

OBJECTIVE 5

Improve and Strengthen Humanitarian Architecture to Support Scale-up of Infectious Disease Response Capacity

Sub-Objective 5.1: Support humanitarian system and sector capacities to coordinate and respond to pandemics (Sub-Objective 5.2 not included in evaluation scope as the funding includes this evaluation)

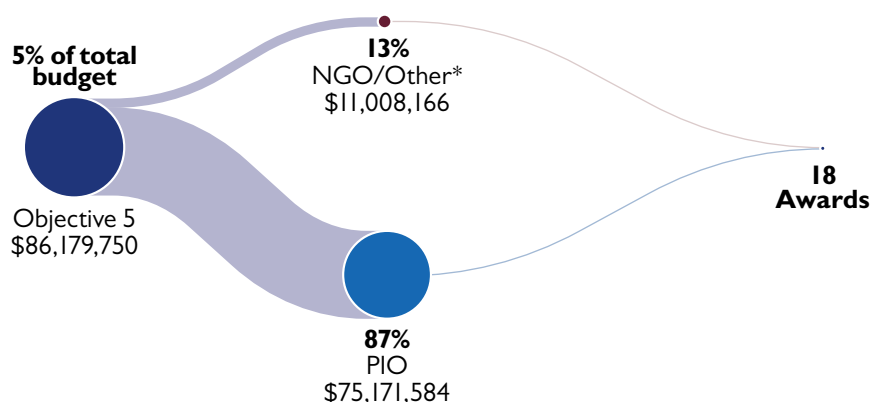
Sectors: Global awards for Health, Protection, Humanitarian Policy, Studies, Analysis, or Applications (HPSAA), Humanitarian Coordination, Information Management, and Assessments (HCIMA), and Nutrition

KEY FINDINGS

- Objective 5 funded documentation of lessons and case studies from the pandemic and award activities (6 awards produced 9 lessons learned reports and 44 case studies)
- Substantial global-level funding allowed some IPs to assume credible leadership roles as hubs of coordination and technical leaders in their respective sectors
- Building capacity in a short time-period proved difficult for global awards: 82 percent of awards received extensions
- Many IPs remain reliant on BHA funding to continue program operations that were started or expanded from the Supplemental

Note: Thematic 1 study builds on the findings of this objective.

OVERVIEW OF AWARDS



World Health Organization (WHO) was the top recipient for Objective 5

11 Global Awards were primarily investigated for this objective

*Other includes Obj 5.2 university and research awards (including this evaluation)

KEY CAPACITIES



Vaccine Capacity
2 Awards



RCCE/CEA/AAP
2 Awards



Situation/Service Monitoring
2 Awards



Surge Capacity
6 Awards



Medical Supply Chain
3 Awards



Training/Skill Building
9 Awards

PROMISING PRACTICES

- Global awards built surge and rapid response capacities for key sub-sector areas related to the impacts of the pandemic, including: Community Engagement and Accountability (CEA)/Accountability to Affected Populations (AAP), Gender Based Violence (GBV), Sexual and Reproductive Health (SRH), Mental Health and Psychosocial Support (MHPSS), and Nutrition
- Online and virtual modalities provided a platform for training and building capacities worldwide
- Translation of work products into multiple languages, with considerations for reading levels and accessibility, expanded access to key knowledge

PROGRAMMING CONSIDERATIONS

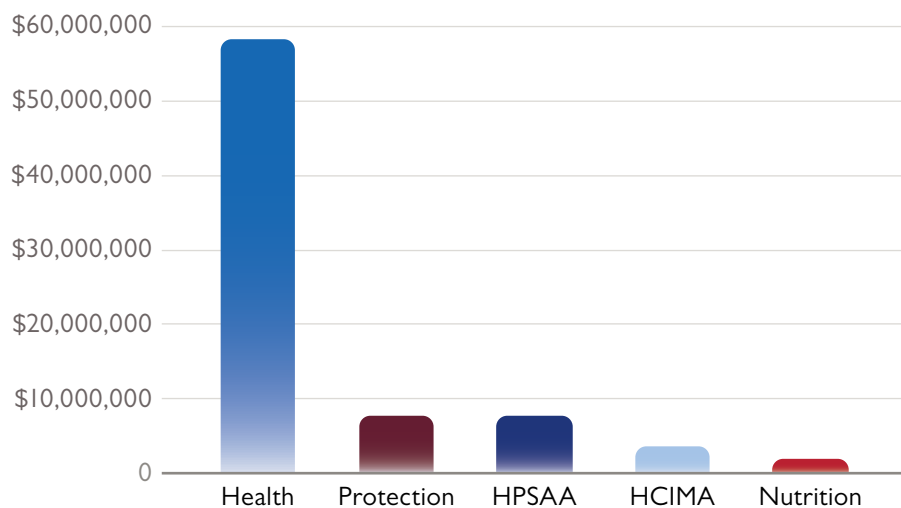
- BHA, in coordination with Bureau for Global Health, Centers for Disease Control and Prevention (CDC) and other major donors, should be prepared to inject additional funding towards this objective by developing a clear map of the capacity gaps in the international architecture and creating a strategic plan with outcome measures.
- BHA should work closely with Bureau for Global Health and CDC to ensure that investments by these organizations are synergistic and appropriate to the mission and structure of these organizations.
- BHA should work with IPs to develop clear outcome measures for multisectoral pandemic preparedness and response capacities and include them in concept note requirements.

Background

In 2014, the Global Health Security Agenda (GHSA) was developed to support progress and metrics for the 2005 International Health Regulation (IHR) (CDC, 2022). Despite this agenda and others designed for pandemic preparedness, the world was not ready for the COVID-19 pandemic (Frutos et al., 2021). It is widely agreed that additional widespread health emergencies will continue to occur in coming years (Meadows et al., 2023). The pandemic has spurred momentum for enhanced policies and investments in pandemic preparedness and response. Allocated in the second year of the pandemic, Objective 5 funding allowed global partners to build capacity in areas identified as weak during the initial onset of the pandemic, combat some of the lasting effects, among other achievements.

Objective 5 funding was primarily distributed across 11 global awards.¹ PIOs received 92 percent of the objective funding. The global awards span five sectors (Figure 8).² Three awards were multi-sectoral. The Health sector was the main focus of Objective 5, centered around building global and regional capacity for health emergencies and improving RCCE/CEA in humanitarian settings. Protection funding for global awards covered multiple aspects of the sector, including MHPSS, GBV, SRH, and Child Protection/Education. Humanitarian Policy, Studies, Analysis, or Applications (HPSAA) awards varied widely, from boosting training for outbreak response, to improving global coordination capacity and humanitarian situation monitoring. The singular Nutrition award focused on building technical capacity, research, and support for nutrition in emergencies. A review of award reports revealed that while all awards supported individual countries in some manner, four awards targeted country-level programming at a high level through implementing activities and training. The main primary data sources used for Objective 5 include over 20 KIs with global award IPs and BHA managers (over 30 respondents).

Figure 8. Obj 5 Funding by Sector



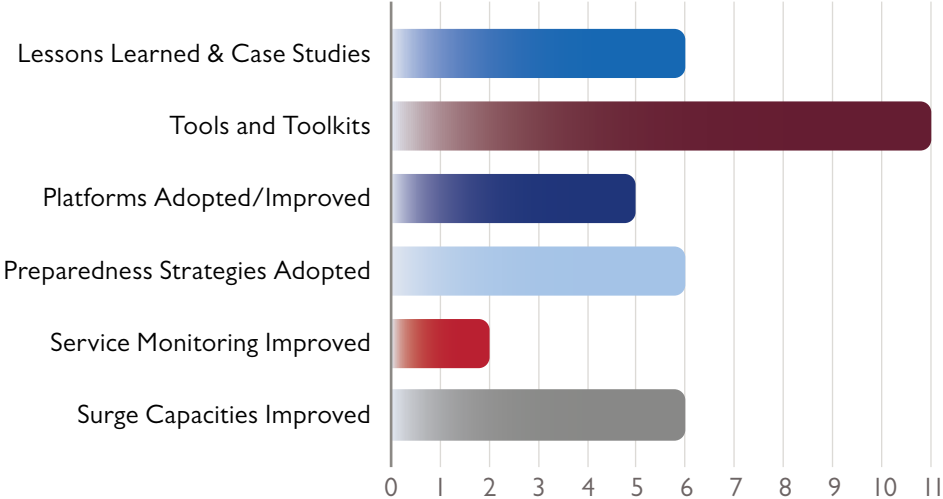
¹ For evaluation purposes, Objective 5 awards include 11 Global PIO and NGO awards which are not-solely designated under the HCIMA sector. Awards were selected via a review of global award alignment with the objective. While country level awards may have also supported pandemic capacities, this section of the brief focuses on the global level awards given the objective's humanitarian architecture emphasis.

² Evidence for the two Objective 5 HCIMA Awards overlaps with evidence used for the Objective 4 brief. Additionally, evidence for the Protection Award overlaps with evidence used for the Objective 3 brief.

Indicator Results (Outputs)

Key Finding: Obj 5 awards excelled at documenting key learning from COVID-19 and developing shared tools for global humanitarian actors: Given the multisectoral and new-to-BHA nature of the objective, indicators were not consistent across award reports. However, a review of final reports revealed that four of five completed awards met indicator targets, the remaining six ending in 2024 were making progress towards completing most targets.³ Through content analysis of award reports, key outputs related to humanitarian architecture and infectious disease preparedness and response capacity were identified (Figure 9). Collectively, six awards produced nine lessons learned reports and 44 case studies on COVID-19 and program implementation.⁴ All awards designed tools and toolkits, which served to support many targets including preparedness planning, to measure community trust and capacities, etc. Four awards built platforms, which facilitated virtual safe spaces, electronic referrals for GBV survivors, and information sharing with key partners. Six awards created new strategies and/or standard operating procedures that facilitated greater preparedness. Additionally, six awards sought to build or improve rapid response and/or surge capacity within respective sectors.

Figure 9. Obj 5 Indicators by Number of Awards



Outcomes and Key Drivers

Key Finding: Global awards were successful in meeting their objectives, however many awards lacked key outcome level indicator measurements. Interviewees across the awards stated that the funding allowed them to perform, expand, and scale-up program operations. Some interviewees mentioned that success led to greater levels of regional and country level investment and expansion of programs. Examples include implementation of guidance on MHPSS as country-level policies, nationwide expansion of the use of e-referral pathways for GBV, expansion of emergency education needs assessment capacities, and regional investment in the continued implementation of humanitarian leadership training. Many awards also made workforce improvements through training and filling gaps in key response positions. Outcomes in coordination include greater collaboration with partners on provision of services and technical support for humanitarian settings at all levels, including global, regional, country, and local. While most IP KIs indicated outcome level success, the majority of reported indicators are highly output focused. Some BHA award managers also had difficulty commenting on the tangible outcomes of the funded programs.

³ One award does not report traditional indicator data. Funding is based on milestones.

⁴ Outputs will likely increase as awards continue to finish.

“I think it was a huge opportunity to really inject capacity, and get us to think differently, and to apply what we had learned in COVID-19.” ~ IP KII Global

Key Finding: Obj 5 allowed IPs to strengthen a wide array of preparedness and response capacities across sectors. Eight awards sought to improve organizational or governmental capacity within their technical sector. Two awards built logistics and/or supply chain capabilities for epidemics and two augmented needs assessment capacities. There were also two awards which addressed RCCE/AAP/CEA. The nutrition award provided immediate help desk, surge support, and learning reports during the pandemic. Two awards that began in 2021 provided guidance on vaccine implementation in humanitarian settings and building community trust. KIs found that substantial funds allowed WHO and IFRC to assume credible roles as hubs of coordination and technical leaders. The WHO Country Business Model has started building staffing capacity among Priority 1 humanitarian countries and standardized WHO regional/country appeals.

Box 6. RCCE Collective Service Impact Study (IFRC et al., 2023)

The RCCE Collective Service was established in June 2020 to build collaboration between IFRC, UNICEF, WHO for the COVID-19 response.⁵ The BHA-funded impact evaluation provides insights on the impact of the program and implications for the future of the service. This study found that the service was successful in providing coordination and technical guidance for RCCE. However, a key theme is that the continuation of the service will require renewed vision and support. Potential future avenues included expanding the scope of the services to work on developing country-level capacities for RCCE preparedness and implementation, continued use of the service to respond to public health emergencies, or continued RCCE coordination at the regional level with support from individual partners outside of the formal collective service.

Promising Practices

Obj 5 bolstered coordination during the pandemic for surge and response capacity in the areas including CEA/AAP, GBV/SRH, MHPSS, and Nutrition. Though there was little indication that the coordination structures strengthened would be mobilized to respond to new threats. The development and deployment of digital technologies was also a key practice, including through remote and online training, remote situation monitoring, and information sharing of key sector knowledge to individuals worldwide, which is consistent with findings from the COVID Big Picture Reflection Lessons Learned Report (2024). For example, online MHPSS resources for COVID-19 (including toolkits, storybooks, etc.) reached an estimated 4.5 million readers, and the provision and improvement of Virtual Safe Spaces for multiple countries allowed for women to safely access culturally appropriate information about SRH and GBV. Translation of program tools into multiple languages, with considerations for reading levels and accessibility concerns in mind expanded access to key knowledge in program areas. In the area of community engagement and RCCE, two awards, though not explicitly designed that way, resulted in complementary approaches to bottom up and top-down capacity enhancements. One award worked with local and country-level partners to build trust for vaccine implementation, while the other focused on building global coordination and capacity through the provision of technical assistance, surge capacity, and guidance for collective feedback (Box 6).

⁵ Activities were funded by the Bill and Melinda Gates Foundation

Challenges and Durability

Key Finding: The short-term nature of funding led to difficulties in executing programs within proposed timeframes. One key challenge among program implementation was the short-term nature of the funding. Eighty-two percent of awards received extensions, pushing end dates into 2023 and 2024. Additional challenges mentioned in award reports and KIIs included delays due to hiring bureaucracy, difficulties hiring technical experts with appropriate expertise and language skills, and conflict or insecurity interfering with implementation.

Evidence related to the durability of infectious disease response capacities developed was mixed. While IPs felt that some capacities would be sustained, viewpoints from BHA and information related to financing and staffing indicated that sustainability of some aspects could be a challenge. Although all awardees that were interviewed indicated that their programs included durable components that will last after the funding ended. Types of durability mentioned included improvements in workforce training and readiness, continued provision of services, greater capacity to leverage funding for future projects, and the continued availability of tools, technical briefs, trainings, and job aids for use in future crises. However, BHA KIIs had varied points of view on program durability, some noting the programs remain reliant on continued BHA financial investments. This was echoed by half of IP KIIs that stated that they will remain highly reliant on BHA funding after the Supplemental ends.

“There is absolutely no alternative donor in the pipeline to fund the [program].” ~ IP KII Global

Programming Considerations

1. BHA/USAID, in coordination with Bureau for Global Health, CDC and other major donors, should be prepared to inject additional funding towards improving and strengthening humanitarian architecture to support scale-up of infectious disease response capacity by developing a clear map of the gaps in the international architecture and creating a strategic plan. This capacity map can guide investments that are outcome oriented (specific capacities to be developed and means of verification). Multi-year funding will be required.
2. BHA should work closely with Bureau for Global Health and CDC to ensure that investments by these organizations are synergistic and appropriate to the Mission and structure of these organizations. For example, Bureau for Global Health emphasizes the development of health systems, CDC has excellent and deep technical expertise, BHA can act rapidly and has substantial field experience in complex humanitarian emergencies.
3. BHA should work with IPs to develop clear outcome measures for multisectoral pandemic preparedness and response capacities and include them in concept note requirements. Outcomes should articulate the capacities that are needed such as IPC, surveillance systems, laboratory capacity, supply management systems, community engagement, as well as protection and nutrition secondary effects.. The sustainability of these capacities also should be addressed.

Efficiency/Timeliness

Key Finding: Partners faced various challenges implementing the Supplemental awards, with the most common delays and difficulties related to IP internal procedures followed by supply chain and procurement issues. (Table 5). This evidence comes from 120 excerpts across 33 KIIs with IPs and BHA activity managers and aligns with data from the IP e-survey. Internal IP procedural hurdles that impeded efficiency in implementation ranged from slow processes for grant start-up to inconsistent decision-making by program leadership. Similar to the FY 2020 programming, IPs also struggled with adequate human resources.

Additionally, the pandemic introduced multifaceted and novel challenges on a global scale that continued for years. These difficulties impacted resource availability, the prices of goods, disrupting medical and food commodity supply chains, and impeding or delaying standard procurement processes across sectors.

Key Finding: BHA requirements were less a factor in FY 2021 and conflict settings a larger hindrance to programming, as compared to FY 2020. Some delays were linked to BHA requirements and procedures, such as around pharmaceutical procurement, but this is not a key factor as it was in FY 2020. More than in the first year of the pandemic, IPs perceived challenges of complex emergency settings as affecting their implementation in FY 2021-2022, with conflict and insecurity leading to restricted access, high staff turnover, and obstacles building trust and capacity within communities.

Table 5. KII themes on reasons for delays by salience

Top factors hindering timely implementation	Mentions
IP internal procedures	26
IP capacity and/or personnel limitations	22
Procurement	16
Conflict-induced challenges	15
BHA requirements	15
COVID-19 protocols/restrictions	15

“Delay in procurement was one of the main challenges that we faced. During COVID-19 the supply chain management was disrupted and there was no way to purchase medicines as usual or equipment and supplies” - IP KII MENAE

Responses from the IP e-survey (n=78) echoed obstacles related to timely and efficient implementation. One-third (32%) reported encountering no major obstacles, while the remaining IPs discussed key themes aligning with the KII analysis. These included COVID-19 restrictions, increased prices for goods, and supply chain scarcity.

Key Finding: Factors facilitating efficient implementation mirror those from FY 2020. BHA support was identified as the most prominent enabling factor across KIIs. Working relationships with local actors was another common facilitating factor, in building capacity with municipal authorities, having preexisting relationships with the community, and building partnerships (consortium) with national organizations or health partners (i.e., Ministries of Health, MOH). See Box 7.

Box 7. Factors facilitating efficient implementation:

- BHA support and flexibility: technical, operational, and for coordination
- Relationships with local actors
- Use of technology, new virtual platforms
- Existing infrastructure and pre-positioned assets and supplies

“BHA is truly a partner in how we work together. And they’re not only a partner in terms of how you can come to them with the challenge, but they also have technical people who can add another head to the table...” – IP KII OA

Key Finding: Coordination and capacity building with government partners emerged as critical to the success of the COVID-19 response and humanitarian programming, an area for which some IPs desire more guidance. Governments are the duty bearers for disaster response, and while fragile or fragmented, play a critical role in many humanitarian contexts. Others, including the UN, and international and local actors provide support to the efforts to respond. During the COVID-19 response, the IASC Clusters played an important role in coordination at the global and country office levels, even though there were gaps and challenges (see Objective 4). The responses varied by country but provide learning for BHA and IPs. Across the IP e-survey responses on key challenges and successes of the awards, just three IP respondents described impediments from coordinating with local/national authorities, while 16 IP respondents described the importance of collaborating with government partners such as for RCCE, identifying needs, and health system supports. Some IPs asked for more guidance from BHA on this theme. The success of coordination for the COVID-19 responses was often tied to the effectiveness of governance in-country. As a relevant and timely learning from COVID-19 responses, Thematic 1 study covers this topic.

4. CONCLUSION

Here we presented high-level findings across each of the BHA Funding Objectives for the FY 2021 COVID-19 Supplemental. Across objectives, there were several areas of overlap between key findings and programming considerations. Those are outlined here. Note: Brief 3 details high-level conclusions and recommendations on the FY 2021 Supplemental's performance (see Box 8).

Cross-objective key findings included:

- Maintaining and re-establishing services across sectors helped lessen the direct and indirect impacts of the COVID-19 pandemic.
- Many contexts experienced covariate shocks and in some cases, COVID-19 was not the most pressing concern but exacerbated humanitarian populations' vulnerability.
- The sustainability of the investments and results documented here are a key concern across sectors.
- BHA provided a high level of flexibility to IPs to rapidly adapt to evolving needs and contexts (e.g., Ukraine, Mozambique), including reaching novel populations.

Cross-objective programming considerations included:

1. Greater coherence within the humanitarian system (e.g., data sharing, etc.) and multisectoral activity layering are conduits for sustainability/durability, identification of vulnerable populations, and better overall response.
2. Engaging local government and populations for capacity building and coordination is critical for durability.
3. Remote modalities offer promising solutions to meeting hard-to-reach populations.
4. Populations novel to some IPs, including refugees, LGBTQIA+, urban, and indigenous groups greatly benefitted from activities from the Supplemental and should be prioritized by BHA and IPs.

Box 8. Check out the other deliverables of this COVID-19 evaluation series:

- **Performance Evaluation Brief 1 (internal to BHA)—Funding design and management.** Addressing Evaluation Question 1: How did BHA manage the FY 2021 COVID-19 Supplemental assistance to ensure relevance, efficiency, and timeliness, and what are key shifts from the FY 2020 to FY 2021?
- **Performance Evaluation Brief 3—High-level conclusions on performance.** Addressing Evaluation Question 3: To what extent did the funding meet BHA's Goal to address the humanitarian needs of the most vulnerable populations arising from the COVID-19 pandemic? (includes overall recommendations)
- **Thematic 1 Evaluation Report:** Pandemic preparedness capacities in humanitarian settings
- **Thematic 2 Evaluation Report:** Lessons on BHA surge funding

SEPTEMBER 2024

CONTACT:

Maryada Vallet, maryada@tangointernational.com

ACKNOWLEDGEMENTS:

This brief was drafted by Maryada Vallet, Shalean Collins, Tim Frankenberger, Nancy Mock, Liz Satow, Tripura Talagadadevi, Erin Franklin, Suzanne Nelson, Husam Al Zuwayny, Tommaso Russo, Charles Brands, Michelle Lacey, and Macie Tarr, with support from others on the TANGO/Tulane team. We wish to thank the evaluation activity managers for their review and guidance: Nancy Peek (BHA), Jaclyn Brennan-McLean (BHA), Melissa Bressner (ITR), and Leulseged Kasa (LASER PULSE). We are also grateful for the extensive feedback and reflections provided by participants, BHA and IP stakeholders. This input has been critical to ensure the evaluation can be relevant and useful for future humanitarian response.

PHOTO CREDITS:

Page 9: USAID/Kenya

Left: ANED Consultores/Honduras



USAID
FROM THE AMERICAN PEOPLE



**PURDUE APPLIED
RESEARCH INSTITUTE**



**PURDUE
UNIVERSITY**

TANGO
INTERNATIONAL
TECHNICAL ASSISTANCE to NGOs



**TULANE UNIVERSITY
SCHOOL of PUBLIC HEALTH
& TROPICAL MEDICINE**