccine donations and funding for vaccine delivery at two COVID global summits (in collaboration with the broader CARE federation); and other national-level lobbying efforts in some of the more than 100 countries where CARE operates (as a federation).

Finally, following the success of the initial global COVID funding request for $11 bn, CARE and its partners launched an intense and targeted campaign effort with the U.S. government between December 2021 and late March 2022, aimed at securing $17 bn in supplemental funding—including funding for vaccine delivery. This effort was largely unsuccessful as the White House did not submit the request to Congress.

Fast and Fair: A Local-to-Global Initiative



Important Events in the Fast and Fair Timeline



Source: United Nations Development Programme's Global Dashboard for Vaccine Equity
Think Global Health COVID-19 Timeline

Methodology

The evaluation team conducted 8 bellwether interviews in May and June 2023 with representatives of U.S. and global development and/or advocacy institutions, as well as the U.S. government. The evaluation team also interviewed 4 CARE staff or former staff members. We applied a thematic analysis to this qualitative content, using the three guiding questions of the evaluation.

Other data collection methods were:

- **Repeat of *Our Best Shot* analysis** – We repeated the qualitative analysis of policy statements and official documents that was conducted in *Our Best Shot.* First, We identified documents that were published after the *Our Best Shot* report from various agencies within the humanitarian and global health space. We then coded the documents to see how frequently different themes occurred.
- **Costing methodology comparison** – We conducted a review of twelve major costing methodologies published by nine organizations. Next, we deployed a comparative analysis on key elements of these methodologies and identified the timeline of publication and visualized it accordingly, depicting the elements under review.
- **Timeline creation** – First, we manually reconstructed a graph of COVID vaccination rates by country income category. We then annotated this timeline with key events relevant to Fast and Fair and the global vaccine effort, in order to properly assess the importance of the events within the context of vaccinations over time.
- **Key term web search** – We used the search engines Google and Twitter to identify all usages (minus deletions of repetitive entries made by Google) of the term “tarmac to arm(s)”, used by CARE and others to draw attention to the challenges of COVID vaccine delivery.
- **Literature review** – We reviewed academic and non-academic publications on COVID vaccine inequality.
- **Background document review** – We reviewed several background documents provided by CARE, including a case study of Fast and Fair’s U.S. government-focused advocacy regarding the so-called COVID supplemental bill.
- **Outcomes tracking and rating** – Starting with capturing outcomes listed in background documents or via interviews, we ranked these outcomes according to the depth of the outcome and the strength of evidence provided.

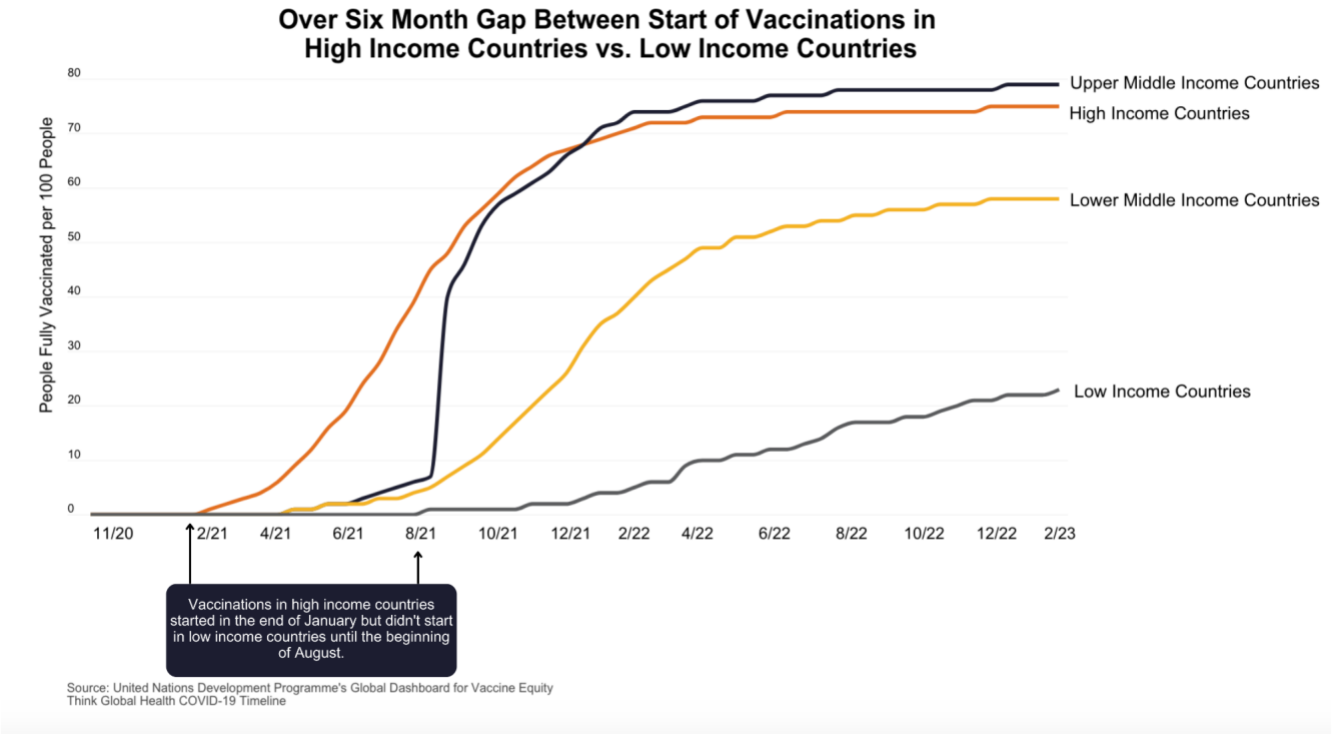
Along with creating a retroactive theory of action for the advocacy and influence aspects of the initiative, the contribution ranking method was used to assess the strength of the evidence against each aspect of change.

Findings

Overall

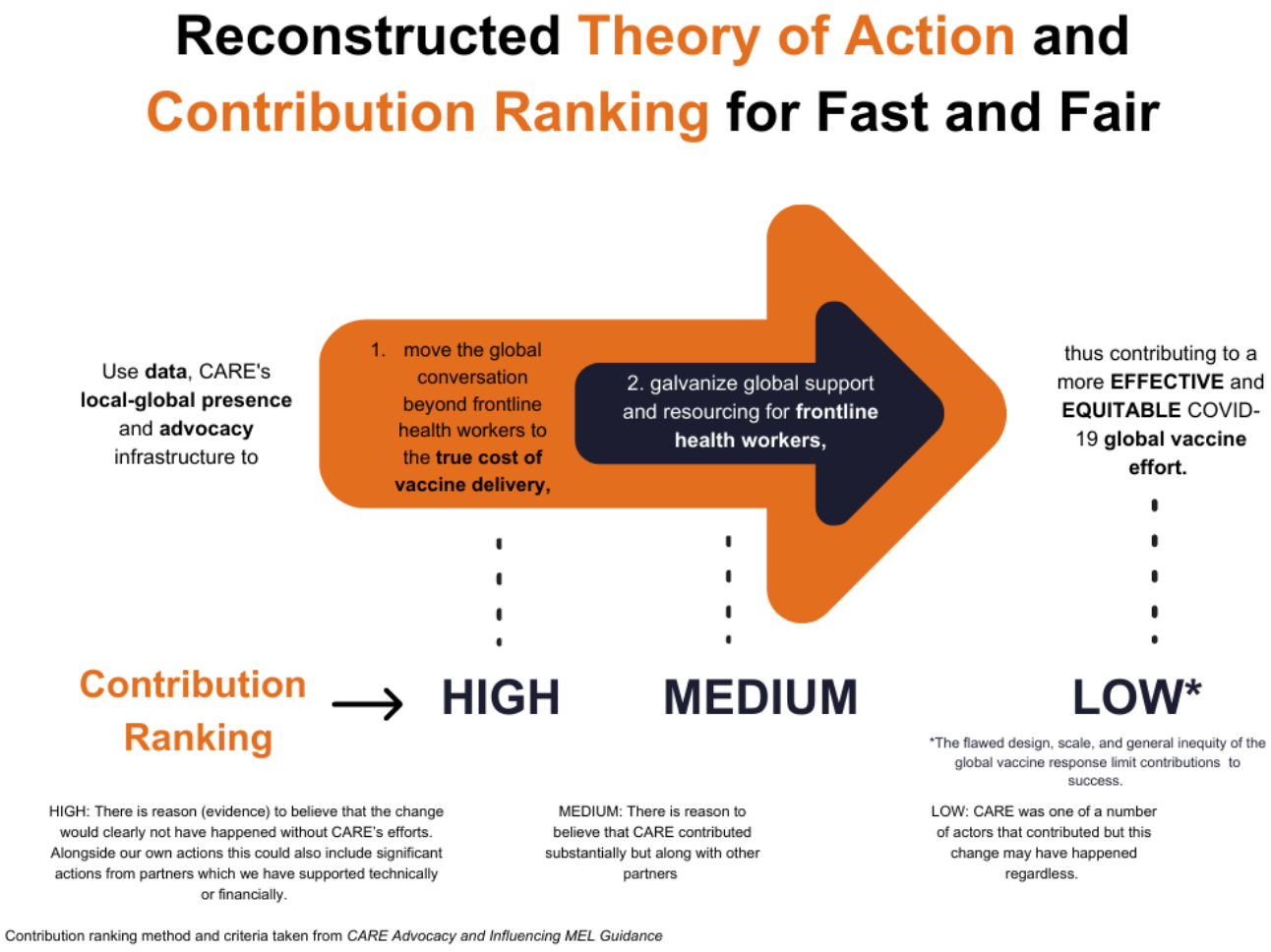
In the context of a global response to COVID that was generally considered inequitable, what did CARE achieve? When reviewing all our data sources together, we are able to reconcile some contradictions and “blind men and the elephant” limitations in favor of a more holistic view. We find that some of the reactions from interviewees – ranging from disappointment to

admiration and praise for CARE's work – can be better understood when placed in the context of time and expectations. Fast and Fair, which was swiftly deployed in response to the pandemic, built momentum and yielded results over time, extending even into 2022 when the pandemic was no longer in the headlines, and even today. This also comports with the acceleration of vaccination in low-income countries.



Expectations of what was realistic for CARE to achieve varied significantly and revealed the diverse perspectives of the initial shapers of Fast and Fair at CARE. They came from such disparate CARE teams as Health Equity and Rights, Thought Leadership, and Advocacy. We used these expectations and hopes of the early shapers, retroactively expressed, to construct a working theory of action more specific to the advocacy and influencing aspects of Fast and Fair.

Using the contribution ranking method, we conclude that CARE was largely successful in leveraging its experience, data, advocacy prowess, and local-to-global presence in achieving systemic impact, particularly in catalyzing material support for the true cost of vaccine delivery (HIGH contribution). To a lesser extent CARE also catalyzed global support for frontline health workers (MEDIUM contribution). CARE's efforts no doubt resulted in large numbers of vaccinations as well as frontline workers that were protected and paid – events that would otherwise not have happened. Nonetheless, perhaps few non-state actors were in a position to bend the inequitable trajectory of the response. Thus, CARE's contribution to the overall result is additive rather than transformative (LOW contribution).



Evaluation Questions

With these broader observations and conclusions in mind, we assessed CARE's contributions vis-à-vis the questions guiding this evaluation and found the following:

#1 - Did CARE make high-leverage changes within the global-local system that are relevant to Fast and Fair? What are those outcomes?

This evaluation concludes that CARE did indeed make high-leverage changes:

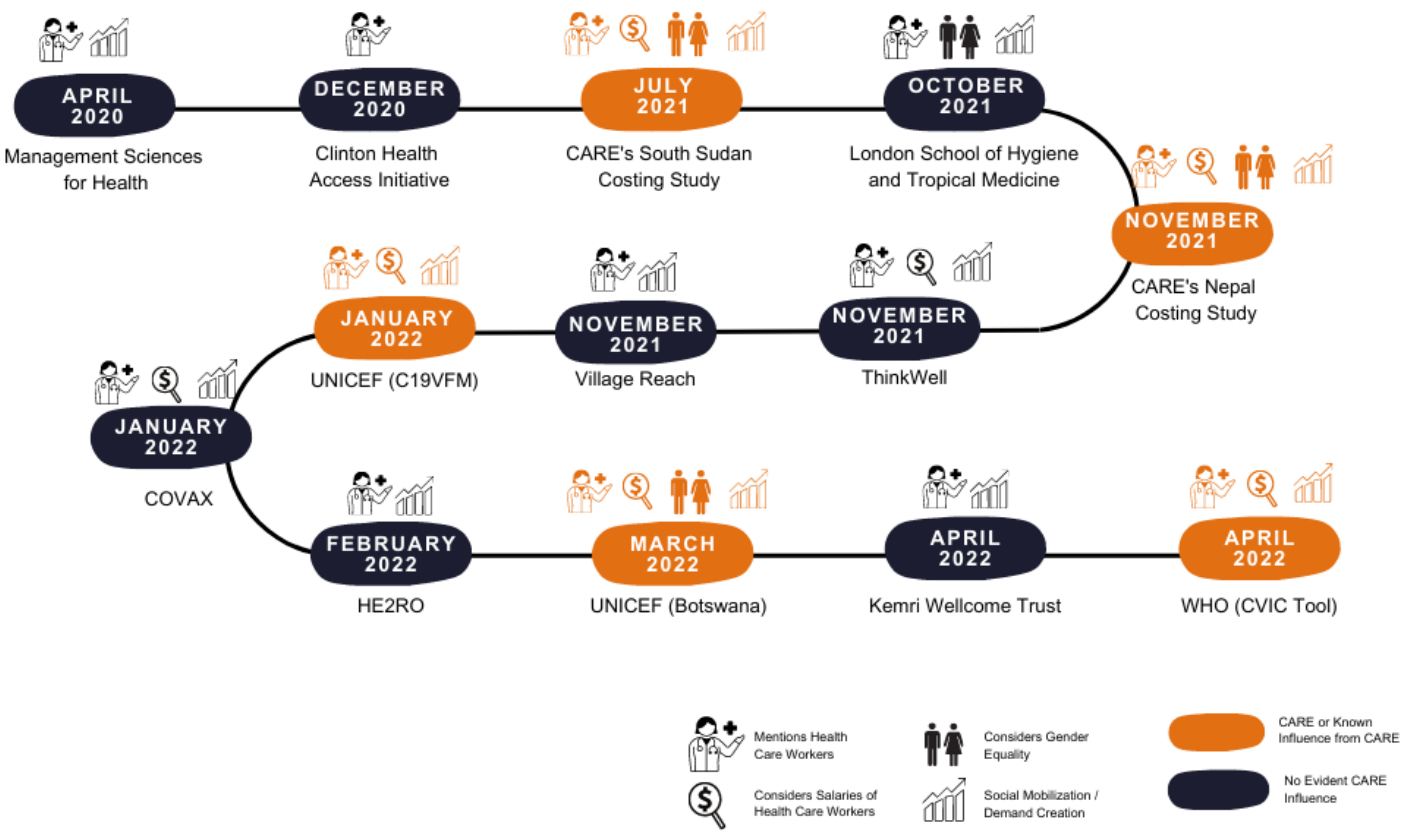
Setting New Standards on the Cost of Vaccine Delivery

CARE appears to be a, or even *the*, global leader in drawing attention, and ultimately resources, to the need for more robust costing of vaccination, inclusive of delivery in difficult environments.

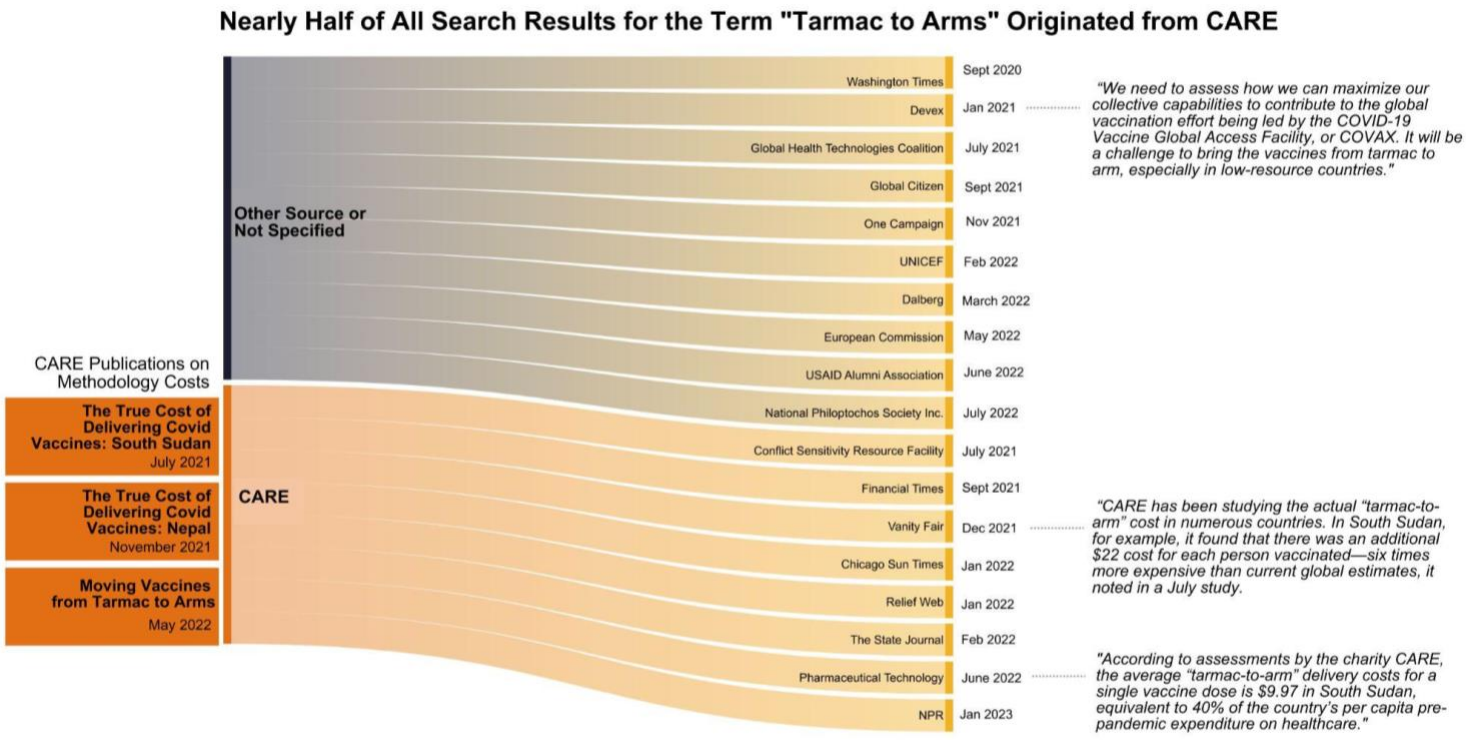
- *Institutional* —Starting in 2020, CARE brought concrete data and evidence to global actors and decision-makers that influenced their costing methodology, public statements and strategies regarding vaccination. For example, CARE influenced the costing methodologies of UNICEF, the World Health Organization (WHO), and the World Bank as well as the vaccination positions of The Bill and Melinda Gates Foundation. One of the more specific contributions of CARE within its approach to costing was its focus on paying and protecting formal and volunteer frontline health workers, most of whom are women. The phrase "tarmac to arm(s)" promoted by CARE to convey the importance of the full chain of delivery, exemplifies this targeted and data-supported message. The costing methodology work is likely to have influenced global commitments regarding vaccinations and delivery (next section).

> COVID-19 delivery costs represent the additional costs to the health sector of delivering COVID-19 vaccines exclusive of vaccine costs. The cost of delivering healthcare services during the COVID-19 pandemic has been significant. We reviewed several on-going projects and models used by different international and national organizations to guide the costing of COVID-19 delivery. These methodologies employ various economic models based on case studies done in developing countries on initial rollout strategies. The major cost drivers arise from the need to implement new safety measures and address shortages in staffing, provide personal protective equipment (PPE) to healthcare workers, pay staff, and make investments in new equipment and technology.
>
> CARE's emphasis is on the need for investments in recruitment, training and protection of healthcare workers at the point of service 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. And we managed to get that up significantly higher, get the cap removed." – Interviewee



- *Public/global community*—Beyond specific institutions, CARE helped educate key officials in the US as well as media figures on the importance of vaccine delivery, thus broadening the conversation beyond vaccination donations. There is evidence that this understanding will endure beyond the COVID era. For example, in early 2023, the global development-focused blog, Goats and Soda, featured the term “tarmac-to-arms” as a global development buzzword and interviewed CARE to elucidate this.



Influencing Global Commitments on Vaccine Donations and Delivery

Through both its domestic and international advocacy, CARE was able to influence commitments from the U.S. and other governments regarding vaccine donations and delivery. Public statements from U.S. President Biden and European Commission President Ursula von der Leyen specifically reference the term “tarmac to arms,” highly promoted by CARE, as a call to not neglect vaccine delivery.

Commitments from various high-income country governments, while far insufficient of the global need, improved over time. Notably, the second virtual Global COVID-19 summit, convened by President Joe Biden in May 2022, and attended by 100 world leaders, was a bright spot in what had been an underwhelming and inequitable global response. In contrast to the first summit, according to CARE, leaders created “a new set of bold global goals,” which reflected the advocacy messages of CARE and partners, including emphasis on last-mile delivery (completely missing from the first summit). Other highlights include:

- The goal of achieving 70% global vaccine coverage by September 2022, as set by the World Health Organization (WHO), received widespread support.
- The US Government and several other governments emphasized the crucial importance of “tarmac to arms” investments in delivery systems to ensure vaccines are efficiently distributed and administered.

- There was a general agreement among many stakeholders on the necessity of investing in pandemic prevention and strengthening health systems as a global public good.
- However, the proposed target of $10 bn to support vaccine delivery fell significantly short of the actual global cost estimated by CARE, which amounted to approximately $190 bn.

New commitments also included funds specific to vaccine delivery, health systems strengthening and other CARE-advocated focus areas, including:

- $370 M to support vaccine delivery
- $380 M to GAVI to facilitate vaccine distribution
- $1.4 bn to oxygen, expanded testing and health care systems strengthening
- $1 bn contribution to a global health security fund

"The goals of this [second] Summit represent a huge leap forward in the leadership, ambition, and coordination necessary to put an end to this pandemic." —Sofía Sprechmann Sineiro, CARE International Secretary General in an email to CARE National Directors

#2 – Did CARE have influence in multiple domains of systems change? What are those outcomes?

Our findings are that CARE did have impact in more than one domain of systems change, though not across the multiple dimensions necessary to claim broad systems impact. CARE defines systems impact as "improving people's lives by improving systems so that they work better for people." We assessed CARE's systems influence according to its global theory of change which specifies three domains of change for systems change: agency, structure (further broken down by CARE into norms, practices and policies), and relations. The importance of looking at systems changes across multiple domains is that it gives some indication of the reach, level of transformation and durability of changes across systems. For example, according to models such as FSG's Water of Systems Change (Kania et al., 2018), shifts in norms, or expectations regarding accepted behavior, while intangible, are more transformative than more tangible systems changes such as practices and resource flows.

We chose not to focus on "agency," which is less relevant in the global systems-focused context of this evaluation. Therefore, regarding *structure* and *relations,* we found the following:

STRUCTURE – Norms, Policies and Practices

Influencing Norms Regarding the Vaccine Effort

While shifting **NORMS** at a global scale is a task of formidable proportions, some evidence exists that CARE helped shift the following norms:

- **The need for vaccinating populations in the Global South.** While it is hard to gauge to what degree this norm was shifted, given the highly inequitable vaccination effort, expectations for equitable vaccination did change over time:

"I think broad global pressure including from NGOs and advocates for rich countries to do more helped to create an environment where major commitments for vaccines supply would be welcome. On the delivery side, constant messages from WHO, UNICEF, the global community in general, that there was a commitment to seeing vaccination happen…and country leadership...engaging with countries one by one created incentive and pressure for vaccination to happen. There was a norm for vaccination to happen. Creating that norm made a big difference." – Interviewee

- **What constitutes an effective vaccination effort**. This strand of public education – undertaken both at the technocratic level with global institutions and with more lay audiences – can be said to be part of a much greater discourse on the appropriateness, relevance and potential harms of aid (e.g., the effects of donated food on local food markets). In the era of COVID, CARE therefore made an important contribution to what constitutes well informed and executed humanitarianism.

"I didn't think that in a year we'd get fair pay for every health worker in the world. But we shifted the rules of what is normal and what we have to look at." – CARE staffer

"The space between $17bn and getting to the impact is a long road to begin with. But forcing people to focus on the problem differently is worthwhile." – CARE staffer

An area where CARE and partners were less successful was in shifting norms to take onboard the rights-based concept of equity as being central to an equitable vaccine effort. Indeed, our findings, particularly from the interviews, reveal widespread disappointment with the naked self-interest that characterized the global vaccine response. At the same time interviewees generally did not believe that heavy human-rights centric messaging would have worked in a context of such stark inequality.

More Mentions of Delivery Plans, Fewer Mentions of Frontline Health Workers After *Our Best Shot* Publication

	Our Best Shot March 2021	Follow Up Analysis May 2023	% Change
Sample Size	58	30	
Discussed Cost of Delivery & Rollout Plans	17%	43%	↑ +26%
Mentioned Frontline Health Workers at All	72%	22%	↓ -50%
Focused on Workers' Rights and Wellbeing	21%	14%	↓ -7%
Presented Sex Disaggregated Data	0%	0%	– 0%
Considered Gender Equity	2%	4%	↑ +2%

Securing Resources for the Global COVID Response

In terms of shifting **POLICIES,** including for the allocation of resources, the evidence is mixed, revealing on the one hand success in influencing early appropriations of funding for the global vaccine effort with the U.S. government while not securing supplemental funding. Documentation from CARE on the results of its advocacy efforts detailed the effort and its outcomes noting that, "In the 12 months that followed the March 2020 COVID-19 pandemic declaration, CARE worked closely with partners to secure approximately USD 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 impact of the pandemic."[13] This large amount of funding was broken down into:

- $5.3B for USAID and $3.7B for State Dept. global health programs including $4B for GAVI to acquire and support delivery of vaccines;
- $3.6B for international disaster assistance;

[13] Advocacy and Influencing Impact Reporting (AIIR) Tool, CARE, September 2, 2021

- and $1.1B for Economic Support Fund to respond to secondary impacts such as GBV and food insecurity;
- $800M for Dept. of Ag to provide emergency food aid.

As mentioned, efforts to influence a U.S. COVID supplemental bill in early 2022 were largely unsuccessful though they clearly showcased CARE's leadership in shaping the ask. CARE's documentation[14] notes that based on CARE's research and advocacy, the D.C-based advocacy coalition, along with more than 80 members of Congress, called on the White House to include the $17 bn ask as part of their supplemental funding in the fiscal year 2022 budget. (This request was repeated nearly verbatim by the USAID COVID Response Implementation Framework). Lamentably, the White House did not submit the request to Congress, though the White House did submit a further supplemental request for the FY23 budget in November 2022, out of which $38 billion was for the Ukraine crisis and $10 billion was for health funding, of which an estimated need was for $1 billion for Global Health Programs for COVID. This suggests that while the original ask for $17 bn never made it to Congress, CARE and partners' advocacy efforts may not entirely have been in vain.

Several interviewees pointed out that CARE and partners could and should have considered different tactics, including putting more political pressure on the Biden White House and greatly simplifying the messaging directed at politicians; several also concede that domestic issues, including attention shifting away from COVID and diminishing perceptions of risk on the part of the U.S. populace and lawmakers, would have stymied any efforts.

"In the fall of 2021 there was a failure to make the case as to why we needed to re-up investment in the global response. Here the Biden administration fell down and the [advocacy] community fell down… I've seen a number of instances where the DC-based advocacy and implementation community is very slow to deploy the kind of sharp advocacy that could clarify a moral question and put decision makers on the spot." – Interviewee

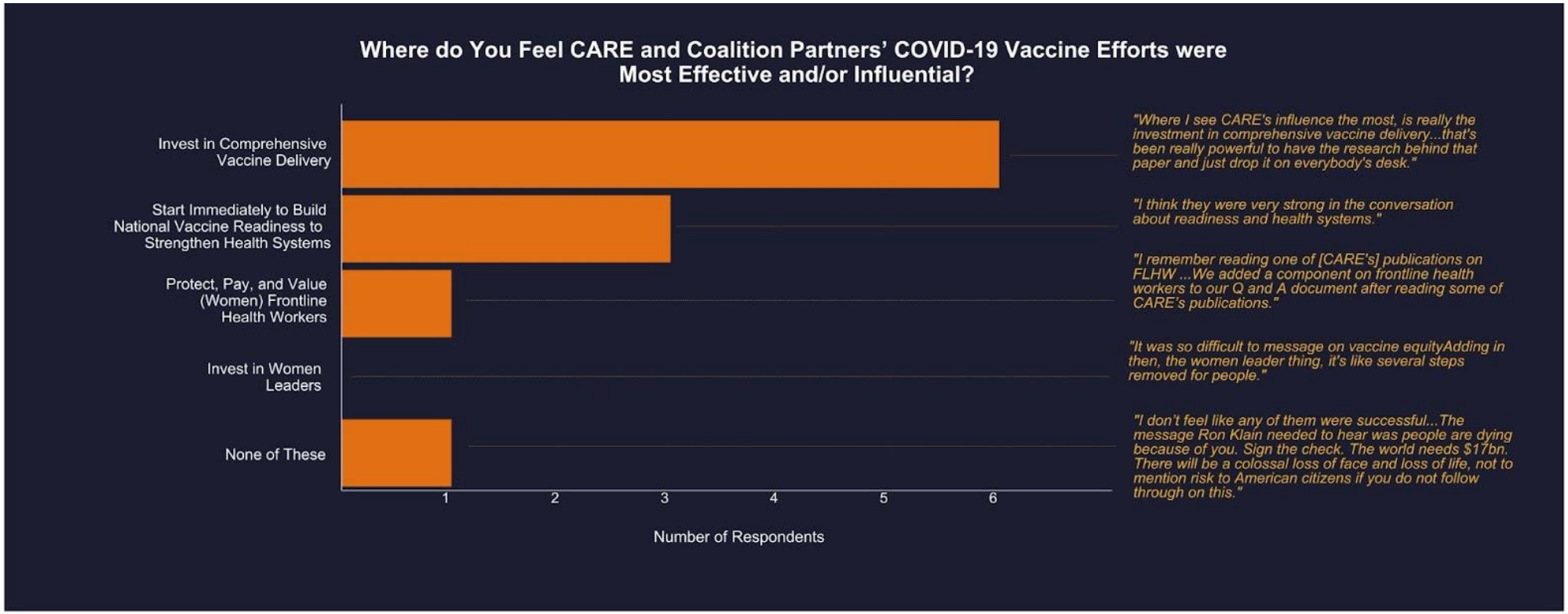
"And it probably was a time that we should have been more outside of the box and just kind of thrown caution to the wind and, you know, taken some more, I don't know, activist approaches. But we were all in the situation of wanting to protect our relationships with policy makers and not blow the house up." – Interviewee

"There was too much emphasis on the MRNA vaccines which were not built for equity, they were built for high income environments and very difficult to set up in low income countries…. But the advocates were so focused on sharing MRNA vaccines as opposed to others whereas from the health perspective any vaccines [would have been good]." – Interviewee

Changing Practices on the Cost of Vaccine Delivery

CARE can also be said to have shifted **PRACTICES** in the area of costing methodologies and emphasis on last-mile delivery, as evidenced in a prior section.

[14] Advocacy and Influencing Impact Reporting (AIIR) Tool, CARE, November 2, 2022


Where do You Feel CARE and Coalition Partners' COVID-19 Vaccine Efforts were Most Effective and/or Influential?
Invest in Comprehensive Vaccine Delivery
Start Immediately to Build National Vaccine Readiness to Strengthen Health Systems
Protect, Pay, and Value (Women) Frontline Health Workers
Invest in Women Leaders
None of These
1
2
3
4
5
6
Number of Respondents
"Where I see CARE's influence the most, is really the investment in comprehensive vaccine delivery...that's been really powerful to have the research behind that paper and just drop it on everybody's desk."
"I think they were very strong in the conversation about readiness and health systems."
"I remember reading one of [CARE's] publications on FLHW ...We added a component on frontline health workers to our Q and A document after reading some of CARE's publications."
"It was so difficult to message on vaccine equityAdding in then, the women leader thing, it's like several steps removed for people."
"I don't feel like any of them were successful...The message Ron Klain needed to hear was people are dying because of you. Sign the check. The world needs $17bn. There will be a colossal loss of face and loss of life, not to mention risk to American citizens if you do not follow through on this."

RELATIONS

Galvanizing D.C-based Coalitions

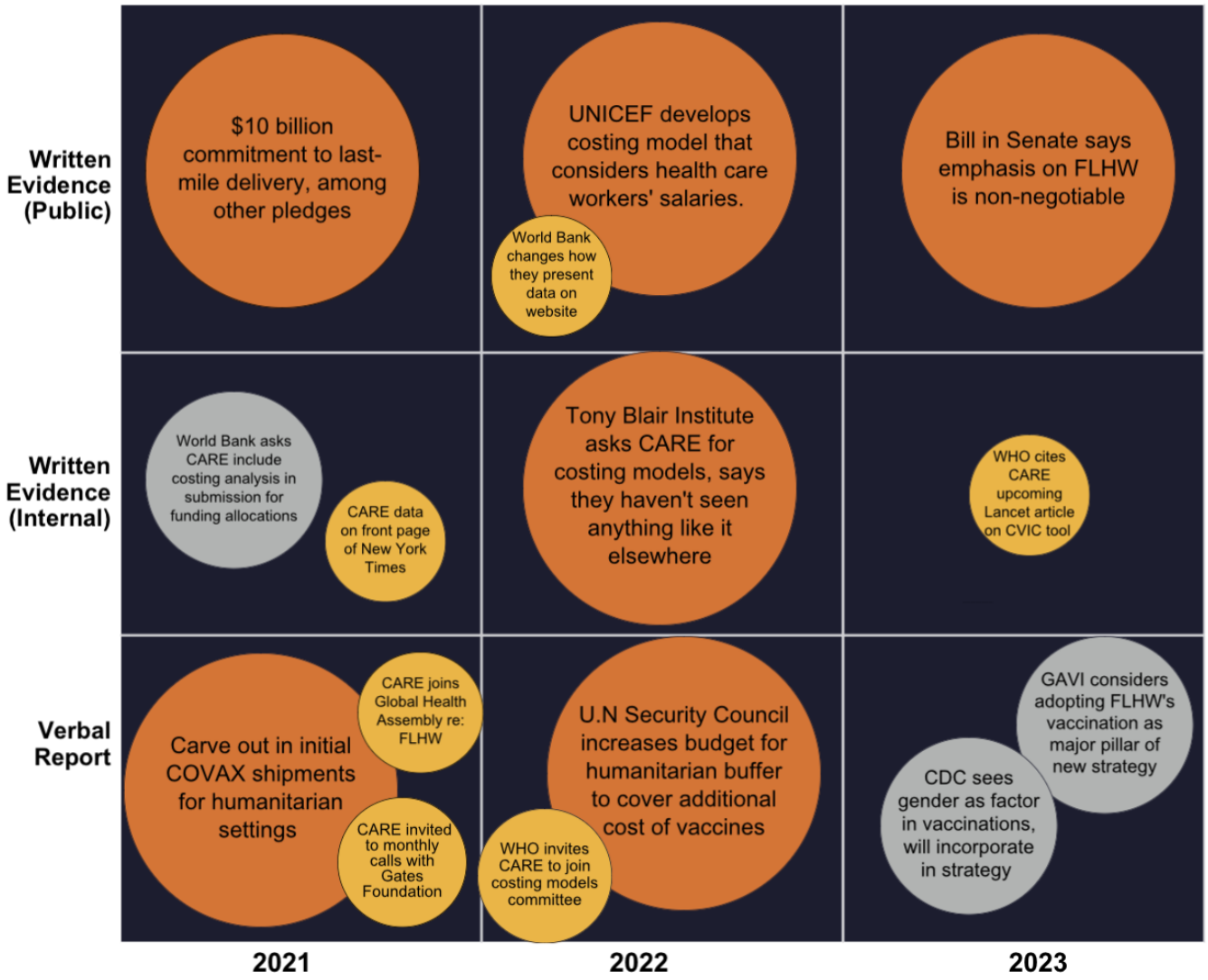
Notes from the case study of Fast and Fair's U.S.-based advocacy on the supplemental bill indicate that CARE and partners brought about some changes in relationships, including: galvanizing and utilizing networks of organizations that don't always work together; and bringing multiple (10) coalitions together (e.g., food security, pandemics, child health).

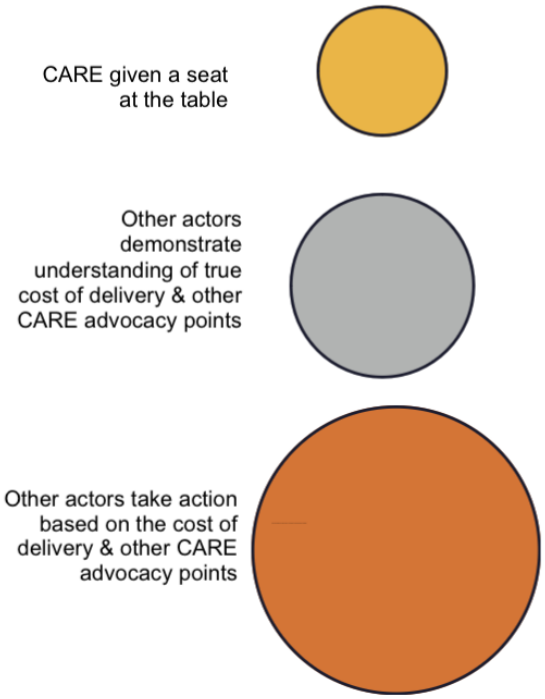
> *"When the next thing happens, we know we can organize outside of existing structures."*
>
> *–Interviewee from prior Fast and Fair advocacy assessment*

OTHER

Finally, other areas where CARE contributed to outcomes are captured in this table.

Outcomes of Fast and Fair





#3 -- What is the fidelity between intended theories of change and action, and actual outcomes/impacts?

In the early months of the pandemic, CARE staff wanted to supply data and evidence to bring more visibility to the health workers that make vaccinations possible. They also wanted to move the conversation beyond health workers alone to a broader appreciation of the health systems, women's leadership, health workers and more, that get vaccines into arms. Therefore, the CARE teams that collectively undertook the design of Fast and Fair undertook to supply this perspective, grounded in evidence, into global advocacy and influencing efforts.

"We were clear in this very crowded space that our goals were about shaping the dialogue, getting real-world, real-time data into the discussion, getting economic data into the evidence and RoI pieces to make the evidence case." – Former CARE staffer

With this theory of action in mind – that data and evidence along with CARE's influencing and advocacy work – would sway decision-making, we conclude that there is high fidelity between initial expectations and outcomes and actual outcomes. Why does this matter? It suggests that CARE's assumptions regarding the effectiveness of its advocacy and influence mechanisms are largely correct and can be relied upon for repeated impact.

"I feel like once we landed on a theory of change, we were pretty systematic about sticking to it. Part of our niche and role was investing in frontline health workers. They are not being resourced. How can we get that data in front of people who make decisions? That was what our outcome goals were and they pretty much stayed the same". – Former CARE staffer

Conclusions and Recommendations

While the global response to COVID was considered largely inequitable, it nonetheless proved an important experiment in global cooperation and humanitarianism. Seen as a litmus test of the extent to which nations would balance national needs with the goals of global equity, it has a largely poor track record. Vaccination rates were highly inequitable and followed a trajectory based on countries' income levels. At the same time, the COVID era birthed new commitments and mechanisms for global health equity, e.g., Act-A, that resulted in real shots in arms. Seen through the lens of incremental progress towards human rights ideals, the global vaccination effort has some accomplishments.

What is clear from the timeline of events was that the wheels of global solidarity turn slowly in contrast to the speed that is required to respond equitably to a global pandemic. At least six

months transpired between the rapid uptick in vaccination in high income countries and the start of the much more gradual increase in vaccination in low-income countries. What is also starkly evident from the chart of vaccination rates is that while high income, upper middle income, and lower middle income countries followed a largely exponential trajectory of vaccination, lower income countries had a gradual increase in vaccination. It is therefore a tale of (at least) two vaccination journeys.

In addition, given the huge disparity between the cost of vaccinating low-income populations vs. high-income populations – an added health care expenditure of 0.8% versus 56.6%[10]– it raises the question of what more realistic or more effective strategies might have been considered, including, as one interviewee put it, focusing on non-MRNA vaccines[15] which did not have cumbersome cold chain requirements.

What are the implications for CARE's contributions? The stark contrast between the fate of low-income countries and "the rest" brings credence to CARE's deliberate emphasis and advocacy on behalf of low-income countries and difficult environments with weak health systems. The fact that some of CARE's costing work was informed by the South Sudan context, one of the most challenging environments to work in, solidifies CARE's role from early days in the pandemic as a voice not only for those in such beleaguered and often forgotten communities, but the health workers who labor to reach such communities, often at great risk and with little compensation.

"In late 2021, vaccine availability ceased to be an issue, high income countries were trying to find homes for their surplus vaccines and having trouble placing them because the uptake wasn't there. That was a flaw…there hadn't been nearly enough investment in readiness to deliver." – Interviewee

What would the path to greater impact have looked like for CARE? Speculation for such a large-initiative in the context of such an unprecedented and sweeping global emergency, is a risky exercise. The refrain of "hindsight is 20-20" came up repeatedly in interviewees. We limit our recommendations to the need for CARE to regularly and unflinchingly question some of the fundamental assumptions upon which its interventions rest. For example, the assumption that nations–whether rich or poor–would not be primarily driven by self-interest was called into question by interviewees.

"We had a system that was premised on rich countries sharing and doing so in real time and that was politically unrealistic and was also reflective of the architecture we had at the time where none of the production facilities were outside of India and South Africa…The path to equity will be through diversified vaccine production that has diversified financing." – Interviewee

[15] In contrast to traditional vaccines that contain a weakened or dead bacteria or virus, messenger, or mRNA vaccines prompt the body's cells to make a protein, or part of a protein, that triggers an immune response.

"In 2021 we could have taken a realistic look and said let's get real – there won't be huge floods of money; we have to look at this a different way." – Former CARE staffer

A path to greater impact could also involve addressing more fundamental factors that crippled the global vaccine response, including the financing of global health–an area in which systems-focused international NGOs like CARE could have substantial sway in influencing relevant norms and discourse. For example, Stein notes that, "...the financialization of global health is not just driven by institutions, but also by changes in health discourse."[16] Stein further notes that, "discourse is more important for the world of finance than for other modes of capital accumulation (such as manufacturing or trade) because finance itself is largely conceptual and linguistic in nature [[32]]."[17]

Ultimately, we can say with confidence that CARE's advocacy and influencing work, informed by its on-the-ground experience, shaped commitments and contributions towards the global vaccination effort. This almost certainly resulted in large numbers of vaccinations and more compensation of frontline health workers that would otherwise not have happened. Additionally, CARE helped shape the pandemic-era and the ongoing discourse around it, as well as the norms of what global responsibilities of richer nations to poorer nations are, and what it means to provide effective assistance and uphold human rights.

[16] Stein, F. (2022, December). Risky business: COVAX and the financialization of global vaccine equity. *Globalization and Health, 17*(1), 1-11.

[17] Ibid.

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