Strategic Joint Evaluation of the Collective International Development and Humanitarian Assistance Response to the COVID-19 Pandemic

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Foreword

The COVID-19 pandemic presented an unprecedented test of the global community's ability to respond swiftly and co-ordinate effectively across borders and sectors to mitigate both the immediate effects of the pandemic and the broader socio-economic repercussions. International development co-operation and humanitarian assistance emerged as a critical element of the global response.

The COVID-19 Global Evaluation Coalition (hereafter referred to as the "Coalition") was established in 2020 to provide actionable insights and support international co-operation in its response. Comprising more than 60 organisations, including evaluation units from Organisation for Economic Co-operation and Development (OECD) and non-OECD member countries, UN agencies and multilateral development and humanitarian institutions, the Coalition leveraged diverse experiences to create high-quality, timely evaluations and feed evidence into real-time decision-making while adapting the evaluation processes to challenging circumstances.

In 2022, the Coalition launched the "Strategic Joint Evaluation of the Collective International Development and Humanitarian Assistance Response to the COVID-19 Pandemic" to address the gap in evaluative evidence on the overall results of the response effort. The evaluation seeks to generate credible evidence, assessing the relevance, coherence, effectiveness and efficiency of international assistance and co-operation during the COVID-19 crisis, and draw lessons to strengthen future responses to global crises.

This evaluation builds on and complements other evaluations of COVID-19 responses. It is exceptional in terms of the way it was carried out – involving partners from all parts of the intentional development community – and in its global scope and system-wide perspective. The evaluation is the culmination of five years of evaluative work including extensive document review, case studies and in-country visits, interviews and eight learning workshops, including a high-level learning event marking the fifth anniversary of the pandemic in March 2025.

The primary anticipated users of the evaluation are policy- and decision makers from humanitarian and development agencies and governments working to deliver effective and impactful development co-operation. This includes bilateral providers, UN agencies and other multilateral organisations, international financial institutions (IFIs), partner country governments, foundations, philanthropic organisations, civil society organisations and local communities, as well as other actors involved in international co-operation during the COVID-19 pandemic. Additionally, the evaluation will inform the public, ensuring transparency and strengthening accountability for results.

In today's context, where international co-operation and efforts to support sustainable development are under mounting pressure, this unique collaborative evaluation provides a positive example of working together to make co-operation more effective and ensure that development partners deliver on their commitments.

Acknowledgements

This report is the result of a collective effort from the more than 60 institutions involved in the COVID-19 Global Evaluation Coalition and builds on the work of several dozen participants who provided guidance, substantive input and financial support for this work over the past four years.

Co-ordination and management of the evaluation was led by the Evaluation Unit of the Reform and Partnerships for Development Impact (RPDI) Division of the Organisation for Economic Co-operation and Development's (OECD) Development Co-operation Directorate (DCD), in its role as Secretariat for the Development Assistance Committee (DAC) Network on Development Evaluation (EvalNet) and the COVID-19 Global Evaluation Coalition.

The Secretariat would like to thank all EvalNet members for their support and engagement in the preparation of the study and the work of the Coalition. This work would not have been possible without EvalNet members and observer organisations staff who provided written inputs and participated in individual interviews throughout the process and who are too numerous to list here.

The inception phase was managed by Jenna Smith-Kouassi with Ludhiya Johnson and Mayanka Vij, under the strategic guidance of Megan Kennedy-Chouane and Rahul Malhotra. An IOD Parc team of independent evaluators, led by Naomi Blight, managed the research phase including conducting interviews, document review, data analysis, and a first draft report. From IOD Parc, Callum Taylor, Liz Paton, and Sonia Pérez contributed to authoring the report with support from Nick York, Josh Fuchs and Jordan Williams. The analysis and report were finalised by Megan Kennedy-Chouane and Stefano Contratto, under the guidance of Robin Ogilvy, Pilar Garrido and Julia Nielson (OECD) with support from the evaluation Steering Group. Ole Winckler Andersen (DIIS) provided strategic advice and quality assurance throughout the process.

The study has benefitted from the contributions of many colleagues. The authors would particularly like to thank the following: Jenna Smith-Kouassi, Jinyi Ding and Mayanka Vij for their work in designing the study and research during the inception phase; Harsh Desai, Kerri Egger, Emily Bosch, Renwick Irvine, Yasmin Ahmed, Ida McDonnell, Francesca Colombo and Caroline Penn for substantive inputs; and Ola Kasneci and Nelson Torbay-Holguin for management and administrative support. In addition, the contributions of Sonia Cristina Mairos Baptista Ferreira on the analysis regarding disability, and Abhirup Bhunia for background research on the case studies, were also greatly appreciated. The authors are grateful for the support received from the OECD Directorate for Communications; Stephanie Coic for graphic design; Suzanne Parandian for editing; and Meral Gedik for preparing the report for publication.

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Abbreviations and acronyms

Acronym	Abbreviation
ACT-A	Access to COVID-19 Tools Accelerator
ADB	Asian Development Bank
AFD	French Development Agency (*Agence française de développement*)
AfDB	African Development Bank
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
AMC	Advance Market Commitment
CABEI	Central American Bank for Economic Integration
CDC	Centres for Disease Control and Prevention
CELAC	Community of Latin American and Caribbean States
CEPI	Coalition for Epidemic Preparedness Innovations
CERF	Central Emergency Response Fund
COVAX	COVID-19 Vaccine Global Access
COVID-19	Coronavirus Disease 2019
CRS	Creditor Reporting System
CSO	Civil society organisation
DAC	Development Assistance Committee
EBRD	European Bank for Reconstruction and Development
EU	European Union
FAO	Food and Agriculture Organization
FDI	Foreign direct investment
GBV	Gender-based violence
GDP	Gross domestic product
GHRP	Global Humanitarian Response Plan
GNI	Gross national income
HDI	Human development index
HIC	High-income country
HIV	Human Immunodeficiency Virus
HSS	Health systems strengthening
IAHE	Inter-agency Humanitarian Evaluation
IASC	Inter-agency Standing Committee
ICAI	Independent Commission for Aid Impact
ICU	Intensive care unit
IDA	International Development Association
IDEV	Independent Development Evaluation (of the AfDB)
IDP	Internally displaced person
IFI	International financial institution
IFRC	International Federation of Red Cross and Red Crescent Societies
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
LDC	Least developed country

Acronym	Abbreviation
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, and queer or questioning
LIC	Low-income country
LMIC	Lower middle-income country
MOPAN	Multilateral Organisation Performance Assessment Network
NGO	Non-governmental organisation
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ODA	Official development assistance
ODF	Official development finance
OECD	Organisation for Economic Co-operation and Development
OECS	The Organisation of Eastern Caribbean States
OOF	Other official flows
PAHO	Pan American Health Organization
PBL	Policy-based loan
PHEIC	Public health emergency of international concern
PPE	Personal protective equipment
SDG	Sustainable Development Goal
SERP	Socio-economic response plans
SGBV	Sexual and gender-based violence
SIDS	Small Island Developing States
SPRP	Strategic Preparedness and Response Plan
SRF	Solidarity Response Fund
UK	United Kingdom
UMIC	Upper middle-income country
UN	United Nations
US	United States
UNCTAD	UN Trade and Development
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
UNOSSC	United Nations Office for South–South Co-operation
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
Currency codes	
GBP	Great British Pound
USD	United States Dollar
NZD	New Zealand Dollar

Executive summary

The COVID-19 crisis triggered an unprecedented response from the international development co-operation and humanitarian system. From 2020 to 2022, official providers and philanthropic organisations disbursed USD 126 billion of assistance targeting the COVID-19 response, within an overall international assistance package topping more than USD 886 billion (USD 1.1 trillion gross). Official health assistance increased by 73% from 2019 to 2020 (USD 47 billion committed) and reached a record high of USD 59 billion in 2021. Vaccine assistance totalled USD 1.5 billion in 2022, with the largest commitments going to least-developed countries (USD 334 million) and the Africa region (USD 339 million).

This unique strategic evaluation assesses these efforts from the perspectives of relevance (the extent to which co-operation was designed to respond to partner country needs and priorities); coherence (alignment across different interventions); effectiveness (meeting of objectives); and efficiency (timeliness and use of resources). It draws on a set of case studies, interviews with key informants, a synthesis of evaluation reports, and analysis of international finance flows to identify lessons for the future.

In line with other global studies, the evaluation identifies major weaknesses of current approaches to global co-operation and health crisis management. Most of the stated goals of the pandemic response were not met – demonstrated most starkly by the millions of lives lost. International development assistance efforts were insufficient – in both volume and impact – to overcome these broader failings and were undercut by other government actions. At the same time, many co-operation strategies worked well. No area demonstrates this paradox more starkly than the efforts to support vaccine equity: The pandemic saw high levels of funding for vaccines, an innovative global mechanism, and successful campaigns in some countries. Yet global outcomes were far off target. By the end of 2022, only 34 doses had been administered per 100 people in low-income countries, compared to 212 doses in high-income countries (Our World in Data, 2025; WHO, 2025).

Within this circumscribed context, development co-operation was most effective when the urgency created by the crisis served as a catalyst for co-ordinated, decisive action, reinforced by both high-level political commitment and technical expertise. A “get it done” attitude drove speed, enabled flexibility, streamlined certain bureaucratic processes, and sharpened focus on what really matters.

Development agencies quickly set up internal co-ordination mechanisms to adjust strategies, ensure ongoing programmes stayed in operation, mobilise new funding, and respond to requests for support. This initial responsiveness was facilitated by using existing channels and partners, and the provision of budget support and other flexible core or pooled funding. At the same time, the evaluation found that most development actors missed the opportunity to make some of these temporary crisis measures permanent.

Over the period examined (2020-2022), Development Assistance Committee (DAC) members largely delivered on their commitments to protect funding for the most vulnerable countries – though the collective effort still fell far short of needs. The DAC average of official development assistance (ODA) to gross national income (GNI), increased from 0.30% in 2019 to 0.33% in 2020, even in the face of major fiscal constraints. Funding to least developed countries and other vulnerable countries rose markedly in 2020.

Resources were provided in timely ways, but not always efficiently and equitably. While using existing channels allowed disbursements to be made with unprecedented speed, it was less able to meet new, crisis-specific needs and, in some instances, was blind to other partners that may have been better placed to respond. Prioritising high-visibility, in-kind support was expensive and at times detracted from more effective systems-focused approaches. There were few examples of ongoing learning to revisit decisions as needed and adjust to changing priorities.

International funding for the social sector increased during the crisis and was particularly effective when it worked through country systems to scale up social protection. There were many good examples of co-ordination at the country-level, especially where national response plans and cross-sector, multi-partner mechanisms enabled not only sharing of information but also aligned decision making.

Finally, the lack of coherence between development co-operation and other policy actions – including closing borders to asylum seekers and hoarding vaccines – undermined stated goals and worsened outcomes. A narrow framing of national interest proved counterproductive, while approaches recognising the mutual benefits of an effective global response delivered better results for all.

Eight lessons from the crisis response

Though outcomes of the COVID-19 crisis response depended on many factors (the country context, providers involved, previous investments and capacities, etc.) some common themes emerge. The crisis underscored the necessity for reforms in international co-operation, in particular the weaknesses created by fragmentation and the lack of needs-based approaches to allocating resources. The crisis also confirmed the continued relevance of key principles for effective co-operation, including the necessity for country ownership, alignment with national priorities, and strengthening and use of national systems. While this potential is too often not met – the evaluation finds many positive examples of the potential of international co-operation to respond effectively at speed and scale to reduce human suffering.

Looking forward, international co-operation actors can draw on eight key lessons:

1. Within development agencies, develop crisis response plans and strategies that **support rapid decision making**, and co-ordinate across all parts of government – and with partners.
2. Fund quickly in line with **known best practices**, while using available evidence to identify emerging needs (including of vulnerable populations) and **building learning into the crisis response** to manage changing priorities and adjust strategies as needed.
3. Build on **established partnerships** with governments and multilateral institutions to enable rapid deployment of large-scale financial resources, enhancing timeliness, efficiency and effectiveness.
4. Ensure **co-ordination mechanisms and agreements** between funding, implementing and national partners **are in place** in advance of a crisis. Such agreements should enable rapid adjustment of existing programmes, support joint analyses, and facilitate the deployment of funding quickly for the most likely expected needs and priorities.
5. Align the appropriate financial instruments for crisis response **to country-specific needs and contexts** and prioritise the use of cost-effective tools such as cash transfers and budget support to scale up relevant support to meet these needs.
6. Systematically invest in and **integrate national social support systems** into crisis response plans. Avoid creating parallel or one-off systems (including oversight mechanisms) and instead fund with the longer term in mind, using the crisis context to strengthen and scale up national health and social protection systems, and increase reach.
7. Strengthen in advance and prioritise funding through the **multilateral system** – while avoiding duplicative bilateral actions – for a co-ordinated, flexible response. Leverage benefits of unearmarked and pooled funding.
8. **Work across government to address incoherent policy actions** that undermine development and humanitarian goals. Reconsider **how national interest is framed and implemented** to ensure that perceived protection of national interest in the short term does not ultimately undermine outcomes for all.

1 Evaluating development co-operation during the COVID-19 crisis

This chapter provides a brief overview of the economic context in which the COVID-19 pandemic emerged, as well as the health and socio-economic impacts of the pandemic and the trends in international development co-operation and humanitarian assistance when the crisis emerged. It offers an introduction to the evaluation approach and methodology, and presents the COVID-19 Global Evaluation Coalition, a project launched by the Organisation for Economic Co-operation and Development (OECD) and partners to help consolidate lessons from the pandemic for future crises.

The novel Coronavirus Disease 2019 (COVID-19) pandemic has resulted in millions of deaths and a global crisis that disrupted lives and economies around the world (Our World in Data, 2024[1]; Gill and Schellekens, 2021[2]).[1] The pandemic triggered an unprecedented response as communities, governments, international organisations, and private sector actors worked to address the health impacts and mitigate the economic and social fallout of containment measures.

In 2020 as the pandemic spread, international development co-operation and humanitarian assistance surged, as countries and agencies worked together to address urgent humanitarian and health needs and reduce the impacts on long-term sustainable development goals. Countries worked together to provide support where needed and deployed resources at an unprecedented pace. Ultimately, income level was not closely correlated with country outcomes – with some low-income countries responding effectively (The Independent Panel, 2021[3]). International co-operation and assistance played a positive role in those successes. In many ways, the crisis showed the potential of international development and humanitarian assistance to respond at speed and scale to reduce human suffering – even while illustrating its limitations in the face of the broader response and ultimately concluding that this potential was not fully met.

This evaluation analyses the international co-operation and humanitarian assistance provided during the crisis with the goal of contributing to the global development community's learning. It focuses on understanding how international co-operation – both humanitarian and development assistance – responded to the COVID-19 crisis from 2020 to 2022 (the emergency phase). The emphasis is on the management and delivery of international assistance, and the extent to which it benefitted people as intended. It covers all types of international assistance, including South-South support, triangular co-operation and support not reported to the OECD's Creditor Reporting System (CRS), which tracks funding from governments and philanthropies for eligible countries.

While exceptional in many ways, the crisis presents a valuable learning opportunity for co-operation during crises and for "normal times". The pandemic crisis changed some of the ways development and humanitarian partners operated and demonstrated both effective and less effective ways of working together, co-ordinating actions and deploying resources. Operating in crisis mode resulted in innovations and a willingness to try, learn and adjust.

This opening chapter considers the context of the evaluation, including the economic setting, and an overview of the health and socio-economic impacts of the COVID-19 pandemic. This is followed by a discussion of the humanitarian and development co-operation landscape into which the pandemic arrived at the end of 2019. It concludes by outlining the goals of the evaluation and the approach taken, which reflect this context.

The following chapters present the findings of the strategic evaluation, firstly examining the overall international co-operation response to the pandemic, then considering this in the light of the four evaluation criteria: relevance, coherence, effectiveness and efficiency. The report concludes with a synthesis of the key lessons as well as the benefits these can bring to development co-operation moving forward.

1.1. The economic context of the pandemic

At the outset of the COVID-19 pandemic, the global economy was already grappling with significant challenges, including limited fiscal space of many government budgets, rising inflation, mounting economic vulnerabilities and rising public debt. In 2019, global debt, comprising both public and private sectors, reached USD 197 trillion, an increase of USD 9 trillion from the previous year, with the global average debt-to-GDP ratio rising to 226% (IMF Blog, 2021[4]). This substantial debt burden constrained many countries' abilities to respond effectively to economic shocks including that created by the COVID crisis. The International Monetary Fund (IMF) reported that in 2019, nearly half of the low-income countries assessed were either at high risk of or already experiencing debt distress (IMF, 2020[5]).

The onset of the pandemic and containment measures then led to a sharp contraction in economic activity, exacerbating these vulnerabilities. Lockdowns and disruptions to global supply chains resulted in plummeting tax revenues, a decline in export earnings and falling foreign direct investment (Moosa and Merza, 2022[6]). Global trade volumes shrank by 5.3% in 2020 (WTO, 2021[7]), while international tourism collapsed, with arrivals falling by 74%, devastating economies reliant on the sector (UN Tourism, 2021[8]). Research in other fields continues to explore the efficacy of the pandemic response, and the policy implications, including reflections on trade-offs. An illustrative example came from the case study research in Cambodia, where interviewees reflected on the trade-offs made: imposing closures to save lives from COVID-19 put lives at risk from other threats, including gender-based and intimate partner violence.

Emerging markets suffered massive capital outflows, estimated at USD 83 billion in March 2020 alone, as investors sought safe havens in advanced economies (Batini, 2020[9]). These economic shocks deepened fiscal pressures, as governments increased spending rapidly to respond to the pandemic, forcing many governments to increase borrowing, pushing global debt levels even higher, while increasing related costs.

1.2. The health and socio-economic impacts of COVID-19 and the response

Despite global health and economic risks, from an historic perspective, the world was well-positioned to respond effectively to the pandemic (e.g. record low poverty; technology advances; improved health system capacities). And yet, the overall international response failed to prevent large scale loss of life and devastating secondary effects.

Both the SARS-CoV-2[2] virus itself and the associated containment and mitigation measures had profound impacts on the health and well-being of populations worldwide. Seven million deaths were reported worldwide, although excess mortality estimates suggest the true toll likely exceeded fifteen million (OXFAM International, 2022[10]; Our World in Data, 2024[1]; Gill and Schellekens, 2021[2]).[3] As of May 2025, over 777 million cases of COVID-19 had been confirmed globally (WHO, 2023[11]).

There was a significant variation between countries in terms of mortality rates, and the timing of different waves of illness and total number of deaths attributed to the pandemic. There was also a marked variation between countries within the same income group.[4]

Though some countries' health systems pivoted to the provision of telehealth to replace in-person consultations, this was not sufficient to prevent large-scale backlogs in healthcare services in many countries (Dorn et al., 2023[12]). Health service disruptions affected routine vaccinations, with many LMICs experiencing a decline in coverage for routine immunisation levels. From 2019-2021, the number of zero-dose children,[5] globally, increased by an estimated 40% (Kaur et al., 2023[13]). South and Southeast Asia experienced particularly acute declines in routine immunisation coverage (Rachlin, Danovaro-Holliday and Murphy, 2022[14]). Most children who were affected lived in LMICs (Gill and Schellekens, 2021[2]).

The effects of the COVID-19 pandemic went far beyond health, impacting multiple areas of society and the economy. From March 2020, the crisis saw widespread global socio-economic disruptions, with lockdowns and other containment measures negatively impacting global growth projections, threatening many small and medium-sized businesses, and increasing levels of unemployment. According to the International Monetary Fund (IMF), no country was spared, with gross domestic product (GDP) declining sharply in advanced, emerging-market and developing economies (IMF, 2020[15]). In total, 3.3 billion individuals in the global workforce were estimated to be at risk of losing their livelihoods, with jobs in the service sector, tourism and informal sectors particularly at risk.

The pandemic had far-reaching impacts on fiscal space, with the effects varying by countries' capacities to access capital during the crisis and implement economic rescue packages. The pandemic response triggered the worst global recession since the Second World War, contracting the world economy by 3.1% in 2020 alone (World Bank, 2023[16]). Governments implemented unprecedented fiscal measures, with global stimulus packages totalling over USD 17 trillion by the end of 2021 (IMF, 2022[17]). The US federal government alone invested an estimated USD 4.6 trillion domestically in its COVID-19 recovery (U.S. Government Accountability Office, 2023[18]).

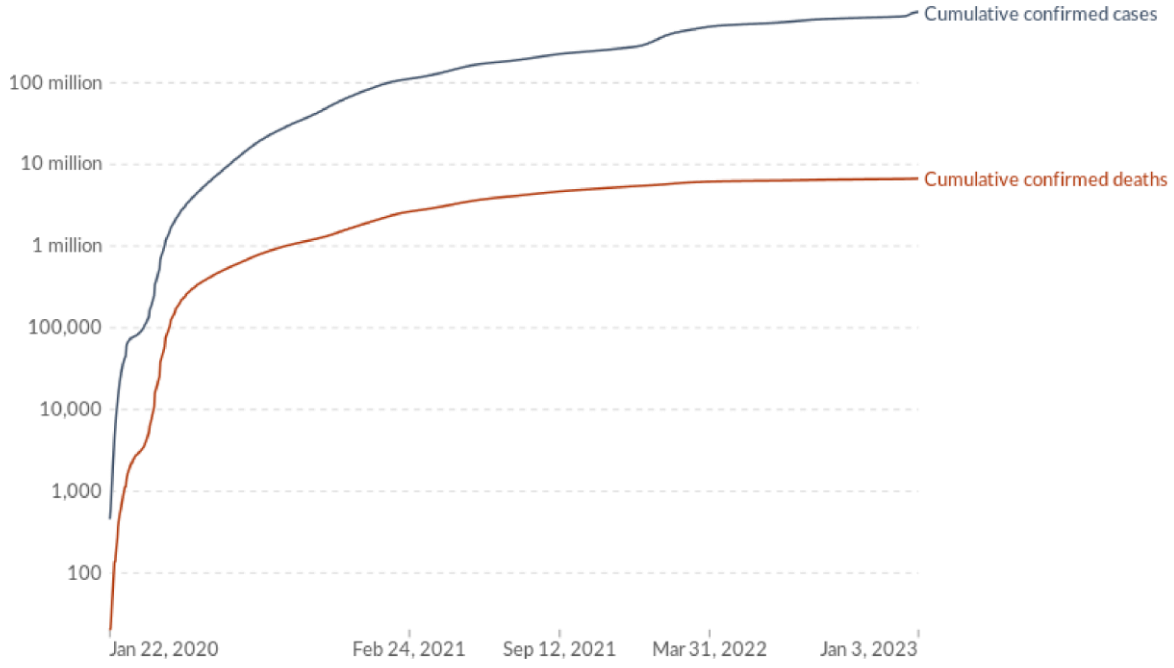
Human development was severely affected, reversing decades of progress in education, healthcare and income. The pandemic overwhelmed many national health systems and significantly disrupted essential primary care services. By the end of 2021, essential health services had been disrupted in nearly every country. In 2022, the United Nations reported that the COVID-19 crisis had led to a decrease in immunisation coverage and an increase in the overall number of deaths from tuberculosis and malaria (UN, 2022[19]). Severe disruptions in education systems worldwide deepened a global learning crisis, and progress towards poverty reduction reversed, particularly in Sub-Saharan Africa and Latin America and the Caribbean (Sánchez-Páramo et al., 2021[20]). The Human Development Index (HDI) recorded a decline for the first time since its inception in 1990, and progress towards the achievement of the sustainable development goals (SDGs) slowed, and in some cases reversed course (UNDP, 2022[21]).

The socio-economic effects of the crisis deepened many pre-existing inequalities and vulnerabilities both within and between countries. The COVID-19 disease itself along with the secondary effects of the crisis response had disproportionate effects on different people in each country. Certain populations experienced higher rates of COVID-19 infection, hospitalisation, morbidity and mortality, with the over-60s and those with certain medical conditions at higher risk of becoming seriously ill.

In terms of secondary effects, women, who make up an estimated 70% of global health and social care workers, were disproportionately affected (UN Women, 2021[22]). Barriers in access to financial resources and healthcare, mobility options and decision-making spaces further exacerbated the disproportionate impact of the pandemic on women (CBi, 2021[23]). Women also faced job losses to a greater extent than men (ILO, 2021[24]). Moreover, a 30% increase in reported cases of gender-based violence (GBV) was observed during the crisis (UNFPA, 2022[25]). The gendered impacts of the pandemic are said to have far-reaching consequences that are further amplified in contexts of fragility, conflict and emergencies (UN Women, 2021[22]).

Children were also significantly affected, including through the death of caregivers, widespread closure of schools and childcare centres and long-term limitations of their outdoor activities (see Box 1.1). People with disabilities also faced unique threats to their rights and wellbeing during the crisis.[6]

Figure 1.1. Cumulative confirmed COVID-19 cases and deaths, World, 2020-2022



Source: Our World (2025[26]), Total confirmed COVID-19 deaths and cases per million people, https://ourworldindata.org/grapher/cumulative-deaths-and-cases-covid-19?time=2020-01-22..2023-01-03.

Box 1.1. Children and the COVID-19 pandemic

While often described as being less vulnerable to the COVID-19 disease, children in all countries were significantly affected, in particular by the secondary socio-economic impacts and mitigation measures. Children and families in the poorest countries were most at risk. Key pandemic effects included:

- pushing more households and children into poverty
- intensifying the hardships of poor children
- exacerbating the learning crisis (including school closures)
- threatening child survival and health
- increasing child malnutrition
- reducing access to life-saving vaccines
- reversing progress in the fight against HIV
- mounting risks of violence, exploitation and abuse
- putting more girls and boys at risk of child marriage.

Source: UNICEF (2022[27]), ''COVID-19 and Children: UNICEF Data Hub'', https://data.unicef.org/covid-19-and-children/.

1.3. The context of international development co-operation

The COVID-19 pandemic unfolded within an already complex international development and humanitarian landscape. The advent of the Sustainable Development Goals (SDGs), the signing of the Paris Agreement, and the emergence of the Grand Bargain in 2016 marked a shift towards a more diverse and fragmented development co-operation environment with increasing engagement from non-DAC members and new

financial mechanisms, including climate funds. In parallel, mounting geopolitical tensions, populist movements and domestic funding challenges in OECD countries reshaped the priorities and structures framing international aid. The increasing frequency of climate-related shocks and natural disasters impacted countries' growth and development prospects and was jeopardising hard-won gains, increasing food insecurity, health risks and vulnerability (OECD, 2019[28]).

The COVID-19 crisis not only tested but also exacerbated these pre-existing challenges, placing extraordinary pressure on global health systems, economic structures and development financing.

The move away from an outdated paradigm of wealthy, western nations as benevolent donors and the global south as passive recipients was already changing well before the pandemic (OECD, 2019[28]). The crisis confirmed this shift, and the role of major countries of the global south, including the People's Republic of China (hereafter 'China') and South Africa, brought to the forefront the multidimensional nature of risks, with all countries experiencing need, and support flowing in multiple directions.

Shifts in global wealth, politics and power contributed to further complexity, bringing a diversity of perspectives, principles, programmatic approaches and financial mechanisms into the development landscape. Trust in governments and institutions was plummeting, and populism, protectionism and exclusive nationalism were on the rise (Bieber, 2020[29]; Foundation for European Progressive Studies, 2020[30]; Williams, Kestenbaum and Meir, 2020[31]; Bernes T, 2020[32]; OECD, 2019[28]). The advent of climate funds and rising climate finance introduced new funding streams and governance structures, reshaping financial flows and influencing both development and humanitarian priorities. For partner countries, the growing diversity of development providers and finance flows created greater choice.

This increasingly crowded space and the diversity in partners' geopolitical, humanitarian and economic interests increased the political stakes in international co-operation for both providers and partner countries. Many of these trends were accelerated by the pandemic.

International development assistance had consistently increased since the 1960s, keeping pace with overall growth in the gross domestic product (GDP) of provider economies (OECD, 2024[33]), falling only slightly in the 1990s, but otherwise serving as a stable external resource for developing countries even during crises, relative to foreign direct investment and private flows (OECD, 2024[33]).

However, many targets related to development finance, including the commitment to spend 0.7% of gross national income (GNI) on development assistance, were not being met. Before the pandemic, only Denmark, Luxembourg, Sweden, the Republic of Türkiye (hereafter "Türkiye") and the United Kingdom were meeting the international target of spending 0.7% of GNI on ODA (OECD, 2019[28]).

Other key trends prior to the crisis included a rise in the proportion of ODA commitments to humanitarian assistance and a growing share of bilateral support channelled through multilateral organisations (OECD, 2023[34]). There was also an increase in the use of loans for development assistance and a decline in the use of grants, despite growing levels of indebtedness in ODA-recipient countries (Dodd, Breed and Knox, 2021[35]). Development spending had also come under increasing pressure due to new climate finance commitments, rising humanitarian needs and in-donor refugee costs (due to an increase in displacement).

As early as the end of 2019, development actors, including South-South providers, members of the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC), multilateral development banks, and UN agencies, began to take note of the emerging pandemic and to understand its potential implications for developing countries, which were at risk due to vulnerabilities such as limitations in health workforce capacity and health systems, as well as inequalities in access to medical supplies and materials (Chancel and Voituriez, 2021[36]).[7]

The first response task forces were convened in early 2020 with many development and humanitarian institutions quickly establishing crisis response mechanisms and developing response plans and scenarios. Statements of support and commitments for assistance emerged quickly, and many of these

included an intention to target and prioritise those countries considered most affected or most at risk (CIKD, 2023[37]; OECD, 2020[38]). These vulnerabilities were understood not only in terms of general vulnerabilities related to income levels and fragility, but also the spread of the COVID-19 virus, capacity of health systems and exposure to the secondary economic effects, such as economies reliant on tourism.

1.4. The need for and aims of a strategic joint evaluation

Evaluating the contribution of international assistance to overall development results has long been a priority area of action for both provider and recipient countries, as well as other development and humanitarian actors. Evaluations produce evidence that can help increase the effectiveness and results of interventions, and – in the context of international co-operation – also provide a basis for mutual accountability.

In 2020, the COVID-19 Global Evaluation Coalition (hereafter referred to as the "Coalition") was established to promote adaptation of evaluation methods and processes as well as to provide credible evidence to inform international co-operation responding to the COVID-19 crisis (Box 1.2). This strategic, joint evaluation of the crisis response concludes the Coalition's work, and fills a gap in understanding the overall role of international co-operation in the crisis to identify lessons.

Box 1.2. The COVID-19 Global Evaluation Coalition

The COVID-19 Global Evaluation Coalition project was launched in 2020 by the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) Network on Development Evaluation (EvalNet) along with the United Nations Evaluation Group (UNEG), the Evaluation Co-operation Group (ECG), and evaluation units from partner countries (non-DAC members). The Coalition comprised more than 60 participating institutions (see Annex A).

The Coalition's purpose was to help ensure that lessons were learned and that the global development community delivered on its promises. This collaborative project aimed to provide credible evidence to inform the international co-operation responding to the crisis and subsequent recovery. The evaluation and learning work were carried out in a modular and phased approach, culminating in this report.

Gaps in the evaluation landscape

Globally – as well as nationally – various pieces of research and evaluations have looked at the broader pandemic response efforts. Williamson et al describe how the pandemic "highlighted profound weaknesses in the global governance of health; inadequate preparation, co-ordination, and accountability hampered the collective response of nations at each stage" and called for major changes to the global health architecture to mitigate the health and socioeconomic damage of future global health threats (Williamson et al., 2022[39]).

A range of other reviews of the overall pandemic response – from the World Health Organization (WHO), the United Nations, the Group of 20 (G20), and the Independent Panel for Pandemic Preparedness and Response (The Independent Panel, 2021[3]) – echo these findings, providing important lessons for international co-operation efforts (Box 1.3). This context limited the potential for international development and humanitarian assistance to achieve many of its objectives and provides an important backdrop for interpreting the findings of this evaluation, which focuses on international assistance.

International development organisations have also conducted a variety of evaluations and internal reviews of their respective crisis response efforts, including thematic evaluations and evaluations of particular response mechanisms. In 2020, the OECD began tracking the crisis responses from development institutions and evaluation plans related to COVID-19 and carried out an initial mapping of COVID-19-

related evaluations (Johnson and Kennedy-Chouane, 2021[40]), which found that most evaluations focused on individual programmes or institutional performance within UN agencies or multilateral development banks. Less work had been done to examine the response of bilateral providers, particularly non-DAC members or the overall response of national governments, despite the latter being the primary drivers of country-level outcomes. An update evaluation landscape in 2022 confirmed these findings and the persistent gap in cross-cutting analysis, especially in developing countries (Lagoa, 2022[41]).

During 2020-2022, DAC peer reviews and peer learning exercises supported the exchange of experience and early lessons learned from crisis-related international assistance to support the ongoing response. The Coalition drew on initial reviews and evaluations in its 2021 study "The COVID-19 pandemic: How are humanitarian and development co-operation actors doing so far? How could we do better?" (Johnson and Kennedy-Chouane, 2021[40]), which focused on the institutional aspects of the early response to identify emerging lessons, which were fed into the ongoing response.

Despite the relatively large number of reviews carried out, no evaluation had examined the collective effort across development actors, leaving gaps in knowledge regarding critical aspects of the crisis response – such as the overall outcomes in a particular country. This evaluation helps to fill these gaps. It responds to the request of Coalition participants for a system-wide perspective, which was initially expressed by participants in 2020 and confirmed during a series of learning workshops held in late 2021.

It also responds to the joint commitment of the OECD DAC to "learn lessons from the crisis and … use our experience to inform policy choices during the recovery to fortify efforts to achieve the 2030 Agenda for Sustainable Development" (OECD, 2020[42]).

Box 1.3. The Lancet Commission on lessons for the future from the COVID-19 pandemic

As summarised by an expert commission convened by The Lancet in 2022, the multiple failures of international co-operation include:

- the lack of timely notification of the initial outbreak of COVID-19
- costly delays in acknowledging the crucial airborne exposure pathway of SARS-CoV-2, the virus that causes COVID-19, and in implementing appropriate measures at national and global levels to slow the spread of the virus
- the lack of co-ordination among countries regarding suppression strategies
- the failure of governments to examine evidence and adopt best practices for controlling the pandemic and managing economic and social spillovers from other countries
- the shortfall of global funding for low-income and middle-income countries (LMICs), as classified by the World Bank
- the failure to ensure adequate global supplies and equitable distribution of key commodities—including protective gear, diagnostics, medicines, medical devices, and vaccines—especially for LMICs
- the lack of timely, accurate, and systematic data on infections, deaths, viral variants, health system responses, and indirect health consequences
- the poor enforcement of appropriate levels of biosafety regulations in the lead-up to the pandemic, raising the possibility of a laboratory-related outbreak
- the failure to combat systematic disinformation
- the lack of global and national safety nets to protect populations experiencing vulnerability.

Source: (Williamson et al., 2022[39])

Evaluation purpose and use

The evaluation – launched in 2022, conducted in 2023-24 and completed in 2025 – was timed to build on the body of institutional, thematic and global evaluations that had been completed and to extract broader lessons. It focuses on coherence and overall results, which were beyond the scope of individual studies.

The evaluation has three objectives:

- to document the international co-operation efforts to support the pandemic response efforts in partner countries, including support for equitable access to COVID-19 vaccines and vaccinations
- to answer evaluative questions of the relevance, coherence, efficiency and effectiveness of international assistance and co-operation during the crisis
- to generate lessons and good practices for governments, communities, development agencies and stakeholders, which will ultimately improve the effectiveness and impact of international co-operation and future crisis responses.

Learning from such experiences is key to ensuring the preparation of the global community to respond to future crises, as well as improving the effectiveness of co-operation in "normal" times.

The evaluation also seeks to understand the performance of DAC members against the crisis response intentions articulated in the April 2020 DAC Joint Statement (OECD, 2020[42]) and the November 2020 DAC High-level Meeting Communiqué (OECD, 2020[43]), which included calls for a collective and coherent response, support for equitable access to vaccines, and protection of ODA volumes.

1.5. Evaluation approach and design

The evaluation approach reflects the global reach of the COVID-19 crisis, the broad scope of the evaluation, the extent of evaluative work already available and the range of actors involved.

Evaluation approach

It adopted a modular, non-experimental case-based approach. Four preparatory modules – a synthesis of evaluations (Module 1), a study of philanthropic responses (Module 2), a set of provider cases and a set of recipient cases (Modules 3 and 4) – create the evidence blocks for this final global report. The evaluation was carried out collaboratively with Coalition participants, OECD staff and an external team of consultants (see Annex B for a full description of the methodology, data collection, case studies and limitations).

Evaluation scope

The strategic evaluation assesses the international development co-operation and humanitarian assistance provided to ODA-eligible countries (partner countries) from January 2020 to December 2022, covering the emergency phase of the pandemic during which most assistance was provided. Given the far-reaching effects of the pandemic, nearly all elements of international support in 2020-2022, except for major conflict or disaster response assistance, are considered relevant for understanding the crisis response and are therefore in scope.

The evaluation examines the collective response through the lens of the criteria of relevance (responsiveness to needs and priorities), coherence (alignment of action across policy areas and across actors), effectiveness (achievement of objectives and results) and efficiency (use of resources and timeliness).

The evaluation gathered *evidence* to answer the following six overarching questions:

- Descriptive: How did national governments and development and humanitarian actors respond to the COVID-19 pandemic?
- Relevance: To what extent did COVID-19 support meet partner countries' needs and priorities, including those of the most vulnerable?
- Coherence: To what extent did responses align to ensure coherent approaches at global and country levels?
- Effectiveness: What are the early (up to 2022) results of the collective response to COVID-19?
- Efficiency: To what extent were funding and programming decisions and interventions timely and informed?
- Learning: What good practices, innovations and lessons emerged from the collective response to COVID-19?

These six overarching evaluation questions, and a set of sub-questions, framed the evaluative analysis, and assessment of the policy and programmatic intentions of actors were structured under each criterion.

The term "collective response" is used throughout this report to refer to the entirety of actions undertaken by development and humanitarian actors including bilateral development agencies (hereafter referred to as "bilateral providers"), United Nations agencies, multilateral institutions and non-governmental actors in responding to the COVID-19 pandemic in partner countries.

The scope of the evaluation includes all international assistance (including support not measured by the OECD) provided in 2020-2022, grouped into three broad conceptual categories:

1. adjustments made to internationally funded development and humanitarian interventions already in place at the outset of the pandemic to adapt to or provide continuity in the evolving context
2. new COVID-19-specific support to the health sector and other directly impacted sectors including social protection, which were tagged[8] using a COVID-19 purpose code or key word in the OECD Creditor Reporting System (CRS) database – the most comprehensive database available on international development and humanitarian support (Box 1.4.)
3. all other assistance provided from 2020-2022, which, although not specifically focused on the COVID-19 pandemic, is considered relevant for understanding the overall response effort.

Assistance includes ODA (i.e. grants and concessional loans), other official flows (i.e. non-concessional loans and financing) that were provided through development co-operation modalities, and non-official flows from philanthropic foundations that report to the OECD. It includes bilateral, trilateral (triangular) and multilateral co-operation, as well as other forms of co-operation such as South-South co-operation, to create a full picture. For private and official providers that do not report to the CRS, available data from other sources (UN studies, providers' own reports, news articles, etc.) were used where possible.

The global COVID-19 crisis affected all countries, including provider countries, and resulted in a substantial amount of international assistance both between and across countries of different income groups. While assistance received by countries not eligible for ODA – such as Czechia and Italy – was not within the scope of this study, the multi-directional nature of the response should be acknowledged.

The evaluation does not focus on the performance of individual partner governments' responses to the pandemic in their own countries, or policy measures such as border closures or national policy responses such as lockdowns, containment measures, school closures or vaccine mandates. Rather, when referred to, these are used for contextual purposes, with the evaluation looking at how international partners supported national efforts. It also does not examine medical aspects, such as vaccine efficacy.

Data collection and analysis

Building on an initial mapping, the OECD identified a total of 178 publications, which were synthesised in early 2023 – forming the foundational evidence base for the evaluation (Schwensen and Schiebel Smed, 2023[44]). The synthesis focused on the key questions of coherence and co-ordination; flexibility and adaptation; timeliness; innovation; localisation; vaccine equity; and the humanitarian-development-peace nexus.

Case studies – of both providers and recipients of development assistance – were the second key source of evidence. Case studies were selected to provide a mix of characteristics across key elements of the response and the pandemic impacts. They were used to provide contextual detail and help explain trends or findings from the other modules (see Annex B) and furnish illustrative and descriptive examples that support the key findings emerging from the aggregated analysis to triangulate findings and inform lessons. The case studies include a mix of country-led reports and evaluations, and research caried out by the OECD or Coalition participants specifically for this joint evaluation.

The evaluation includes case studies of the totality of assistance received during the COVID-19 crisis in Bangladesh, Burkina Faso, Cabo Verde, Cambodia, Georgia, Kenya, Lebanon, and Nicaragua and a global study of Large Ocean States or Small Island Developing States (SIDS) as a group. Country case studies were used to understand how development and humanitarian actors worked together in different contexts, focusing on the interplay between international partners and national governments.

These cases were complemented by an in-depth analysis of provider experiences, including the international assistance of China, France, Germany, Mexico, the Netherlands, New Zealand, Saudi Arabia, South Africa, Spain and the United States, examining priorities, types of co-operation, funding, and programming. This analysis identified factors (positive or negative) that affected the responsiveness and adaptability of programming, as well as the mechanisms that were in place to co-ordinate efforts, internally and with other actors. Evaluation reports of other bilateral providers, as well as UN agencies and multilateral development banks, contributed to this analysis as well.

This evaluation report synthesises and triangulates evidence from each of the previous modules, together with the analysis of CRS data and additional document review and interviews (Box 1.4). To analyse the data across the four modules, the evaluation team developed an expansive coding framework, which was based on the six evaluation questions and 17 sub questions and used MAXQDA software tool to analyse the data. Data were triangulated through the cross-refencing of data sources; team analyses and “sense-making” sessions. Findings were validated with the evaluation manager, quality assurance lead, and the Steering Committee, and through learning events involving more than 100 stakeholders in 2024-2025.

Evaluation management, conduct and limitations

The five-year evaluation process was managed by the OECD and conducted by Coalition participants, OECD staff and a team from IOD Parc. It was guided by Coalition participants through a representative Steering Group (Annex A) with inputs from members of the DAC Network on Development Evaluation.

The evaluation’s broad scope and distinct objective meant that it could not (and did not attempt to) look at the specific performance of individual countries or actors, nor assess the effectiveness of individual interventions. The evaluation applied principles of appreciative inquiry to systematically identify and understand what worked well, in which contexts and why. This approach was most suitable given the unprecedented nature of the crisis and the focus of the work on learning and aimed at increasing openness and frankness among interviewees.

The evaluation does not assess the global pandemic response as such, but focuses only on international development co-operation and humanitarian assistance, which are ultimately a relatively small part of the picture, both in terms of finance volumes and compared to other policy measures.

Trends in development and humanitarian assistance from 2016-23 were examined to provide context for understanding policy and behavioural changes in response to the crisis. However, the evaluation did not examine the longer-term effects and economic recovery from 2023 onwards.

This strategic joint evaluation was designed to fill a specific, shared learning need, and had a number of limitations in terms of data availability, overall approach, reliance on already completed evaluations, and implementation (Annex B). While the evaluation looks at private philanthropies (i.e. those that report to the OECD), coverage of the role of the broader private sector is limited. The evaluation does not cover international assistance provided by individuals, on which there are not consistent data available.

Despite the complexity, limitations in data, and breadth of the evaluation, there was a consistently high degree of convergence across evidence sources on common themes, issues and challenges, which supports the credibility of these findings and lessons. Notably, across a range of evaluations with different methodological approaches, many common findings emerged. These have been triangulated with evidence from the case studies and additional desk research to reach the conclusions presented here.

Box 1.4. Measuring COVID-19 support in the OECD Creditor Reporting System

What is the OECD Creditor Reporting System (CRS)?

The OECD Creditor Reporting System (CRS) database collects data on official development assistance (ODA) and other flows to developing countries. The CRS database provides the most complete data available for tracking development assistance, including ODA and other official flows (OOF). Since 2018, the CRS database includes assistance provided by 39 private foundations (private philanthropy for development) including donor-reported information on the recipient's location, sector and purpose, and the implementing agency of philanthropic grants (OECD, 2023[34]). Seventeen non-DAC providers currently report on ODA flows to the OECD on a disbursement basis. Thirteen reported on COVID-19-related spending in 2020-2021. Variation in reporting, especially among non-DAC members, limits the comparison; however, some interesting trends can still be deduced.

How is COVID-19 support measured?

Contributions to the COVID-19 response are tracked in two ways in the CRS database:

- **The "COVID-19 control" purpose code** was introduced in 2020 and can be assigned to "all activities related to COVID-19 control, e.g. information, education and communication; testing; prevention; immunisation, treatment, care" (OECD, 2020[45]). Support for development or distribution of vaccines, as well as for personal protection equipment (PPE) and COVID-19 tests would all fall under this purpose code.
- **The #COVID-19 keyword** tracks the multifaceted pandemic response beyond direct disease controls. The keyword #COVID-19 is used for activities across any sector that "have the principal objective of supporting control of the COVID-19 pandemic and the response to its socio-economic impacts", and that "would not have taken place if not for responding to the COVID-19 pandemic" (OECD, 2020[46]).

How were CRS data used in this evaluation?

CRS data covering all assistance between 2016 and 2023 were used to examine trends and how providers adjusted spending to respond to the crisis starting in 2020. The data were looked at by:

- sector and provider – and aggregated by country receiving assistance (i.e. by income group, fragility, land-locked, Small Island Developing State [SIDS], and geographic region)
- channels (multilateral, bilateral, non-governmental organisations) and
- type of funding (grants, loans, concessional and non-concessional).

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Notes

[1] Data gathered on deaths during the pandemic indicate that the actual number of deaths from COVID-19 was significantly higher than reported. According to Oxfam, the lack of testing and underreporting were especially high in the poorest countries. Their modelling (using measures of excess deaths) estimates that by 2022,19.6 million people had died due to COVID-19. On a per capita basis, deaths in low- and lower-middle-income countries were 31% higher than high-income countries, and for every death in a high-income country, an estimated four other people died in a low- or lower-middle-income country (see https://www.oxfam.org/en/press-releases/covid-19-death-toll-four-times-higher-lower-income-countries-rich-ones).

[2] SARS-CoV-2 is the name of the virus responsible for COVID-19 disease, COVID-19 being the designation of the new strain that emerged in 2019.

[3] It is important to exercise caution when interpreting the available data on COVID cases and deaths and to acknowledge widespread underreporting of pandemic case numbers and deaths due to data paucity, a lack of testing capacity, difficulties in tracking death causes in challenging settings, politically motivated undercounting, and limited health system resources (see Endnote 1). In this evaluation case numbers and COVID-attributed deaths are used to look at the overall impacts of the pandemic, as well as to understand the outcomes of the pandemic response and to compare between countries.

[4] Global mortality rates and the total number of deaths attributed to the pandemic decreased over time due to the reduced severity of newer variants, improved treatment approaches, shifts in the affected population towards younger cohorts, higher COVID-19 vaccination rates (in high-income countries), population immunity from prior infections, and hospitals becoming gradually less overwhelmed (see https://ourworldindata.org/grapher/total-covid-cases-deaths-per-million).

[5] Zero-dose children are defined as those that lack access to or are never reached by routine immunisation programmes. They are operationally measured as those who did not receive their first dose the diphtheria-tetanus-pertussis (DTP) vaccine, https://www.who.int/data/gho/indicator-metadata-registry/imr-details/7792.

[6] Further analysis is planned to identify and share lessons on disability inclusion and intersectional approaches, and the role they played in an effective crisis response.

[7] Country vulnerabilities to the pandemic have been extensively analysed elsewhere, and are varied across all income groups, not just among ODA-recipient countries.

[8] From an initial analysis of reporting of development assistance to the OECD Creditor Reporting System (CRS) and analysis by several DAC members, it was clear that the use of the COVID-19 keyword (and to a lesser extent the purpose code that was developed to track new COVID-19-specific funding) were used somewhat inconsistently across provider institutions. This reflected different strategic approaches, the timing of funding decisions, and other factors such as institutional mandates, access to pandemic-related funding mechanisms, and the overall priorities of the reporting funder. Further, given the far-reaching effects of the pandemic, it was clear that useful lessons could be learned not only the use of funds specifically tagged as “COVID-19-related”, but also from how existing programmes and partnerships were adjusted and adapted. As a result, the scope of the evaluation was defined to cover all assistance in 2020-2022.

2 Global solidarity in the face of the COVID-19 crisis: Funding and types of international assistance

The COVID-19 pandemic was not only a public health emergency but also a test of global solidarity and financial resilience. This chapter outlines the global response architecture and the roles of the United Nations - including the World Health Organization (WHO) - and international financial institutions. It examines efforts to ensure equitable COVID-19 vaccine access through the Access to COVID-19 Tools (ACT) Accelerator and the COVAX facility. It describes how international development co-operation and assistance responded, exploring the commitments and policy shifts made by providers of development assistance, including DAC members and South-South providers. It provides a comprehensive overview of international development finance flows during the COVID-19 crisis 2020-2022, including shifts in funding allocations by channel, sector and type of finance.

The COVID-19 pandemic triggered an unprecedented response by international development assistance, as governments, international organisations and development agencies mobilised to address urgent humanitarian and health needs and mitigate the economic and social fallout from the crisis.

This chapter outlines key events in the international co-operation crisis response, and lays out the global response architecture, including the global effort to support equitable access to COVID-19 vaccines. Next it explores the commitments and policy shifts made by providers of development assistance, highlighting their overall objectives and strategies for maintaining ongoing programmes and meeting the new needs of vulnerable countries and populations. Finally, the chapter provides a comprehensive overview of international development and humanitarian finance[1], including allocations by country, channels, funding types and sector, as well as funding for vaccines and funding from philanthropic providers. This descriptive analysis lays the groundwork for the analysis of relevance, coherence, effectiveness and efficiency in subsequent chapters.

2.1. COVID-19 global response timeline and architecture

COVID-19 first emerged during late 2019 with the outbreak in Wuhan, the People's Republic of China (hereafter 'China'), followed by WHO declaring it a Public Health Emergency of International Concern on 30 January 2020. From February 2020 the international response started at scale. Governments enacted travel bans, lockdowns and other emergency health measures to try to contain the spread of the virus and provide testing and treatment. Urgent, co-ordinated vaccine development efforts culminated in mass immunisation campaigns by late 2020. Domestic social and economic support packages were ramped up to address the far-reaching consequences of both the pandemic and the prevention and control measures – and international assistance was mobilised to support governments responding to the crisis (OECD, 2025[1]).

The global response was framed within the UN pandemic response architecture. This was quickly established and underpinned by the following four overarching global frameworks:

1. The World Health Organization (WHO) developed the **2019 Novel Coronavirus Strategic Preparedness and Response Plan** (SPRP) (WHO, 2020[2]) and provided the framework for the international health response. It was subsequently revised in 2021 and again in 2022 to reflect new knowledge and the ways in which the pandemic had evolved.
2. The **Global Humanitarian Response Plan COVID-19** (GHRP) (UNOCHA, 2020[3]) set out the Inter-agency Standing Committee (IASC) strategy for addressing needs in humanitarian contexts, with priorities on containing the spread of COVID-19; decreasing the deterioration of human assets and rights, social cohesion and livelihoods; and protecting and assisting refugees, internally displaced persons (IDPs), and migrant populations.
3. The **UN framework for the immediate socio-economic response to COVID-19** (UNSDG, 2020[4]) set out an approach for ensuring that five key pillars were addressed in the international socio-economic response: 1) the protection of health services and systems as a first priority; 2) support for social protection and basic services; 3) support for jobs, small and medium-sized enterprises (SMEs), and the informal sector; 4) support for the macroeconomic response and multilateral collaboration; and 5) social cohesion and community resilience.
4. The **Access to COVID-19 Tools Accelerator (ACT-A),** was a broad framework supporting vaccines, diagnostics, therapeutics and health systems strengthening (HSS), with COVAX as its vaccine pillar. Launched in April 2020, it brought together governments, philanthropies, UN agencies and multilateral institutions. COVAX was co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, the Vaccine Alliance, and WHO, with the United Nations Children's Fund (UNICEF) serving as the main delivery partner. COVAX aimed to accelerate vaccine development, secure doses, and ensure equitable distribution to all countries, focusing on low-income countries (LICs) through its Advance Market Commitment (AMC).

These frameworks interacted with existing global and country-level development and humanitarian co-ordination mechanisms including UN Country Teams (UNCTs),[2] the Humanitarian Cluster System[3] as well as donor co-ordination mechanisms and technical working groups within individual national governments. In addition to individuals, religious groups and local communities who played significant roles in responding to the pandemic in every country, the private sector and philanthropic actors played a major role in partner countries by providing funding and other support for vaccine development, supply and logistics, production and supply chain operations, and health system financing (OECD, 2025[5]).

2.2. International development co-operation and humanitarian assistance during the COVID-19 pandemic

In the early months of 2020, international development and humanitarian actors (including development agencies and ministries of provider countries) began taking specific steps to: 1) identify needs – both new or linked to existing programmes – and support needs assessments and the development of national and institutional response plans; 2) develop their own institutional responses, including forming decision making bodies and activating crisis response mechanisms; 3) adjusting existing programmes; and 4) mobilising or reallocating funding to respond to the skyrocketing needs.

While the COVID-19 crisis affected all countries, the intensity of its impacts came in waves, arriving at different times in different regions and countries. There was an outpouring of support and solidarity, with a huge amount of domestic and international support from not only the public sector, but also the private sector, non-governmental organisations, faith-based institutions, individuals and communities. Assistance flowed between countries of all different income groups.

Statements by leaders from many countries – for example China, France, Germany, Mexico, Saudi Arabia, South Africa, and Türkiye – expressed similar sentiments of urgency and global solidarity, and commitments to act quickly, supporting global action to leave no one behind.

In early April 2020, DAC members, who historically represent the largest providers of official development assistance (ODA), met to collectively set out their intended policy and programmatic direction for the pandemic response. In a joint statement, DAC members articulated that the pandemic would have profound economic consequences, which would severely impact the poor, especially those in fragile states. DAC members outlined the following commitments (OECD, 2020[6]):

- protecting official development assistance (ODA) budgets, while acknowledging the pressures on domestic public finances – which implies maintaining or increasing funding levels and making COVID-related support “additional” to existing funding
- supporting least developed countries (LDCs) and other “countries with specific needs” (including Small Island Developing States [SIDS]), with a coherent and co-ordinated response
- taking a “humanitarian-development-peace nexus” approach.

The intention was to respond to immediate needs (e.g. health, social safety nets and humanitarian needs) and to support recovery. Members called for support from all development actors, including the private sector and civil society organisations (CSOs), which are critical in providing support to vulnerable people. Strengthening health systems, sharing epidemiological and clinical data, as well as sharing materials necessary for research and development, including on vaccines, were highlighted as priorities. Finally, members committed to sharing evidence and best practice data “on what works to counter the virus” (OECD, 2020[6]).

The co-chairs of the Global Partnership for Effective Development Co-operation also made a statement on the global pandemic, stating that "Efforts to provide support need not only be increased, they must also become more targeted and co-ordinated to reach those most in need." (GPDEC, 2020[7]). They outlined the importance of country ownership, inclusive partnerships, focusing on results, and transparency and accountability to work together effectively.

DAC members also agreed to freeze ODA statuses and graduations, to ensure that no country would lose ODA eligibility during the pandemic, making it easier for countries to receive the funds (OECD, 2022[8]).

Overall international assistance (2020-2022)

The pandemic saw an increase in all types of international assistance, including official development finance (ODF) and philanthropic flows, with a record-high level of flows to developing countries in 2020 totalling USD 289 billion. Overall, from 2020 to 2022, international assistance to developing countries from all official providers and philanthropic foundations amounted to USD 886 billion in net terms (USD 1.1 trillion in gross terms). Within this broader assistance, ODA and other concessional finance remained almost constant in 2021 and then rose sharply again in 2022 (largely due to support for Ukraine and unrelated to the COVID pandemic). Other official flows (OOF) also rose in 2020 but then dropped in 2021 before increasing in 2022, while philanthropic flows also increased in 2020 and then fluctuated slightly (Figure 2.1).

The largest providers of ODF across the 2020-2022 period were the United States (USD 136 billion); Germany (USD 83 billion); EU Institutions (USD 72 billion); and the World Bank's IDA (USD 52 billion). While China does not report to the OECD, estimates based on reporting by the China International Development Cooperation Agency (CIDCA) show that considerable international assistance was deployed, including in-kind donations of equipment and vaccines (CIKD, 2023[9]). Other major non-DAC providers over 2020-2022 were Türkiye (USD 27.8 billion), Saudi Arabia (USD 14.9 billion), the United Arab Emirates (USD 5.8 billion), Qatar (USD 2.0 billion), and Kuwait (USD 1.1 billion). These countries mainly targeted humanitarian aid (49% of the total among these providers, in gross terms) and general budget support (25%) among all sectors (OECD, 2025[1]).

Total COVID-19-related funding, including outflows from multilateral organisations and philanthropic foundations, amounted to USD 126 billion (of which USD 89 billion was ODA) (OECD, 2025[1]).

In terms of net disbursements, multilateral agencies played a significant role in responding to the COVID-19 crisis in 2020-2022 with both concessional and non-concessional financing. The World Bank Group disbursed USD 98 billion in net terms (USD 47 billion from the International Bank for Reconstruction and Development [IBRD] and USD 523 billion from the International Development Association [IDA]). The International Monetary Fund (IMF) mobilised a massive COVID-19 support package with concessional outflows jumping from USD 274 million in 2019 to USD 9.4 billion in 2020 (OECD, 2025[1]).

As Figure 2.2 shows, net ODA disbursements from provider countries (DAC and non-DAC) had plateaued in the years immediately preceding the pandemic, with a slight drop from USD 187 billion in 2018 to USD 182 billion in 2019. The COVID-19 pandemic drove up funding commitments and disbursements from bilateral providers as a group. Total net ODA disbursements from these providers reached USD 194 billion in 2020 and USD 209 billion in 2021. ODA from official bilateral providers then witnessed a sharper increase in 2022, reaching USD 247 billion, mainly due to support provided to Ukraine in response to Russia's full-scale war of aggression.

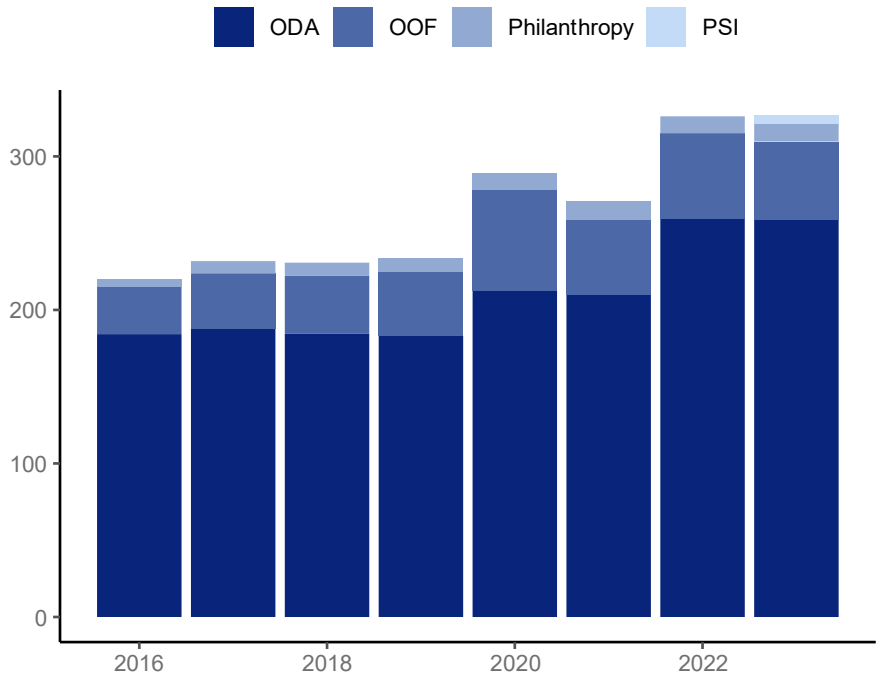
During the crisis period, COVID-19-specific bilateral funding amounted to USD 66 billion (of which USD 65 billion was ODA). The largest providers of COVID funding in 2020 were Germany and Japan. Over the three-year period, the largest were the United States, Germany, and Japan.

These overall trends include considerable variation across provider and recipient countries, as needs and priorities of both recipients and providers changed (at times directly linked to the pandemic, and at times reflecting the country context or other crises). Chapter 3 on Relevance discusses this further.

For example, assistance to the Philippines roughly tripled in 2019-2020, propelling it into the top three recipient countries, despite not featuring in the top ten recipient countries prior to the pandemic. Kenya also saw a substantial increase in assistance in 2020 compared to previous years; however, unlike the Philippines, this spike was short-lived, with funding returning to pre-pandemic levels from 2021 onwards. In contrast, Egypt experienced a decline in assistance, dropping from USD 6.8 billion in 2019 to USD 5.5 billion in 2020, before rebounding to USD 12 billion in 2021 with a sizeable influx of budget support. Trends in assistance flows to other countries remained consistent throughout the pandemic period. For example, assistance to India remained at a high level; Bangladesh experienced steady increases in funding that aligned with the pre-pandemic trajectory; and Afghanistan, Lebanon and Viet Nam all saw continued declines in assistance, in keeping with trends observed prior to 2020 (OECD, 2025[1]).

Figure 2.1. Financial flows to developing countries, all official providers and philanthropic foundations, 2010-2023

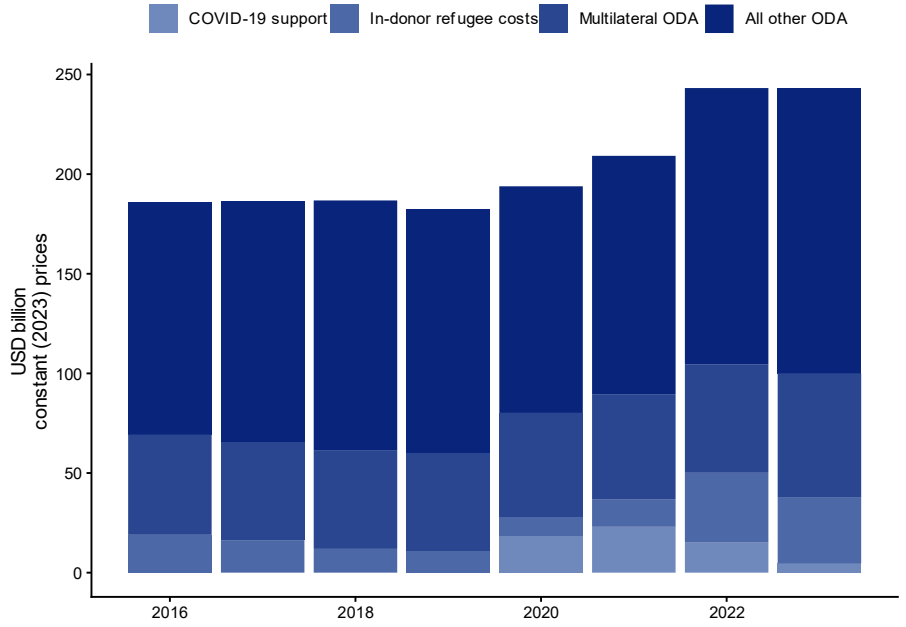
USD billion net disbursements, constant 2023 prices



Notes: ODA = official development assistance; OOF = other official flows; PSI = private sector instruments (not measured prior to 2023). ODA includes concessional outflows from the core budgets of multilateral organisations.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure 2.2. Total volume of official development assistance, including COVID-19-related, 2016-2023

All official bilateral providers, USD billion net disbursements, constant 2023 prices



Notes: COVID-19 support is defined by filtering for activities that are assigned either the COVID-19 control purpose code (12264) or the "COVID-19" hashtag in the Creditor Reporting System (CRS) database. In-donor refugee costs are defined by filtering for activities that are assigned the co-operation modality H02-H06. All flows are shown in net terms.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Providers' relative levels of effort during the pandemic

In 2020, five countries – Norway, Luxembourg, Sweden, Germany and Denmark – met the ODA target of 0.7% of GNI. During the crisis, the DAC average increased from 0.30% in 2019 to 0.33% in 2020, and a peak of 0.37% in 2022, showing that many overcame economic challenges and huge levels of domestic spending to protect or increase development assistance. Ireland, the Netherlands and Türkiye all maintained their ODA as a percentage of GNI close to their 0.7% targets, at 0.67%, 0.66% and 0.62%, respectively. Conversely, many other providers, remained well behind – or dipped further below – the ODA/GNI target.

Contrasting changes to gross national income (GNI) and ODA volumes suggest varying levels of effort among providers during the crisis. Figure 2.3 shows rates of change in individual providers' GNI and ODA from 2019 to 2020. While the crisis' economic impact and national COVID responses determined the fiscal space available, the choice to allocate ODA in line with increasing global needs reflected deliberate policy decisions made by providers.

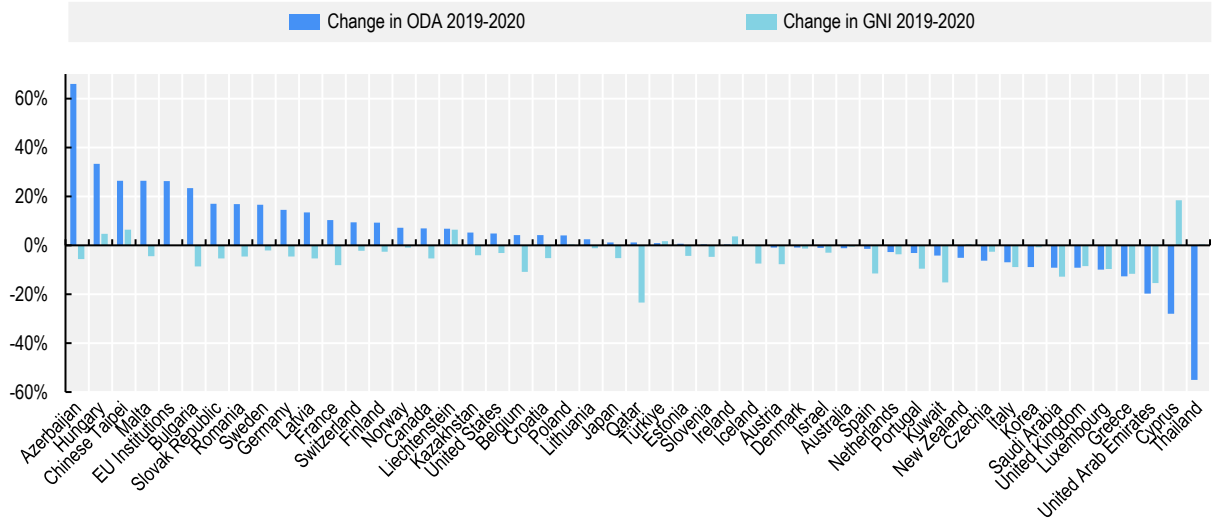
Several providers stand out for increasing international assistance substantially despite experiencing economic contractions. Among DAC members, France, Germany, Latvia, the Slovak Republic and Sweden all increased their ODA by 10% or more between 2019 and 2020, even as their economies contracted. France increased its assistance by 10%, despite an 8% drop in GNI, with much of this coming in the form of ODA loans. Similarly, Germany (+14.5% ODA, -4.6% GNI) and Sweden (+16.6% ODA, -2.1% GNI) increased aid levels even amid economic decline. Among non-DAC providers, Hungary, Chinese Taipei, Malta, Bulgaria and Romania also increased their ODA by 33.4%, 26.4%, 26.4%, 23.4% and 16.9%, respectively (although it should be noted that some of these changes involve small absolute amounts).

Ireland (+0.3% ODA, +3.7% GNI) and Türkiye (+0.9% ODA, +1.7% GNI), both increased ODA, while also experiencing economic growth in the first year of the crisis. Other providers, however, reduced ODA levels even as their economies remained on a stable to positive trajectory, as was the case for Denmark (-0.9% ODA, +1.3% GNI), and New Zealand (-5.1% ODA, +0.5% GNI).

Finally, some providers experienced both economic decline and a sharp reduction in aid. The United Arab Emirates and Greece experienced the most dramatic contractions, reducing ODA by 19.7% and 12.7%, respectively, alongside a 15.5% and 11.7% drop in GNI. The United Kingdom, historically one of the largest providers, reduced ODA by 9.1% in the context of an 8.4% fall in GNI due to a policy decision taken to reduce international aid in the face of the pandemic crisis (ICAI, 2023[10]).

Figure 2.3. Annual percentage changes in total ODA and GNI, 2019-2020

All official bilateral providers, percentage change from 2019 to 2020



Sources: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52; World Bank Development Indicators https://databank.worldbank.org/source/world-development-indicators.

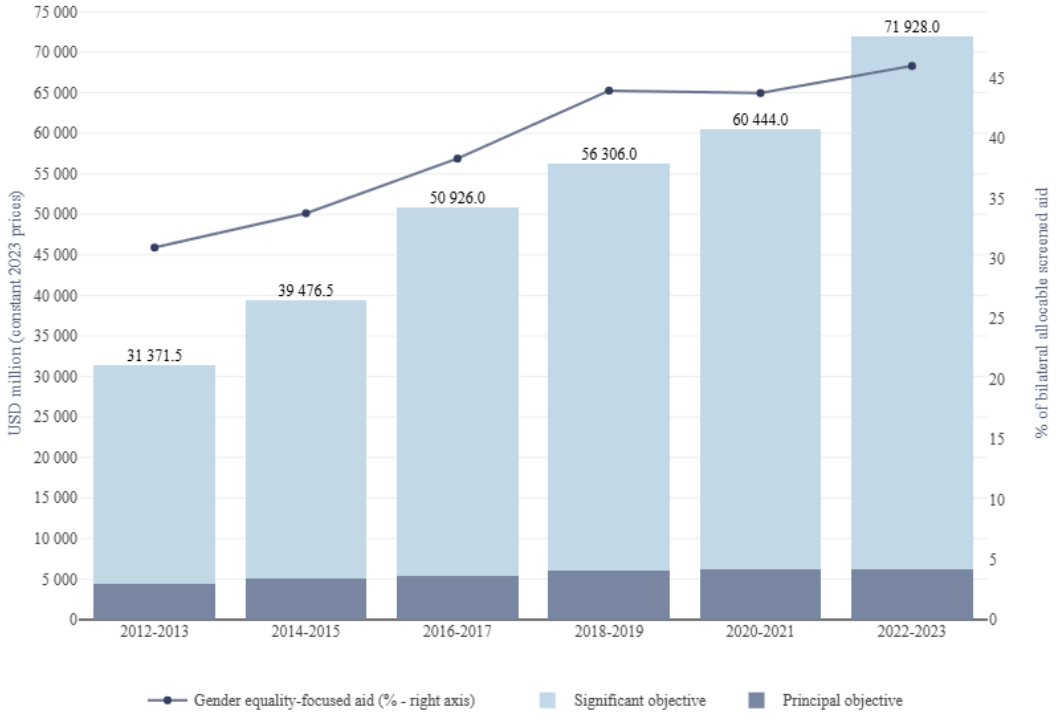
Targeting gender equality and the rights of people with disabilities

The CRS database tracks data for targeting of gender equality and disability. During COVID-19, many governments, providers and implementing agencies actively sought to reach these vulnerable populations and adapted their programmes over time to enhance inclusivity (ALNAP, 2024[11]).

Figure 2.4 shows that while the absolute amount of assistance with gender as a significant objective increased from USD 50.2 billion to USD 54.2 billion in the first biennium of the pandemic (2020-2021)[4], its share remained essentially the same, at 43.8%.

Figure 2.4. Official development assistance with a gender objective, DAC members, 2012-2023

All official bilateral providers, two-year average, constant 2023 prices

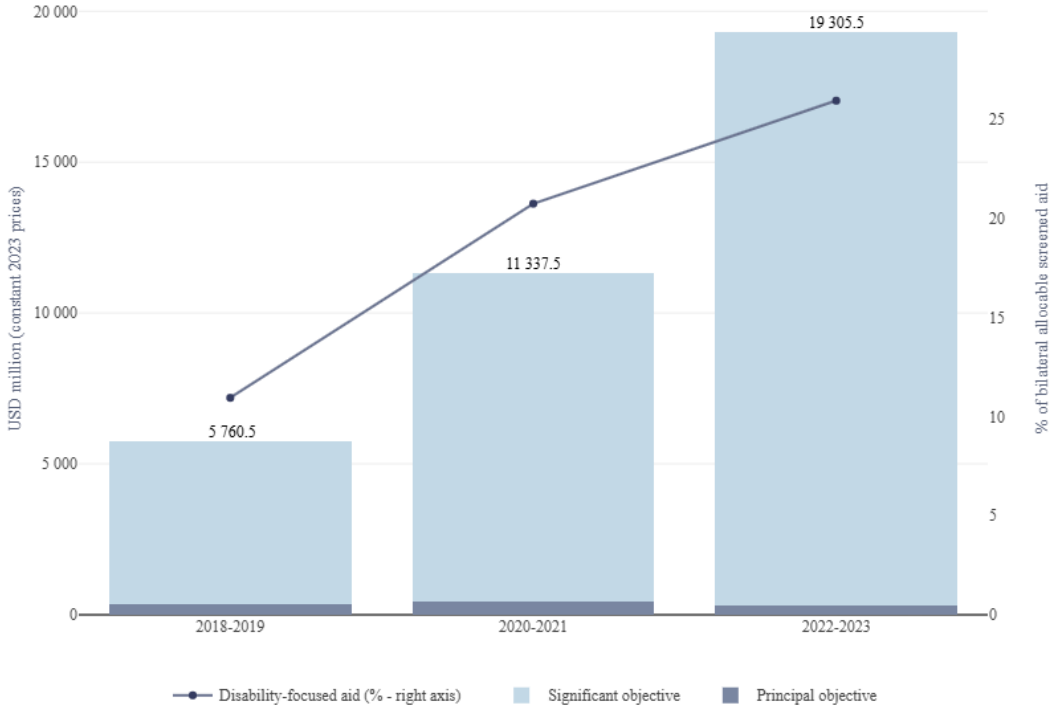


Note: Estimates are based on two-year averages of bilateral allocable commitments to account for volatility in the use of commitments data. The line shows ODA with a gender objective as a percentage of the total assistance.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

The bars in Figure 2.5 show the amount of ODA that includes disability as either a principal or significant objective, while the line shows the amount as a percentage of total assistance. The absolute amount of disability-related ODA almost doubled between the 2018-2019 and 2020-2021 biennia (+97%) from USD 5.8 billion to USD 11.3 billion. The percentage of assistance that included disability objectives also increased during the pandemic, from 11% in 2018-2019 to 21% in 2020-2021. This reflects a positive trend in ODA with a disability objective, with the 2022-2023 biennium also witnessing a large increase both in terms of total amounts and percentage.

Figure 2.5. Official development assistance with a disability objective, DAC members, 2018-2023

All official bilateral providers, constant 2023 prices



Note: Estimates are based on two-year averages of bilateral allocable commitments to account for volatility in the use of commitments data.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

2.3. Focus of international assistance by sector and country

Sector-specific allocations – which represent about half of total ODA – varied significantly during the crisis, with assistance allocated across all sectors. This reflects the far-reaching, multidimensional impacts of the COVID-19 crisis and continued attention to overall sustainable development priorities.

There was an increase in funding for the health sector, and other sectors indirectly impacted by the pandemic containment measures, such as education and food security (Figure 2.6).

Health funding commitments increased by 73% from 2019 to 2020 (USD 49 billion), reaching a record high of USD 59 billion in 2022. Health took a more predominant place in the sector mix overall, ranking third in 2020 and 2021 by total commitments. Health funding represented 11% and 16% of ODF respectively, compared to 8% in pre-pandemic years. After these first two pandemic years, the situation almost returned to pre-pandemic levels, with health representing 9% of ODF in both 2022 and 2023.

While health was the primary focus of COVID-19-specific spending, overall assistance was highest in the social infrastructure and services sector (the largest sector in 2020), followed by humanitarian aid and economic infrastructure. Economic and social infrastructure continued to be the main sectors by total commitments, 28% and 24% of commitments, respectively. In 2020, support targeting social infrastructure (including support for water and sanitation, and education) surpassed economic infrastructure, which was the top sector throughout the rest of the observed period.

The sectoral funding patterns of individual providers highlight diverse strategies and variation in how sectoral allocations changed (or not) from 2019 to 2022. (Annex C provides figures for each country.)

Germany maintained relatively stable distributions across sectors, except for an increase in health commitments between 2020-2022. New Zealand, also elevated health-related spending in 2020-2021 (from USD 37 million in 2019 to USD 66 million in 2020), making it the third-largest sector in 2021, reflecting its assistance strategy in the Pacific region. Similarly, Spain increased its health-related commitments both absolutely and relative terms, in 2021-2022, with health becoming the third-largest sector for both years. In 2021, the United States increased both humanitarian aid, which rose to second place, and health commitments, which climbed to fourth position. The Netherlands' allocations also demonstrated a shift, with commitments to social service sectors surging so substantially in 2020 that they surpassed the typically dominant "other sectors" category (due to the inclusion of in-donor refugee costs and administrative expenses in this category).

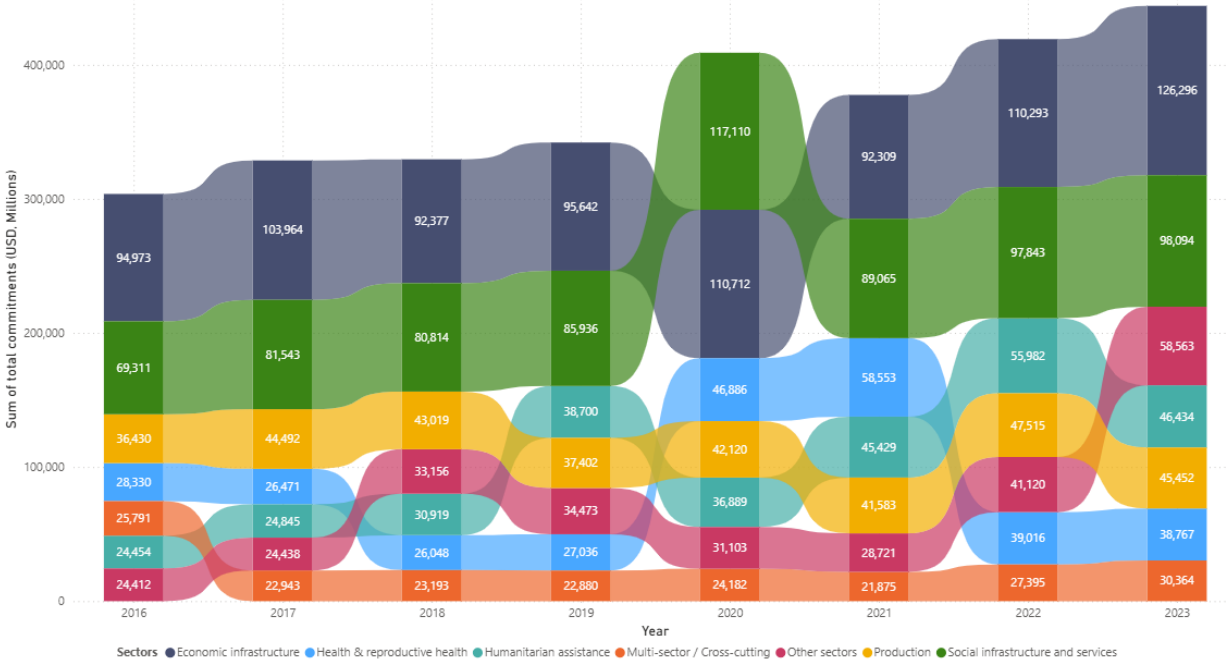
From 2020-2023, Korea and Japan committed over 40% of their assistance to economic infrastructure and services – well above the DAC average and consistent with their pre-pandemic spending. In contrast, Sweden focused on social infrastructure and services (36%). Saudi Arabia's assistance also rose during the pandemic, with "other sectors" expanding significantly from 2021 onward, primarily due to substantial budget support provided to Egypt (Figure C.12 in Annex C).

The use of budget support was instrumental in responding to the crisis, particularly in certain recipient countries that received large emergency funding packages (e.g. Burkina Faso, Cabo Verde, Cambodia and Kenya). In Figure 2.6 the increase in budget support becomes visible in 2022, with "Other sectors" rising to USD 41 billion due to support provided countries in their economic recovery from the crisis (e.g. Egypt).

Importantly, for the period under evaluation, the increases in funding for health (especially in 2020 and 2021) and social infrastructure do not seem to have significantly displaced funding for other priorities, though this is difficult to determine at the aggregate and there is evidence of broader trade-offs in the aftermath of the pandemic (Penn et al., 2025[12]).

Figure 2.6. Volume of official development finance, by sector, 2016-2023

All official providers and philanthropic foundations, USD billion commitments, constant 2023 prices



Note: Includes flows on a gross basis from DAC countries, non-DAC bilateral providers, the core budgets of multilateral organisations, and philanthropic foundations.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Funding patterns by recipient region, country and income group

There are some key differences in sector allocations between regions (see Annex C). In Africa, commitments to the health sector more than doubled; in the Americas they increased by 25% from 2020-2021, as vaccines were deployed. Conversely, in Asia, commitments to health decreased by about USD 100 million in 2021, while humanitarian assistance increased 2.5 times from 2020-2021 (from USD 331 million to USD 818 million). Humanitarian assistance also became the second largest sector in 2021 in the Americas, reaching USD 658 million in commitments, with slight declines in the economic sectors.

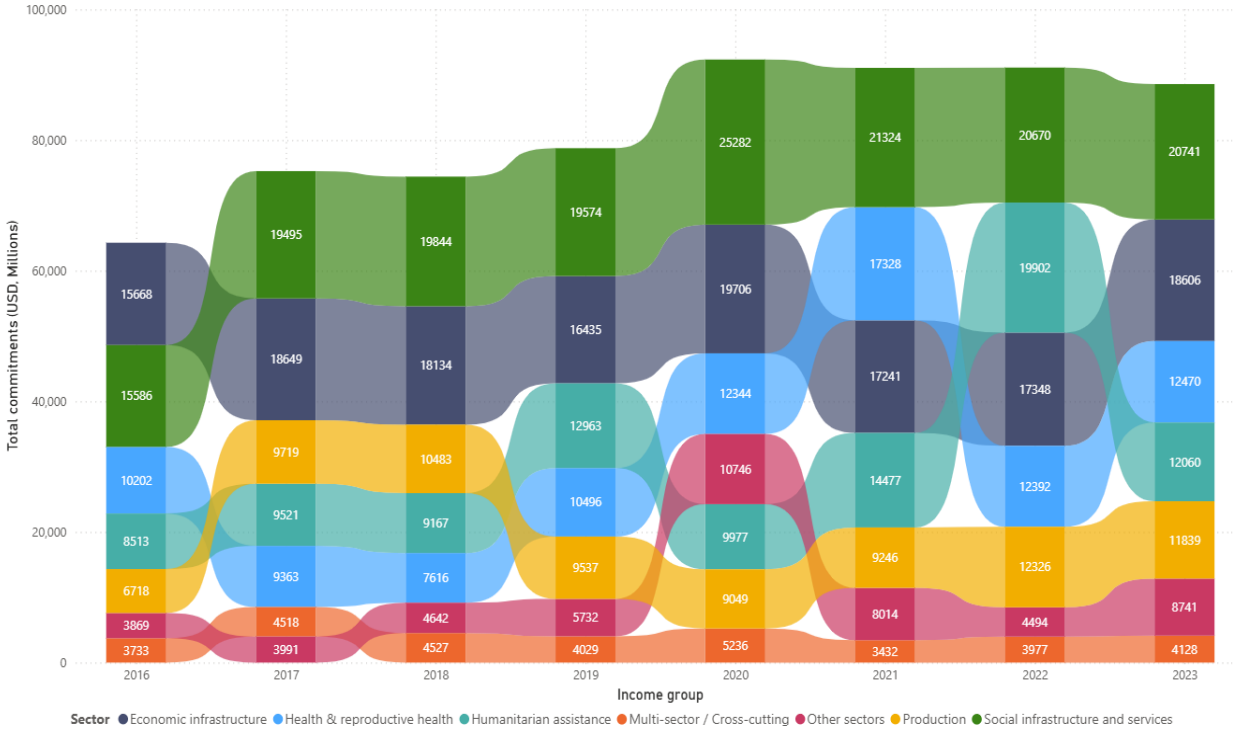
In terms of countries receiving assistance, there was also great variation in the types of support. In Georgia, for example, health sector commitments increased by 146% from 2019 to 2020 (though still represented a small percent of total support – see Annex C); humanitarian assistance also increased from USD 85.6 million to USD 211.6 million (147%) and then again in 2021 reaching USD 356 million, with support to vulnerable groups. Kenya also experienced a sharp and sustained increase in health sector funding during the pandemic, rising from USD 386 million in commitments in 2019 to USD 945 million in 2020 and USD 1 billion in 2021, making it the largest sector in terms of assistance that year, overtaking economic infrastructure, which had declined significantly from pre-pandemic levels. In Lebanon, assistance continued to be dominated by the humanitarian and social infrastructure sectors during the pandemic, though health sector commitments roughly doubled. Bangladesh, meanwhile, saw a marked rise in commitments to health and social infrastructure in 2021, displacing all other sectors except economic infrastructure, which remained the largest throughout. But by 2022, these sectors had largely returned to their pre-pandemic levels. Interestingly, commitments to “other sectors” saw a temporary spike across in 2020 potentially reflecting the need and desire to rapidly disburse large amounts of funding flexibly.

In terms of income groups, while social infrastructure remained the largest sector, health sector commitments increased across all income groups (see Annex C). The increase in health funding is most visible for least developed countries (LDCs) saw their commitments to health increasing significantly from all providers, from USD 10.5 billion in 2019 to USD 12.3 billion in 2020 (+18%) and to USD 17.3 billion in 2021 (an additional 40%, making health the second sector by commitments) as vaccines and other support to address the impact of the pandemic were deployed (Figure 2.7). Humanitarian assistance also increased significantly in 2022, reaching nearly USD 19.9 billion and becoming the second most funded sector. Lower-middle-income countries (LMICs) also saw an increase in health in 2020 and 2021, however social and economic infrastructure remained the main sectors; “other sectors” largely increased in 2022, becoming the third sector at USD 22.4 billion.

In 2020, per capita assistance rose across all income groups, with the largest percentage increase in the wealthiest group of recipient countries (UMICs) (Figure 2.8). However, after the first two years of the pandemic, per capita assistance to UMICs and LICs declined from 2021 to 2022, while support to LMICs continued to rise, reflecting the increase in ODA to Ukraine.

Figure 2.7. Official development finance to least developed countries, by sector, 2016-2023

USD million commitments, constant 2023 prices

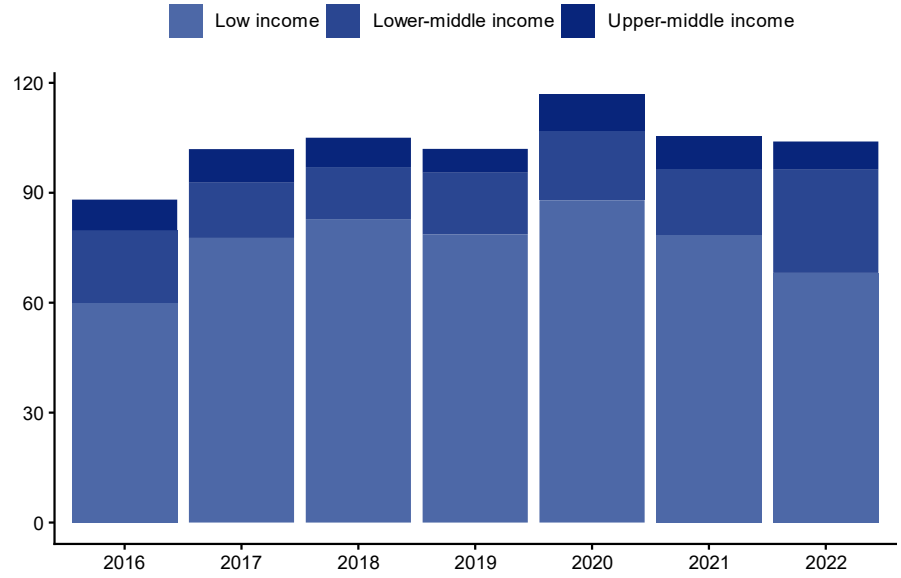


Notes: Includes flows on a gross basis from DAC countries, official non-DAC bilateral providers, multilateral organisations, and philanthropic foundations. “Social infrastructure and services” includes education, population policies, governance, and water and sanitation. “Economic infrastructure” includes transport, energy, communications, banking and financial services, and business. “Other sectors” includes general budget support as well as debt rescheduling.

Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure 2.8. Official development assistance per capita, by income group, 2016-2023

All official providers, bilateral net disbursements, USD per capita



Notes: Income groups are based on the World Bank income group that aligns with the calendar year being analysed. Countries classified as high-income or not classified by the World Bank are excluded from the analysis to adjust for the effect of outliers.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flow) (Database), http://data-explorer.oecd.org/s/52.

2.4. Funding channels and financial flows during the crisis

To reach those in need, international assistance was disbursed by bilateral and multilateral development agencies, as well as through multi-bi support (bilateral support disbursed at country level to multilateral agencies) via different channels (e.g., governments, NGOs and private sector). International development and humanitarian assistance used a range of funding instruments (concessional and non-concessional, grants and loans, and debt-related action). This section looks at how financial flows changed during the crisis (2020-2022) setting the stage for analysis of relevance, effectiveness and efficiency.

Multilateral organisations

Multilateral agencies played a crucial role in supporting the global response to the COVID-19 pandemic, including receiving a higher share of COVID-19-tagged assistance, compared to overall assistance. Assistance via multilateral organisations was viewed as a way to ensure international support remained relevant, scalable and coherent – especially in early 2020, when countries' specific needs were still unclear. Total multilateral assistance, and its share of all assistance provided, had been slowly increasing since 2016, reaching USD 51.9 billion in 2022, before a slight decline in 2023, as shown in (Figure 2.9).

Multilaterals were crucial in co-ordinating responses, leveraging expertise, and ensuring distribution at speed and scale. Bilateral providers recognised the advantages multilaterals have in terms of their expertise (such as vaccine distribution, supply chains and procurement) and in their ability to mobilise resources and distribute assistance quickly and at scale.

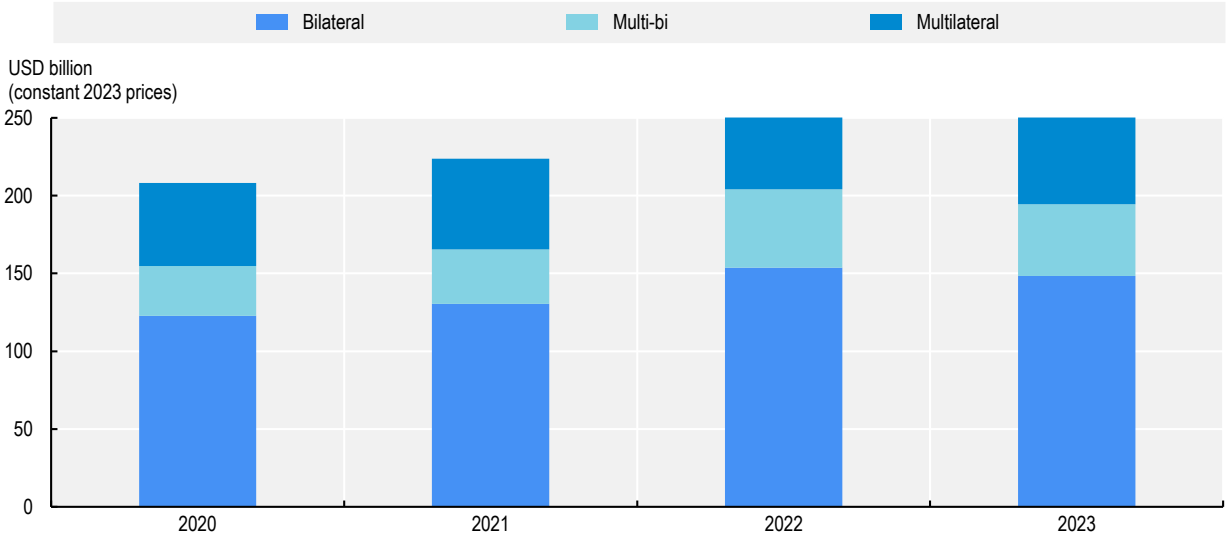
The largest DAC contributors to multilateral funding in 2020 were the United States (USD 6.6 billion), Germany (USD 7.2 billion) and the United Kingdom (USD 3.3 billion). Significant contributors to multilaterals, as a percentage of overall assistance, were Sweden (76%) and Denmark (52%). France

rapidly increased its provision of bilateral assistance through multilaterals from USD 323 million in 2019 to USD 1.1 billion in 2020, a 245% increase in one year.

From 2020-2022, 14% of bilateral assistance was channelled through multilaterals ("Multi-bi" in Figure 2.9), slightly above the 12% recorded from 2016-2019. The share of core contributions to multilateral organisations ("Multilateral") also increased in 2020 and 2021 reaching 26%, compared to 13.0% for overall assistance during the same period. This is part of a general trend that saw bilateral providers leaning on the multilateral system to scale up co-ordination mechanisms across development actors, to address the health, socio-economic and humanitarian impacts of the crisis, as well as provide flexible and timely responses depending on needs.

Figure 2.9. Official development assistance by bilateral and multilateral channels

DAC and non-DAC donors, USD billion disbursements, constant 2023 prices



Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

The World Bank Group disbursed over USD 157 billion between April 2020 and June 2021, aiding over 100 developing countries (World Bank, 2021[13]). Similarly, by March 2022, the IMF had made USD 250 billion – a quarter of its USD 1 trillion lending capacity – available to member countries (IMF, 2022[14]). In addition, key UN agencies contributed significant resources to the pandemic response, including WHO (co-ordinating vaccine distribution and the COVID-19 Solidarity Response Fund), UNICEF (distributing billions of COVAX vaccines) and the World Food Programme (delivering emergency food and cash transfers to vulnerable populations, air logistics service, support to national social protection expansions, and continuity of national school feeding programmes).

Multilateral assistance followed a stable growth trend before the pandemic but saw notable shifts during COVID-19. Prior to 2020, multilateral assistance increased by 6-7% annually, with most funding directed to UN agencies (70%), followed by the World Bank (10%) and regional development banks (6%). However, in 2020 and 2021, growth accelerated to 13% and 11%, respectively, while the distribution among multilateral institutions remained largely unchanged. By 2022, UN agencies' share declined slightly to 65%, with increased allocations to the IMF and other institutions. In 2023, total multilateral assistance returned to 2021 levels, but funding to UN agencies increased, offsetting reductions to the IMF, World Bank and other multilateral entities (OECD, 2025[1]).

Amid concerns that earmarked funding was limiting the flexibility of multilateral agencies, there was an initial reduction in such restrictions at the outset of the pandemic, enabling a more responsive approach and a rapid scale-up of operations. However, over the course of the pandemic, earmarking gradually returned to pre-pandemic levels as the need for accountability on the use of funds increased (IAHE, 2022[15]).

In 2019, 78% of the UN Development Programme's (UNDP) resources were earmarked, meaning additional resources for pandemic response had to be through the reallocation of resources or the mobilisation of new donor funding. In the first two quarters of 2020, only four countries (Australia, Belgium, France and the Netherlands) supported WHO with additional flexible voluntary funding (Gulrajani, 2020[16]). WHO, the UN agency tasked with directing and co-ordinating authority on international health, had one of the highest rates of earmarked funding at 80% (Woskie and Wenham, 2024[17]). This was true of the broader UN system, with around 58% of funding earmarked in 2019 (UNDP IEO, 2022[18]).

The Netherlands' pandemic funding comprised 64.4% unearmarked funds, enabling it to respond quickly and flexibly (OECD/IOB, 2025[19]). An evaluation of the UK's Foreign, Commonwealth and Development Office's (FCDO's) response found that unearmarked contributions promoted coherence and co-ordination, boosted efficiency, and enabled emerging needs and gaps to be rapidly filled (ICAI, 2022[20]). Norway concluded that significant core funding for some key multilaterals provided greater flexibility and allowed for a quick response and adjustment of priorities due to COVID-19 (NORAD, 2020[21]).

In the context of the COVID crisis, bilateral providers directed support via the multilateral system out of principle and as a way of ensuring global needs could be met even amid uncertainty. In total, donors provided USD 188.7 billion to the multilateral system between 2020-2022 (OECD, 2025[1]). Many governments placed trust in multilateral institutions, providing flexible funding to enhance coherence between bilateral and multilateral efforts. Among bilateral providers, however, there is considerable variation across providers in terms of the proportion of funding directed through multilateral channels and the extent to which their response to the pandemic marked a shift in funding strategies or continuity. Some smaller donors relied heavily on multilaterals, while others barely engaged with them. For example, the largest users of the multilateral system in percentage of overall assistance were Kazakhstan (71%), Cyprus (67%) and Ireland (41%), whereas Türkiye (0%), Poland (1.1%) and Bulgaria (1.2%) provided almost no funding through these channels (OECD, 2025[1]).

The Independent Commission for Aid Impact's (ICAI's) evaluation of the United Kingdom's humanitarian response found that its early prioritisation of supporting multilateral delivery generally worked well, with its flexible contributions proving an efficient way of targeting relevant needs and disbursing funding, as well as supporting coherence (see Chapter 4) (ICAI, 2022[20]).

Norway also preferred using multilateral channels, channelling 77% of its total ODA for COVID-19 into 12 projects with seven multilateral organisations (NORAD, 2020[21]). Similarly, Spain explicitly recognised the importance of a multilateral co-ordinated response and channelled 61.2% of its ODA through international organisations, funding projects directly and indirectly related to COVID-19 (Government of Spain, 2024[22]). The Netherlands also delivered the bulk of its COVID-19 response through the multilateral channel, with its decisions and funding allocations being both principle-driven and informed by needs assessments conducted by key multilateral organisations (OECD/IOB, 2025[19]). Japan contributed to the establishment of a framework for providing additional funding through the Global Fund, as well as allowing the use of Grant Flexibility (Ministry of Foreign Affairs of Japan, 2025[23]).

Drawing on their experience in large-scale humanitarian operations in response to pandemics, UN organisations were quickly able to prepare a response to the humanitarian and socio-economic impacts of the crisis (UNSDG, 2022[24]). For example, an independent evaluation found that the WFP was very timely in this regard, declaring its Level 3 emergency response before the end of March 2020. By December 2020 they had recast their medium-term programme framework to become the "Socio-economic response and

recovery programme framework" and in early 2021 integrated COVID-19 into global operational planning, rather than a standalone emergency (WFP, 2022[25]).

The United Nations Population Fund (UNFPA) also moved quickly to make existing emergency core funding streams available and put COVID-19-specific funding mechanisms in place. It prioritised programme countries with the highest needs and least ability to finance their own development, notably those in fragile and humanitarian situations (UNFPA, 2024[26]). Similarly, UNICEF declared a Level 3 emergency in April 2020 and invested considerably in analysing needs. The broad range of evidence generated contributed to the global evidence base and supported countries' knowledge of their populations' needs (UNICEF, 2022[27]).

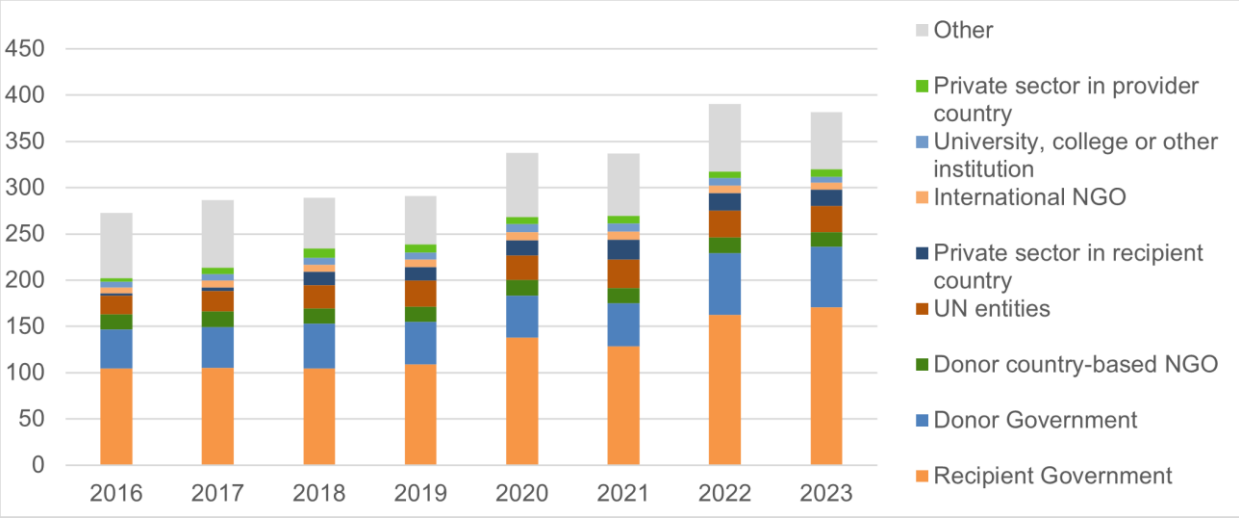
Other funding channels

Governments in recipient countries were another preferred channel for disbursing assistance, both before and during COVID-19, receiving an average of 40% of total flows from 2016-2023 (see Figure 2.10) and showing a slight increase in 2020 linked to budget support. Other major channels included donor governments (16%), UN entities (8%) and donor-country based non-governmental organisations (5%).

The distribution of assistance shifted following the onset of the COVID-19 pandemic. In the four years prior to the pandemic (2016-2019), recipient governments accounted for 37.1% of assistance, increasing to 41.5% during the pandemic period (2020-2023). In contrast, donor-country-based non-governmental organisations (NGOs) saw a decline in their share, from 5.8% pre-pandemic to 4.6% post-pandemic.

Figure 2.10. Official development finance disbursed through different channels, 2016-2023

All official providers, USD billion disbursements, constant 2023 prices



Notes: Includes official development assistance and other official flows. From 2023 onwards, PSI is no longer included in the analysis of ODA cash flows.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Financing instruments

As the pandemic unfolded in early 2020, international development and humanitarian institutions had several options of financing instrument, each with its own risks and benefits. There was significant variation across bilateral providers in terms of the types of finance used – though most remained consistent with pre-pandemic trends (see Annex C for examples from select providers).

Resource constraints favoured the use of loan instruments. Concerns about debt sustainability in a context of a steep increase in public debt, particularly in developing economies (World Bank, 2025[28]) affected decisions about the types of loans and often led to actions such as freezing of repayments.

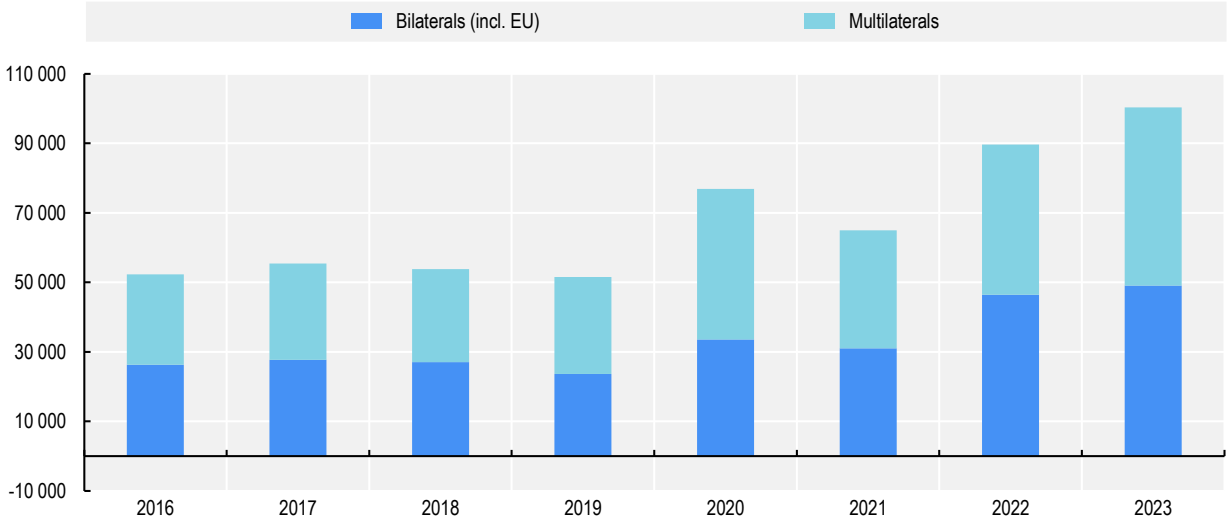
Use of loan instruments

In 2020, all funding types saw an uptick in use – except mobilised private finance – with increases in grants, concessional loans and other official flows. The largest increase in 2019-2020 came in the form of concessional loans. From 2020-2021, grants increased, while both concessional loans and other official flows dropped, resulting in a net decrease year on year.

Figure 2.11 displays the volume of ODA loan disbursements from 2016-2023, covering all donors and flow types. The percentage of assistance provided via ODA loans increased from 13% of the total development finance mix in 2019 to 18% in 2020 (corresponding to a 42% increase in total amounts). From 2021-2022, as the intensity of the pandemic diminished and global economic conditions began to stabilise, the pattern shifted slightly again. ODA grants as a percentage of total assistance increased slightly, while ODA loans initially fell in 2021 but then rebounded in 2022. This reflected strategic adjustments to the easing of the immediate crisis as well as support to vaccine rollouts in 2021.

Figure 2.11. Official development assistance loans by provider group, 2016-2023

All official providers, USD billion disbursements, constant 2023 prices



Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Pre-pandemic, multilaterals accounted for around half of all ODA loans, with bilateral providers, including EU institutions, providing the other half. However, in the first year of the pandemic, this pattern significantly changed as the total loan disbursements soared from USD 52 billion in 2019 to USD 77 billion in 2020, with multilaterals providing 83% of loans. ODA loans from multilateral providers increased by 55% in 2020, adding an additional USD 15 billion. ODA loans from national governments and the European Union also increased by 42%, but in 2021 they decreased by 8%, before picking up again in 2022.

In 2022, the overall volume of ODA loans increased markedly, in part due to the exceptional increase in loans committed in 2020 and 2021 to respond to the COVID-19 pandemic, as well as new loans to Ukraine (Kiernan, Turroques and Ahmad, 2024[29]). The largest individual providers of ODA loan disbursements (aggregated across 2020-2022) were the World Bank (USD 50 billion), Japan (USD 32 billion), and the European Union (USD 28 billion). The European Union more than doubled its ODA loan disbursements from USD 3.5 billion in 2019 to USD 7.2 billion in 2020, and then almost doubled again in 2022.

The largest recipients of ODA loan disbursements (aggregated across 2020-2022) were Ukraine (USD 16.4 billion), Bangladesh (USD 16.1 billion) and India (USD 15.3 billion). While Bangladesh and India are regularly in the top ten countries by volume of assistance, and both received significant COVID-19-related support, the jump in assistance to Ukraine in 2022 was in response to Russia's full-scale war of aggression.

In total, 54 countries were provided with total loan disbursements worth USD 1 billion or more. From 2020-2021, Kenya received approximately USD 1.2 billion in COVID-19-related assistance, accounting for 8% of its total aid during this period. Of this, 61% was in grants and 8% was in concessional loans. The remaining 31% consisted of non-concessional loans (OECD, 2025[30]). In contrast, COVID-19-related assistance commitments to Bangladesh amounted to USD 5.9 billion, equivalent to around one-fifth of the total development finance committed to this country over this period. Concessional loans represented a third of COVID-19 related finance to Bangladesh (OECD, 2025[31]).

Navigating fiscal vulnerability and debt distress with concessional lending

With the pandemic testing the fiscal resilience of development institutions, the increase in loan use may reflect the sudden pressure that donor countries and financial institutions faced to balance providing support with their own economic challenges (UN, 2020[32]). Within the first three months of the pandemic, two-thirds of the 62 countries receiving IMF support did so via concessional loans (IEO, 2023[33]). The IMF doubled its emergency lending capacity by increasing concessional support via its Poverty Reduction and Growth Trust and its Catastrophe Containment and Relief Fund (UNDP IEO, 2022[18]). In Kuwait, assistance was provided via the Kuwait Fund for Arab Economic Development, which provides concessional loans using a demand-driven approach (OECD, 2020[34]). Qatar and France also predominantly utilised concessional loans.

However, due to the high risk of debt distress and rising interest rates, driven in part by increased borrowing from provider countries for their own domestic pandemic responses, there was a strong push to use concessional finance and grants. Approximately half of LMICs had high public debt levels prior to COVID-19, a trend that worsened due to the pandemic. Even prior to the pandemic, over 30 African countries spent more on debt service than on healthcare. According to the World Bank's 2024 International Debt Report, LMICs accumulated significant debt during the pandemic years, driven by the need to scale-up health services and provide economic relief amid sharp declines in economic activity and government revenues. This trend persisted in 2023, as countries continued to navigate the post-pandemic recovery and address mounting development challenges.

The external debt of LMICs reached a record USD 8.8 trillion in 2023, while debt servicing costs for LMICs also reached an all-time high (Gill and Schellekens, 2021[35]). By early 2023, 54 ODA-eligible countries were at moderate or high risk of debt distress and nine were already in distress – the majority of which

were African nations (OECD, 2023[36]). Generally, fragile and conflict-affected states, commodity-dependent countries, and small states were more likely to be at moderate or high risk of debt distress (World Bank, 2022[37]). Countries such as Burkina Faso, Burundi, the Republic of the Congo, Côte d'Ivoire, Ghana, Liberia, Senegal and Sierra Leone saw significant rises in their debt burden between 2018 and 2023, reaching at least 15% of GDP (UNAIDS, 2025[38]).The terms of the loans countries could access, combined with large falls in exports, foreign direct investment (FDI) and recessions, undermined the fiscal space of governments in many LMICs, resulting in some countries being required to make debt payments at the expense of health and other social services, hampering their ability to respond with the health and stimulus packages that were commonplace in HICs (U.S. Global Leadership Coalition, 2021[39]).

In contrast, some governments sought to avoid new debt by reallocating existing budgetary resources to fund their pandemic response. While this strategy provided immediate relief without worsening debt levels, it came at the cost of diverting funds from other critical sectors, potentially stalling long-term development objectives. The opportunity costs of these reallocations were high: for every dollar shifted, countries lost an estimated USD 1.20 to USD 1.60 in potential returns from postponed or cancelled public investments. Sectors such as education, infrastructure and social services bore the brunt of these cuts, which could have long-term consequences for economic growth and social development (Allan and Bayley, 2023[40]).

To support vulnerable countries in debt management during the pandemic, the G20 set up the Debt Stress Suspension Initiative. G20 countries agreed in March 2020 to defer debt payments until the end of 2021. The World Bank and the IMF supported the implementation of the initiative by monitoring spending, enhancing public debt transparency and ensuring prudent borrowing. Established in May 2020, the initiative helped countries concentrate their resources on fighting the pandemic and safeguarding the lives and livelihoods of millions of the most vulnerable people. Forty-eight out of 73 eligible countries participated in the initiative before it expired at the end of December 2021. From May 2020 to December 2021, the initiative suspended USD 12.9 billion in debt-service payments owed by participating countries to their creditors (World Bank, 2022[41]). However, that relief did not apply to private lenders or payments to the World Bank itself which means only 41% of debt payments qualitied for relief (COVID Collective, 2022[42]).

Grants

Grants are transfers of cash, goods or services for which no repayment is required. Grants provided immediate financial relief without adding to the debt burden of recipient countries, which was particularly important and relevant for low-income countries with limited fiscal space. The overall amount of ODA grants disbursed has increased steadily from USD 178 billion in 2016 to USD 233 billion in 2022. Annual percentage increases in ODA grants were below 2% in the years preceding the pandemic (2016-2019). However, total ODA grants then increased by 5% in 2020 and reached 18% in 2022.

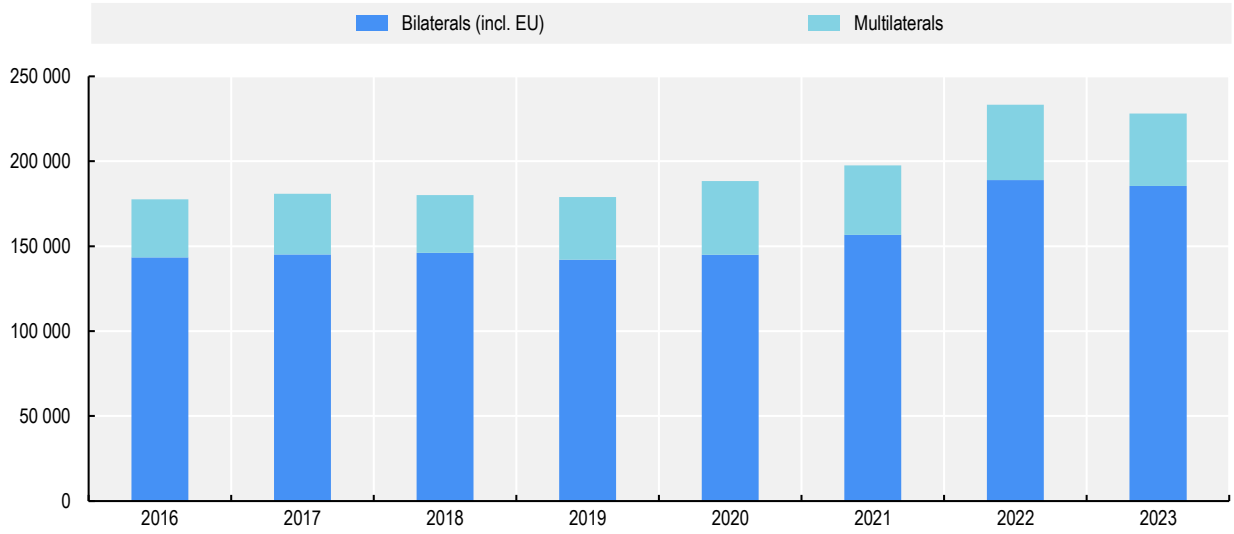
Bilateral providers increased their ODA grants by nearly USD 3 billion from 2019-2020, while also increasing loans. Grant disbursements increased again in 2022 with bilateral providers increasing their share of ODA grants by 21%, the highest share in the reporting period. Multilaterals, conversely, had the largest increase (18%) in 2020, and maintained the same level – above USD 40 billion – throughout the pandemic.

Between 2020-2022, the largest providers of ODA grants were the United States (USD 133 billion), Germany (USD 73 billion), and the European Union (USD 54 billion). The World Bank was the largest multilateral donor, disbursing USD 19.1 billion, followed by the Global Fund with USD 15.4 billion.

Some providers, including Austria, Hungary and Finland, increased their grant disbursements by more than 20% from 2020-2022 (32%, 24% and 21%, respectively). Others, such as Greece, New Zealand, Türkiye and the United Arab Emirates, reduced their ODA grant disbursements during the same period.

Figure 2.12. Figure Official development assistance via grants by provider group, 2016-2023

All official providers, USD billion disbursements, constant 2023 prices



Notes: Bilaterals include DAC and non-DAC countries, as well as EU institutions. Multilaterals refer to concessional outflows from the core budgets of multilateral organisations that voluntarily report their data to the OECD.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Box 2.1. Up close: Saudi Arabia's COVID-19-related assistance

In November 2020, Saudi Arabia chaired and hosted the G20 in Riyadh and played an active role in its presidency, succeeding in mobilising G20 members to commit sizeable funding to respond to the COVID-19 pandemic.

Saudi Arabia has committed and disbursed a significant amount of funding to assist various countries worldwide in responding to the pandemic, often working in challenging contexts of high need and fragility. From 2020-2022, the average annual assistance to developing countries provided by Saudi Arabia more than doubled compared to 2016-2019 levels. In 2020-2021, Saudi Arabia's external assistance reached USD 3.8 billion on average per year, compared with USD 1.8 billion in 2018-2019, (average per year, commitment basis). The composition of Saudi Arabia's assistance also changed: in 2020-2021 it was 100% grant based, while in previous years most of the aid was provided as concessional loans.

Saudi Arabia's COVID-19 international response of more than USD 825 million was managed by King Salman Humanitarian Relief. This included funding to 33 countries for the purchase of COVID-19 vaccines, medical supplies and equipment, as well as USD 10 million in financial support to the Solidarity Response Fund managed by the World Health Organization (WHO) and about USD 300 million to international research institutions working to develop COVID-19 vaccines. WHO received grants equivalent to USD 109 million commitments, Gavi received USD 108 million (of which USD 106 million to COVAX) and CEPI, USD 150 million. Local and central governments of partner countries received USD 64 million. Concerning vaccine doses, in addition to the Gavi donation, Saudi Arabia provided 1 499 270 vaccine doses (valued at some USD 6.4 million) to Bangladesh. As part of the broader crisis response, Saudi Arabia provided significant budget support to Egypt in 2021.

Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52; Interview with King Salman Humanitarian Aid and Relief Center (KSRelief), May 2024.

Box 2.2. The World Bank's support to the COVID-19 response

The World Bank Group announced "broad, fast action" to help developing countries strengthen their pandemic response. It focused on supporting public health interventions, working to ensure the flow of critical supplies and equipment, and helping the private sector continue to operate and sustain jobs. The aim was to deploy USD 160 billion in financial support over 15 months to help more than 100 countries. This included USD 50 billion of new IDA resources through grants and highly concessional loans. These global amounts translated into significant funds in many countries. For example, in Kenya, in 2020, USD 1 billion in financing was approved to support the COVID response.

Source: World Bank (2020[43]), ''World Bank Approves $1 Billion Financing for Kenya, to Address COVID-19 Financing Gap and Support Kenya's Economy'', https://www.worldbank.org/en/news/press-release/2020/05/20/world-bank-approves-1-billion-financing-for-kenya-to-address-covid-19-financing-gap-and-support-kenyas-economy.

2.5. Funding for vaccines and vaccination rollouts

The COVID-19 vaccine development and rollout were unprecedented in terms of their scale, speed and reach, and formed a key component of the crisis funding for nearly all providers of assistance in line with the November 2020 DAC high-level meeting call to make "affordable vaccines, tests and treatments available to all" (OECD, 2020, p. 3[44]).

Providers channelled vaccine donations both multilaterally and bilaterally. Key channels included Gavi (USD 6.2 billion), central governments (USD 559 million), and CEPI (USD 541 million) (OECD, 2025[1]). Most vaccines were channelled globally (unallocated by income). Least-developed countries were the largest recipient group of vaccines by total disbursements at USD 754 million, followed by lower-middle-income countries at USD 744 million (see Figure 2.14).[5] The largest recipient region was Africa at USD 882 million, followed by Asia at USD 725 million and the Americas at USD 355 million (Figure 2.15).

According to OECD figures, from 2021-2022, disbursements for vaccines totalled USD 8.6 billion, with the large majority being disbursed during the first year. In 2021, the donations totalled USD 6.8 billion (or 3% of the total ODA), amounting to more than 932 million doses.[6] Within the 2021 figure, about one-third (USD 2.4 billion) were donations of excess doses from domestic supplies (amounting to nearly 353 million doses); USD 3.9 billion was for donations of doses specifically purchased for developing countries; and USD 0.5 billion went towards ancillary costs (OECD, 2025[1]).

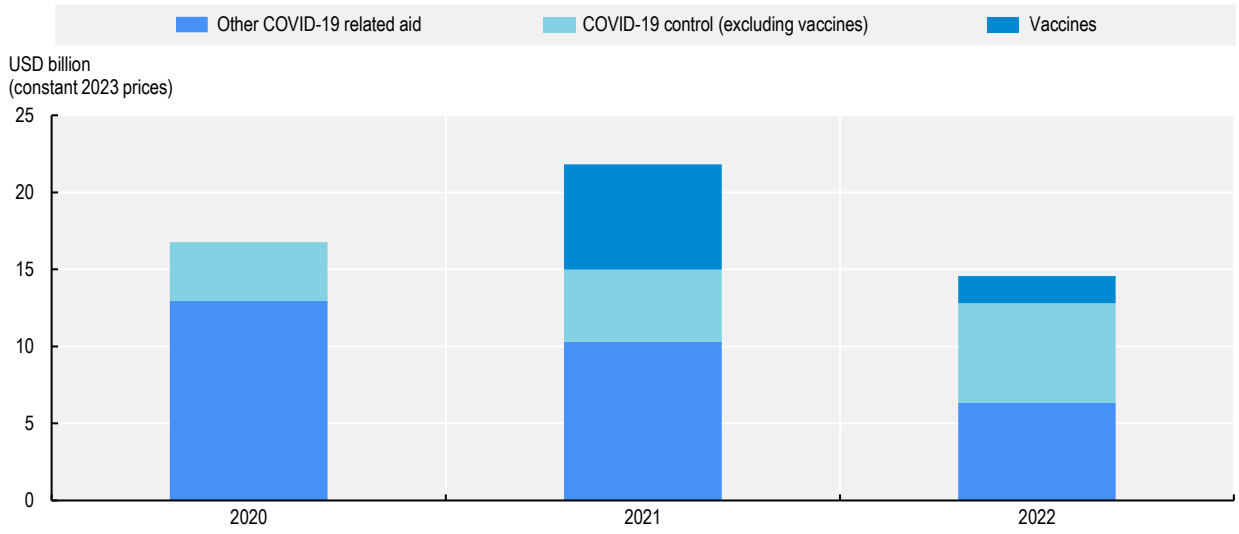
Almost 1.7 billion vaccine donations were pledged throughout the course of the pandemic (Launch and Scale Speedometer, 2023[45]). The vaccines donated by DAC members accounted for more than 80% of the overall number of shipped donated vaccines. The largest DAC donors in terms of shipping volume were the United States (around 578 million doses), Germany (136 million), and France (91 million) (OECD, 2025[1]).

From 2021-2022, the largest contributors in terms of funding disbursements for vaccines were the United States (USD 4.5 billion), Germany (USD 909 million) and France (USD 606 million). Some countries, however, did not report vaccine donations to the CRS as ODA. This includes China, which is estimated to have sold 1.85 billion vaccines and donated a further 328 million (Bridge Beijing, 2022[46]).

As for other providers, Japan combined vaccine provision and support to cold chains. For example, Japan provided approximately 7.35 million doses directly to Viet Nam. The provision of cold chains and the introduction of digital vaccination records were promoted via a grant to UNICEF, which contributed to the promotion of vaccination among children aged 5 and over and their mothers, which was being promoted by the Government of Viet Nam (JICA, 2024[47]).

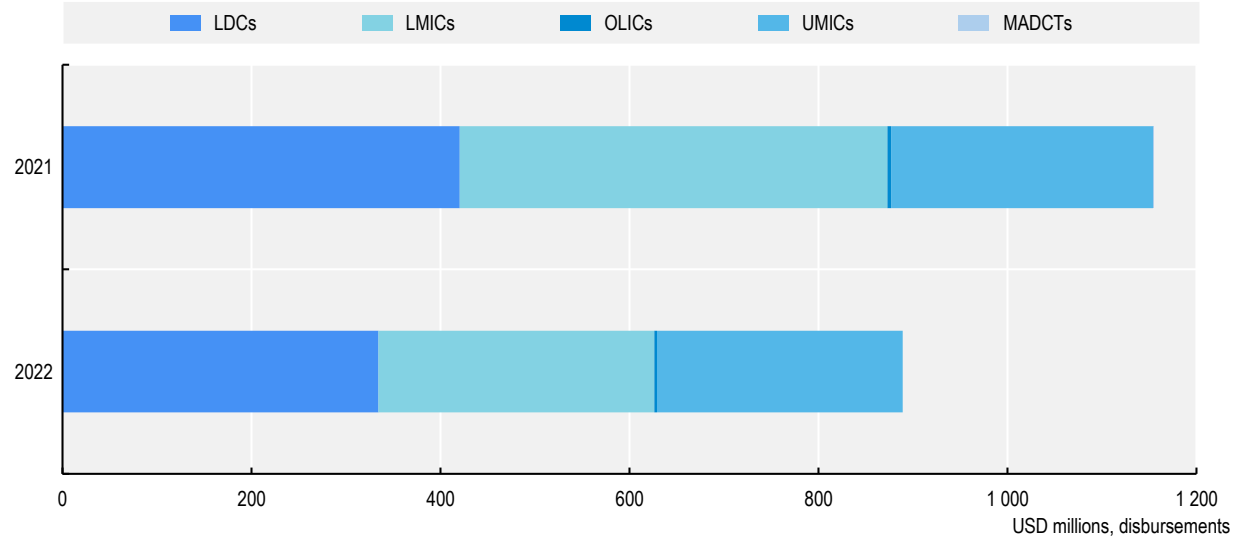
Figure 2.13. COVID-19-related official development assistance and vaccine funding, 2020-2022

All official bilateral providers, USD billion disbursements, constant 2023 prices



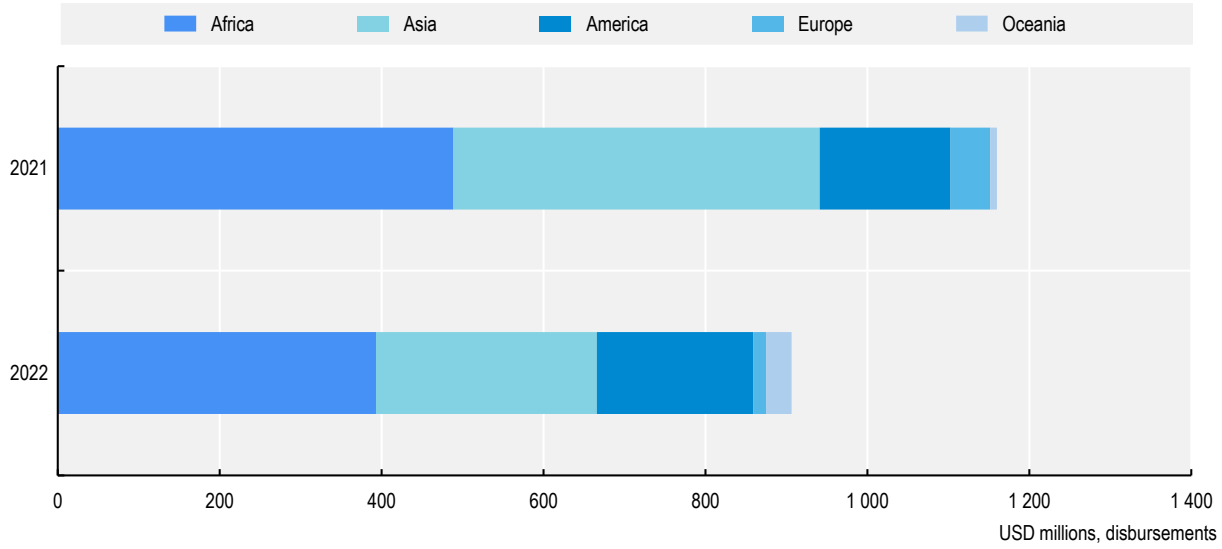
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure 2.14. Disbursements for vaccines in official development assistance, by income group, 2021-2022



Note: 2021 is used as the base year as COVID-19 vaccines were not widely available before January 2021. The data in these graphs includes direct procurement and delivery of vaccines, as well as donations of funding and excess supply to vaccine facilities such as Gavi COVAX. However, a large number of vaccine disbursements (around USD 6.5 billion) from DAC members to these facilities are unspecified by region or income group.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure 2.15. Disbursements for vaccines in official development assistance, by region, 2021-2022



Note: 2021 is used as the base year as COVID-19 vaccines were not widely available before January 2021. The data in these graphs includes direct procurement and delivery of vaccines, as well as donations of funding and excess supply to vaccine facilities such as Gavi COVAX. However, a large number of vaccine disbursements (around USD 6.5 billion) from DAC members to these facilities are unspecified by region or income group.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Ireland provides an illustrative example of how many EU members supported the vaccine effort as part of a broader, multilateral approach to the crisis. In addition to funding WHO and bilateral support, the Department of Foreign Affairs provided early support for the establishment of the COVAX mechanism set up by the WHO, Gavi, the Vaccine Alliance, UNICEF and CEPI in 2021 to accelerate the production and equitable distribution of COVID-19 vaccines. Ireland provided a total of EUR 13.5 million to this facility including prompt release of funding for country readiness measures such as the provision of equipment and technical support to low-income countries to boost their ability to roll out large, safe, and rapid vaccination campaigns delivery of vaccination campaigns. In addition to funding for the COVAX facility, Ireland donated over 4 million COVID-19 doses, the majority of which were distributed to countries in Africa via the COVAX facility (Department of Foreign Affairs and Trade, Ireland, 2025[48]).

The United States provided cross-government support to vaccine supply and rollout, with an initial goal of contributing to achieving 70% coverage in the countries it supported by 2022. As of July 2023, international providers, partner governments, multilateral organisations and implementing partners had contributed to fully vaccinating an average of 45% of the population across the 123 countries that received support, falling well short of the 70% goal (GAO, 2023[49]). The United States, and other countries, scaled back this goal to focus more on vulnerable populations.

South-South and South-North co-operation played an important role in vaccine access. Countries in Latin America, Africa and Asia engaged in knowledge exchanges and direct assistance to supply vaccine components and equipment and to bolster vaccine rollouts. A survey conducted by the United Nations Office for South-South Co-operation's (UNOSSC's) division for Asia and the Pacific found that all 17 countries surveyed had received support and that most had also provided support to neighbouring countries and others.

In August 2020, Mexico and Argentina agreed to produce 250 million COVID-19 vaccines, to be distributed in those countries as well as other Latin American countries "on an equal basis" (OECD, 2025, p. 15[50]). An Argentine laboratory produced the active substance, while a Mexican company led packaging. Mexico's

Fundación Carlos Slim was the financier, reaching an agreement with AstraZeneca to produce vaccines "without economic benefit" (OECD, 2025, p. 15[50]). Among the countries that received the first donations of vaccines from Mexico were Belize, Bolivia and Paraguay. By October 2021, Mexico had donated more than 1.1 million vaccines within the region (OECD, 2025[50]).

OECD figures show that nearly two-thirds of disbursements for vaccines were routed multilaterally to the COVID-19 Vaccine Global Access (COVAX). COVAX was funded by governments, philanthropic organisations, multilateral institutions and the private sector. Importantly, COVAX's Advance Market Commitment (AMC) targeted funding from wealthier nations to subsidise vaccines for 92 low- and middle-income countries. As of April 2022, the vast majority (96.1%) of COVAX funding came from donor governments and the European Commission; with the remainder donated by foundations, corporations and organisations (Gavi, 2022[51]).

International development and humanitarian actors made substantial contributions to supporting vaccine access by employing a range of strategies, including funding, partnerships with multilateral organisations, bilateral donations, and the continuation of existing programmes. COVAX was the most important delivery vehicle for vaccine equity, supplying, as of December 2022, almost 75% of all doses to low-income countries.

As of April 2022, the vast majority (96.1%) of COVAX funding came from donor governments and the European Commission, with the remainder donated by foundations, corporations and organisations (OECD, 2024[52]). COVAX's Advance Market Commitment (AMC) targeted funding from wealthier nations to subsidise vaccines for 92 LMICs. However, limited supply, delayed funding and competing procurement strategies limited potential success (Box 5.11 in Chapter 5).

Several examples from providers illustrate the significant contributions bilateral providers made to COVAX:

- In 2020, China provided USD 20 million to support Gavi's work for the 2021-2025 strategic period. In 2021, China further pledged USD 100 million to the COVAX Advance Market Commitment (AMC), marking its largest voluntary pledge to an international organisation to date (Gavi, 2025[53]).
- Japan contributed about USD 1.5 billion to COVAX and provided 19 million vaccine doses to 25 countries through the facility (Gavi, 2024[54]). In addition, over 24 million vaccine doses were provided bilaterally to seven countries (Ministry of Foreign Affairs of Japan, 2023[55]).
- The Netherlands donated 16.1 million vaccine doses through COVAX, representing over 70% of the country's total donated doses (OECD/IOB, 2025[19]).
- New Zealand donated USD 18.2 million to COVAX to provide safe access to COVID-19 vaccinations for developing states in Polynesia (Samoa, Tonga and Tuvalu); the Western Pacific (Fiji, Papua New Guinea, the Solomon Islands and Vanuatu); Southeast Asia (Indonesia and Timor-Leste); and Africa (Cameroon, Malawi, Mauritania, Niger and South Sudan) (CBi, 2021[56]).
- The Kingdom of Saudi Arabia responded to the global pandemic with a contribution of USD 150 million and USD 41 million in donated doses through COVAX (Gavi, 2025[57]).
- Spain, channelling the majority of their vaccine donations through COVAX, invested close to EUR 300 million (Ministerio de Asuntos Exteriores, Unión Europea and Cooperación, 2024[58]).
- The United States, as the largest donor to COVAX, provided USD 4 billion in funding for the 2021 financial year (Gavi, 2025[59]).

Other major donors to COVAX included Brazil (USD 86.7 million) and Kuwait (USD 50 million). Smaller contributions (under USD 1.2 million) came from Moldova, Malaysia, Mauritius, the Philippines and Viet Nam (Gavi, 2022[51]), further underscoring the role of South-South co-operation in the pandemic response.

COVAX achieved significant goals, including delivering almost two billion doses to more than 110 countries (Gavi, 2022[60]), though many challenges to achieving equitable access remained (see Chapter 5).

2.6. Philanthropic funding

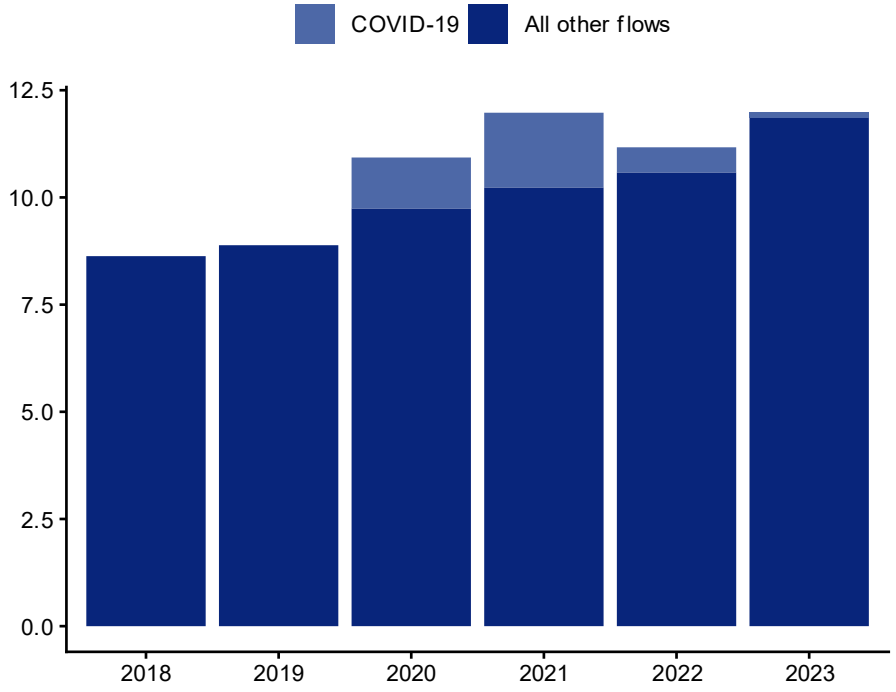
Private philanthropy for development was on a gradual upward trend prior to the pandemic, increasing from USD 8.6 billion in 2018 to USD 8.9 billion in 2019 (Figure 2.16). With the onset of the pandemic, total philanthropic flows increased significantly, rising to USD 10.9 billion in 2020 and peaking at USD 12 billion in 2021. As the pandemic waned, total philanthropic flows also decreased in 2022. The latest data for 2023 show an increase back to USD 12 billion.

The USD 3.5 billion in international philanthropy for the COVID-19 response from 2020 to 2022 was highly concentrated among a limited number of donors, with the top five donors representing 86% of the total contribution. These were the Mastercard Foundation (USD 1.3 billion), the Gates Foundation (USD 1.2 billion), the Wellcome Trust (USD 208 million), the Rockefeller Foundation (USD 159 million), and the LEGO Foundation (USD 98 million). Philanthropic spending for all purposes across 2020-2022 totalled USD 34.0 billion, with COVID-19-related spending representing 10.3%.

The pandemic crisis catalysed innovative financial approaches, such as the issuance of social bonds. The Ford Foundation led this effort with a USD 1 billion bond to stabilise non-profit organisations that sought to address inequity during and after the pandemic (OECD, 2021[61]). This novel funding mechanism, which was later adopted by the Rockefeller Foundation and others, raised USD 2.9 billion collectively, supplementing traditional grant making without reallocating existing resources. Low interest rates in 2020 made these bonds financially feasible, allowing foundations to amplify their impact through expanded grant making and targeted recovery efforts.

Figure 2.16. Philanthropy's contribution to the international COVID-19 response

All philanthropic providers, USD billion disbursements, constant 2023 prices



Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

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Notes

[1] Official development finance (ODF) comprises official development assistance (ODA) (including humanitarian assistance) provided by governments, and other official flows (OOF). In addition, the study includes non-official flows from philanthropic organisations and where possible analysed official flows not reported to the OECD as ODF – such as assistance provided by China and Mexico – for which comparable quantitative data are not available. As such, the expression "international development assistance" used encompasses this broader scope of financing, referring to all international assistance provided in 2020-2022 to eligible countries, unless otherwise specified.

[2] There are United Nations Country Team (UNCT) in 130 countries, covering all 162 countries where there are UN programmes. The UNCT includes all the UN entities working on sustainable development, emergency, recovery and transition in programme countries. The UNCT is led by the UN Resident Coordinator, who is the representative of the UN Secretary-General in a given country. See https://unsdg.un.org/about/how-we-work.

[3] The humanitarian cluster system is a co-ordination mechanism used by the United Nations and other humanitarian organisations to respond to crises. It is designed to organise humanitarian actors into core sectors, such as water, health and food security. The aim is to improve the efficiency and effectiveness of the response, avoid duplication and ensure that affected people's needs are met in a timely and appropriate manner. More info at: https://www.unocha.org/we-coordinate.

[4] The gender marker in the CRS is reported and tracked on a two-year basis. Reporting on the gender marker is mandatory, while reporting on disability is voluntary.

[5] A large number of vaccine disbursements (around USD 6.5 billion) from DAC members are unspecified by region or income group. These unspecified allocations were mostly provided to global vaccine efforts, i.e. Gavi and COVAX AMC.

[6] Calculated using total disbursements for excess supply donations and donations for developing countries reported in CRS, divided by the average price per dose (USD 6.72 in 2021 and USD 6.66 in 2022). Excludes ancillary costs.

3 Doing the right things: The relevance of the international COVID-19 response

This chapter offers an analysis of the relevance of international development co-operation provided during the COVID-19 crisis, in terms of how well assistance was designed to align with partner countries' needs and priorities as the crisis unfolded. It begins by defining relevance in the crisis context and then looks at how needs and priorities were identified, including how uncertainty was managed and how lessons from past crises were used. It describes what influenced funding flows to different countries. The assessment then looks at where assistance went, assessing the potential of international assistance to align with COVID-specific needs, the needs of particular countries and the increasing needs of vulnerable populations.

This chapter presents findings regarding the relevance of international assistance during the COVID crisis. For this evaluation, relevance is defined in terms of how well international assistance was designed to align with partner countries' needs and priorities, including their national responses to the COVID-19 pandemic and the needs of vulnerable groups. The analysis focuses on the *potential* for assistance to meet these needs (was it aimed at doing the right things) while the following chapters look further at the extent to which these needs were met.

The chapter begins by looking at how needs were defined and identified, and the extent to which available evidence was used, as well as how ongoing programmes were adjust and funders and implementers worked to "keep the lights on" through new barriers – such as movement restrictions or school closures. The analysis then looks at overall alignment with country needs, including allocations by income category, COVID-19-specific vulnerabilities, other country vulnerabilities, and the targeting of specific vulnerable groups. In a context of uncertainty and changing needs and priorities, relevance also required assessing whether international assistance was delivered in ways that allowed flexible adaptation to evolving needs and priorities, which is explored as well. Throughout, case studies and other examples are used to identify key drivers of relevance during the crisis.

The findings reveal a mixed picture. In terms of the decisions made by individual development and humanitarian actors, assistance was relevant to the needs and priorities of countries, including providing critical health support and the expansion of social and economic programmes to meet broader needs. In addition, ongoing programmes and projects were adjusted to the crisis in ways that maintained relevance and delivery of critical services.

At the aggregate level, across countries, relevance of international assistance was high in regard to countries with the greatest overall vulnerability (least developed countries, fragile contexts and Small Island Developing States), with a distinct increase in funding in response to the crisis. The link between international assistance and COVID-19-specific needs is less clear. It does not appear that low-income countries with the greatest COVID-19 burden received significantly more support – overall or for the health sector – during the pandemic. The analysis finds that there was some level of "relevance by chance" in a context where all countries had growing needs, with new needs emerging across many sectors. Likewise, within countries, the collective response was also largely responsive to the needs of vulnerable populations that were already being targeted, but less well aligned with newly emerging needs overall.

3.1. Understanding relevance in a crisis context

The relevance of the collective international response hinged on reaching those in need – through targeting funding to known needs or funding in ways that allowed sufficient flexibility for implementing partners or other intermediary actors to identify and adapt to those needs.

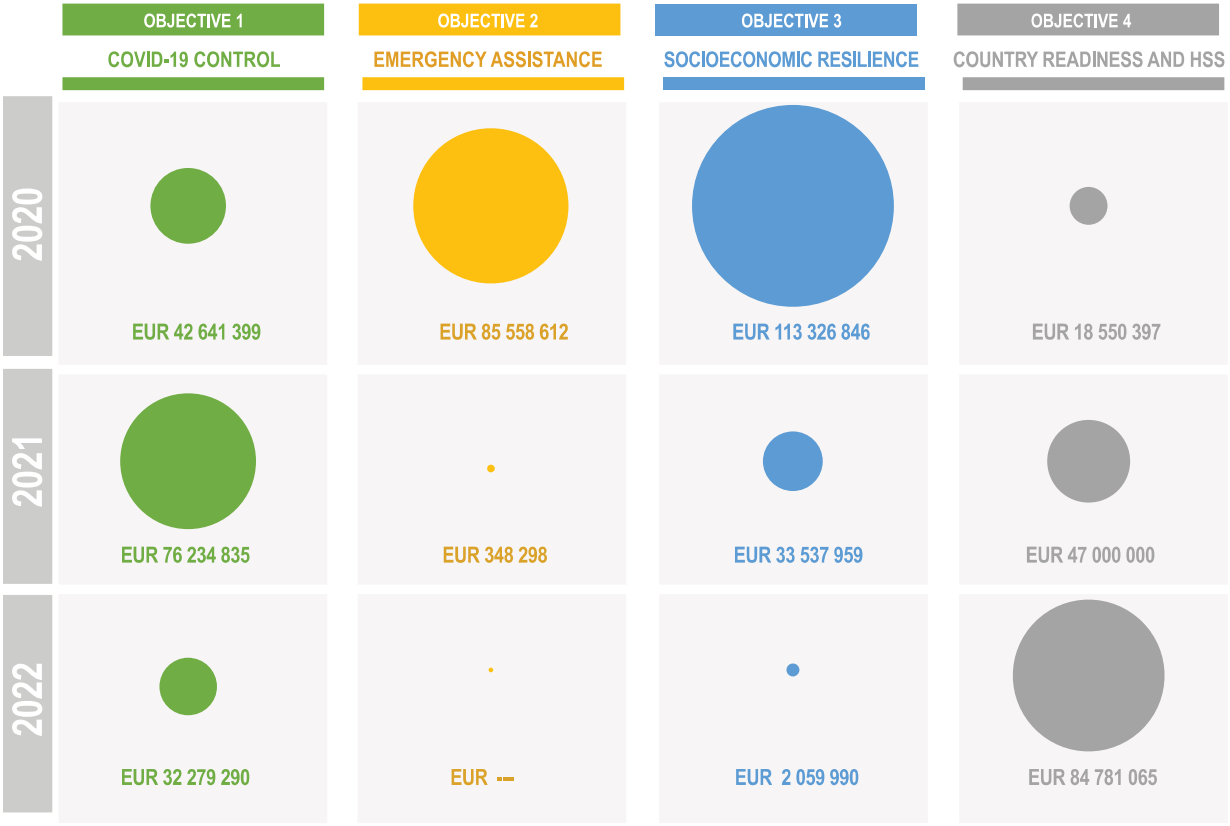
The needs and priorities of different countries in 2020-2022 were linked to contexts at the outset of the pandemic, including income level, governance capacity geography, economic and political context, as well as their connections to the global economy and to international partners. The pandemic, and related measures, also created new needs and exacerbated existing needs.

During the 2020-2022 crisis, the needs assessed for relevance included:

- needs related to the emergency health response, including measures to stop the spread of the virus and treat those infected with COVID-19
- vaccine supply and vaccination programmes
- socio-economic needs and broader development needs related to governance and capacities (both pre-existing and in a context of near universal economic contraction)
- humanitarian needs, both generally and specific to the pandemic and its impacts.

The Netherlands' crisis response strategy is typical of a relevant, multi-pronged crisis response across multiple needs. The Netherlands' support was aimed around four objectives, and funding for each shifted over the course of the three years under study, which was important for maintaining relevance. Analysis of the Netherlands' approach shows that the country both identified relevant needs and provided resources accordingly (Figure 3.1).

Figure 3.1. Overview of the Netherlands' COVID-19 aid package allocations by objective, 2020-2022



Note: The data, which include ODA and non-ODA contributions, are from 2020, 2021 and 2022 and include activities tagged as CRS code 12264-COVID-19 control as well as activities with the word COVID in the activity or budget description. The size of the circle indicates the size of the budget allocated for that specific objective as a share of the total budget of that year.
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

3.2. Identifying needs and priorities during the pandemic

The novelty of the SARS-CoV-2 virus, along with the global scale and speed of the impact of the COVID-19 pandemic meant that decisions were made imperfectly. Countries along with their development and humanitarian partners often had to make trade-offs, sometimes with limited information. Development and humanitarian actors faced three challenges: 1) identifying how new needs and priorities specifically related to the pandemic (for example, public health communication campaigns to reduce spread, or training of healthcare workers to administer vaccines); 2) understanding the needs and priorities related to the secondary impacts of the pandemic including containment measures; and 3) managing the ways in which the pandemic was impacting ongoing programmes and the needs and priorities of those target populations (e.g. adjusting to remote schooling, and relocating school-based feeding programmes while schools were shut).

The initial approaches to responding to the needs and priorities of developing countries, including vulnerable populations, despite information limitations, were effective given the dynamic context and the level of uncertainty development actors were operating in at the start of the pandemic. This approach involved both mobilising new funding and allowing ongoing programmes or projects to adjust to meet newly emerging needs (or to continue working in different contexts, such as during movement restrictions).

In the early months of the pandemic, uncertainty and a desire to move quickly meant that providers preferred working through preestablished partnerships, building on existing networks and contextual understanding, using both formal and informal needs assessment processes to identify and understand needs. However, both at country level and globally, this resulted in some risks to relevance, or cases of "relevance by chance" rather than relevance by strategic design or decisions based on identified or assumed needs.

The UK government applied a "no regrets" decision-making approach in their development co-operation assistance. In the face of uncertainty, it prioritised interventions that would benefit communities independent of the course of the pandemic, rather than delaying the response until more data were available. In evaluating the UK response, humanitarian actors were found to have adopted a similar approach, acting on imperfect data rather than risking loss of life, noting that it was widely attributed to having enabled timely action (ALNAP, 2024[2]).

Experiences from Germany and France (Box 3.1) identified the focus on existing priority countries as having been helpful in responding quickly but also limiting responsiveness to crisis-related needs. (DEval, 2024[3]; AFD, 2024[4]). The People's Republic of China (hereafter 'China') also built on several existing partnerships and programmes. In June 2020, within the framework of the Forum on China-Africa Cooperation, a special China-Africa summit on solidarity against COVID-19 was held between China and the African Union. The corresponding joint statement explicitly outlined China's commitment to offering material, technical, financial, and humanitarian support to African countries through the African Union, aimed at helping countries in the region overcome COVID's impact. China provided funding and supplies that were largely relevant to the health response (such as technical support from medical excerpts and provision of protective equipment), though these seem to have been based primarily on existing relationships and were not clearly linked to specific identified needs (CIKD, 2023[5]).

Japan was able to leverage its relationships constructed in the past and human resource development efforts over many years in Viet Nam and Malawi. Since 2007, Japan has provided ongoing technical co-operation to Malawi to improve the quality of its healthcare services. The resulting good relationship with the Ministry of Health in Malawi enabled Japan to quickly understand the immediate needs and provide co-operation that was tailored to Malawi's health system (Ministry of Foreign Affairs of Japan, 2025[6]). Other experiences – documented in evaluation reports and the case studies – support this finding that long-standing relationships were an advantage in respond effectively to the crisis.

As the pandemic evolved, so did the global approach to the identification of and disaggregation of needs and priorities. The second iteration of the World Health Organization's (WHO) Global Health Response Plan marked a shift towards country-level analysis and planning, resulting in increased potential to engage with local and national actors, particularly in contexts where humanitarian co-ordination structures and mechanisms already existed. This included special attention to fragile, conflict-affected and vulnerable settings, where limited capacity, fiscal space and ability to access the necessary equipment due to global supply bottlenecks were recognised as major constraints to managing the pandemic and maintaining service delivery. However, this was not uniformly the case.

Restrictions on movement – lockdowns, social distancing, boarder closures and withdrawals of staff from country offices – often constrained the ability to undertake local needs analyses and to understand new vulnerabilities in different communities. This was especially true for institutions that used international staff (many of whom were repatriated in some countries) or relied on externally conducted country visits to determine needs. health

Decentralised systems performed better, as there was greater scope for adjusting ways of working based on real-time information on what was happening in a particular context.

Many bilateral providers did undertake needs assessments or use country-level assessments conducted by the United Nations and national partners to understand in-country contexts and inform their allocation and programming decisions. For example:

- Enabel, Belgium's federal development agency, undertook a real-time exercise that allowed them to understand the decision-making mechanisms during the crisis, and the agility and capacity for innovation in times of crisis. It also allowed them to highlight what worked well and why, what required adaptation or further reflection, what facilitated the response, and the constraints and challenges encountered and how these were addressed (Vancutsem, 2020[7]).
- In Bangladesh, providers engaged in a national needs assessment working group to inform targeted interventions (OECD, 2025[8]).
- In Georgia, the government effectively identified the country's needs and communicated them through various channels. Collaborating with the World Bank Group, they developed the Georgia Emergency Response Plan and utilised pre-existing IMF support to partially implement its anti-crisis plan, leveraging a donor co-ordination platform and establishing a dedicated website to regularly communicate COVID-19 health-related needs (OECD, 2025[9]).
- The Large Ocean Countries / Small Island Developing States (SIDS) case study noted that strong provider co-ordination informed a more comprehensive understanding of the priorities and the ability to address emerging needs (European Commission, 2025[10]).

A significant challenge was the lack of funding for and structural weaknesses in data collection and analysis. Prior to the pandemic there were major challenges in the global data collection around Sustainable Development Goal (SDG) indicators, as well as fragmentation across different sources of data and evidence. The COVID-19 crisis compounded these challenges by the rising costs occasioned by the challenging operating environment. Much of the analysis of the impact was estimated and it quickly became clear that pre-2020 SDG data were out of date or unreliable. This limited the ability globally and nationally to assess impact against the SDGs and target the most effected groups including the most vulnerable.

Limited funding provided for results monitoring and evaluation hindered the ability of institutions and governments to understand the relevance of their strategy to national needs and priorities related to the pandemic response. More systematic investment in reflection and learning by some agencies showed the usefulness of such an approach which provided a deeper understanding of needs, improved targeting and gave clearer insights into outcomes. For example, the Food and Agriculture Organization (FAO) provided a positive example through its use of real-time data collection and its adaptation of existing data systems and tools to the COVID-19 context, which enabled timely decisions and appropriate course corrections (FAO, 2022[11]).

Even with these overarching challenges, there were many positive examples of the identification of needs or risks directly or indirectly related to COVID-19, with concerted action being taken to address them. For example, at the beginning of the COVID-19 pandemic, WHO predicted that malaria deaths in Africa could double if access to malaria prevention programmes and treatments were severely interrupted. However, in 2021, the African Leaders Malaria Alliance, with support from international partners, announced that an increase in deaths had been averted, with over 90% of planned net distribution campaigns being delivered, and more children in areas of highly seasonal transmission being reached with antimalarial medicines than in previous years (Devex, 2020[12]).

The World Bank is a good example in the approach to designing country-level responses in a two-fold manner, addressing both immediate COVID-19-related needs and a long-term view. In Afghanistan, for example, the first component was to urgently deliver essential primary and secondary health services, while the second component was longer term and included an element of preparedness, enhancing the

health system capacity to prevent and respond to infectious disease outbreaks (World Bank, 2022[13]). In Paraguay, the first component focused on immediate containment strategies for COVID-19, while the second one focused on providing technical assistance for health system strengthening, including improving institutional arrangements for co-ordination (World Bank, 2020[14]). In Burkina Faso, a logistics commission was established, which was responsible for providing logistical resources – such as wheels, protection, health products and diagnostic tools – and logistical co-ordination. This was a way of ensuring that necessary resources were deployed to fill gaps, such as respiratory protection masks, the COVID-19 diagnostic test, rolling logistics for medical transport, technical medical equipment and materials, and patient biological monitoring reagents (Government of Burkina Faso, 2025[15]).

The international response of the United States was framed around its COVID-19 Global Response and Recovery Framework, released in July 2021 and updated in September 2022 (USAID, 2022[16]). It outlined the commitment to ending the emergency phase of the pandemic, integrating COVID-19 response activities into existing health systems, and strengthening global readiness for future pandemic threats by working with partners to vaccinate high-risk and vulnerable populations, scaling and integrating testing and treatment, and preparing for future variants. The US experience was one of remarkably few good examples of learning during the response and adjusting the strategy overtime (Box 3.2).

The African Development Bank (AfDB) is another interesting example as it responded to the COVID-19 crisis in Regional Member Countries through a phased deployment of policy-based operations (PBOs). Initial phases prioritised urgent health interventions and social protection for vulnerable groups. Subsequent phases shifted their strategic focus to economic stabilisation and recovery. This phased approach allowed the bank to address immediate public health needs while laying the groundwork for long-term economic resilience (AfDB IDEV, 2022[17]).

Box 3.1. France's health response to the pandemic

France's Health in Common initiative provides a useful example of the challenge of matching continuity and speed with effectively aligning with priority needs. The relevance of the initiative to country needs and priorities was considered broadly satisfactory (AFD, 2024[4]). In line with the French Development Agency's (AFD) intervention framework, African countries, particularly French-speaking ones, were prioritised, receiving respectively, 74% and 63% of the total amount allocated. The ocean basins where France has territories (Indian Ocean, Pacific Ocean and Atlantic Ocean) also received strong support.

While Mauritius and the Dominican Republic received substantial amounts in the form of loans, their geographical proximity to French territories would not appear to have been a determining factor. Madagascar also received a significant proportion of the initiative's grants. However, in a context of crisis, and with future crises in mind, adhering strictly, without revision, to AFD's overall intervention framework raises several questions. The priority given to French-speaking countries can be questioned. Multi-country projects could have targeted neighbouring countries (not necessarily French-speaking countries) to enable their governments to put in place more coherent and effective measures for the surveillance and control of the disease (AFD, 2024[4]).

Source: AFD (2024[4]), *Evaluation of the Health in Common 2020 Initiative (HIC 2020)*, https://proparco-prod-waf.cegedim.cloud/en/ressources/evaluation-health-common-2020-initiative-hic-2020.

Box 3.2. USAID's iterative process to analysing the impacts of the pandemic

In April 2020, the United States Agency for International Development (USAID) conducted a best case/worst case exercise to project possible trajectories for the COVID-19 crisis and its impact. In August 2020, the agency evaluated the changing landscape against these scenarios as part of a strategic review. The analysis gathered information on the state of the pandemic at that time, including outlining the various impacts of the pandemic on different sectors and geographic areas.

USAID conducted follow-up landscape analyses in March 2021, January 2022 and November 2023, to provide high-level syntheses of data, both from its own data and that of external sources, to better understand the global impacts of the pandemic. The data included real-time daily updates on case numbers and second-order impacts, modelled forecasts of COVID-19's impacts, quantitative estimates of underlying risks and vulnerabilities, high-frequency phone surveys of households, and qualitative research and reports from third-party institutions.

The analyses gathered information on the impacts of the health crises on partner countries, including their health systems; actual and projected cases and mortalities; vaccine distribution; impacts on governments, economies and households; mobility constraints and migration; education; and intersectional factors that exacerbated the impacts felt by certain groups. The reports did not offer recommendations for policy or programming but presented analysis on which areas were most heavily effected and the implications of the impacts.

In 2022, USAID conducted an agency-wide pause and reflect exercise on the COVID-19 response and how well the institution had adapted to the changing needs of the pandemic context. This was an iterative process to analyse evidence and insights to generate lessons learnt and inform future decision making on crisis readiness and responses. The focus of the exercise was on adaptations, second-order effects, unintended outcomes of pandemic responses, localisation and inclusive development.

Source: OECD (2022[18]), Development Co-operation Peer Reviews: United States 2022, https://doi.org/10.1787/6da3a74e-en; USAID (2022), COVID Big Picture Reflection: Lessons Learned Report.

3.3. Learning during and from the crisis response

There was mixed evidence on the uptake of lessons from other crises to inform the design of the pandemic response, and the extent to which ongoing learning was integrated into development and humanitarian actors' activities to enable identification to improve the ongoing response or future responses.

Although many development actors and national governments explicitly called for and worked to apply lessons in the early stages of the pandemic, there was still a consensus among interviewees that some mistakes were made that could have been avoided with greater attention to the available evidence base. The COVID-19 response suffered from an underinvestment in preparedness and adaptations to be ready to respond before the crisis hit, as well as relatively weak support for locally led action and community engagement. There was insufficient attention to protecting vulnerable groups or to sexual and gender-based violence (SGBV) and mental health needs. These findings echoed challenges from previous crises (ALNAP, 2024[2]).

Key lessons from previous crises, such as outbreaks of Avian Influenza, SARS, Ebola and Cholera, included providing a response that went beyond just health needs and acknowledged the need for large volumes of flexible funds. Successes in applying these lessons included the mobilisation of large volumes of funding, the reallocation of funding to enable timely responses, and the inclusion of water, sanitation

and hygiene (WASH) activities in community outreach. There was an unprecedented number of rapid evidence reviews and syntheses from global evaluation communities with evaluators putting on hold evaluation plans to focus on supporting the ongoing response (OECD, 2021[19]),drawing lessons from past crises affecting health and food systems, including the global HIV/AIDS pandemic (UNEG, 2021[20]). This included providing context specific social protection measures (with considerations to economic, financial, infrastructural, political, environmental and social factors), utilising cash transfers and broadening scope to include not only core target beneficiaries but also the most vulnerable when tackling food insecurity (UNEG, 2021[20]). UNAIDS was pro-active in identifying key messages to inform the COVID response (see Box 3.3). In 2011, a crisis response window (CRW) was established by a World Bank fund to provide prompt support to eligible countries experiencing severe crises caused by natural disasters, economic shocks, or public health emergencies. For example, an allocation in 2017 to Yemen helped them deal with a Cholera outbreak amid continuous conflict (IEG/World Bank, 2019[21]). This was mirrored in the Fast-track COVID-19 Facility that the World Bank established to address immediate needs from COVID-19 (World Bank, 2020[22]).

During the Avian Influenza outbreaks from 2006-2014, weak connections between the government and grassroots organisations in some countries hindered the reporting of critical case information for disease monitoring (IEG/World Bank, 2014[23]). Reporting was also affected by limited behaviour change among affected communities, who often downplayed the risk of human disease (FAO, 2010[24]). This lack of timely and reliable access to community-level data undermined the effectiveness of investments in formal disease monitoring and surveillance systems, highlighting the need for the mobilisation and co-ordination of civil society and community-based organisations for effective COVID-19 monitoring. Coalition participants reported many examples of where these lessons were used to inform COVID-19 response strategies, though there is limited evidence to assess the full effectiveness of these efforts.

The Ebola crises proved that co-operation and coalition building between countries can strengthen response performance and address longer-term needs; the Africa Centres for Disease Control and Prevention (Africa CDC) was set up as a regional network after Ebola to improve the response of public health institutions to disease outbreaks or public health threats across the continent (see Box 3.2 and (Gold and Hutton, 2020[25])). Kenya's experience also highlighted how the government developed a COVID-19 contingency plan very early in the pandemic (January 2020) by adapting its existing National Ebola Virus Disease co-ordination structures (OECD/AfDB, 2025[26]).

However, interviews and multiple evaluations show many examples where available evidence was not sufficiently applied and mistakes were made that could have been avoided (OECD, 2022). For example, a lack of attention to the needs of children – especially girls – out of school was cited by many respondents as insufficiently addressed, despite knowledge from past crises about the often-devastating impacts of school closures (including regressive effects). An opinion survey, which mainly captured the views of staff working in bilateral development co-operation agencies, found that of ten areas identified, the "use of evidence from previous crises" and the "need for consultation of partner country stakeholders" were the areas where most felt improvement was needed (OECD/DEval, unpublished[27]).

Many countries support the COVID-19 Global Evaluation Coalition project as a means of promoting learning and accountability (Box 3.4), and about half of DAC members evaluated their COVID response or carried out other structured learning exercises (OECD, 2022[28]). Evaluation units of UN agencies and multilateral banks reported many evaluations related to COVID response projects and strategies.

Still, all partners identified a key weakness in the lack of instruments or mechanisms for learning from the crisis and deriving lessons. Case studies and additional evidence also show that experience from past emergency responses, such as from the 2014-2015 Ebola pandemic in West Africa or the HIV/AIDS pandemic, was not systematically applied due to weak knowledge management systems. Instead, knowledge use was largely ad hoc and person to person, based on staff's prior professional experience.

Notably, weaknesses in knowledge management had been highlighted by evaluations of previous crisis responses, and yet still proved to be a weakness during the COVID-19 crisis (WFP, 2022[29]).

The learning-related and evidence use challenges faced in international cooperation mirrored the broader crisis context where many governments struggled to account for the multiple negative effects of pandemic-related restrictions, and to balance efforts to contain the disease with broader socio-economic harm (Williamson et al., 2022[30]). Likewise in international development and humanitarian agencies, the crisis response highlighted persistent gaps in mechanisms to inform decision making with existing evidence, enable ongoing learning, monitor results, gather impact data, and use cost-benefit analysis (OECD/IOB, 2025[31]). Exploring ways to make monitoring, learning and evaluation actionable and realistic in times of crisis – especially for implementing partners – could improve future accountability and facilitate learning.

Some relevant key messages on relevance and learning emerged from the case studies:

- South Africa's evaluation found that "Having means for monitoring and evaluating the implementation of an international relations strategy would enable policymakers and implementers to understand in real time if their strategy is achieving the intended results and, if not, to make mid-course corrections. […] It allows them to learn lessons about managing such crises and so develop the institutional memory that will lead to more effective responses to any future crisis." (Presidency of South Africa, 2021, p. 599[32]).
- The German case study and an evaluation of AFD's crisis response both identified the lack of a cross-government body to monitor and identify lessons, as weaknesses (DEval, 2024[3]; AFD, 2024[4]). In the German case, the COVID-response mechanism was wrapped up quickly and did not have a clear mandate to capture lessons or support ongoing reflection beyond the immediate response period.
- The national report on China's international pandemic assistance provides a description of funding and supplies but does not provide much detail in terms of lessons or areas that could be improved in future crisis responses (CIKD, 2023[5]).
- The Spanish case study recommended that future similar strategies have a results framework to allow for a better assessment of achievements and areas for improvement (Ministerio de Asuntos Exteriores, Unión Europea y Cooperación, 2024[33]).
- According to the findings from the Netherlands' study, an overarching strategic crisis response plan based on lessons learned and with high-level political support could improve the crisis preparedness of the Ministry of Foreign Affairs and minimise risks of institutional memory loss and strategic uncertainties following ad hoc political decision making. Task forces set up to respond to the crisis were disbanded before capturing formal operational lessons for future crises. Further, the evaluation team did not find institutionalised lessons from past crisis responses (HIV/AIDS and Ebola in particular), and the use of previous experience likely depended on decisions of individual policy officers.

Establishing crisis response plans ahead of time could assist in capturing and making available key insights from past experiences. Such pre-plans could also provide guidance on the basic elements of a crisis response such as which partnerships and channels to leverage, which co-ordination mechanisms to activate, and how to establish feasible monitoring and reporting requirements. Finding a balance between strategic planning and a timely response could lead to benefits in terms of relevance, coherence, efficiency and effectiveness (OECD/IOB, 2025[31]).

Box 3.3. UNAIDS lessons from HIV for an effective, community-led COVID-19 response

In 2020, UNAIDS published seven key takeaways from its work with the HIV crisis to inform the COVID-19 response, providing a useful example of learning from previous crises. Though it is difficult to determine the extent to which these were fully incorporated into the COVID response, many stakeholders highlighted that these lessons later proved to be highly relevant and were useful when applied, for example as part of public health communication around vaccination campaigns:

1. Engage affected communities from the beginning in ALL response measures – to build trust, ensure suitability and effectiveness, and to avoid indirect or unintended harms and ensure the frequent sharing of information.
2. Combat all forms of stigma and discrimination, including those based on race, social contacts, profession (healthcare workers), and those directed towards marginalised groups that prevent them from accessing care.
3. Ensure access to free or affordable screening, testing and care for the most vulnerable and hard to reach.
4. Remove barriers to people protecting their own health and that of their communities: fear of unemployment, healthcare costs, presence of fake news/misinformation, lack of sanitation infrastructure and so forth.
5. Restrictions to protect public health must be of limited duration, proportionate, necessary and evidence-based and reviewable by a court. Put in place exceptions where necessary for vulnerable groups and to ameliorate the consequences of such restrictions. Blanket compulsory bans are rarely effective or necessary. Individuals should not be criminalised for breaching restrictions.
6. Countries must work to support each other to ensure no country is left behind, sharing information, knowledge, resources and technical expertise.
7. Support and protect health care workers. Be kind to each other. Join and support efforts that build trust and amplify solidarity, not sanctions.

Source: UNAIDS (2020[34]), "Rights in the time of COVID-19: Lessons from HIV for an effective, community-led response", https://www.unaids.org/sites/default/files/media_asset/human-rights-and-covid-19_en.pdf.

Box 3.4. The Coalition's work to feed evidence into the pandemic response

In 2020, the participants of the COVID-19 Global Evaluation Coalition worked together to rapidly synthesise and communicate relevant evidence from previous evaluations to inform the pandemic response as it unfolded. The Coalition carried out a mapping of synthesis work to support the harmonisation of shared lessons. It also produced its own "Lessons from Evaluation" series. Many participants saw an uptick in requests from evaluation units to provide evidence to inform the unfolding response efforts. They noted an openness to drawing on lessons and a measure of humility in the face of an unprecedented crisis.

- Five briefs in the Lessons from Evaluation series were produced in an average of 10-15 days, pulling together evidence on topics that were being discussed in meetings of development ministers convened by Canada and the United Kingdom. Through the evaluation department of Global Affairs Canada, the evidence briefs were fed into preparatory reading packs and helped create more informed discussions of response strategies.
- The UNDP Independent Evaluation Office produced a series of lesson briefs on topics including social protection and health sector support, by May 2020.
- Building on the Coalition's initial brief, four UN agency evaluation departments joined forces to develop the "Evidence Summary on COVID-19 and Food Security" report which was used widely to inform nutrition and food security related efforts (UNEG, 2021[20]).
- The Independent Evaluation Office of the Asian Development Bank used findings from past evaluations to support the vaccine roll out efforts (ADB, 2021[35]).

Note: Norad and Norway's Public Health Agency worked with the OECD to synthesise findings on digital tools for supporting vaccine uptake, communicating with the public about vaccines and the effects of digital interventions for promoting vaccination uptake (Glenton and Lewin, 2020[36]; Lewin and Glenton, 2020[37]).

3.4. Alignment of international assistance to COVID-19 crisis needs

When looking at international assistance, needs and priorities are understood not only in terms of the pandemic risks themselves and general needs including population vulnerabilities, the fiscal capacity of the government, and higher needs related to overall income levels. Whilst the pandemic had a global impact, both the pandemic and response measures impacted countries very different, and countries had different levels of resources, readiness and capacity to respond.

Provider response to the pandemic needed to reflect the diversity of emerging needs (and a high level of uncertainty about how specific needs might change) as well as a general understanding of a country's vulnerabilities (for example prioritising SIDS or least developed countries).

Multiple factors drove allocations, including historical ties and existing co-operation relationships (as illustrated by Türkiye's pandemic assistance in Figure 3.2); geopolitical dynamics between countries; perceived levels of vulnerability to the pandemic, including response capacities; and practical considerations such as access and proximity. Dynamic exchanges resulted in requests for support and responses, sometimes with consolidated requests and sometimes bilateral. For example, Finland received and responded to several requests for assistance, including from long-standing partners such as Nepal, as well from some countries with whom they did not regularly collaborate (Ministry of Foreign Affairs of Finland, 2022[38]). Mexico and New Zealand both provided support primarily to neighbouring countries in their respective regions. The United States and China both provided assistance to a large number of

countries, including major support to historic partners (CIKD, 2023[5]); (USAID, 2022[16]). France's Health in Common pandemic initiative prioritised Africa and the three ocean basins in line with its overarching co-operation strategy (AFD, 2024[4]).

In the aggregate there was only a weak correlation between regional or country risk and funding provided. In some cases, total funding did align well with pandemic-related indicators of needs (such as total cases or fatalities) but this seems to have been more as a result of happenstance, rather than of strategic targeting.

Meeting needs globally involved matching needs to funding sources available for different countries. For example, in Nicaragua, where most large funders were not operating bilaterally in 2020, the Central American Bank for Economic Integration (CABEI) provided Nicaragua with a USD 300 million loan to support projects on education, health, housing, road infrastructure, agriculture/rural development, fishing, climate change, and micro and small businesses (OECD, forthcoming[39]). Spain's ODA allocations showed a relevant split across sectors targeting the COVID-19 response, particularly social services (Ministerio de Asuntos Exteriores, Unión Europea y Cooperación, 2024[33]). However, this was not always the case. For example, in SIDS there was less of a concerted effort to proactively address the broader socio-economic impacts beyond immediate public health needs such as testing, PPE and vaccines (European Commission, 2025[10]).

Case studies and peer reviews show that bilateral support was only partially needs based. In the Netherlands, for example, the bilateral response involved interministerial co-ordination, which experienced some challenges due to ad hoc political decision making. The lack of needs assessments to assist in determining which countries to support bilaterally led to some internal incoherence. In France, the reliance on existing partnerships was more of a driver of funding decisions than needs assessments.

Figure 3.2. Distribution of Turkish medical aid across countries during the pandemic

Source: Güngör (2021[40]), Foreign aid during the COVID-19 pandemic: Evidence from Turkey, https://www.graduateinstitute.ch/library/publications-institute/foreign-aid-during-covid-19-pandemic-evidence-turkey.

Support by country income group

Despite early indications in 2020 that rates of COVID-19 infection and mortality were higher in high-income countries (HICs), in 2021, there was an increase in cases in lower-middle-income countries (LMICs). Lower vaccination rates in middle-income countries (MICs) compared with HICs, meant they had a higher share of cases and mortality. Surges in case numbers and recorded deaths in low- and medium-income

countries, including in Latin America and Asia, occurred at different times. The timing of lockdowns and other public health measures also varied.

While, overall, low- and middle-income countries reported relatively fewer deaths, the cascading socio-economic impacts of policy decisions related to the pandemic were very high in poorer countries and the averages obscure significant variation between countries (Our World in Data, 2024[41]). There is ongoing research and debate about the suitability and effectiveness – including unintended effects – of various policy responses (e.g. school closures, support to businesses and social protection), which created the backdrop for international co-operation efforts, including efforts to serve as trusted advisors and technical partners. The ultimate potential effectiveness of international efforts was considerably constrained by these broader contexts.

Building on existing relationships – the approach taken by all bilateral providers studied – had advantages in terms of efficiency (particularly speed) and effectiveness, even if it meant there was less room for increasing relevance through allocation decisions. This observation was supported by several other evaluations, as well as the global analysis of where assistance was spent in 2020-2022. The New Development Bank's (NDB) provision of USD 1-2 billion loans to its members countries, was another example of existing relationships underpinning rapid, large-scale funding that was broadly targeted and highly relevant, while not being specifically needs-based (Box 3.5).

An example comes from Lebanon, a country significantly affected by COVID-19 and other crises, which depended on outside support to address the needs of those most vulnerable people including refugees and host communities. Prior to the pandemic, Lebanon was among the top five recipient countries of German development co-operation. From 2020-2022, Germany provided EUR 144 million to support Lebanon through one of its main response programmes, the Emergency COVID-19 Support Programme (DEval, 2024[3]).

Box 3.5. The New Development Bank's COVID-19 fast track support

The New Development Bank (NDB)'s Emergency Assistance Programme Loan was approved 19 March 2020. Its financing facility approved up to USD 10 billion in loans to support the COVID-19 response in its founding member countries of Brazil, China, India, Russia and South Africa.

An evaluation report by NDB's Independent Evaluation Office (IEO) estimates that through this financing, the member countries were able to provide much needed support to 2.2 million health workers, as well as USD 4.17 billion in income support to 206.5 million women, and ex-gratia payments of USD 13.5 each to 28.1 million senior citizens, widows, and individuals with disabilities. Additionally, the COVID-19 Response Programmes targeting India were estimated to have contributed to generating 5.4 billion person-days of employment, with 52% going to women. It ensured that 100% of district hospital doctors and nurses were trained to meet WHO standards, with 61% of them being women.

Source: NDB (2023[42]), ''Evaluation of NDB's Fast-Track Support To The Covid-19 Emergency'', https://www.ndb.int/wp-content/uploads/2024/02/COVID-19_Evaluation-Report_Feb20_final.pdf.

Responding to COVID-19-specific needs

While country contexts and relationships between providers and recipients vary significantly, analyses show that COVID-19-related needs did impact funding decisions. Through a combination of adjusting ongoing programmes and funding new initiatives, providers were able to support relevant activities to meet changing needs.

Existing health conditions and social vulnerabilities led to higher rates of COVID-19 infection, hospitalisation, morbidity and mortality. Globally, the number of new deaths attributed to the pandemic generally decreased with the reduced severity of newer variants, improved treatment approaches, shifts in the affected population towards younger cohorts, higher COVID-19 vaccination rates and population immunity from previous waves, as well as hospitals becoming gradually less overwhelmed (Horwitz et al., 2021[43]; Eggermont, 2021[44]).

Several countries saw significant increases in the amount of health-related assistance received, with Colombia seeing a 15-fold increase from 2019-2020. In some cases, this funding seems to have effectively targeted countries the most impacted by the pandemic. For example, Iran and Peru – both of which were among the hardest-hit countries in terms of COVID-19-related deaths (Johns Hopkins, 2023[45]) – saw 10-fold increases in support from 2019-2020. Other notable increases in health-related assistance in LICs include Mauritania (299% increase from 2019-2020), Cambodia (126% increase), and Madagascar (87% increase). An analysis of health funding flows for the ten low-income countries[1] with the highest cases or deaths per capita shows an increase in health-related assistance to these countries between 2020-2022. However, assistance for these high-need countries was already growing by an average of 12.8% per year from 2014, showing that ODA was likely already targeting the high levels of health needs.

The decrease in health disbursements beginning in 2022 may reflect the transition from the emergency response to the recovery phase, which prioritised economic recovery. Russia's full-scale war of aggression against Ukraine also significantly shifted spending starting in 2022. For many recipient countries, however, sustained funding remained essential. The rapid reduction in assistance to health highlights the challenge of sustaining large volumes of funding outside of a crisis response.

The case studies also highlight how COVID-19 unfolded differently across countries. Georgia experienced the highest disease burden among the case study countries, with 489 351 cases and 4 517 deaths per million, more than double the figures reported in the next most-affected country, Lebanon (Our World in Data, 2025[46]). Lebanon and Cabo Verde also had high disease burdens and received relatively high levels of ODA per capita. They were able to vaccinate 35% and 56% of their populations, respectively (WHO, 2025[47]). However, in Lebanon, while some new funding announcements were made during the COVID-19 pandemic, overall development finance continued to decrease over this period, despite the increasing needs in the country (OECD, 2025[48]). Interestingly, Bangladesh, which received the lowest ODA per capita among the case study countries, achieved a vaccination rate of 86% of its population completing a primary series (WHO, 2025[47]). In contrast, Cambodia had similar levels of COVID-19 cases and vaccination rates but received more than twice as much ODA compared to Bangladesh.

In Burkina Faso, a logistics commission was established, responsible for logistical co-ordination as well as ensuring that necessary resources were deployed to fill gaps, such as respiratory protection masks, COVID-19 diagnostic tests, rolling logistics for medical transport, technical medical equipment and materials, and patient biological monitoring reagents (Government of Burkina Faso, 2025[15]) .

Several evaluations, including the COVAX evaluation, the system-wide evaluation of the UN development response, and those by Finland, France, and Germany highlighted that multilateral actors played an important role in achieving a relevant, effective, cost-efficient and timely crisis response as they were able to call on existing systems, long-term contracts and comprehensive experience in humanitarian aid (DEval, 2024[3]; AFD, 2024[4]; Itad, 2022[49]; UNSWE, 2022[50]).

The COVID-19 response programmes of France, Germany, the Netherlands, Spain and Saudi Arabia all found that the distribution of most funds to existing partnerships was found to contribute to enhancing the efficiency of the programme in terms of timeliness but also the relevance of the programme as most existing partners were highly vulnerable and in need of support during the pandemic (Ministerio de Asuntos Exteriores, Unión Europea y Cooperación, 2024[33]). These underlying drivers of timeliness and relevance were broadly applicable and can apply to future support.

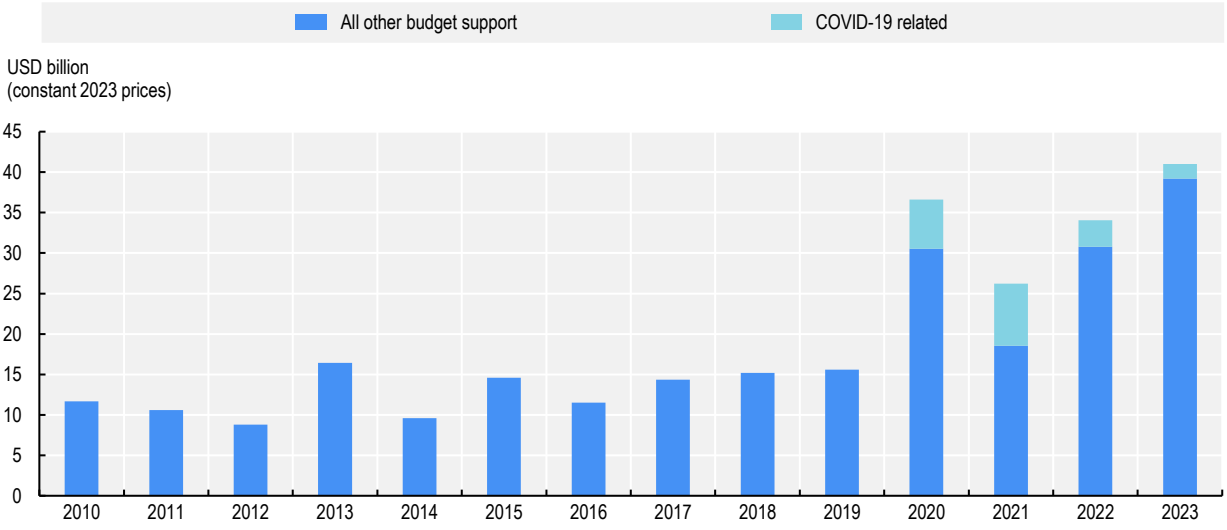
Flexibility to respond to needs: the use of budget support

Budget support and policy-based lending became key instruments during the emergency phase of the COVID-19 response, in contrast to a low and stable use before the pandemic (OECD, 2025[1]). Budget support was used to increase the fiscal space in countries, thereby maintaining macroeconomic stability in recipient countries. While much of this support was not specifically tagged as COVID-19-related, it had an important role in stabilising government spending in the face of economic contraction and the need to quickly fund pandemic-related priorities, including the health sector and social protection measures (Figure 3.3).

Budget support and macro-financial assistance helped partner governments to finance their emergency fiscal and socio-economic packages and created a platform for policy dialogue. Budget support was a major channel used by many bilateral providers, as well as the European Union and multilateral development banks to ensure timely and effective delivery of flexible support to partner countries packages (European Commission, 2022[51]; OECD, 2021, p. 6[52]). In some countries, this built on existing partnerships and provided continuity for ongoing reforms. In other cases, the exceptional circumstances led to the use of budget support where it had not previously been provided – showing the increased flexibility demonstrated in the crisis setting.

Figure 3.3. General and COVID-19 related budget support, 2016-2023

All donors, USD billion disbursements, constant 2023 prices



Note: This graph was created by filtering a combined 2016-23 CRS dataset for co-operation modality. General budget support was then split by COVID-19-related assistance using purpose code 12264 and keywords containing "COVID".
Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

- In Cambodia, development partners provided significant budget support and macroeconomic support packages, creating much-needed fiscal space and contributing to both an effective pandemic response and the economic rebound of the country. They collaborated with the Cambodian government to enhance social protection policies, implementing cash transfers and cash-for-work programmes that targeted the poor and vulnerable populations, mitigating the secondary social and economic effects of COVID-19 (OECD, forthcoming[53]).

- In the Africa region, the African Development Bank's (AfDB) support enabled the provision of services, such as water and electricity, either for free or at reduced rates while also supporting humanitarian efforts. Nigeria was among the countries that were able to develop a social safety net register for transient vulnerable and poor populations, increasing the number of beneficiaries of support. It continues to provide information on vulnerable households that are likely to be affected by similar crises in the future (AfDB IDEV, 2022[17]).
- Bangladesh, with a general government gross debt in 2020 of 34.5%, actively sought budget support from providers for its response and recovery plan for the education sector and cash support programmes (World Economics, 2025[54]; IMF, 2025[55]). The AFD provided essential budget support to Bangladesh, specifically directed towards strengthening the healthcare system and reinforcing non-contributory health protection mechanisms (OECD, 2025[8]). The majority of Saudi Arabia's aid to Bangladesh in 2020-2021 consisted of budget support whereas in previous years aid was predominantly geared towards infrastructure.
- In Nicaragua, which faced a particularly challenging context in 2020 due to political rupture with several key partners, the IMF provided multi-sector budget support of USD 464 million in Rapid Credit Support, along with Rapid Financing Instrument support of USD 124 million. This was conditional on enhancing fiscal transparency, especially related to COVID-19 spending (IMF, 2020[56]).
- New Zealand developed a series of emergency budget support packages to respond rapidly to COVID-19 in the Pacific Small Island Developing States (SIDS) and helped to preserve countries' cash reserves and government revenues, allowing partner governments to finance priority measures, such as economic stimulus packages, social protection payments, and support for small businesses, particularly in tourism Box 3.6.
- Japan provided a 50 billion yen "COVID-19 Crisis Response Emergency Support Loan" to the Government of Viet Nam enabling measures such as deferring consumption tax, corporate tax, rent and other payments in specific sectors affected by the COVID-19 pandemic; subsidizing loan interest payments; and providing low-interest loans to ethnic minorities and residents of mountainous areas. Such financial support also served as a social safety net for industries and vulnerable groups in the country that were severely affected by the pandemic and contributed to the development of an environment that is resilient to infectious diseases.

The use of budget support depended on the overall governance and public financial management context of the country, as well as partner relationships and the risk appetite of providers. Budget support was provided most often in settings where it was already being used by the two involved partners and the governance context was favourable. It was less available to poorer countries and those with weaker institutions where there was a lack of trust between providers (Wilton Park, 2020[57]).

Budget support was particularly relevant in contexts where pre-existing high levels of debt limited access to other sources of financing for the COVID-19 response (Centre for Disaster Protection, 2023[58]). In Cabo Verde, which had a high general government gross debt of 143.8% in 2020, the bulk of pandemic aid was provided through budget support, with the central government securing more than 86% of COVID-19 assistance through this means. This approach was relevant as it significantly expanded the country's fiscal space, preventing any further extension of its debt-stress and enabling the Government of Cabo Verde to implement its national pandemic response, improve its health and social responses and ease the impact on the most vulnerable. Despite budget support forming the bulk of assistance, the debt-to-GDP ratio went up sharply, from 109% to 144% in 2020, and then decreased to 121% in 2022, leaving the country vulnerable to global economic challenges, including inflation (OECD, 2025[59]).

Unearmarked and pooled funding played an important role for the flexibility of funding during the crisis. The case study from the Netherlands found that the decision to primarily provide unearmarked and pooled funding granted useful flexibility that enabled partners to provide relevant support as circumstances changed. The Spanish case study recommended that in the future the government use general contributions to multilateral organisations, which then decide on priorities, to avoid an imbalance between pillars, with overfunding of some over others, as happened with the vaccine pillar compared to diagnosis, treatment or strengthening of health systems pillars. It was also found that some of the instruments of Spanish co-operation are too rigid to respond to emergency situations, which limits support to non-targeted interventions or generic funds.

The evaluation found that pooled funds were another important part of the funding landscape in responding to the pandemic, particularly due to the flexibility, timeliness and responsiveness that they provide (DEVNIT, 2022[60]). For example, the UN Central Emergency Response Fund (CERF), a global pooled fund designed to provide rapid access to flexible funding for countries in crisis, was used to support lifesaving activities in response to the COVID-19 pandemic. The provision of unearmarked, core funding for national and international non-governmental organisations (NGOs) and multilateral organisations, was emphasised across several evaluation reports and studies as a key enabler of flexibility and adaptation (Norad, 2020[61]; ICAI, 2022[62]; UNICEF, 2020[63]; OCHA, 2021[64]; EBA, 2022[65]; Sida, 2021[66]).The availability of flexible funding was fundamental for a timely response, particularly in the early stages of the pandemic.

Box 3.6. New Zealand's budget support to Pacific governments for a rapid COVID-19 response

New Zealand provided emergency fiscal budget support to help 12 Pacific Small Island Developing States to maintain stability and recover from the COVID-19 pandemic. This included four countries where New Zealand did not have reform-linked budget support programmes in place. Whilst rapid deployment precluded in-depth dialogue on policy reform, the approach allowed partner governments to finance priority measures. As a result, a COVID-19 package of NZD 50 million was rapidly delivered, allowing partner government-driven recovery and facilitating governments to finance priority measures such as economic stimulus packages, social protection payments and support for small businesses, particularly those linked to tourism.

New Zealand's support not only maintained the stability of state institutions and public services, but it strengthened relationships between its Ministry of Foreign Affairs and Trade (MFAT) and affected partner countries. New Zealand intends to increasingly use this experience of emergency fiscal budget support, as well as its existing reform-lined budget support, to channel part of its scaled-up climate financing.

To ensure the economic and social resilience of the Pacific SIDS during the pandemic, this funding was provided in addition to New Zealand's existing reform-linked budget support as a complementary measure to avoid undermining pre-existing reform focused budget support. New Zealand's years of experience in delivering reform-linked budget support was seen as a crucial factor in the success of this approach as it ensured familiarity with partner government systems and helped Pacific SIDS maintain stability and recover from the crisis. (OECD, 2023[67]).

Source: OECD (2023[67]), *Using Budget Support to Respond Rapidly to COVID-19 in Pacific Small Island Developing States*, https://www.oecd.org/en/publications/2021/03/development-co-operation-tips-tools-insights-practices_d307b396/using-budget-support-to-respond-rapidly-to-covid-19-in-pacific-small-island-developing-states-sids_10d612ff.html; New Zealand Ministry of Foreign Affairs and Trade (2025[68]), *New Zealand's International Development and Humanitarian Response to the COVID-19 Pandemic (2020-2022)*, https://www.mfat.govt.nz/assets/Aid-Prog-docs/Evaluations/2025/OECD-COVID-19-Global-Evaluation-Coalition-New-Zealand-Case-Study.pdf.

Targeting vulnerable countries

Certain countries and territories are generally considered more vulnerable based on economic, geographic, political, and societal factors (OECD, 2024[69]). The four categories of countries and territories most in need are LDCs, landlocked developing countries, SIDS and fragile contexts (some of these categories overlap and a country can be counted in more than one).

The surge in support during the COVID-19 crisis is more pronounced when looking at vulnerable countries (heavily indebted poor countries, LDCs, land-locked developing countries and SIDS) (Figure 3.4), with ODA as a percentage of GNI increasing in 2020 due to both economic constriction and increased assistance. However, funding for these groups of vulnerable countries quickly returned to pre-pandemic levels or in most cases dropped below those levels in 2022.

For heavily indebted poor countries (HIPCs), there was a small uptick in aid received in 2020, from 5.41% to 6.84%, likely reflecting emergency COVID-19 support. However, this quickly tapered off, falling to 5.75% in 2021 and declining further to 4.79% by 2023, below pre-pandemic levels. A similar pattern was observed for landlocked developing countries (LLDCs), where ODA as a share of GNI rose from 3.63% in 2019 to 4.35% in 2020, before steadily decreasing to 2.95% in 2023.

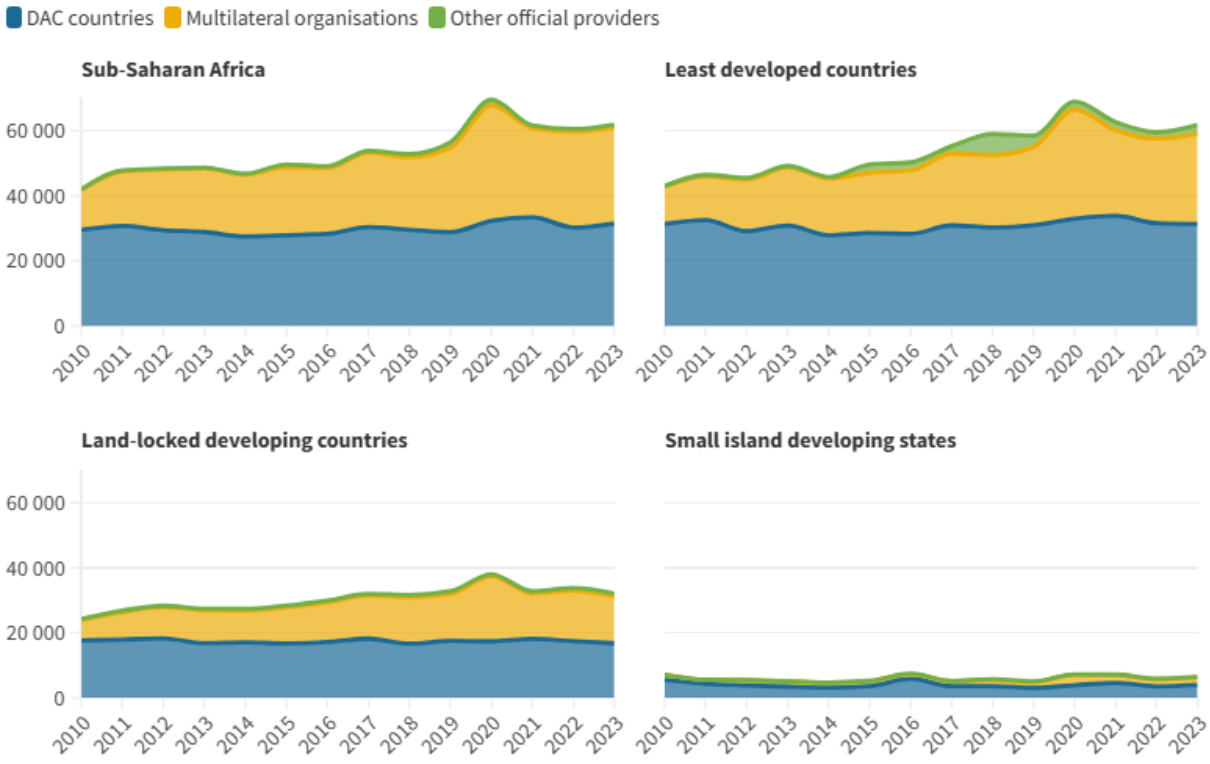
Least developed countries (LDCs) saw a slight pandemic increase of ODA, from 4.67% in 2019 to 5.61% in 2020. But again, this was not sustained, falling back to 4.09% in 2022, before edging up slightly to 4.26% in 2023, broadly in line with pre-pandemic trends. Small Island Developing

States (SIDS) experienced greater volatility. After dipping in 2019, ODA rose to 2.28% in 2020, declined slightly in 2021 and 2022, and then rebounded to 2.19% in 2023.

Figure 3.5 shows a different perspective on this trend, based on the amount of assistance received by groups of countries and territories most in need. Each of these classifications experienced a similar trend from 2016-2023 with assistance increasing steadily from 2016-2019. They then experienced a larger than usual increase in 2020, a slight decrease between 2020-2021, and a relative stabilisation in 2022-2023.

Figure 3.4. Official development assistance to countries in need, 2010-2023

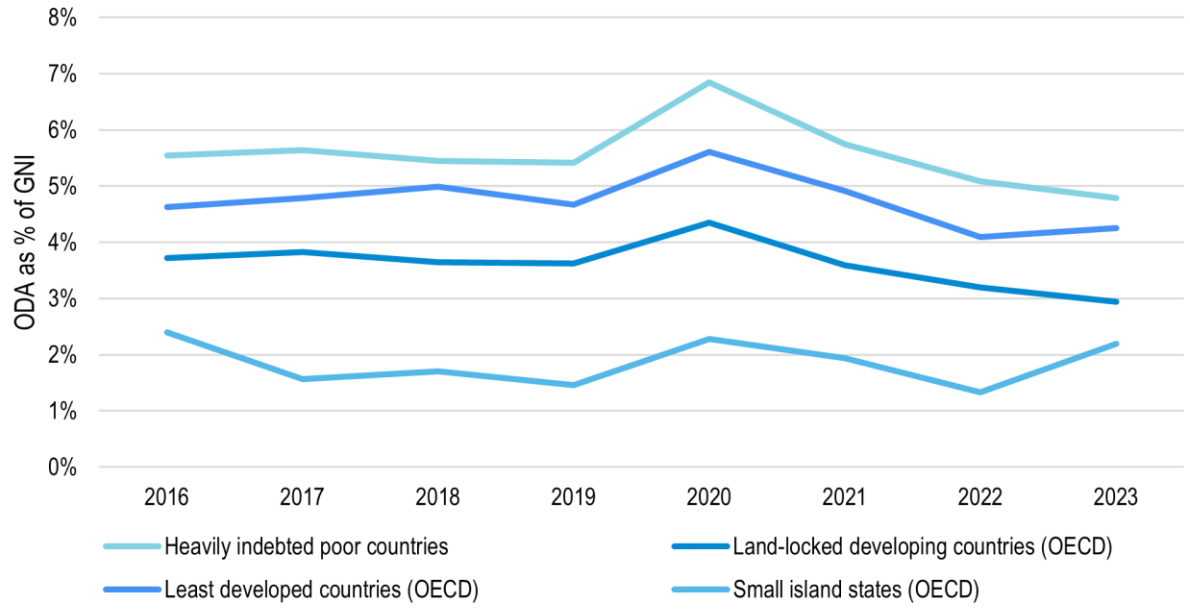
All providers, USD millions, constant 2023 prices



Source: OECD (2025[1]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52; OECD (2024[69]), Countries and territories most in need, https://web-archive.oecd.org/temp/2024-03-07/380032-countries-most-in-need.htm.

Figure 3.5. Official development assistance received as a percentage of GNI, 2016-2023

All donors, all flows, net disbursements using constant USD



Notes: Graph created using data as per source, which calculates the figure as net official development assistance (ODA) divided by gross national income.
Source: Our World in Data (2025[70]), Foreign aid received as a share of national income, https://ourworldindata.org/grapher/foreign-aid-received-as-a-share-of-national-income-net?tab=chart&time=2016..latest&country=Heavily+indebted+poor+countries~Least+developed+countries+%28OECD%29~Land-locked+developing+countries+%28OECD%29~Small+island+states+%28OECD%29.

Reaching vulnerable populations

The pandemic had distinct impacts on different groups of people, including different ages and social groups (unhoused, mentally ill or disabled people). Men were affected more than women by the COVID-19 disease, in terms of incidence, hospitalisation and death, especially in South Asia and Latin America (Grown and Sánchez-Páramo, 2021[71]; Flor et al., 2022[72]). However, women and young people were more negatively impacted in terms of jobs, income and safety, with women more likely to lose their jobs in developing countries (Bundervoet and Davalos, 2021[73]). This was attributed to the higher number of women working in the informal and social sectors than men, as well as women engaging in higher levels of unpaid work at home, including caregiving (Georgieva et al., 2020[74]). Many women and girls faced disproportionate increases in caregiving demands, with the crisis deepening unequal intrahousehold power dynamics and existing inequalities (OECD, 2020[75]).

Addressing the unequal impacts of the pandemic – particularly in terms of gender inequality – and targeting marginalised people and communities, was a high-level priority for many development and humanitarian actors. This was in line with broader trends in the strategic priorities of development agencies leading up to the pandemic, which increasingly emphasised inequality and leaving no one behind. While the evidence shows that the crisis response did not see a step change in the approach, it does provide many positive examples of how vulnerable populations were reached, such as that of Ireland (Box 3.8).

There is limited evidence and data on how well the COVID-19 response addressed the needs of vulnerable groups in different contexts, including people living with disabilities, the elderly, Indigenous populations, and the lesbian, gay, bisexual, transgender, intersex, and queer or questioning (LGBTIQ+) community (ALNAP, 2024[2]). Assessments occasionally considered vulnerable groups, but few applied a systematic protection, gender, or inclusion lens, often relying on rough estimates for disability data (IAHE, 2022[76]). The specific needs arising from intersecting factors such as age, gender and disability were poorly understood and inconsistently addressed.

Evaluations highlighted weaknesses in the needs analyses of vulnerable groups and in the availability of gender-based analyses, such as the needs of children with disabilities, women subject to gender-based violence (GBV), and female-headed households. Gaps were also noted in the availability of disaggregated data, with the humanitarian needs of older people and people living with disabilities being given insufficient attention, despite it being known that they were particularly vulnerable to COVID-19 (IAHE, 2022[76]). The case study of Georgia illustrates well the dynamic seen across many crisis responses: a strong emphasis at the political level, but unclear implementation and results of the commitment to an equitable crisis response (OECD, 2025[77]).

This lack of robust needs analyses was compounded by the scale of the need, limitations in movement, difficulty in accessing vulnerable populations and a lack of disaggregated data by vulnerability indicators (e.g. age, gender and disability). The evaluation carried out for the Inter-agency Standing Committee (IASC) highlighted that in countries where access to the most vulnerable people was already constrained or denied before the pandemic, such as in Somalia, Syria and Nigeria, there was little mention and limited understanding of the needs of these acutely vulnerable communities (IAHE, 2022[76]).

In all countries, there was a worrying rise in gender-based and intimate partner violence, sometimes referred to as a “shadow pandemic”. Access to services supporting survivors of domestic violence was reduced due to pandemic-related movement restrictions, and in some cases, people were forced to lock down at home with abusers (U.S. Global Leadership Coalition, 2022[78]; UN, 2020[79]).

Development partners made important efforts to scale up support and ensure continuity of services – especially in 2021 when the scale of the problem became clear. For example, UNICEF advocated for social workers to be classified as essential staff in Sri Lanka and China, ensuring they had permits to allow them to continue their work with GBV survivors in Zimbabwe, and supporting a helpline in Mauritania, which has responded to hundreds of calls about rape, domestic violence and harassment (UNICEF, 2021[80]).

Multilateral agencies provided positive examples of advocating for and working to include the needs of the most vulnerable in their responses. Given the increase in GBV, many agencies, including UNFPA, advocated for the necessity of sexual and reproductive health rights and GBV services, despite the difficult circumstances. UNFPA’s approach to assessing the needs of populations was multifaceted and tailored to the specific contexts of different countries (UNFPA, 2024[81]). The WFP stressed the importance of recognising shifts in patterns of vulnerability and identifying new populations in need of its support. It worked to ensure that beneficiary targeting was adapted to needs, including through the identification of new beneficiaries and the transfer of existing beneficiaries to new forms of assistance, such as from school feeding to social protection schemes (WFP, 2022[29]).

The system-wide evaluation of the UN’s socio-economic response to COVID-19 found that the level of attention paid to gender equality, human rights, disability inclusion, and the “leave no one behind” principle in the socio-economic response plans (SERPs) and other planning documents varied across countries. A review of SERPs found a lack of focus on important vulnerable groups, such as Indigenous people, minorities, people living with HIV/AIDS, people with disabilities and the LGBTIQ+ communities (ICAI, 2022[62]). In Cabo Verde, an After-Action Review convened by WHO highlighted challenges faced by vulnerable people including the homeless and mentally ill within the healthcare system.

In terms of philanthropic support, foundations supported global health initiatives such as vaccine research and vaccination rollout, and provided more targeted support to the regions, communities and individuals who were most vulnerable during the pandemic. For many philanthropies, this involved a specific focus within their healthcare interventions, such as LDCs, racial and social minorities, refugees and migrants, and at-risk workers (OECD, 2025[82]). It also meant looking beyond the healthcare sector to address the socio-economic impact of the pandemic on other sectors and areas of life. The two largest providers of global philanthropic support for COVID-19 – the Gates Foundation and the Mastercard Foundation – aimed at supporting the poorest and most vulnerable countries, particularly those in Sub-Saharan Africa (Dowell, 2023[83]). This prioritisation is reflected in the regional distribution of funding: USD 1.8 billion (55% of all COVID-19 philanthropic funding in 2020-2022), went to Sub-Saharan Africa.

An evaluation of the International Organization for Migration's (IOM) COVID-19 response found its existing work with vulnerable populations largely continued, adapting to the context in which many existing vulnerabilities were exacerbated, and new needs were created. The IOM advocated for the inclusion of all populations in response planning, based on needs and not population groups. As a result, migrants' needs were included in national COVID-19 response and recovery plans, as well as in the GHRP. Programmatically, many projects were adapted or designed specifically to address the needs of vulnerable populations. In Mexico, the Country Office worked with the shelters and child protection authorities to design internal protocols that focused on protecting women and children and identifying situations where people were at risk, particularly children and victims of violence (including sexual violence).

Box 3.7. Relevance – a focus on gender in Georgia

A Rapid Gender Assessment of the COVID-19 situation in Georgia (carried out in March 2021) found widespread disparities between men and women, with women falling behind in vaccination rates. The Government of Georgia developed an anti-crisis package for vulnerable groups, which emphasised women in the informal sector and those who were unemployed.

An ordinance passed in October 2020 to increase the salaries of healthcare workers was reported to have particularly benefited woman in the industry. Georgia had a very high pre-COVID-19 incidence rate of gender-based violence (GBV).

The Georgian government was praised for continuing to enforce rigorous measures against GBV throughout the pandemic through emergency assistance and human trafficking hotlines.

Source: OECD (2025[9]), "The Development and Humanitarian Response to the COVID-19 Pandemic in Georgia (2020-2022)", https://doi.org/10.1787/a56d49ff-en.

Box 3.8. Ireland's crisis response: Putting the furthest behind first

Reaching the furthest behind first is the overarching frame of Ireland's international development policy. "Furthest behind" is a context-specific and relative term describing those people and groups in a society that are most disadvantaged. This commitment informed Ireland's pandemic response.

The COVID-19 pandemic strengthened Ireland's understanding of and commitment to global solidarity, cooperation, and multilateralism. As well as working to secure health for all domestically, Ireland's Departments of Foreign Affairs and Health collaborated on multiple projects to improve access to medical countermeasures such as vaccines, diagnostics, and medicines in low-income countries. The approach focused on the furthest behind and built on lessons from the HIV and Ebola crises.

In addition to global level engagement and support for the WHO and COVAX, across the network of Ireland's embassies in low-income countries, multiple programmes were supported to help protect disadvantaged communities from the worst effects of the pandemic. For example, in Tanzania, the Embassy worked with Cardinal Rugambwa Hospital in Dar es Salaam to provide lifesaving treatment, including oxygen, PPEs and patient monitors. In Malawi, the Embassy worked with the Ministry of Health, UNICEF and UNDP to enhance the capacity of health workers in the provision of critical care, supported large scale community vaccination campaigns, disease surveillance, and provided PPE and equipment for cold chain storage of vaccines.

Source: Government of Ireland (2025[84]), Irish Support for Global Responses to COVID-19 Reaches €123 Million, https://www.gov.ie/ga/an-roinn-gn%C3%B3tha%C3%AD-eachtracha/preaseisiuinti/irish-support-for-global-responses-to-covid-19-reaches-123-million/.

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Note

[1] The following low income countries were included in the top ten either in terms of cases per capita or deaths per capita, with significant overlap between the two groups: Afghanistan, Burundi, Ethiopia, Gambia, Guinea-Bissau, Mozambique, Malawi, Rwanda, Sudan, Somalia, Syria, Togo and Uganda.

4 Working together: Coherence of the international COVID crisis response

This chapter examines the coherence of the international development co-operation response to the COVID-19 crisis through four different lenses: overall coherence of assistance globally (including regional co-ordination, co-ordination between providers and co-ordination of vaccination efforts); the consistency of other policies with development and humanitarian efforts; the organisation of the response within provider development agencies; and finally, the set-up and effectiveness of co-ordination in countries receiving support. Special attention is given to the co-ordination of vaccination efforts, as these were a key focus of the crisis response and illustrate the challenges faced across other intervention areas. This chapter looks at factors that enhanced or hindered coherence and offers insights for future international co-operation.

The overall picture on coherence is mixed. Successes were noted, especially where existing institutions and co-ordination mechanisms were employed at the country and regional levels. There was also an unprecedented multilateral effort to co-ordinate the distribution of vaccines and increase equitable access. The use of electronic communication platforms facilitated virtual meetings between stakeholders, with co-ordination becoming less formal, but more proactive, at least in information sharing, especially where international staff stayed in-country. UN country offices played a key role in supporting joint responses and co-ordinating international funders, national governments and other partners. Within development agencies, drivers of coherence included the designation of a single crisis response body with a whole of government mandate.

Still, significant weaknesses in coherence of international co-operation efforts were reported, with gaps and overlaps of support; parallel efforts instead of streamlined; and a disconnect between political and technical level decision making. The overall global response with incoherent, with the WHO providing insufficient leadership. In the international assistance space, parallel development and humanitarian assessment and planning mechanisms placed an unnecessary burden on host governments, undermined ownership, fragmented the support provided and generated inefficiencies. Most critically, incoherent domestic policy actions undermined the international co-operation efforts, particularly on access to COVID vaccines. Bilateral providers supported the COVAX facility and the equitable distribution of vaccines, but at the same time made bilateral agreements with manufacturers that limited the vaccine supply and directly undermined access for lower income countries.

4.1. Global coherence of the COVID-19 response

Multilateral development organisations and UN agencies were at the heart of the crisis response, and many bilateral providers took a multilateral approach to the crisis, scaling up support through multilateral channels to enable a coherent response. However, the WHO and other global entities did not fulfil their leadership and co-ordination roles sufficiently (Williamson et al., 2022[1]). In addition, especially among larger provider countries, unilateral decision making persisted in parallel and allocations of funding were not co-ordinated between countries.

Fragmentation and a lack of co-ordination have long been flagged as weaknesses in international assistance as well as a consistent challenge within the global health landscape. Several initiatives to remedy this have been tried with varying degrees of success (e.g. Lusaka Agenda, SDG3 Global Action Plan for Accelerating Health, IPH+, UHC 2030). Efforts to enhance health co-ordination and collaboration at the global level prior to and during the pandemic did not always account for factors such as political leadership, governance and funding structures, that can either reinforce or hinder country-level co-ordination (WHO, 2024[2]). Experiences during the COVID crisis brought forth these weaknesses in the global health and crisis response architecture.

The role of the multilateral system

It was recognised early in the pandemic that the scale of the crisis would require concerted and improved co-ordination and as such was highlighted as a priority in the Development Assistance Committee (DAC) members joint statement (OECD, 2020[3]). Working through experienced and trusted partners and using existing co-ordination mechanisms was considered to be a key factor in enabling a coherent response, as this helped to co-ordinate actions efficiently. The prioritisation of the multilateral system is reflected in the higher share of COVID-related funding that was provided to multilaterals, compared to all assistance.

Drawing on findings across more than 100 evaluations, the synthesis found that the multilateral system was key for scaling-up existing co-ordination mechanisms across development actors, organisational levels and ways of working to launch a coherent response to the health, socio-economic and humanitarian

impacts of the crisis (Schwensen and Schiebel Smed, 2023[4]). For example, the Netherlands allocated funding and vaccines primarily through multilateral organisations and initiatives, which supported an externally coherent response (OECD/IOB, 2025[5]).

Likewise, the Spanish case study found that funding multilateral actors supported coherence and enabled multilateral agencies to adapt their support to country needs. The commitment to a multilateral response proved to be successful in the face of the global crisis and allowed Spanish development co-operation to position itself as an actor that effectively overcame geopolitical divisions to assist other countries during the crisis (Ministerio de Asuntos Exteriores, Unión Europea and Cooperación, 2024[6]). In contrast, the German case study found the share of funding channelled through multilateral organisations did not rise during the crisis, despite the considerable advantages of multilateral organisations in promoting global public goods such as health protection and pandemic control, as well as effectiveness, timeliness and economic efficiency (Römling et al., 2024[7])

The multilateral system was key for scaling-up existing co-ordination mechanisms across development actors, organisational levels and ways of working, enabling a coherent response to the health, socio-economic and humanitarian impacts of the crisis. However, there was a lack clarity of roles and responsibilities in some cases between partners and agreed ways of working (MOPAN, 2022[8]).

The World Bank's COVID-19 recovery efforts emphasised the establishment of "One Health" co-ordination within countries to support multisector responses and strengthen co-ordination structures (WHO, 2022[9]). The World Bank also co-ordinated closely with the International Monetary Fund (IMF), as well as with the Asian Development Bank (ADB) (e.g. on social protection and education support) and in Latin America with the Inter-American Development Bank (World Bank, 2021[10]). UN agencies worked together to co-ordinate procurement early in the pandemic, when there were critical shortages of lifesaving supplies (MOPAN, 2022[8]).

Fragmentation in the pandemic response

While there was a considerable effort to co-ordinate pandemic-related support, many of the pre-pandemic challenges related to fragmentation continued or even worsened as providers responded to a context of overwhelming needs. Chronic underinvestment in certain institutions also meant that the multilateral system was less well positioned to play this role .

As described above, existing types of structures and tools (notably a consolidated humanitarian response plan, and a multi-donor trust fund at the UN – see Chapter 2) were used to co-ordinate international co-operation. Many of these were exceptional in scope, and the multilateral system also supported the creation of new mechanisms, including WHO's One Health initiative and the COVAX initiative, to address the global scale and multi-dimensional aspects of COVID-19 (MOPAN, 2022[8]).

While assessments show that each of these worked well as delivery mechanisms, they did not succeed in global co-ordination as such, given there were many other efforts – notably unilateral actions of provider governments – happening in parallel.

The COVID-19 Global Humanitarian Response Plan (GHRP)[1] functioned as a consolidated appeal, rather than acting as a single resource mobilisation mechanism as intended (MOPAN, 2022, p. 32[8]). Consequently, some UN agencies launched their own appeals outside those of the GHRP, which worked against coherence. Furthermore, the WHO Health Emergency Programme and the associated contingency fund for emergencies – established in 2016 following the Ebola outbreak – were underfunded, reducing readiness to respond to COVID-19 (MOPAN, 2022[8]; Gulrajani and Silcock, 2020[11])

The multi-funder UN COVID-19 Response and Recovery Trust Fund (also based on the experiences from Ebola) facilitated coherence between humanitarian and socio-economic support (NORAD, 2020[12]). By pooling funding for joint programming among UN entities, and using existing implementing entities, the

fund was a strong driver of strengthened coherence across UN agencies, especially at the country level (UNSDG, 2022[13]) (UNDS, 2023[14]). Entities involved in pooled funding projects noted that the funds effectively incentivised joint work, and worked to reduce reporting and other administrative requirements, though they remained transaction heavy for those involved (UNDS, 2021, p. ix[15]).

Though most providers supported multilateral and pooled funding, most did so in parallel to bilateral assistance, which undermined both efficiency and coherence. For instance, the United States provided health support to Gavi, UNICEF and other COVAX partners, as well as launching a new, whole-of-government response called the Initiative for Global Vaccine Access (Global VAX). Likewise, the People's Republic of China (hereafter 'China') provided funding to the COVAX global effort, while also donating large volumes of vaccine doses directly to priority partner countries (CIKD, 2023[16]). OECD DAC peer reviews illustrate that this was the case for nearly all OECD DAC members, with most providing COVID-related assistance to multilaterals and bilaterally to countries based on their own priorities.

There was no overarching co-ordination mechanism to drive or even inform, overall allocations across countries. This led to fragmentated approaches to resource mobilisation that reduced coherence and left gaps in funding (UNSDG, 2022[13]). Longstanding competition among UN agencies for resources remained a challenge and was most pronounced in the contexts in which resources were scarce (WHO, 2024[2]).

Regional co-ordination

While co-ordination at a global scale was fragmented, there were strong examples of effective regional approaches and regional entities were important co-ordination platforms for pandemic responses.

The pandemic highlighted the important role of the co-ordination and planning of regional development actors as part of the response, assessing needs, developing comprehensive plans, and helping avoid a duplication of effort. Platforms supported knowledge and information exchange; the identification of needs; the co-ordination of supplies; the sharing of resources, information and procurement; and the co-ordination of policy measures. Regional co-ordination mechanisms played an important role in responding to transboundary issues; contextualising global policy frameworks, country needs and priorities; building national ownership; and facilitating South-South co-operation (MOPAN, 2022[8]).

For example, Mexico and China both provided material assistance to Latin America and the Caribbean through the regional mechanism of the Community of Latin American and Caribbean States (CELAC) (see Box 4.1). Other countries found that the benefits of such regional approaches were under-valued and more could have been achieved with a regional approach.

The Team Europe approach sought to align the pandemic response of the European Union and its Member States. The success of the Team Europe approach was evident in the Caribbean and Pacific regions, where the European Investment Bank (EIB), the European Commission and other Team Europe members collaborated with local organisations, such as the Caribbean Development Bank, to provide affordable access to vaccines and financial resources, ensuring that the Caribbean could better manage the pandemic's effects. One notable achievement of the initiative was securing EUR 300 million in additional funding from the EIB to boost vaccine deliveries through COVAX, targeting SIDS and other vulnerable regions (European Commission, 2025[17]).

The case study on the Small Island Developing States (SIDS) found good evidence suggesting that regional co-ordination, particularly in the Pacific and Caribbean regions, was effective and included information sharing among providers, including national governments, partner countries and regional organisations. For example, the Pacific Islands Forum brought together leaders, ministers, regional organisations (e.g. the Pacific Community) and UN agencies to co-ordinate a regional response (European Commission, 2025[17]). Co-ordination with SIDS governments was reduced due to providers dealing directly (bilaterally) with them. Key informants and several evaluations highlighted the need for providers

to align with regional bodies and use them more intentionally to better align their support and enable greater coherence (European Commission, 2025[17]; AFD, 2024[18]).

The Pacific Humanitarian Protection Cluster (PHPC) supported governments in the Pacific region to address the challenges of geographic isolation and border closures. The PHPC supported shared decision making on critical issues, such as the movement of goods and people, ensuring that support reached isolated and vulnerable populations. Information sharing within the PHPC framework helped align national responses with regional priorities, further demonstrating the responsiveness of bilateral programming to the needs of SIDS. Strong sectoral co-ordination was important in crisis responses and clusters/sectors broadly performed well in providing strategic technical direction and offering relevant guidance and support.

Box 4.1. Responding to the COVID-19 crisis in the Latin America and Caribbean region

In 2019, under the leadership of Mexico, the Community of Latin American and Caribbean States (CELAC) identified the need for a project to monitor and analyse viruses in the Latin America and the Caribbean (LAC) region. Mexico had gained experience in its fight against AH1N1 (swine flu) in 2009. The first meeting of CELAC took place on 30 January 2020, the same day the WHO Director General declared that the outbreak of COVID-19 constituted a public health emergency of international concern. The region went on to establish the CELAC Network of Experts on Infectious Agents and Emerging and Re-emerging Diseases. Strong regional leadership played a pivotal role in co-ordinating responses, mobilising resources and fostering collaboration among countries. CELAC continued to arrange meetings, support specific studies and initiate joint declarations between CELAC–FAO, CELAC–CARICOM and CELAC–the Organisation of Eastern Caribbean States (OECS). The objective was to contribute to greater knowledge and transparency regarding information on specific issues related to the pandemic.

These regional entities proved critical in matching assistance to needs, including facilitating triangular co-operation, ensuring that expertise, funding and resources were effectively channelled to where they were most needed.

Co-ordination between providers

Both in international fora, and especially at the country level, providers co-ordinated both between themselves and with national governments and other partners, which illustrate good practices that can be replicated in the future. However, the lack of any overarching mechanism to enable co-ordination and the slow and limited role of the WHO in driving and co-ordinating action globally – together with the pressure created by competing interests – meant that assistance was not as well co-ordinated as it could have been.

In addition to the DAC statement in 2020, which emphasised the need for quick and co-ordinated action not only among DAC members, but also with other providers and private sector actors, there were many positive initiatives to co-ordinate responses between providers of international assistance:

- Ministers of Development Co-operation in Nordic countries began meeting together in mid-2020 and co-ordinated closely in the early days of understanding the pandemic impacts, implications and taking decisions on response strategies (Ministry for Foreign Affairs of Finland, 2022[19]).
- New Zealand – in co-ordination with Australia, the ADB and the World Bank – provided grant funding in the form of emergency budget support across the Pacific. From a Pacific regional perspective, New Zealand's response supported the Polynesian countries in reducing the impact of the virus. It also strengthened relationships and trust between the New Zealand and Polynesian health systems (Ministry of Foreign Affairs and Trade of New Zealand, 2025[20]).

- At the 2021 UN General Assembly Meeting, China announced the Global Development Initiative (GDI) to "speed up the implementation of the 2030 agenda" and to address the needs of countries impacted by the pandemic and adapting to climate change. In January 2022, the Group of Friends of the Global Development Initiative was launched with the support of the United Nations (Schwarz and Rudyak, 2023[21]).
- Team Europe was set up by the European Commission to facilitate greater co-ordination and scale-up of resources across the Commission, as well as foster coherence with EU Member States and European Development Finance Institutions, building on the spirit of "Working Better Together". A fast-track assessment of the EU's response to the pandemic concluded that "co-ordination, co-operation and partnerships with EU Member States, UN organisations, non-EU donors and other partners" helped the European Union to offer expertise that had not been part of the pandemic "co-operation envelope" for certain countries (e.g. health in Fiji) (European Commission, 2022[22]).
- As illustrated in Box 4.1, Mexico played a key role in helping to co-ordinate among providers in the Latin America and Caribbean region.
- The German case study rated the co-operation of multiple bilateral and multilateral donors – such as through basket funds – as effective, particularly where it enabled bundling the knowledge of various partners along with large funding volumes (Römling et al., 2024[7]).

Many UN agencies reported increased collaboration through strategic and technical inter-agency co-ordination mechanisms and joint programming. However, the UN COVID-19 Socio-Economic Response and Recovery Plans (SERPs) or Socio-Economic Development Plans (SEDPs) which were intended to help this co-ordination, often served more for UN funding calls rather than true drivers of partnership between international agencies and governments. The 2022 interim system-wide evaluation of UNDS's response found that partnerships and collaborations were formed among UN entities at country level (UNSDG, 2022[13]). The UN Framework was an effective instrument in guiding coherence at country level, through adapting socio-economic response plans (SERPs) to local contexts. However, the three-pillar structure of the UN COVID response presented challenges for the UN country teams (UNCTs) in integrating planning across all three pillars (UNSDG, 2022[13]). While there was recognition of the need for a holistic response, existing levels of collaboration and co-ordination between humanitarian, development and peace actors were not generally strengthened during the pandemic (IAHE, 2022[23]). Furthermore, the IMF, multilateral development banks and other global financing instruments were not consistently or effectively engaged with UNCTs across countries to ensure coherence in policy engagement, advocacy and programming (UNSDG, 2022[13]).

Co-ordination between international financial institutions (IFIs) was mixed. The IMF and the World Bank, worked together during the pandemic in pressing for official debt relief and multilateral vaccination support initiatives. They also worked in close co-operation with country teams in assessing the impact of the pandemic at country level. However, their coherence was sometimes compromised due to differences in approach. For example, the IMF generally prioritised rapid disbursement through its emergency facilities to meet urgent needs, whereas the World Bank placed greater emphasis on debt sustainability issues and lending through its policy-related instruments. Secondly, the institutions were not always aligned on assessments of countries' debt sustainability (IEO, 2023[24]).

Co-ordination of vaccination efforts

The co-ordination of vaccination efforts at a global scale was fragmented, despite the deployment of an innovative multilateral initiative with the ACT-A and COVAX vaccine pillar. COVAX, which prioritised joint procurement and collaboration, was hindered by parallel, unilateral efforts, as well as by provider countries procurement of vaccine for domestic use – in some cases at volumes far exceeding their needs – which drove up prices and increased inequity (as discussed further below).

The aim of COVAX was to drive a coherent and equitable global response, and this effort largely succeeded in accelerating the speed at which countries received vaccines. There was a good coherence of efforts within the scope of the facility itself. However, significant challenges arose due to the lack of co-ordination between the procurement efforts of COVAX and those of individual donor countries, as well as their domestic actions which undermined the co-ordinated global effort. Individual countries with strong purchasing power, such as the United States and the United Kingdom, were able to order huge quantities of vaccine doses from suppliers for their domestic population, leaving little for COVAX to procure. To illustrate, by June 2021, high-income countries (HICs) had placed orders for six billion vaccine doses, while COVAX had only secured 2.3 billion (Launch and Scale Speedometer, 2023[25]).

Co-ordinating donations of vaccines across multilateral and bilateral channels was also a challenge. Some providers chose to donate vaccines directly to partner countries, often to strengthen bilateral relationships and increase the visibility of the provider country. These rather ad hoc bilateral donations were out of sync with and often worked against the evidence-driven strategic allocation strategy of COVAX.

For example, island nations closely linked to certain donor governments – such as Samoa and the Marshal Islands with the United States – swiftly received direct donations (European Commission, 2025[17]). Another example pertains to the Netherlands and their decision to donate vaccines to Suriname, which was partly due to their desire to strengthen bilateral ties and societal connectedness (OECD/IOB, 2025[5]). Likewise, in addition to support from COVAX, several international partners – including China and Australia – prioritised donating doses bilaterally to Cambodia, due to strong historic relationships and Cambodia's relatively strong roll-out capacity. While from the perspective of effectiveness Cambodia was a success story, globally such practices deepened inequalities (OECD, forthcoming[26]).

Partnerships between providers and multilateral health organisations, including via COVAX were crucial in co-ordinating global vaccine distribution (MOPAN, 2022[8]). Such collaborative efforts were essential in pooling resources to facilitate equitable distribution and uptake. This was especially pertinent in regions with minimal healthcare infrastructure, where multilateral actors could co-ordinate through joint platforms to provide technical assistance and other support to facilitate vaccination campaigns, alongside the donation of the vaccines themselves. Unfortunately, this accompanying health systems' support for administering vaccines was insufficient or not reliably available (Gooding, Webster and Wiafe, 2021[27]). Furthermore, the way some vaccine donations were managed – notably stocks that arrived with short expiry windows – made it difficult for health systems to rollout available doses (Gooding, Webster and Wiafe, 2021[27]) (IAHE, 2022[23]). For example, in April 2021, the Democratic Republic of the Congo had to return 1.3 million doses to COVAX because they could not be administered before the expiration date (IAHE, 2022[23]).

At country level there were mixed experiences: some countries – including Bangladesh, Cabo Verde, Cambodia and Georgia – reported well-co-ordinated national vaccination campaigns strongly supported by international partners, while others highlighted challenges in both delivery and co-ordination. An after-action review in Mozambique (WHO, 2021[28]), highlights several of the most frequently identified shortcomings and lessons: Despite the good practice of establishing a COVID-19 Vaccination Coordination Committee at all levels (central, provincial and district) to ensure a harmonised approach across various sectors and stakeholders, including religious leaders and Ministry of Health partners, and enhance community participation, the vaccination campaign made very slow progress and was undermined by uncoordinated efforts. Challenges included low levels of collaboration among COVID-19 vaccination partners leading to duplication of efforts, and insufficient communication on vaccine delivery dates leading to disruptions and delays. Weak community engagement led to vaccination hesitancy in some areas and combatting misinformation was a major challenge.

Private sector involvement in the COVID-19 response

The COVID crisis highlighted both the contributions and challenges of private sector engagement in international co-operation (Kabwama et al., 2022[29]; Wallace et al., 2022[30]).The private sector played a significant role in the COVID-19 response across developing countries, complementing public and development co-operation efforts in health service delivery, logistics and social protection. However, official development finance for private sector entities dropped, particularly in the first year of the pandemic.

A study across four countries in Africa (Democratic Republic of Congo (DRC), Nigeria, Senegal and Uganda) found that the private sector supported expansion of access to COVID-19 testing services through establishing partnerships with the public health sector (Kabwama et al., 2022[29]). In the DRC and Nigeria, private entities supported contact tracing and surveillance activities, while in Senegal and Uganda, governments established partnerships with the private sector to manufacture COVID-19 rapid diagnostic tests. The private sector also contributed to provision of personal protective equipment, risk communication and health service continuity. Another study of Bangladesh, Ghana, Nepal and Nigeria also highlighted that the private sector supported the response by providing facilities for quarantine, isolation and treatment through the conversion of unused space.

Nonetheless, the two studies highlight challenges, notably around co-ordination issues, as in some cases the lack of formal frameworks for public–private partnerships resulted in fragmented efforts and duplication of resources, as well as concerns related to reporting, quality and cost of services, calling for quality and price regulation in the provision of services.

There is limited available evidence on the effectiveness of different approaches to involving the private sector in bilateral development agencies' response, or how these were co-ordinated with multilateral efforts – though many providers gave examples of how they involved companies in their crisis response. The UK FCDO worked with social enterprises to set up COVID booths to facilitate testing early in the pandemic in Bangladesh, and there were some indications that these were successful (Global Partnership for Effective Development Co-operation, 2021[31]). Czechia created a new instrument to supply health products to their priority countries. Japan also reported that Japanese technology and products provided to developing countries played a lifesaving role during the pandemic (JICA, 2024[32]). For example, through grant assistance, Twinbird Corporation's portable ultra-low temperature, vibration-resistant refrigerators for carrying vaccines were distributed in East Timor and Mozambique, enabling delivery of the COVID vaccines to the "Last One Mile" such as remote areas with rough roads.

4.2. Policy coherence for sustainable development

Well before the COVID crisis, it was clear that even the most effective and well-coordinated international assistance will only lead to good outcomes if it is supported by other policy actions of both provider and recipient countries. International development and humanitarian assistance cannot be understood in isolation, as other policy actions greatly influenced – both positively and negatively – the overall outcomes of the crisis response.

While few evaluation functions are mandated to look at policy areas beyond international assistance, several studies have identified major challenges with policy incoherence (Schwensen and Schiebel Smed, 2023[4]) (Williamson et al., 2022[1]) i.e. where other policy decisions by provider countries compromised their development co-operation efforts. Some of the key areas included:

- Export bans, vaccine hoarding and purchase agreements that raised prices and reduced supply: Vaccine policies of many countries – including purchases by several rich nations in quantities far exceeding their population's needs – undermined otherwise effective international assistance and multilateral co-operation for equitable access to COVID vaccines.

- Public spending and debt: The knock-on effects of increased public expenditures and public debt drove up the costs of borrowing for developing countries (IMF, 2025[33]).
- Travel bans and closures: The closure of country borders likely had no effect on the trajectory of the outbreak, but had a substantial impact on the rights of refugees and on the economies of low- and middle-income countries (LMICs) by disrupting trade and supply chains, causing a collapse in tourism and hospitality, and reducing remittances and foreign direct investment (Williamson et al., 2022[1]).
- Refoulement of refugees and asylum seekers: Border closures and other movement restrictions related to the pandemic had significant repercussions for refugee rights and for protection actors. In 2020, across all regions of the world, there were approximately 1.5 million fewer arrivals of refugees and asylum seekers than expected. There is clear evidence that some states used the pandemic as a purported justification to introduce restrictive measures detrimental to the rights of refugees (UNHCR, 2022[34]). A Joint Evaluation of the Protection of Rights of Refugees during the COVID-19 pandemic carried out under the auspices of the COVID-19 Global Evaluation Coalition by the United Nations High Commissioner for Refugees (UNHCR), Finland, Colombia, Uganda and the Active Learning Network for Accountability and Performance (ALNAP) looked at how the COVID-19 pandemic challenged the protection of the fundamental rights of refugees, and how the combined response of key actors worked to avoid exclusion.
- Disinformation and misinformation: Widespread misinformation and even intentional disinformation was not sufficiently addressed, undermining public confidence with long term consequences.

Incoherence was at times driven by short-term political interests including a desire for high visibility, which led to a supply-driven, hardware-heavy approach often with insufficient attention to efficiency and relevance.

Incoherent policy actions were often framed as serving national interests. However, several studies have shown that during the COVID crisis, incoherence undermined the global response, which ultimately lead to worse outcomes for all (Williamson et al., 2022[1]). Furthermore, there is evidence from many countries of high-levels of public support for international assistance and in some countries support increased during the COVID crisis (Box 4.2). While there may be public communication goals for demonstrating the contribution of specific provider countries, there is little evidence that such approaches are necessary nor effective at increasing public support for international assistance. In any case, the risks in terms of cost, efficiency and effectiveness should be duly considered as waste and low impact can in the longer term undermine public support.

Experiences from several providers showed that a more global framing of national interest and global public health, resulted in more support for international assistance during the crisis, and in more coherent and effective international assistance. A good example was New Zealand's public health security strategy of involving neighbouring countries in its national vaccine procurement strategy, which helped all countries in the region reach their vaccination targets – benefiting New Zealand as well as its developing country partners (Ministry of Foreign Affairs and Trade of New Zealand, 2025[20]).

Box 4.2. International solidarity during the crisis: Public opinion in Germany

Opinion-based data from the German public in mid-2020, found that:

- The public favoured greater global solidarity to cope with the coronavirus pandemic.
- The indicators for "own health concerns" correlated slightly positively with support for development co-operation — i.e. the greater the concern for the health of family and friends or one's own health, the greater the approval of increased development and humanitarian spending.
- Trust in Germany's own government correlates positively with support for increased global solidarity, creating potential risks if trust declines. This finding is consistent with previous studies that found trust in one's own government positively affects the support for co-operation.

The results of a representative survey among 1 000 individuals in Germany conducted in November 2021 found that despite the acute, ongoing pandemic crisis in Germany, there was still a high level of public support for measures to tackle the pandemic in the Global South:

- The level of support among the German population for development policy measures to tackle the coronavirus pandemic in the Global South remained high, especially for support to health care and food security measures. In contrast, those surveyed were more sceptical towards granting debt relief or providing economic aid.
- The population supported donating an increased number of vaccine doses to countries of the Global South, and perceived vaccine distribution as unequal and unfair.
- With regard to patent protection for COVID-19 vaccines, public opinion was divided.

Sources: Bruder et al. (2020[35]), "Public Opinion on International Solidarity in the Coronavirus Pandemic", DEval Policy Brief 2020, German Institute for Development Evaluation (DEval), Bonn; Eger et al. (Eger et al., 2022[36]), "COVID-19: The general public's attitudes towards development policy measures and vaccine distribution: Results of a survey on international solidarity during the coronavirus pandemic", DEval Policy Brief 2/2022, German Institute for Development Evaluation (DEval), Bonn, https://nbn-resolving.org/urn:nbn:de:0168-ssoar-79708-5.

4.3. Co-ordinating international assistance within provider governments

Bilateral providers had many good examples of aiming for whole-of-government crisis response efforts, including formal mechanisms, such as taskforces and platforms, for co-ordinating foreign ministries, development agencies, ministries of health, the private sector including pharmaceutical companies (e.g. China, Italy, Mexico, and Japan) and civil society organisations (e.g. Italy, Spain) (OECD, 2020[37]). Several DAC members have described efforts to restore supply chains and international trade. The clear message that emerges is the usefulness of having a single, dedicated body (either pre-established or ad-hoc), and to establish channels for collaboration both within government and with relevant partners.

Consistent with other studies of whole-of-government approaches, the combination of technical know-how (of line ministries or specialised agencies) with a high-level political vision (from the Head of Government) seems to have been a driver of effective action, especially in creating a sense of urgency that helped overcome barriers. Likewise, formal mechanisms that used or built on existing structures, and had a clear mandate with decision-making power, seem to have worked best.

Providers established a range of approaches for internal, whole-of-government co-ordination of international assistance. These varied in terms of institutional lead (centre of government or the foreign ministry); whether they were created during the crisis or built on existing co-ordination mechanisms; and the degree of formality.

- Germany's Emergency COVID-19 Support Programme (*Corona-Sofortprogramm*) used a crisis committee mechanism to co-ordinate across the German Federal Ministry for Economic Cooperation and Development (BMZ) and implementing organisations. This was found to have helped with internal coherence with regard to the distribution of funding, though it did not actively steer the programme, monitor the success, or take up lessons afterwards. (Römling et al., 2024[7]). For a future global crisis of a similar extent, the German Institute for Development Evaluation (DEval) recommends that the BMZ should appoint a specific office to be responsible for institutionally anchoring a crisis response programme, and for incorporating and making available the insights gained from internal and external learning and assessment processes. The appointed office should be responsible for implementing preparatory measures to be applied in the event of a future crisis. In particular, when setting up any future crisis response programme, it should be defined who is responsible for its planning, steering and subsequent evaluation (DEval, 2024[38]; AFD, 2024[39]).
- The Netherlands Ministry of Foreign Affairs (MFA) instituted two co-ordination task forces – the Corona Task Force to co-ordinate the Dutch development co-operation and humanitarian assistance response within the ministry and the International COVID-19 Support Task Force with the Ministry of Health to co-ordinate in-kind donations (OECD/IOB, 2025[5]). These task forces were important drivers of coherence (OECD/IOB, 2025[5]). However, the Netherlands found that despite these mechanisms, the different collaborating Dutch ministries were guided by different priorities and this, combined with, at times, ad hoc political decision making, resulted in strategic uncertainty and incoherence in the Dutch response.
- In the United States, USAID and the U.S. Department of State jointly supported efforts to develop sustainable financing options for global heath security, including using bilateral and multilateral channels to assist developing countries to address the pandemic and to prevent future threats. USAID co-ordinated efforts to address key pharmaceutical system bottlenecks to the manufacture of vaccines, as well as the knowledge and products required to develop vaccines (USAID, 2022[40]), building on existing cross-government partnerships such as the President's Emergency Fund for AIDS Relief (PEPFAR), and the President's Malaria Initiative. In addition, USAID and the US Center for Disease Control (CDC) collaborated with the COVAX initiative and other global and regional organisations, as well as with the broader donor community, to ensure co-ordination of activities.
- In South Africa an intergovernmental mechanism, anchored in the foreign ministry and mandated as a single point of leadership, was identified as an important mechanism for coherence and consistency of policymaking and implementation (Presidency of South Africa, 2021, p. 599[41]).
- Likewise, the Mexico example showed that a single co-ordinating entity – the Mexican Agency for International Development Cooperation (AMEXCID) within the Ministry of Foreign Affairs – with a mandate to co-ordinate actions across health, military and other parts of government, was operationally effective in delivering assistance, and supported Mexico's regional leadership (OECD, 2025[42]).
- The New Zealand case study concludes that strong domestic collaboration is required for the successful delivery of vaccines and other assistance. To enable co-ordination, New Zealand's Ministry of Foreign Affairs and Trade (MFAT) established a new temporary division during the COVID-19 pandemic, which convened multi-agency meetings. The programme oversaw New Zealand's contribution to the vaccine rollout in six Polynesian countries and Fiji, and was built on a foundation of robust collaboration and communication between the Global Health team at the

Ministry of Health, and the health team within the Pacific and Development Group (PDG) in MFAT which was established before the crisis. Because the crisis response (the "Pacific Resilience Approach") was delivered via a cabinet mandate, it meant that all New Zealand government agencies operated under a shared strategy and guiding principles when engaging with the Pacific (Ministry of Foreign Affairs and Trade of New Zealand, 2025[20]).

- In Spain, inter-ministerial co-ordination through a tripartite committee led by the Prime Minister's Office together with relevant ministries proved to be a success. During the crisis it was a useful tool to articulate the capacities and interests of the different ministries, as well as to provide a rapid and flexible response in a changing situation. The design included ad hoc spaces for participation in addition to the usual channels (inter-ministerial and inter-territorial commissions), notably the "Day After" platform, which had a broad participation of actors and experts in Spanish development co-operation and sector-wide approaches. This approach reinforced coherence across Spanish co-operation sectoral instruments and strategies (Ministerio de Asuntos Exteriores, Unión Europea and Cooperación, 2024[6]).

In terms of pre-pandemic preparedness, there was a mix of experiences. Some reported that their crisis contingency plans were inadequate in the face of the scale, duration and global scope of the COVID crisis, while others described effectively building on crisis response plans. An evaluation of Finland's Ministry of Foreign Affairs found that "the MFA managed rather well without pre-existing crisis response plans and pandemic-specific risk analysis. It would have benefited from a headquarters preparedness plan to support moving human resources at crises and better preparedness to monitor the effectiveness of the COVID-19-time development cooperation" (Ministry for Foreign Affairs of Finland, 2022[19]).

4.4. Co-ordination at country-level

A key success factor in a well-coordinated crisis response was government capacity and leadership – around which international partners could align and co-ordinate actions.

National governments and development partners employed several approaches to co-ordinate pandemic responses in partner countries, including government convened donor co-ordination mechanisms (such as the Troika in Burkina Faso), UN Country Team-led co-ordination and technical working groups. In settings where humanitarian responses were underway, UN-defined clusters, including the health cluster were used to co-ordinate action across agencies.

Effective COVID-19 co-ordination was linked strongly to government capacity (e.g. South Sudan, Ethiopia and Rwanda) (Gooding, Webster and Wiafe, 2021[27]). In Cambodia, for example, a strong national development co-ordination council has worked for many years to lead development policy and planning and co-ordinate the support of international partners. High-level government leadership and political will was vital in supporting and guiding response co-ordination at country level but was mainly effective when it was accompanied by partner country decision making power, and balanced with technical input and collaboration with development partners (Schwensen and Schiebel Smed, 2023[4]). Despite the importance of the government-led co-ordination, partner country co-ordination remained uneven, impacting agility (MOPAN, 2022[8]). In some countries, both prior to and during the pandemic, there were functioning co-ordination mechanisms to bring partners together, whereas in others, these were absent or operated only for information sharing, rather than driving enhanced coherence (MOPAN, 2022[8]).

Multisectoral co-ordination mechanisms were of critical importance during the pandemic response to ensure a coherent response, particularly when integrating public health programming with livelihoods and cash assistance to address food security and cost barriers to health services. Strong political leadership was key to successful responses, as seen for example in Kenya's COVID-19 response which was spearheaded by the Executive Office of the President and employed a comprehensive, whole-of-

government strategy. This approach co-ordinated various governmental levels and agencies and actively partnered with the private sector. A national COVID-19 taskforce was established, bringing together stakeholders such as the Ministry of Health, other government ministries and agencies, UN agencies, development partners, non-governmental organisations (NGOs) and civil society organisations (CSOs). The taskforce participated in various high-level committees, which supported the implementation of Kenya's response to the COVID-19 pandemic (OECD/AfDB, 2025[43]).

Countries that had prior experience or ongoing humanitarian operations tended to be more successful at employing integrated humanitarian-development approaches during the COVID-19 crisis response (IAHE, 2022[23]). According to IAHE's analysis, in Colombia, the health and humanitarian aspects of the response were well-integrated, including during COVID-19, while in many other countries – including the Democratic Republic of Congo (DRC) – the COVID-19 response was siloed and fragmented. In Lebanon and Yemen, COVID-19 response efforts were folded into ongoing humanitarian efforts, focusing on health, food security and livelihoods to address both immediate pandemic health needs and long-term development goals (Humanitarian Action, 2020[44]; Lilly, 2020[45]; OECD, 2025[46]). There are some indications however, of continued fragmentation between development and humanitarian operations, with the pandemic crisis response being added as a third line of support, rather than integrating with more coherence approaches (Schwensen and Schiebel Smed, 2023[4]).

Several evaluations and case studies showed that country-level health support – both before and during the pandemic – was delivered through parallel systems, creating duplication and inefficiencies, as well as failing to deliver stronger national capacities to support sustainable health systems.

Multilateral actors acted as catalysts and hubs for co-ordination, particularly in countries like Nicaragua where there were tensions between the government and other countries which limited bilateral engagement. From January to March 2020, UN country teams began taking rapid collective action under the co-ordination and leadership of Residence Coordinators (RC) supported by Resident Coordinator Office (RCO) staff. This facilitated a rapid transition to collective analysis and planning. Leadership and co-ordination by these offices helped UN agencies to maintain a safe operational presence and meet UN obligations of duty of care to staff during this critical period (UNSDG, 2022[13]).

In Bangladesh, the presence of UN organisations with dual mandates across multiple co-ordination platforms, such as UNICEF, was noted as an enabler of co-ordination across the development of a humanitarian response (OECD, 2025[47]). Bangladesh created a new mechanism for its socio-economic response, with a particular emphasis on coherence and complementarity among development partners. It particularly stressed co-operation with UN agencies and benefiting from their existing expertise. This enabled it to be more strategic in its response (OECD, 2025[47]). In Cambodia, WHO played a key role as the designated intermediary between the government and development partners. This helped to streamline co-ordination among partners and the government, without overwhelming the government with requests. It also made WHO responsible for navigating around sensitive political and scientific issues. Reflecting the same pattern as development partner co-ordination, new and established mechanisms were used for cross government co-ordination, and, in the case of partner countries, provider co-ordination.

The health cluster system[2] played an important part in co-ordinating the humanitarian health response. The system was designed to facilitate collaboration among various humanitarian actors to address health needs at country level. In response to the unprecedented threat to global public health and socio-economic stability, particularly in countries affected by humanitarian crises, the Global Health Cluster (GHC) scaled up its country co-ordination support to provide context-appropriate technical and operational guidance to effectively implement the 2020 Strategic Preparedness and Response Plan (SPRP) and the 2020 GHRP. As a result, the SPRPs for 2021 and 2022, as integral components of the subsequent humanitarian response plans, were also scaled up. These served both to mitigate the direct impact of COVID-19 and to maintain the provision of existing humanitarian health action, including essential health services.

Other factors supporting co-ordination included preexisting relationships with governments, implementing partners and the private sector, as highlighted in the evaluation of UNICEF's pandemic response (UNICEF, 2023[48]). Where partners already knew each other and international staff remained in-country, co-ordination worked better. Preexisting relationships facilitated the shift to less formal, more intimate person to person co-ordination through platforms like WhatsApp and Telegram, especially during intense periods such as lockdowns or restrictions on movement.

Examples from both provider and partner country cases also highlighted a disconnect between high-level political decisions (and announcements) and technical level co-ordination and management. In several provider countries prime ministers or presidents made public pledges of support – sometimes specifying recipient countries or types of support. There were also reports of high-level meetings between heads of state (or ministers) resulting in agreement to provide certain pandemic supplies. However, these political level decisions were sometimes out of sync with technical level co-ordination and planning mechanisms.

For instance, in one provider case, the president announced a volume of vaccine donations to be donated to neighbouring countries that far exceeded the population needs. In another country, local efforts to carefully map oxygen needs in each medical facility, were ignored when one donor provided oxygen production equipment to a particular hospital during a high-level visit, undermining the technical-level's strategic plan for allocating oxygen supplies based on identified needs. There were also examples of high-level commitments that do not seem to have materialised (perhaps due to this disconnect).

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Notes

[1] The COVID-19 Global Humanitarian Response Plan was set up to combine humanitarian funding appeals. It targeted preparedness, prevention, mitigation and response in countries most vulnerable to the pandemic and least able to respond. While unprecedented in its global scale, the approach built on existing structures to co-ordinate humanitarian responses by consolidating funding appeals and action planning for a specific humanitarian crisis.

[2] The UN Cluster System is a co-ordination mechanism established by the United Nations to enhance the effectiveness of humanitarian responses during emergencies. It brings together humanitarian organisations into sector-specific groups, or "clusters" (e.g. Health, Shelter, Nutrition), each led by a designated UN agency. The system aims to ensure more predictable, accountable and co-ordinated support by clarifying roles and responsibilities, promoting joint planning, and avoiding duplication of efforts among humanitarian actors.

5 Effectiveness: Achieving the objectives of international support for the COVID crisis response

This chapter considers the effectiveness of the international co-operation provided during the COVID-19 crisis based on the performance of international assistance actors in relation to their articulated goals. These goals include scaling up support for the immediate health needs related to the pandemic, providing humanitarian assistance, responding to the widespread socio-economic needs created by the crisis, supporting equitable access to vaccines, and reaching vulnerable populations.

This chapter examines the effectiveness of COVID-19-related support in terms of the adequacy of funding to meet needs, as well as evidence of progress towards the objectives – whether stated or implied – of providers, development and humanitarian institutions, and partner countries.

These objectives are:

- addressing the immediate health needs (containing and controlling the pandemic)
- strengthening health systems and health sector support (including domestic health finance)
- support to equitable access to COVID-19 vaccines
- humanitarian assistance
- and socio-economic support.

The evaluation considered the extent to which the objectives of Development Assistance Committee (DAC) members in their 2020 joint statement were achieved – in this chapter focusing on funding and the cross-cutting objective to reach vulnerable populations (OECD, 2020[1]). Finally, the chapter looks at evidence on the role played by CSOs, including NGOs.

It is not possible to make an overall determination regarding effectiveness, as effectiveness varied across countries, providers, and projects. Instead, the evaluation looked for evidence of common success factors, to identify ways of working that drove effectiveness. (These practices are elaborated further in Chapter 7.) The evaluation finds that there were considerable successes, though these were not always achieved at sufficient scale. Overall funding was inadequate, and many goals were not achieved. However, there are also indications of positive results from health-related assistance, vaccine support and socio-economic assistance.

5.1. Preconditions for achieving results: Adequacy of funding to meet crisis-related needs

A key challenge to the effectiveness of the development and humanitarian response was the overall inadequacy of the resources allocated by providers for COVID-19, compared to actual needs.

The DAC's stated objective to protect development finance volumes was met by more than half of members. As described in Chapter 2, development finance commitments and disbursements of many individual providers rose in 2020-2021, particularly on health. Spain's ODA in 2021, for example, was 19.7% higher than the average of the previous three years (2018-2020) (Ministerio de Asuntos Exteriores, Unión Europea and Cooperación, 2024[2]). This was largely due to greater disbursement to the health sector, which, in 2021, was more than seven times that of 2018. Interventions addressing food security, social protection and inclusivity delivered tangible benefits, especially when leveraging enabling factors such as innovative technologies and partnerships. However, the overall funding was not commensurate with needs.

Total international development assistance (including official and philanthropic flows) rose to an all-time high during the pandemic, although this only equated to approximately 1% of the amount that provider countries mobilised for economic stimulus measures to help their own societies recover from COVID-19 (OECD, 2021[3]). For example, the United Kingdom disbursed more than USD 37 billion in ODF (including USD 4.0 billion in COVID-19-specific ODF) during the pandemic (2020-2022). However, domestic government spending on COVID-19 measures was estimated at USD 423-559 billion (Brien and Keep, 2023[4]). Likewise, from 2020-2022 the United States spent some USD 4.6 trillion domestically compared to total global assistance of USD 4.5 billion for COVID-19-related assistance, and USD 134 billion of total assistance (GAO, 2023[5]; OECD, 2025[6]).

Major appeals by the World Health Organization (WHO), the United Nations and the International Federation of Red Cross and Red Crescent Societies (IFRC) remained underfunded by approximately USD 9 billion. For the UN COVID-19 Response and Recovery Multi-Partner Trust Fund (COVID-19 MPTF), which called for USD 1 billion, only 8% was received. Funding for WHO's Strategic Preparedness and Response Plan (SPRP) only reached 60% of requirements. Funding for the humanitarian COVID-19 response also fell far short of requirements, with the Global Humanitarian Response Plan (GHRP) only being 40% funded and resources being stretched across many countries (ALNAP, 2024[7]). As of February 2022, the COVID-19 Response and Recovery Fund had raised just USD 83.6 million and had only allocated funding to 84 countries, a mere 4.18% of its original appeal target. Pledges made by donors at the onset of the pandemic (e.g. during emergency summits or pledging events) were not always backed by sustainable follow-through mechanisms (UN, 2020[8]).

By 2022, COVID-19-specific assistance began to decline as the focus shifted from immediate crisis response to structural recovery, and away from the pandemic, particularly as support to Ukraine rose.

The Food and Agriculture Organization's (FAO) COVID-19 evaluation noted that "fundraising for long-term recovery was less successful than for the early response" (FAO, 2022, p. 2[9]). This finding was backed up by all case studies, where interviewees noted the challenges of moving beyond short-term crisis funding to meet ongoing needs as the effects of the pandemic and containment measures wore on.

5.2. Supporting health and strengthening health systems

It was widely acknowledged that the pandemic risked undermining the significant health and development progress achieved in recent decades, reversing positive trajectories towards the achievement of SDG 3 (WHO, 2021[10]). Thus, there was an urgent need to "repair the broken global health system" (Shamasunder et al., 2020, p. 1[11]). Resilient health systems can respond more effectively to an epidemic, ensuring strong national protection and reducing the negative effect of a pandemic (Zhao et al., 2022[12]).

As described in Chapter 3, health support was therefore highly relevant and there are good examples of effective health-related assistance during the crisis. However, international co-operation remained insufficient to be considered effective overall.

Several common success factors in health support (and other crisis assistance) can be identified. The "crisis-mode" mentality enhanced organisations' openness to innovation, including calculated risk-taking behaviours that might not have been tolerated in normal circumstances. The pressures of operating in a crisis setting allowed funding, implementing and local partners to work together to overcome barriers and find solutions. There are many good examples of different approaches and pragmatic partnerships to overcome barriers.

At the same time the extent of actual innovations was limited due to the emergency setting, which often did not leave time to experiment with new ideas. Adapting proven innovations to new contexts and challenges was found to be more useful than testing entirely novel concepts and solutions. For example, the Clinton Health Initiative in Cambodia took advantage of the national vaccination campaign for older adults to pilot a screening for non-communicable diseases, which resulted in identifying a cost-effective strategy.

Furthermore, the "crisis mode" way of working was hard to sustain. Many development partners reverted quickly to previous ways of working as soon as it was possible. There were also many reports of crisis funding mechanisms being insufficiently flexible, and funders showing a lesser overall appetite for funding long-term, and more systemic responses, even as it became clear that such funding was necessary in 2021 and 2022.

Development finance for health during the crisis

Despite some increases during the 2020-2022 period, funding for the health sector also remained inadequate and under-prioritised despite clear evidence before 2019 that investment in health was needed to build resilience and preparedness for future pandemics. The world is still not on track to meet many of the health-related Sustainable Development Goals (SDGs) (UN, 2024[13]). Insufficient funding for low- and middle-income countries was identified as a key barrier to an effective global COVID response (Williamson et al., 2022[14]).

According to several studies, WHO's budget, both prior to and during the pandemic, was considered inadequate for it to perform its broad mandate to "act as the directing and co-ordinating authority on international health work" within the United Nations (M'ikanatha and Welliver, 2021[15]). In addition, it is heavily reliant on voluntary contributions (80% of its budget) with high levels of earmarked funding (87%), creating limited predictability (WHO, 2024[16]). Many health-related "global public goods", notably pandemic prevention, preparedness and response systems, as well as research and development into products that address global health threats – are underfunded (Penn et al., 2025[17]).

During the COVID-19 crisis, official development finance (ODF) for the health sector (including reproductive health and population services) initially rose sharply, by 73% from 2019-2020 (commitments). It then rose by a further 25% in 2021. By 2022, health sector assistance had increased to USD 50 billion, compared with USD 27 billion in 2019, demonstrating an effective mobilisation of funds to support the health response (OECD, 2025[6]), in line with DAC commitments.

Compared to all sector-specific ODA, health-related assistance rose markedly in relation to other sectors during the crisis (Figure 2.7 in Chapter 2), becoming the third largest sector by volume of commitments in 2022. COVID-19 assistance was just 37% of all health-related assistance in 2020-2022 (Figure 5.1). With overall ODA increasing, this indicates that COVID-19 health support was new or additional, and not a reallocation of funding from other areas – either health or non-health.

As described in Chapter 3, health funding was highly relevant as health systems in many low-income countries (LICs) and lower-middle-income countries (LMICs) faced a combination of high caseloads, shortages of essential supplies and equipment, and low hospital and intensive care unit (ICU) and other health capacities. Healthcare workers experienced high levels of COVID-19 infection, burnout and mental health issues. Significant changes in health-seeking behaviours were also observed: overall attendance at health facilities decreased in many countries due to fears of infection, reduced access to public transport and restrictions on movement (Tran et al., 2020[18]; Holtz, 2021[19]). Many of these risks were identified at the outset and measures taken to provide continuity in the health system even as pandemic-specific measures were implemented. Development partners and governments adjusted strategies to try to fill health service gaps, for example, scaling up childhood immunisation programmes outside of traditional healthcare sites, and advocating for the inclusion of protective services, and violence prevention and support programmes, as essential services.

There was a general increase in health spending across DAC members, though health funding strategies and sector priorities diverged considerably. Australia and Greece provided the largest share – 16% of their total assistance – to the sector, compared to the DAC average of 7.4%. Australia significantly increased its health ODA, from 9% of total assistance in 2019 to 15% in 2021 and 22% in 2022. Korea, Japan and New Zealand also saw increases, with Korea's share rising from 6% in 2019 to 15% in 2020, Japan's from 3% to 7%, and New Zealand's from 4% to 9% over the same period.[1]

The composition of development assistance to the health sector fluctuated somewhat during the pandemic (Figure 5.1). Health assistance for COVID-control totalled USD 5.9 billion in 2020 and rose to 12.3 billion in 202 before dropping to 10 billion in 2022. The initial surge in funding focused on emergency equipment, such as provision of hospital beds, ventilators and personal protective equipment (PPE). Health policy and administrative management more than doubled from its pre-pandemic levels.

Other types of health assistance remained relatively constant during the pandemic, though certain components fluctuated in absolute and relative terms. Disbursements to medical services rose by 41% and disbursements to infectious disease control rose by 37%. Disbursements to basic health care, for example, fell by 12% in 2020, before going up again slightly in 2021 and then decreasing again by 23% in 2022. In contrast, basic infrastructure disbursements rose steadily throughout the pandemic, showing a total 72% increase in 2022 as compared to 2019. Malaria and tuberculosis control remained relatively stable, showing that COVID-19 allocations did not lead to displacement of funds.

The increased level of development assistance for health was not sustained. As a percentage of overall assistance, the health sector (excluding population services) accounted for 6-7% from 2016-2019, rising to 9% in 2020 and 11 % in 2021, before falling back to 6% by 2023 (OECD, 2025[6]).

While contributions to health system strengthening as part of the COVID-19 response was relevant and necessary, higher investment in health system strengthening prior to the onset of COVID-19 would have increased the effectiveness of subsequent international assistance efforts. Several case study countries– including Cambodia and Bangladesh – illustrate how long-term investment in health systems laid the ground for responding to the COVID crisis.

The pandemic raised awareness of the importance of having adequate surveillance systems in place to facilitate both global and national pandemic preparedness and responses. Detection and isolation continue to be primary methods for identifying and managing infectious diseases, significantly reducing mortality and controlling the spread of an epidemic (WHO, 2020[20]). With better detection and isolation systems, a more effective response could have been achieved in many areas. A Global Fund review found that 68% of investments in resilient and sustainable systems for health only serve a “single disease-specific objective”, with just 7% considered to be cross cutting (The Global Fund, 2024, p. 38[21]). This reinforces the need for health systems that are resilient and able to cover a spectrum of public health issues.

Types and success factors of international assistance for health

Beyond the provision of medical supplies, there were many good examples of capacity building and workforce development in the health sector.

International assistance, including triangular assistance (see Box 5.1), was used for both the recruiting and training of healthcare workers in infection prevention control, diagnostics and case management. Health infrastructure development was also prominent, with initiatives funded by international assistance often contributing to constructing emergency hospitals and clinics with quarantine centres, particularly in more underserved areas. The supporting of facility upgrades and improvements – such as building or refurbishing isolation wards, ICUs and testing laboratories, was also a key part of development partners’ support in these areas. An independent evaluation of EBRD’s response also stressed the importance of cross-regional learning and collaboration in enhancing the effectiveness of international support in times of global health emergencies (EBRD, 2022[22]).

There are interesting examples in this regard from the case studies:

- Prior to the pandemic, Cabo Verde faced a deficiency in national testing capacity. The country relied solely on a single laboratory in Praia, which lacked the capability to conduct COVID-19 testing. Under the auspices of the National Institute of Public Health (INSP), Cabo Verde established seven laboratories in response to the COVID-19 pandemic: three in Praia and one each in Sal, Santo Antão, Fogo and Boa Vista. This significantly enhanced the country's laboratory capacity beyond the immediate COVID response. All labs were equipped with skilled staff and the technical capability to process samples and possessed genomic sequencing ability, enabling the determination of genetic makeup. The advanced equipment acquired not only addressed the challenges posed by COVID-19 but also enhanced preparedness for future crises (OECD, 2025[23]).

- France, Germany, the World Bank, the United Nations Children's Fund (UNICEF) and other partners supported Lebanon's health system, including in ways that had lasting capacity benefits beyond fighting the COVID-19 (Box 5.2).
- A key aspect of Spain's pandemic response in increasing health sector capacity was training medical professionals and channelling ODA through national health systems (Ministerio de Asuntos Exteriores, Unión Europea and Cooperación, 2024[2]).
- In Cambodia, WHO provided technical assistance in risk assessment, clinical guidance, diagnosis and management, providing epidemiological surveillance for the Ministry of Health, communication to factory workers and other vulnerable people, and direct support for health facilities. It worked closely with the inter-ministerial committee to routinely update the response plan, including the Master Plan. It also trained 3 000 members of the Rapid Response Teams, while ensuring the uptake of COVID-19 health messaging (OECD, forthcoming[24]).
- Ireland, as a provider, worked to maintain support for other health challenges during the pandemic. It continued support for HIV, tuberculosis (TB) and malaria, helping to mitigate the impact of the crisis on people at risk from these diseases. Over the course of the pandemic Ireland invested over EUR 100 million for global health, sustaining investment in health system strengthening in LICs to combat pre-existing conditions and better prepare for and respond to new and emerging health threats (Government of Ireland, 2025[25]).
- France's Health in Common initiative also achieved results in supported countries. For example, in Cameroon and Senegal projects financed in 2020 contributed to screening people and helped health services manage the emergency, as well as giving a greater understanding of the disease and creating knowledge. France scaled up laboratory capacities by transferring funding between the headquarters of the *Institut Pasteur* and its Cambodia branch, which allowed for a much faster deployment of funding compared to establishing a new contract.
- In Bangladesh, development partners provided significant support to address critical gaps and challenges. This included expanding health personnel capacity for infection preventions and control, establishing additional oxygen systems,[2] preparing the garment manufacturing sector for PPE production, providing procurement assistance, as well as expanding laboratory networks and cold chain capacity (OECD, 2025[26]).

Providers invested in improving supply chain systems and diagnostic or testing facilities which could be sustained and contribute to the longer term strengthening of the health system. They recognised that this kind of support prior to the onset of the pandemic would have been a useful contribution to preparedness.

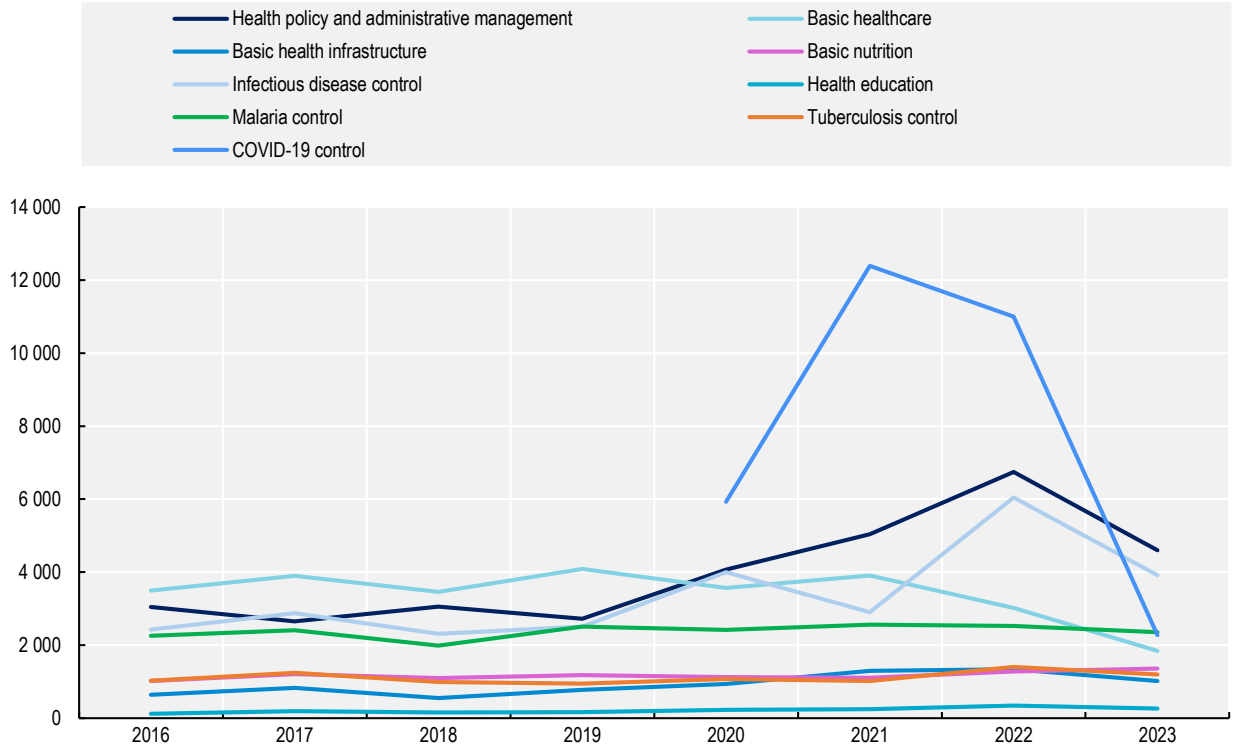
The strengthening of health information systems through, for example, the digitalisation and standardisation of health-related data collection and analysis comprised another part of development co-operation support for health systems. In some cases, this enabled evidence-based planning and decision making. Investments were also made more generally in establishing or improving digital health platforms (which helped reduce physical contact) and in expanding internet access in underserved areas to support essential communications, both within the health sector and to the wider public. An evaluation of the Pan American Health Organization's (PAHO) response in the Region of the Americas noted that it contributed to addressing the digital gaps exacerbated by the pandemic by supporting the digital transformation of the health sector at the country level (PAHO, 2023[27]). The PAHO Virtual Campus for Public Health incorporated accessibility features such as sign language interpretation, captioning, and easy-to-read formats for priority courses. These adaptations allowed health workers to maintain up-to-date competencies and enabled patients with disabilities to access consultations without physical exposure risk.

Regardless of these positive examples of effective health system strengthening during the pandemic, country experiences from both a provider and beneficiary perspective highlight the need for better co-ordinated, equity-focused, and sustainable approaches. Countries that leveraged the opportunity provided by the immediate response to strengthen health systems will be better off in the long term and

provide a useful roadmap for others. Strong and resilient health systems need to be in place prior to a major disaster or pandemic, reinforcing the importance of preparedness.

Figure 5.1. Key purposes of health sector official development finance, 2016-2023

All official providers, USD million disbursements, constant 2023 prices



Notes: For ease of reading, sectors with lower levels of ODF were removed from the chart. That includes: alcohol, drugs and tobacco control; control, prevention and treatment of non-communicable diseases (NDCs); promotion of mental health and well-being; medical training, research and services. From 2023 onwards, PSI is no longer included in the analysis of ODA cash flows, and therefore in the definition of ODF in this graph.
Source: OECD (2025[6]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Box 5.1. Effective island-to-island health support for Cabo Verde

In April 2020, a Cuban medical team comprising 18 physicians, 10 nurses and 5 technicians arrived in Cabo Verde to assist the country in addressing the COVID-19 health crisis. The travel and living expenses of the Cuban medical team were entirely financed by Luxembourg in response to a request made by the Government of Cabo Verde.

This assistance was provided by Cuban health professionals belonging to the "Brigadas Henry Reeve", which has assisted in times of natural disasters and health crises worldwide for the last 15 years. The team had prior experience in health crises, including the 2014 Ebola crisis. Adhering to the local health protocol defined by the Cabo Verdean Ministry of Health, the team assisted with 25 000 COVID-19 cases, with a mortality rate of 0.9%.

Source: Government of Luxembourg (2020[28]), Personnel médical cubain renforce le service de santé du Cabo Verde dans le cadre d'une coopération triangulaire Cabo Verde – Cuba – Luxembourg, https://praia.mae.lu/fr/actualites/2020/personnel-medical-cubain-renforce-cabo-verde.html.

Box 5.2. WHO's COVID-19 response in the Eastern Mediterranean Region

An independent review found that WHO's regional response to COVID-19 in the Eastern Mediterranean Region (EMR) largely met or exceeded expectations. The review identified several best practices which enabled successes, not least the inclusive and experienced leadership in the regional office and many country offices. Effective leadership came particularly from individuals having emergency and operational backgrounds – a finding also supported by IMF's COVID-19-response evaluation which highlighted the value of leadership that demonstrated a "humanitarian" mentality in approaching the crisis. The Eastern Mediterranean Regional Office (EMRO), the co-ordinating body for the crisis response, facilitated extensive communication and collaboration across functions, mobilised expertise across departments and successfully eliminated siloes.

WHO's logistics hub in Dubai (the "Dubai Hub") facilitated stockpiling and centralised logistics, improving timely access to critical COVID-19 supplies in the EMR. The Hub was scaled-up to provide support for WHO globally, including for other crises, e.g. the ongoing cholera outbreak in the region.

Additionally, the Case Management and Clinical Operation pillar's strong on-the-ground presence, and in particular, its efforts in scaling up medical oxygen capacities, played a large role in reducing the severity of COVID-19 cases and in filling gaps in health systems in low-resource settings.

Source: Dalberg (2023[29]), ''WHO's response to COVID-19 in the Eastern Mediterranean Region Independent review by Dalberg Advisors'', https://cdn.who.int/media/docs/default-source/evaluation-office/who-s-response-to-covid-19-in-the-emr---independent-review_february-2023_final.pdf?sfvrsn=130ab01a_3%26download=true; OECD (forthcoming[24]), The Development and Humanitarian Response to the COVID-19 Pandemic in Cambodia (2020-2022): Case Study for the "Strategic Joint Evaluation of the Collective International Response to the COVID-19 Pandemic".

Box 5.3. International assistance for addressing immediate health needs in Lebanon

In Lebanon, health sector support was identified as one of the greatest needs in terms of international assistance due to weaknesses in the system and limited public funding. Specific actions included:

- WHO rehired 2 500 nurses who had previously ceased working during the 2019 budget crisis.
- Funding from France was used to build the capacity of Rafik Hariri University Hospital started in 2019, enabling the hospital to better respond to COVID-19, notably regarding testing capacity and case management.
- UNICEF supported the country in shifting vaccine cold chain facilities to solar power to reduce reliance on the national grid.
- The Lebanese Red Cross supported various government agencies in the effective use of the online central booking system for vaccines at the municipality level.
- The World Bank supported the development of the online vaccine portal, which contributed to the transparency and equity of the vaccination rollout process.

Source: OECD (2025[30]), The Development and Humanitarian Response to the COVID-19 Pandemic in Lebanon (2020-2022): Case Study for the "Strategic Joint Evaluation of the Collective International Response to the COVID-19 Pandemic".

The interplay of external and domestic funding for health

During the COVID-19 pandemic, most countries massively boosted public sector spending including spending on health (Box 5.4). However, development assistance still provided a significant portion of funding for health in many recipient countries. Among 133 recipient countries with available data, 60 (45%) received more in assistance, per capita, than they spent on health across 2020-2022 (WHO, 2024[31]). This was particularly the case in LICs, where 24 out of 25 countries (96%) saw international assistance exceed domestic health expenditure. Notably, in two countries, Gambia and Somalia, annual health sector assistance per capita during the pandemic surpassed the country's own health expenditure per capita during the same period. This pattern was also observed in 49% of lower-middle-income countries (LMICs) and 19% of upper-middle-income countries (UMICs).

For LICs, external assistance for health was key to supporting domestic spending and addressing fiscal constraints during the COVID-19 pandemic. In these countries, domestic health spending initially surged by 16%, from USD 8.2 to USD 9.5 per capita in 2020, before declining again in 2021 and 2022. However, it still remained 7% higher than pre-pandemic levels. International assistance helped support this increase, increasing by 20% in 2020-2021 and continuing to rise by an additional 8-9% in 2022. As a result, the relative importance of health-related assistance in LICs increased during the pandemic, as average assistance per capita rose in real terms and domestic public spending on health per capita fell after the initial surge (WHO, 2024[32]).There is past evidence that donor-funded health assistance has partially substituted for domestic health spending rather than supplementing it (OECD, 2023[33]). WHO data show that from 2000-19, as external health aid increased, government health expenditure declined, reflecting a reduction in incentives for countries to finance health from their own budgets (WHO, 2021[34]). During the pandemic from 2020-2022 both public and household spending increased significantly, before decreasing in most countries (Box 5.4).

In Kenya, the government budgeted USD 374 million for health, social protection and emergency support for businesses in the first year of the pandemic, and a further USD 418 million in 2021-2022 (Cabri, 2021[35]). Over the same period, Kenya received USD 10.4 billion in assistance, including USD 836 million specifically for COVID-19-related support. Similarly, by mid-2021, Georgia had incurred a USD 2.6 billion budget cost due to the pandemic, with USD 330 million allocated to health sector spending (Business Media, 2021[36]). In 2020-2021, Georgia received USD 4.8 billion in international assistance, of which USD 1.4 billion was COVID-19-related. In Cambodia, government spending on the pandemic response exceeded USD 3 billion from 2020-2022, matching the total assistance it received over the same period, including USD 758 million in COVID-19-related funding (Asian News Network, 2022[37]).

Box 5.4. Health financing trends

A recent WHO report looked at how the pandemic affected overall health spending. After surging early in the COVID-19 pandemic, aggregate global health spending fell in 2022, to USD 9.8 trillion, or 9.9% of global gross domestic product (GDP).

- Across all country income groups, except LMICs, average health spending per capita in 2022 fell in real terms from 2021.
- Domestic public spending on health per capita declined in all income groups in 2022. In most income groups, this occurred against a backdrop of rising government spending, implying that health's share of general government spending – a measure of health priority – fell. The exception was in high income countries (HICs), where health priority remained close to 2021 levels, but general government spending declined.
- External aid for health continued to rise in LICs and LMICs in 2022 following a sharp increase in 2021. Aid is particularly important in LICs, accounting for a larger share (31%) of total health spending than domestic public spending (22%).
- In 2022, average out-of-pocket spending on health per capita remained close to its 2021 level in all income groups, except in LMICs, where it increased.
- Across all income groups, health spending per capita in 2022 was above 2019 levels in real terms and close to long-term rising trends from 2000-19.
- Domestic public spending on health remained 6-7% above pre-pandemic levels in most income groups and 11% higher in UMICs. In UMICs and HICs, health priority in 2022 remained above pre-pandemic levels, whereas in LICs and LMICs, it was at pre-pandemic levels.
- Out-of-pocket spending per capita was 3-4% higher than before the pandemic in LICs and UMICs and 11% higher in LMICs but remained close to the pre-pandemic level in HICs.

It is still too early to assess whether the COVID-19 pandemic has continued (or altered) the long-term trends in health spending. It remains unclear whether governments can sustain elevated health spending per capita amid such economic headwinds as slowing economic growth and rising debt service costs as well as competing priorities.

Source: WHO (2024[31]), Global Health Expenditure Database, https://apps.who.int/nha/database/Select/Indicators/en.

5.3. Humanitarian assistance before, during and after the pandemic

Despite early concerns that the crisis could lead to an overuse or misuse of humanitarian funding mechanisms (due to their relative speed and agility) this does not seem to have been the case. Humanitarian funding continued to be driven by broader trends pre-pandemic. Despite growing need – the number of people in need of humanitarian assistance jumped from 132 million in 2019 to 168 million in 2020 and 250 million in 2021 (Humanitarian Action, 2025[38]) – humanitarian aid did not show a significant change in volume during the pandemic period but instead remained on the same course of steady increase. This is demonstrated by the fact that pandemic-related factors did not alter which countries received the largest volumes of humanitarian aid from 2019-2022.

Disbursements of humanitarian assistance within official development finance increased steadily in the years leading up to the pandemic, rising from USD 28.1 billion in 2016 to USD 35.7 billion in 2019 (Figure 5.2). This reflected both growing needs and an increase in the percentage of assistance going to

humanitarian needs – which rose from about 8% in 2016 to 10% in 2019. Despite the unprecedented challenges of 2020, the first year of the pandemic saw only a modest 5% increase in humanitarian funding, similar to the pre-crisis trend and the increase in overall assistance. There is no noticeable effect of the pandemic crisis on total humanitarian funding in 2020-2022 (Figure 5.2).

The pandemic exacerbated humanitarian crises in many contexts where there was already high need, with more people in more countries affected. In some countries, like Iran, the pandemic itself was a main driver of humanitarian needs. The organisation *Défis humanitaires* estimated that 243.8 million people in 75 countries needed humanitarian assistance in 2020, up from 224.9 million in 65 countries in 2019 (Défis Humanitaires, 2021[39]). Most people in need remained concentrated in a small, consistent group of countries experiencing protracted crises, including the Syrian Arab Republic (hereafter "Syria") and Yemen.

The COVID-19 response included flexible and good quality humanitarian funding from bilateral providers, enabling multilateral agencies to work with partners to direct funds rapidly to emerging needs and to fill gaps in humanitarian provisions (Schwensen and Schiebel Smed, 2023[40]). Major bilateral contributors to the multilateral system (such as Finland, Norway, Sweden and the United Kingdom) provided flexible funding (through core and unearmarked funding) to ensure coherence in the multilateral and bilateral response. For example, the United Kingdom's early, unearmarked contributions to the humanitarian system helped promote coherence and co-ordination internationally, as funds could swiftly be allocated to complement other development partners' interventions, which proved to be an efficient way to get money and equipment to where it was most needed (ICAI, 2022[41]). Ireland also adopted a multilateral approach, in addition to its role as an EU member state. Recognising the leadership, standard setting and co-ordination functions of the World Health Organisation (WHO) Ireland substantially increased its funding in 2020 and 2021. Ireland has maintained this increase, with annual funding for the WHO close to triple pre-pandemic levels.

This approach to the COVID response is illustrative of these bilateral donors' effective approach to partnering with multilateral institutions, including those whose mandates were most relevant to the COVID-19 response (such as UNICEF and the WHO), while at the same time engaging in policy dialogue to influence these institutions on topics of common interest, including by taking common positions across countries in the Nordic Plus group.[3] (Sida, 2021[42]; EBA, 2022[43]; NORAD, 2020[44]; Ministry for Foreign Affairs of Finland, 2022[45]).

Total COVID-19-related humanitarian spending across the three years from 2020-2022 amounted to USD 7.3 billion. The top recipients of this funding were: bilateral, unspecified (USD 1.6 billion), Türkiye (USD 649 million) and Syria (USD 486 million). This further underscores the prioritisation of countries facing compounding crises. Pandemic responses often overlapped with existing vulnerabilities, particularly in conflict-affected or fragile states. The decline in COVID-19-specific assistance by 2022 aligned with the shifting donor priorities.

COVID-19-related humanitarian assistance accounted for 9.2% of all humanitarian funding in 2020, declining sharply to 7.0% in 2021 and 2.6% in 2022. This downward trend was driven in part by a shift away from the immediate crisis response, as well as changes over time in the way providers were labelling humanitarian assistance and using the COVID tags (with some "COVID" related assistance also addressing pre-existing needs), rather than any meaningful changes in the allocation of humanitarian funding during the studied period. Qualitative data also showed the evolving focus on sustainable recovery, with an emphasis on addressing secondary social and economic effects rather than humanitarian health needs, from 2021 onwards (UNDP IEO, 2022[46]).

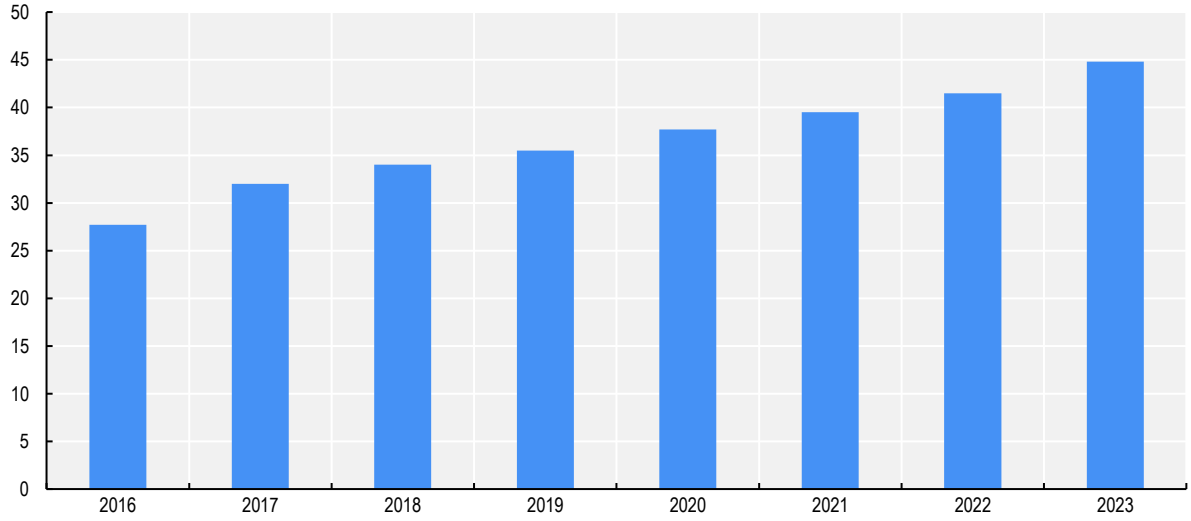
COVID-19 related humanitarian response activities varied across countries depending on the specific country context, i.e. armed conflict in Burkina Faso, refugees in Lebanon and Bangladesh, and floods and hurricanes Cambodia, Honduras and Nicaragua. Support included cash transfers, psychosocial and

mental health support, food distribution, special camps and health services for refugees and internally displaced populations to prevent outbreaks in crowded settings.

In some cases, governments introduced restrictive measures on people in refugee camps or reduced services for refugees – and others – to just essential services, making the efforts of humanitarian organisations critical (IAHE, 2022[47]). In Burkina Faso, a humanitarian assistance sectoral plan was developed as part of the national COVID-19 response plan with a view to protecting the livelihoods (Government of Burkina Faso, 2025[48]). A review of COVID-19 surge funding by USAID's Bureau for Humanitarian Assistance found surge funding allowed implementing partners to provide swift and effective responses in the wake of COVID-19, including in some contexts reaching new populations. Despite the positive impacts, the evaluation also found risks related to the rapid scaling up and then down, and recommended better planning for a smoother phasing out of crisis support (Laser Pulse, 2024[49]).

Figure 5.2. Humanitarian aid within official development finance, 2016-2023

All official providers, USD billion disbursements, constant 2023 prices



Source: OECD (2025[6]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

5.4. Alleviation of the socio-economic effects of the pandemic

A major focus of international assistance was to social protection systems, which were critical in cushioning the socio-economic impacts of the pandemic. Humanitarian assistance and development co-operation facilitated the rapid scaling up cash transfers, food distribution and other social programmes. In Burkina Faso, for instance, over 3.5 million people received food assistance, the livelihoods of over 680 000 food-insecure households were preserved, and 650 000 households were provided with electricity (Government of Burkina Faso, 2025[48]). Many of these efforts were effective and provided meaningful results to people in need, as well as expanding the scope and use of social protection mechanisms with long-term benefits.

For international assistance, two preconditions for achieving good outcomes are targeting relevant needs (Chapter 3) and disbursing funding in a timely way to (potentially) effective programmes. Examples of initial results achieved are useful in demonstrating the ways in which partners worked to address the multidimensional impacts of the pandemic – often making valuable contributions. At the same time, the overall results were in many cases still insufficient to meet needs.

- The UN Secretary-General's UN COVID-19 Response and Recovery Trust Fund worked for three years to support the immediate socio-economic response to COVID-19, providing USD 83.6 million to 97 joint socioeconomic recovery programmes in 84 countries. Over 50 of these programmes commenced within eight weeks of the Fund's launch in April 2020 (UNSDG, 2022[50]).
- An independent evaluation found that Team Europe provided effective support to partner countries and regions (European Commission/ADE, 2022[51]) with support to address socio-economic effects as well as health-related assistance. Budget support enabled the European Commission to rapidly mobilise considerable financial resources in support of partner countries' COVID-19 response, enabling partner governments to quickly channel funds to frontline public services.
- In New Zealand, the success of the vaccine rollout in Polynesia and budget support across the Pacific can be attributed to the groundwork laid by the International Development Cooperation (IDC) programme prior to the pandemic. The advance efforts of the Ministry of Foreign Affairs and the Ministry of Health in consulting with partner countries and identifying health sector needs allowed the pandemic preparedness and response workstream to be efficiently integrated into an existing programme with shared strategic, humanitarian and development goals (Ministry of Foreign Affairs and Trade of New Zealand, 2025[52]).
- In Nicaragua, triangular and UN-led support channelled funding to socio-economic needs, with a large budget support grant was provided in 2020, providing much needed fiscal support to the country. several international partners re-establishing diplomatic relations with the country to enable crisis support. A
- The World Bank's approach targeted both health and broader socio-economic needs across a range of countries (Box 5.5). The World Bank Group's Education Global Practice provided USD 4.2 billion to projects that supported countries in their responses to the COVID-19 pandemic, which included enabling remote learning (World Bank, 2024[53]). In Peru, for example, the World Bank supported the *Aprendo en Casa* programme, which reached over seven million students through a combination of radio, TV and the Internet.
- AfDB focused on humanitarian support and enhancing the economic resilience of businesses, in particular SMEs (Box 5.6). The Kenya case, for example, shows positive results notably around the provision of support to enable access to basic utility services such as electricity and water (OECD/AfDB, 2025[54]). However, the AfDB report also highlights challenges with regards to identification and monitoring of the beneficiaries (AfDB IDEV, 2022[55]).
- International assistance to expand to social protection in Lebanon (Box 5.7) and Cambodia (Box 5.8) benefited many, with some improvements carrying forward beyond the crises.
- The United Kingdom funded social protection payments for groups that were especially vulnerable to lockdown measures. These included the urban poor, the informal sector and migrant workers, people with disabilities, and female-headed households – although coverage of these groups varied among countries. This support was particularly effective in contexts where the United Kingdom had made long-term investments in strengthening national social protection mechanisms – a finding echoed by studies by Japan, Germany, the WHO (Box 5.6) and others.

Box 5.5. The World Bank's approach to addressing health and social needs

The World Bank financed the rapid construction of health facilities in various LMICs through its COVID-19 Emergency Response Project.

Over 80% of the countries in the World Bank evaluation portfolio received support for critical health services and 67% received support to protect the poor and vulnerable. Support largely focused on the delivery of critical health services, including infection prevention and control; case management; surveillance; laboratories; and the expansion of social protection for vulnerable groups, including income support and food support. COVID-19 had a highly unequal economic impact and the social protection support provided by the World Bank played a complementary role to the health and social interventions in 72% of countries.

Source: World Bank (2022[56]), "The World Bank's Early Support to Addressing COVID-19 Health and Social Response - An Early-Stage Evaluation", https://ieg.worldbankgroup.org/sites/default/files/Data/Evaluation.

Box 5.6. The African Development's Bank support in Kenya

The African Development Bank's (AfDB) support to Kenya achieved its main objectives of 1) strengthening the health system for an effective response to the COVID-19 pandemic, 2) building economic resilience, and 3) providing social protection for vulnerable populations.

An independent evaluation found that the measures implemented by the Government of Kenya contained the spread of the COVID-19 virus and mitigated its impact on the economy, especially on small and medium-sized enterprises (SMEs). Moreover, both existing and newly emerging vulnerable populations were supported with cash transfers, delivered weekly through M-Pesa, a mobile technology that expedited the delivery of social assistance.

At the programmatic level, 12 of the 13 outcome indicators agreed upon at the outset of AfDB's support were achieved or exceeded, with the remainder on course to be achieved at the time of the evaluation. The evaluation's assessment of AfDB's support in Kenya shows that the level of preparedness, relevance, efficiency and effectiveness was highly satisfactory, while coherence and co-ordination were satisfactory. Conversely, the evaluation found monitoring, evaluation and reporting were lacking.

Source: AfDB IDEV (2022[55]), "African Development Bank Group's COVID-19 Response Evaluation - Kenya Case Study".

Box 5.7. Addressing socio-economic needs in Lebanon: Relevant and effective, but insufficient

Within the Emergency COVID-19 Support Programme of the German Federal Ministry for Economic Cooperation and Development (BMZ), Lebanon received EUR 144 million, the highest funding allocated to a single country. According to BMZ data, even before the pandemic, Lebanon was among the top five recipient countries of German development co-operation. This pattern is reflected in the results of the overall evaluation, which reveal that funds within the programme were mainly distributed to existing partners. Most of the countries supported showed a high vulnerability and were strongly affected by COVID-19, as was the case for Lebanon. However, specific needs were not systematically assessed.

Lebanon received the funds within the German programme mostly via the German bilateral organisations Gesellschaft für Internationale Zusammenarbeit (GIZ) and the development bank of Kreditanstalt für Wiederaufbau (KfW) (EUR 124 million). Civil society organisations (CSOs) that are well equipped for addressing the needs of the local population and vulnerable groups through participatory approaches, local knowledge and adaptability, received a much smaller share of funds (EUR 5 million), which drew criticism, as CSO's potential advantages in emergency settings might not have been fully leveraged.

All but two of the 21 projects supported in Lebanon within the programme focused on vulnerable groups – mostly Syrian or Palestinian refugees and host communities. As the most vulnerable groups suffered the highest impacts of the pandemic crisis, reaching them was especially important. In a survey, Palestinian respondents rated health support received as generally useful. Thus, the relevance of provided support was high, and it was provided effectively. However, overall support received was insufficient. Surveys also showed unmet needs, and some respondents reported that certain needs were not met at all, including additional needs for remote schooling and food packages.

1. Due to reporting practices Germany's assistance tagged for COVID-19 in CRS is lower than the total support package of EUR 144 million presented here: only EUR 119.93 million was identified as specific COVID-19 support in the CRS system (using a key word or purpose code).

Sources: DEval (2024[57]) 'Evaluation of the BMZ Emergency COVID-19 Support Programme''; OECD (2025[30]), The Development and Humanitarian Response to the COVID-19 Pandemic in Lebanon (2020-2022): Case Study for the "Strategic Joint Evaluation of the Collective International Response to the COVID-19 Pandemic".

Box 5.8. A strong socio-economic response in Cambodia: Leveraging the IDPoor system

The Cambodia case study highlighted the government's effective provision of social assistance interventions (totalling in excess of USD 760 million) with support from funding and technical partners. This support was provided to citizens, especially vulnerable people, to help them overcome the socio-economic effects of COVID-19. It included both a monthly cash transfer programme for poor and vulnerable households and a cash-for-work programme.

The identification of vulnerable people was conducted via an online database: the Identification of Poor Households (IDPoor) system. This allowed individuals, including migrant workers and informal sector workers who had temporarily lost their jobs, to apply for financial assessment. The database also considered vulnerable groups – such as children under five, disabled individuals, citizens with HIV, and those aged 60 years or older – for inclusion in social protection schemes. The Cash Transfer Programme for Poor and Vulnerable Households benefited 0.7 million households and 2.7 million people between June and September 2021 and the cash transfer for IDPoor households reached 19% of the country's population.

The case study found that the cash transfer programme proved effective in protecting poor and vulnerable households from descending into further food insecurity, preventing school dropouts, and offering households cash savings to meet their immediate needs without resorting to additional loans and negative coping mechanisms. The EU learning event discussed the relevance of cash transfer systems as part of the COVID-19 response, as well as how to find and capture the needs of vulnerable groups utilising cash transfer systems already in place.

Source: OECD (forthcoming[24]), The Development and Humanitarian Response to the COVID-19 Pandemic in Cambodia (2020-2022): Case Study for the "Strategic Joint Evaluation of the Collective International Response to the COVID-19 Pandemic".

Tackling food insecurity, nutrition, and sanitation needs

The crisis significantly impacted food security, with many developing countries experiencing heightened vulnerability due to disruptions in supply chains, loss of livelihoods and rising food prices. Hunger affected 9.1% of the world's population in 2023, compared with 7.5% in 2019. It is estimated that 152 million more people were hungry in 2023 than in 2019 (FAO, 2024[58]). Many households in developing countries also struggled with lower incomes due to falling demand in the agricultural sector and disrupted supply chains, impacting rural livelihoods (Rasul et al., 2021[59]). Remittances and migration, important economic lifelines for many households in developing countries, also fell significantly.

School closures also threatened to exacerbate food insecurity for children living in poverty (Van Lancker and Parolin, 2020[60]) as they depended on being in the school environment to access a healthy meal, which would have been provided or subsidised by the government or an international donor. Research conducted by The World Food Programme (WFP) and UNICEF revealed that 370 million children were benefiting from school feeding programmes prior to the pandemic with the largest number of beneficiaries in India (100 million), Brazil (48 million), China (44 million), South Africa (9 million) and Nigeria (9 million) (Borkowski et al., 2021[61]; WFP, 2019[62]). In 2020, 39 billion school meals were missed, affecting the nutritional status of many children (Borkowski et al., 2021[61]). The impact of missed school meals was not equally distributed with lower-income and conflict-affected countries least able to offer alternative solutions (Ferrero, Wineman and Mitchell, 2023[63]). Initial estimates predicted that an additional 3.4-4.5 million children would suffer from stunted growth as a direct consequence of COVID-19 (United Nations, 2020[64]; FAO, 2022[65]).

Evaluations highlight many successful efforts to reach out of school children – and other vulnerable populations – with nutritional support and food assistance, though it is not possible to determine if the scale of need surpassed the capacity of affected countries and their international partners.

The country case studies also revealed the following examples of effectively tackling food insecurity:

- An evaluation of the World Food Programme's (WFP) COVID-19 response found that their assistance was key in preventing significant deterioration in global food security and nutritional status (WFP, 2022[66]). Likewise, a real-time evaluation of FAO's COVID-19 response found that its support helped to strengthen agrifood systems and livelihoods in over 90 countries (FAO, 2022[9]).
- In Lebanon, WFP partnered with funders to provide emergency food assistance to nearly 740 000 people over a four-month period, including vulnerable Syrian refugees and Lebanese populations (OECD, 2025[30]).
- In Cabo Verde, the FAO are credited with helping the country achieve its 2025 nutritional targets, three years ahead of schedule, which is particularly commendable given the country's pre-existing vulnerabilities and issues related to food security (OECD, 2025[23]).
- Targeted programmes focusing on smallholder farmers also supported access to inputs and markets during the pandemic (UNDP IEO, 2022[46])
- A good practice example from Rwanda was the "Feed the Future Rwanda Orora Wihaze Activity", which averted the collapse of the egg market following its loss of access to export markets in the Democratic Republic of the Congo due to the pandemic border closure. The project initially purchased eggs directly from producers and then distributed them via a new domestic market and a child nutrition programme. This relief activity occurred within the first month of the pandemic and quickly evolved into a more sustainable intervention, as several private actors were willing to further develop the egg collection centre (Kiremidijian et al., 2023[67]).
- Support to school feeding programmes and adapting school-based programmes to meet the needs of children out of school due to pandemic-related closures also helped address food insecurity. In Cambodia, for example, the WFP worked with the Ministry of Education, Youth and Sports on a school feeding programme that provided 92 000 children and 2 100 cooks from 1 113 schools across ten provinces with 15 kg of rice and a litre of vegetable oil each (OECD, forthcoming[24]). The intervention is thought to have contributed to minimising school dropouts and allowing households to make cash savings, which could be used to meet other immediate needs.

The pandemic underscored the critical importance of water, sanitation and hygiene (WASH) services. Interventions focused on improving access to clean water, promoting hygiene awareness, and upgrading sanitation facilities, particularly in vulnerable and underserved communities. For example, publicly available handwashing stations installed in urban informal settlements helped to reduce the risk of transmission.

New Zealand contributed NZD 5 million to UNICEF Indonesia's COVID-19 response, supporting 680 000 people by providing them with essential water, sanitation and hygiene supplies to prevent infection spread (Ministry of Foreign Affairs and Trade of New Zealand, forthcoming[68]). Hygiene education campaigns, which were often delivered through community radio or mobile platforms, effectively raised awareness about preventative behaviours (i.e. regular handwashing) in low-income settings. Importantly, such investments in WASH infrastructure have the potential to provide a lasting impact on health outcomes and learning, which extend beyond COVID-19 (Triple Line, 2024[69]). The integration of WASH services with broader public health interventions proved particularly impactful, reinforcing the resilience of communities against health crises. Donor flexibility in reallocating funds toward WASH initiatives from other non-urgent health initiatives also contributed to success with broader health benefits, though WASH played a smaller role in preventing COVID transmission than originally expected.

5.5. Reaching vulnerable parts of the population

Many development co-operation actors committed to "leaving no one behind" in the crisis response, and numerous funding commitments included explicit targets around reaching vulnerable populations. Many governments, CSOs and communities provided direct crisis support to vulnerable groups – including those impacted by the virus itself and others affected by the broader crisis, such as children out of school. Many governments advocated for an inclusive and equitable approach to the crisis response, both nationally and internationally.

- An independent review of the UK's emergency support for vulnerable populations in need due to COVID-19 pandemic found that, whereas the UK government was not always directly involved in supporting groups who had recently become vulnerable, there was evidence that it advocated for their inclusion in national response plans. The United Kingdom supported a study to identify people unable to access existing social protection mechanisms through UN agencies or the National Aid Fund in Jordan and then lobbied for the World Food Programme (WFP) to do so.
- Similarly, provider studies of Ireland, South Africa and the Netherlands show that they all combined direct support with international advocacy for prioritising those most in need (OECD/IOB, 2025[70]; OECD, 2020[71]; Presidency of South Africa, 2021[72]).
- Germany's support to Lebanon prioritised reaching Palestinian and Syrian refugees. A survey of intended beneficiaries showed that the support was highly relevant to needs, although some needs went unmet (see Box 5.7 and (DEval, 2024[73])).
- In Cambodia, the cash transfer programme proved rapid and effective in protecting poor and vulnerable households (see Box 5.7 and (OECD, forthcoming[24])). Development partners reprogrammed and reallocated funds to meet urgent COVID-19 needs, based on the information provided by the Cambodian government through the national and sectoral technical working groups. Despite having a nascent social assistance delivery system, the cash transfers reached a significant portion of the intended population, with between 94% and 97% of eligible households receiving support. The information guiding these decisions was obtained in real time as the pandemic evolved, allowing stakeholders to respond effectively to the immediate demands.

Available evidence makes it difficult to conclude the extent to which these commitments were met in the aggregate, but there is good evidence that efforts were made and there were some successes, especially in reaching groups that were already being targeted. However, a noted weakness in all case study countries and provider evaluations, was that providers and implementing organisations struggled to identify and reach target groups who had recently become vulnerable due to the crisis or were at higher risk to the virus itself (ICAI, 2022[41]). It is also important to note that in a crisis context, universal or near universal programming may be more efficient and effective, given resources required for a more targeted approach.

Meeting the needs of women and girls

An analysis of overall funding (Chapter 2) and strategy statements, show potential, with a strong emphasis on meeting the needs of women and girls. Numerous examples of effective support were identified, such as cash transfers that prioritised women as recipients to facilitate household spending on education, food and health. Specific examples of effective pandemic-related assistance include a project in the West Bank and Gaza Strip, in which local organisations assisted Oxfam and the Ma'an Development Centre in identifying female-led businesses and households in need of cash support to maintain their livelihoods (Start Network, 2020[74]). In Honduras, CARE's local partner provided housing and food vouchers to female returnee migrants in quarantine (Aoude, 2021[75]). The WHO worked to address gender-based violence and other threats in the Americas region (Box 5.10).

However, entrenched gender biases and limited institutional capacity often undermined the scalability and impact of gender-focused interventions during the pandemic (as in non-crisis settings) (UNDP IEO, 2022[46]). For example, policy documents failed to account for the increased care burden many women experienced during COVID-19, and in several countries, women were excluded from decision-making processes. Ultimately, given available information about both pre-existing challenges and the gendered impacts of the pandemic, it seems that development co-operation did quite well in many cases, but that overall support was insufficient to fully address these challenges.

Refugee rights

Refugees were another vulnerable group at greater risk from the crisis. Extraordinary efforts were exhibited by a range of protection actors – from the international community to refugee-led organisations – to support refugee rights in the face of this unprecedented global pandemic.

As described in the joint evaluation of protection of refugee rights (Box 5.9), when it came to the early planning of the pandemic response, refugees, internally displaced people and migrants, especially those in large camps were seen as extremely vulnerable, priority groups, spurring their inclusion in national plans and encouraging co-ordination between humanitarian and development actors, as well as the roll out of COVID programming to refugees. For example, in Costa Rica, Bangladesh, Uganda (Taylor et al., 2022[76]), and Lebanon (OECD, 2025[30]), clinics were established to provide free testing, vaccinations, and basic medical services in areas with high concentrations of refugees (Taylor et al., 2022[76]). The Danish Refugee Council intensified its engagement with community-based child protection committees, gender-based violence activists and legal assistance volunteers to help identify people at risk and in urgent need of assistance (DRC, 2021[77]).

As in other areas, though the overall assistance was not sufficient to meet all needs, projects supported with international assistance were largely relevant and effective. There were considerable efforts at the country-level to integrate refugees into vaccine roll outs. While these integration efforts were largely successful, the countries themselves were so far behind vaccination targets that the final rates of vaccination remained very low well into 2022.

Disability inclusion

Several studies of the crisis response confirm past analyses showing that disability inclusion can enhance the functional effectiveness, operational coherence, and resilience of crisis responses. Systematically embedding inclusive measures into the design, delivery, monitoring, and financing of preparedness and response systems, and aligning them explicitly with the established pandemic response frameworks, will increase the capacity of governments and partners to deliver equitable and sustainable outcomes in future emergencies. Examples from the WHO (Box 5.9), and UN Country Teams (Box 5.9) demonstrate a combination of strategic prioritisation, co-ordination structures, capacity and leadership supported more inclusive crisis response efforts.

Box 5.9. Protection of refugee rights during the pandemic

A joint evaluation of the protection of refugee rights during the COVID crisis makes six recommendations to improve co-operation in the future:

First, states should uphold international refugee law and international human rights law standards, especially during times of crisis and emergencies. This means, among other things, that governments should automatically renew documentation for refugees and asylum seekers whenever government services have to be shut down in any emergency. They should build systems that allow for secure digital registration and documentation that can be renewed remotely. In particular, states should reaffirm international obligations to ensure an exception for refugees and asylum seekers where borders are closed in future pandemics or large-scale emergencies.

Second, in preparation for future pandemics and public health crises, protection actors and others should advocate and plan for the maintenance of essential, in-person protection services to the fullest extent possible. This includes ensuring that protection staff have access to all refugees and asylum seekers within and at the borders of countries during crises, and that refugees and asylum seekers have adequate, safe quarantine facilities that respect their human rights. Protection activities - critically, child protection and GBV - must not be considered an add-on, but should be recognised as essential and life-saving, with necessary equipment and support provided to those delivering these services

Third, the Global Compact on Refugees must be utilised across the board during global crises and humanitarian emergencies. This will require governments and other members of the international community to consolidate reporting on upholding their pledges during the pandemic to demonstrate evidence of its effectiveness for enhancing protection. It will also require awareness raising and promotion of the GCR and its principles.

Fourth, partnerships with and support to local and national actors, including women and refugee-led organisations is critical. GBV and child protection activities should be prioritised during public health crises and other emergencies, and require investment and long term-strategic partnerships with key national protection partners.

Fifth, Information and messaging for refugees must be two-way and needs-based, sensitive to local social, cultural and gender norms, and effectively targeted to also reach those most vulnerable and marginalised, including those with limited access to online communication channels.

Finally, in-person protection services are sometimes needed, especially for survivors of GBV, children at risk and others with protection needs. Guidance that recognises programme adaptations is important, but should also consider the risk of harm versus the benefits of a total shift to remote services. Protection actors should continue to ensure there are appropriate levels of dedicated and experienced child protection and GBV staffing in refugee settings.

Source: UNHCR, 2023 Brief: Refugee Rights & Protection During COVID-19: What Have We Learned? Key Lessons from a Joint Evaluation on the Protection of the Rights of Refugees during the COVID-19 Pandemic.

Box 5.10. Gender and equity mainstreaming for inclusive access

Integrating gender and equity into pandemic operations created more inclusive pathways to services for those facing intersecting vulnerabilities. In the Americas, gender-based violence (GBV) prevention and response were built into emergency health programming from the outset, with health providers trained to recognise and respond to cases under lockdown conditions. Outreach strategies were tailored for indigenous and Afro-descendant populations, using culturally adapted messaging and trusted community intermediaries to increase reach and credibility. These approaches deliberately incorporated accessibility considerations for women and girls with disabilities, such as physical access to protection services and accessible communication formats. By addressing multiple barriers in tandem, these measures reinforced the relevance of public health interventions and improved coherence across health, protection, and social support sectors. They also illustrate how intersectional design strengthens resilience in the face of complex emergencies, making it more likely that no group is excluded from critical services.

Source: PAHO (2023[27]), *Evaluation of the Pan American Health Organization Response to COVID-19 2020–2022. Volume I. Final Report,* https://doi.org/10.37774/9789275127421.

Box 5.11. Organisational enablers of disability inclusion in WHO

WHO's Evaluation of the Policy on Disability identified a set of organisational mechanisms that directly supported the quality and consistency of disability inclusion during emergencies. Engagement of OPDs in programme design, governance, and monitoring improved the contextual fit of interventions and ensured that accessibility barriers were identified early. The appointment of dedicated focal points for disability inclusion at headquarters, regional, and country levels maintained institutional attention even during operational surges. Integrating disability markers into monitoring and evaluation systems enabled systematic tracking and timely course correction, while flexible funding streams supported the adaptation of service delivery modalities to meet accessibility standards. These enablers not only ensured more equitable outcomes during the COVID-19 response but also provide a replicable model for institutionalising inclusion across all stages of preparedness and response. Embedding these mechanisms into organisational structures strengthens both the sustainability and the effectiveness of measures for persons with disabilities.

Source: PAHO (2023[27]), *Evaluation of the Pan American Health Organization Response to COVID-19 2020–2022. Volume I. Final Report,* https://doi.org/10.37774/9789275127421.

Box 5.12. Pursuing human Rights, Gender Equality, Inclusion and Leaving No-One Behind

An independent evaluation found that UN Country Teams showed strong ownership of the guiding principles of Human Rights, Gender Equality, Inclusion, and Leave No-One Behind (HR/GE/LNOB), though the evaluation finds that continuous work is needed for full operationalisation of these principles. A focus on vulnerable groups, including women, refugees, youth, older people, people with disabilities and migrant workers has been evidenced in key COVID-19 planning documents. Resident Coordinators have also played a leadership role in advocacy for rights and inclusion during the pandemic. This has helped UN teams to successfully highlight key vulnerabilities and engage with governments to ensure that national responses address the needs of vulnerable populations.

The strength of response at the country level is related to capacities and architecture for HR/GE/LNOB and Inclusion across the UN country office: examples include the presence of a Human Rights Advisor in some offices and the establishment of empowered interagency groups as well as the presence of key entities with co-ordination mandates. The use of accountability tools and metrics such as mandatory markers, targets and gender equality, youth and disability scorecards have positively contributed to efforts to advance HR/GE/LNOB and disability inclusion in the response to the pandemic. While demonstrating progress over time, the need remains to accelerate efforts to meet standards and improve results.

Source: UNSDG (2022[50]), System-Wide Evaluation of the UNDS Socio-economic Response to COVID-19 Final Report, https://unsdg.un.org/resources/system-wide-evaluation-unds-socio-economic-response-covid-19-final-report (accessed on 29 January 2025).

5.6. Equitable access to vaccines

The OECD Secretary General, Angel Gurría, described the challenges surrounding global access to vaccines against COVID-19 as the “greatest test for mankind as a whole and for OECD countries in particular”, highlighting the need for joined up solutions to end the pandemic and the important role of international development assistance to support access for all (OECD, 2021[78]).

Numerous challenges to equitable access to vaccines have been flagged in the literature – including before the pandemic – and many of these were insufficiently addressed, particularly at the global level (OECD, 2021[78]). This evaluation focuses on the international co-operation dimensions of the vaccine response, including assistance provided to countries bilaterally, and support to COVAX and other multilateral efforts (Chapter 2). In terms of effectiveness, these efforts were mixed. Overall, support for access to COVID vaccines was inadequate, late, undermined by other actions (Chapter 4) with outcomes remaining disappointingly unequal globally. Though the collective global efforts ultimately failed to deliver on objectives related to equity, the role played by development assistance in supplying vaccine doses and materials, and in rolling out vaccination campaigns in partner countries was nonetheless positive.

Support for multilateral efforts including COVAX

Supporting the development and equitable deployment of COVID-19 vaccines was a key stated goal for nearly all development and humanitarian actors, including DAC members who dedicated considerable funding and strategic engagement to the global vaccine campaign. In addition to providing direct funding and doses, many countries also engaged in advocacy efforts to influence the global vaccine response and call for vaccine equity. South Africa and India proposed a temporary Trade-related Aspects of Intellectual Property Rights (TRIPs) waiver in October 2020 to boost the global supply of vaccines, eventually gaining support from some 100 countries that welcomed or fully supported the proposal. Several philanthropic foundations were vocal in advocating for equity in the distribution of vaccines, both between and within countries.

In June 2021, Bangladesh, Cambodia, China, Saudi Arabia and the United Arab Emirates, along with other nations, launched the Belt and Road Vaccine Partnership Initiative supported by China. This initiative emphasised the need for global unity in combating COVID-19 and promoted the fair distribution of vaccines as global public goods to ensure better vaccine accessibility and affordability for developing countries (CIKD, 2023[79]).

Box 5.13. Lessons on the COVAX Facility and Advanced Market Commitment (AMC)

In 2022, Gavi, the Vaccine Alliance commissioned a Formative Review and Baseline Study evaluation to assess what worked well and less well in the design, implementation, and results of the COVAX Facility and AMC, from when COVAX was conceptualised in 2020 through 2021 (a second phase of the evaluation, conducted jointly by the COVAX Pillar Partners is forthcoming in 2025, covering the period through 2023). The evaluation highlighted that by the end of 2021, nearly 1 billion COVID-19 vaccine doses were delivered to 144 countries, with vaccines supplied by COVAX accounting for 79% of all vaccines delivered to AMC participating low-income countries in 2021.

Key lessons include:

- Inclusive design is essential: Early and meaningful engagement with beneficiary countries and civil society is critical for ownership and effective implementation.
- Transparent governance matters: Rapid response must be balanced with transparent, accountable decision-making and clear communication to all stakeholders.
- Market shaping requires preparation: Boosting global vaccine supply depends on early investments in production capacity, tech transfer, and efficient arrangements for donations.
- Flexible allocation and support: Allocation mechanisms must adapt to unpredictable supply, and co-ordinated, timely technical and financial support is vital for successful vaccine rollout. The provision of flexible funding on a no regrets basis can be extremely useful in a range of country contexts during emergency situations.

Source: Gavi (2022[80]), COVAX Facility and COVAX Advance Market Commitment (AMC) Formative Review and Baseline Study, https://www.gavi.org/our-impact/evaluation-studies/covax-facility-and-covax-advance-market-commitment-amc-formative-review-and-baseline-study.

Inequalities in vaccine coverage

While vaccination coverage globally was more equitable than it would likely have been without significant international co-operation, there were still wide disparities across regions and income groups, with poorer countries rolling out vaccines significantly behind richer countries. By the end of 2022, only 34 doses had been administered per 100 people in low-income countries, compared to 212 doses in high income countries (WHO, 2025[81]; Our World in Data, 2025[82]).

Sub-Saharan Africa and the Middle East and North Africa had the lowest vaccination coverage by region, with only 33.0% and 34.3% of their total population having complete primary series coverage, respectively (Our World in Data, 2024[83]). This was followed by Europe and Eurasia, with only 41.3% of the population vaccinated. There was an even wider disparity in vaccination coverage levels by income group with only 30.5% of the population in LICs versus over 61% in LMICs receiving complete primary coverage (USAID, 2023[84]; Our World in Data, 2024[83]).

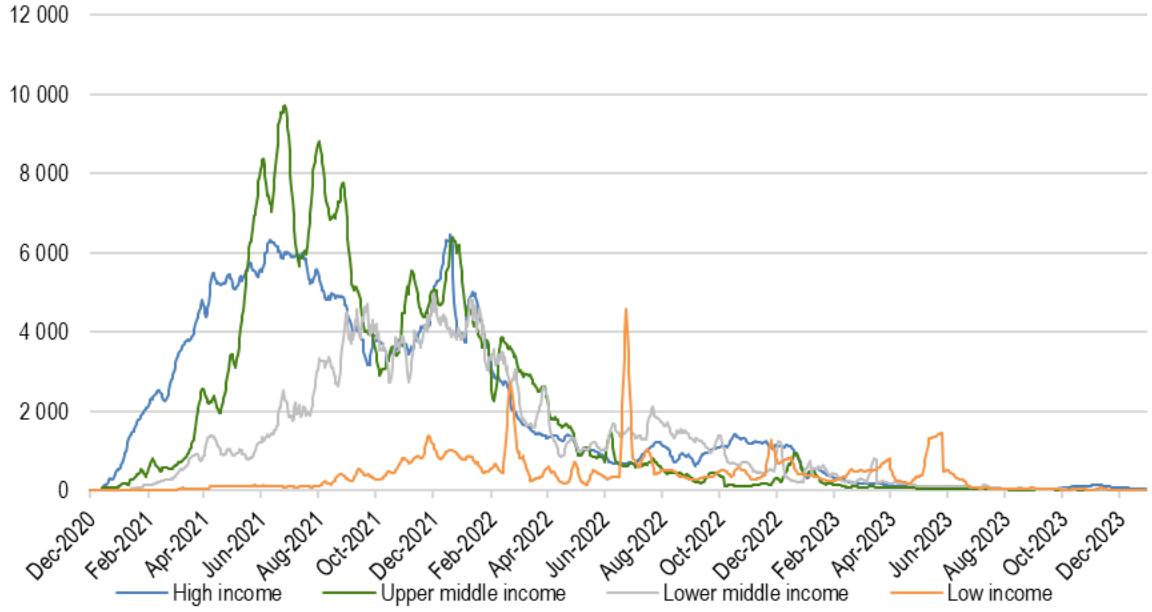
COVAX achieved significant milestones, shipping almost two billion doses to more than 146 countries and decreasing the lag time between rolling out vaccinations in high-income and low-income countries (IMF, 2022[85]), (Gavi, 2022[86]). Instead of historical time lags of months or years, the COVAX programme reduced this to 39 days (WHO, 2021[87]). This is a considerable achievement that should be acknowledged even if the overall vaccination targets were not achieved. Vaccine coverage remained lower in low- and middle-income countries due to delays in vaccine availability and challenges in country level rollout, as well as reduced demand for vaccines once supply increased. COVAX played a crucial role as the largest provider of vaccines to LMICs, but access disparities remained.

A core criticism relates to the timeliness of funding toward vaccination – despite international financial commitments, it took COVAX over 15 months from the onset of the pandemic to raise enough funding to procure vaccines to cover 30% of developing economies' needs. This delayed advance purchase agreements, and thereby also the deliveries of vaccines (IMF, 2022[88]). However, the COVAX design and business model continued to evolve considerably in response to the changing context, evolving needs, and lessons learned. This flexibility was a core strength of the COVAX response. Design features of the COVAX Facility and AMC were adapted over time, including the approach adopted to raise funding for future vaccine procurement, as needed, via the Pandemic Vaccine Pool; secure supply by balancing self-procured and donated doses, as well as the renegotiation of contracts with vaccine manufacturers. The approach for allocating doses across countries was also adjusted, reflecting the shift in demand and supply dynamics over time; and the decision taken to ultimately close the COVAX Facility and move towards a routine vaccination approach (Gavi, forthcoming[89]).

Figure 5.3 presents the seven-day moving average of the number of COVID-19 vaccines administered per million people, broken down by income group. At the beginning of 2021, during the early stages of the vaccine rollout, vaccination procurement was dominated by HICs and UMICs. In the six months following the first vaccination, 87.5% of all vaccines administered were in HICs and UMICs. This distribution pattern reflects how wealthier nations were able to leverage their economic power to secure vaccine supplies early through pre-purchase agreements and robust procurement strategies, again underscoring the broader issue of vaccine nationalism. LMICs and LICs only began to increase vaccination rates towards the end of 2021, which suggests that global efforts, including COVAX, bilateral aid and regional initiatives, eventually had an impact, but this was delayed. Throughout 2021 and 2022, as demand for vaccines soared and new variants of the virus emerged, COVAX adapted its approach. In response to lagging vaccination rates in some countries, the COVID-19 Vaccine Delivery Partnership (CoVDP) was launched in early 2022 to provide intensified support to 34 countries with coverage below 10% at the time of its launch. This partnership focused on accelerating vaccine delivery through funding, advocacy, and technical assistance. From January to November 2022, the completion of the primary vaccine series rose from 28% to 52%. Subsequently, in the CoVDP subset of countries, coverage increased from 3% to 28% by May 2023.

Figure 5.3. COVID-19 vaccination doses administered, by income group, 2020-2023

Per million population, seven day moving average



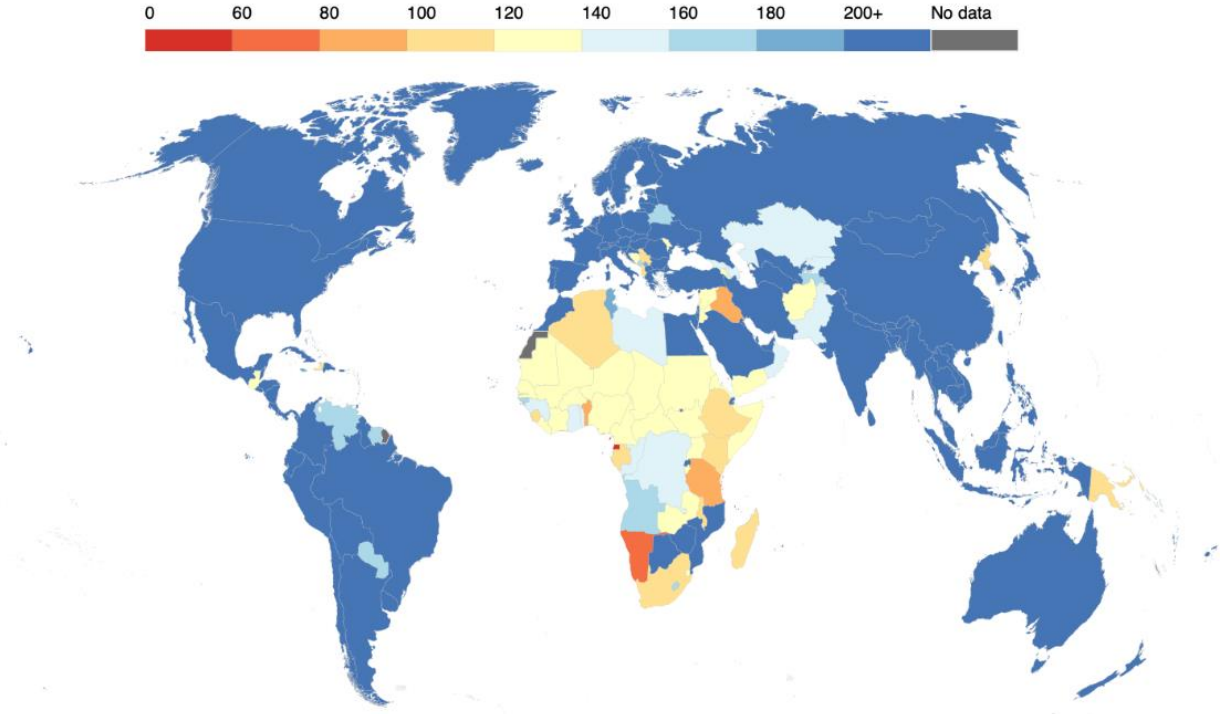
Source: WHO (2025[81]), COVID Vaccination Data, https://data.who.int/dashboards/covid19/vaccines?m49=268; Our World in Data (2025[82]), COVID-19 Pandemic, https://ourworldindata.org/coronavirus.

Inequity in vaccine coverage between regions and income levels is likely to have resulted in higher excess deaths due to COVID-19. One study found that almost 600 000 COVID-19 deaths could have been averted, mostly in the African and Eastern Mediterranean regions, if all countries had achieved 40% primary coverage by the end of 2021 (Watson et al., 2022[90]). Another study indicated that 1.3 million deaths could have been prevented with more equitable vaccination coverage and other measures (Moore et al., 2022[91]). More than 90% of avoidable deaths would have been in LICs and LMICs (USAID, 2023[84]).

Figure 5.4 shows the number of vaccines or expected supply as a percentage of the population at the end of 2022, illustrating the lack of equitable distribution. While most high income countries were able to secure two or more vaccines per capita, much of the African continent was left behind. Many countries with low access to vaccines deployed longer lockdowns as a result, which had adverse social and economic impacts and disproportionately affected low-income households and informal workers. In the second half of 2022, for example, Malawi, Uganda, Zimbabwe's restrictions were all significantly more stringent than richer countries or other low-income countries that had better access (COVID Collective, 2024[92]).

Figure 5.4. Secured vaccines or expected vaccine supply, 2022

Doses, % of total population, as of September 2022



Source: IMF (2022[88]), IMF-WHO COVID-19 Vaccine Tracker, https://www.imf.org/en/Topics/imf-and-covid19/IMF-WHO-COVID-19-Vaccine-Tracker.

Factors hindering equitable access to vaccinations

Several key factors impeded an equitable global distribution of vaccines despite remarkable efforts to achieve a fair access. As discussed in Chapter 4, the actions of provider countries – including their national procurement strategies – reduced the effectiveness of the global vaccination efforts. First, COVAX was undermined in its ability to strategically allocate supplies by wealthier countries who secured a disproportionate share of vaccine doses for their own populations through pre-purchase agreements. This drove up prices and severely limited access for countries that were reliant on receiving doses through COVAX. By early 2021, COVAX had raised enough resources to purchase most of the vaccines it needed but it was unable to compete with HICs for the available supply (Cooper et al., 2023[93]).

The case studies showed that allocation decisions were driven by provider country priorities and national interest, rather than by country need or equity objectives, undermining overall outcomes between lower income countries.

COVAX limitations and policy incoherence

Initial decisions in the design of the COVAX Facility and AMC impeded its success by enabling disproportionate donor influence, with some countries leveraging their position on Gavi's board to align the objectives and interests of the COVAX Facility with their own (Cooper et al., 2023[93]). COVAX's effectiveness was further undermined by donor countries and vaccine manufacturers who systematically broke key COVAX principles, delivering doses late, in smaller quantities than promised, and in ad hoc ways that made rollout in recipient countries difficult. Furthermore, some donors earmarked doses for specific recipients, complicating and potentially weakening COVAX's equitable allocation mechanism

(Puyavalle and Storeng, 2022[94]). A lack of transparency concerning COVAX's governance structure was thought to have exacerbated these challenges further (Puyavalle and Storeng, 2022[94]). Perhaps most significantly, COVAX could not meet its supply objectives due to "vaccine nationalism" and aggressive competition from high income countries securing domestic vaccine supplies for their own populations (Cooper et al., 2023[93]). While by the end of 2021, 11 billion doses had been administered globally, the majority went to HICs. There remained an ongoing need to provide vaccines to LICs, with COVAX continuing to play a crucial role in vaccine development, procurement, and distribution amidst evolving epidemiology.

Health system and supply chain weaknesses

Existing weaknesses in health systems and low absorptive capacity hindered the distribution and administration of vaccines. The delivery of vaccines, particularly when stock arrived with short expiry windows, hampered already struggling systems and while vaccines were provided, the health system support to administer them was not consistently available (IAHE, 2022[47]). Support for cold-chain logistics, training for healthcare workers to administer the vaccines, and public awareness campaigns were cited as essential, yet unevenly deployed across regions. In Afghanistan, only 10% of available vaccinators fulfilled the required educational criteria and only 14% of health facilities had vaccination micro-plans, i.e. comprehensive guides for health workers in all aspects of the vaccination programme (Ulep, 2022[95]).

A primary issue was the inadequacy of the cold chain infrastructure, which is essential for vaccine distribution (Pambudi et al., 2021[96]). Several vaccines such as the Pfizer BioNTech required storage at temperatures between -90°C and -60°C. Almost 20% of vaccination centres and healthcare facilities lacked refrigerators for storing routine vaccines and those that had refrigeration often did not have sufficient space to accommodate COVID-19 vaccines (McKinsey and Company, 2021[97]).

Demand-side challenges also contributed to the low uptake of vaccines in some settings (Ulep, 2022[95]). Few countries had vaccination programmes for older adults, who may be less willing to attend vaccination centres or have other specific concerns that lead to vaccine hesitancy. Trust in governments has proven to be significantly correlated with the willingness to get vaccinated. UNICEF found a strong positive association in Pakistan and in India between trust in the government's effectiveness in vaccine provision and respondents' willingness to get vaccinated. In both countries respondents who trusted the information from the government were more than three times as likely to get vaccinated than respondents who did not trust the information (UNICEF, 2021[98]).

UNICEF also identified a gender gap, with women in India, Nepal and Pakistan being 25% less likely to indicate willingness to be vaccinated than men, emphasising the need to have pro-equity, gender sensitive, tailored strategies based on evidence to encourage vaccine uptake and maintain public trust in vaccines (UNICEF, 2021[98]). In South Sudan, where female vaccination coverage was significantly lower than for men, focus group discussions with women to identify barriers to vaccination informed targeted efforts and evidence-based advocacy through female influencers. This increased vaccination from 25% to 43% among women (WHO, 2022[99]). Thus, targeted communication strategies have proven most effective in increasing uptake of vaccines.

Limited capacity, infrastructure, legal restrictions and bureaucracy

Partner countries with limited bureaucratic and administrative capacity struggled to effectively manage the vaccine procurement and rollout processes. Countries needed efficient distribution networks, and trained personnel to deliver vaccines. Where these infrastructures were weak, vaccine donations alone were not sufficient to ensure the required vaccination coverage. Logistical issues were further exacerbated by limited transport infrastructure, especially in more rural settings.

Barriers to accessing vaccines amongst LMICs and LICs also stemmed from restrictions around exports. The production of vaccines was highly concentrated, mainly in a small number of high and middle-income countries and regions such as the United States and the European Union (UNCTAD, 2021[100]). These countries imposed restrictions on the exports of vaccines and the critical materials needed for production and deployment, which, exacerbated global disparities.

Provider countries that donated vaccines bilaterally faced challenges with monitoring and tracking their donated shipments. There was limited information available regarding the extent to which bilateral donations were distributed. Other factors contributing to uneven distribution and uptake of vaccines included trade barriers (e.g. export restrictions placed by the United States as part of the Defence Production Act), misinformation and a lack of trust in vaccinations among partner country populations.

Challenges in accessing vaccines in humanitarian settings included complex vaccine registration systems, lack of documentation and language barriers. COVAX included a Humanitarian Buffer mechanism to act as a "last resort" measure to ensure access to COVID-19 vaccines for high-risk and vulnerable populations in humanitarian settings. Populations of concern in humanitarian settings include refugees, asylum seekers, stateless persons, internally displaced persons, minorities, populations in conflict settings, those affected by humanitarian emergencies, and vulnerable migrants irrespective of their legal status. Almost 2.5 million doses across six countries were provided but success was limited due to obstacles such as protracted negotiations, lengthy importation processes, and indemnity and liability issues (IAHE, 2022[47]).

Box 5.14. Cambodia's successful "Blossom Plan": Using international assistance to effectively meet vaccination needs

Cambodia is widely considered one of the most successful countries in vaccinating its population against COVID-19, having achieved the vaccination targets in its Global COVID-19 Vaccination Strategy in a Changing World: 100% of health care workers, 100% of the high-risk population and 70% of the general population by end 2021. In addition to the government's own strategy, timely vaccine assistance from China and other partners played a key role in Cambodia's success.

The Cambodian government was proactive in securing vaccines from international partners and the market, announcing its budgetary commitment early on. In December 2020, the government announced that it would use vaccines approved by the WHO; however, by mid-January 2021, with no approved WHO vaccines available, the government decided to use Sinopharm and Sinovac vaccines. Cambodia purchased 28.5 million vaccines and China donated a further 8.3 million doses. Cambodia began vaccinating in February 2021, using these vaccines and others as they become available. Sinopharm and Sinovac received WHO's emergency use listing recommendation later that year (in May for Sinopharm and June for Sinovac).

Other development partners – including Australia, the EU, France, Japan, Türkiye, the United States, UNICEF and the WHO – also helped Cambodia procure vaccines, medical equipment and essential supplies, and worked to strengthen the health system through capacity-building initiatives. Cambodia also received one of the first deliveries through the COVAX facility.

The Cambodian government's multi-pronged approach to securing vaccine supplies and the timely and effective national vaccination strategy, proved pivotal in reducing hospitalisations during the Delta variant surge.

Source: OECD (forthcoming[24]), The Development and Humanitarian Response to the COVID-19 Pandemic in Cambodia (2020-2022): Case Study for the "Strategic Joint Evaluation of the Collective International Response to the COVID-19 Pandemic".

5.7. Engaging with civil society for an effective response

A key success factor that emerged from the case studies and document review was the effective engagement of and work with civil society and other non-governmental groups in delivering COVID-19 response and recovery interventions. To ensure delivery of services required intentional and early engagement with local actors, who have the knowledge of institutional contexts and histories. To that end, those institutions that had prioritised localising decision making and had strong local partnerships – with CSOs or government – were well-placed to be resilient in the face of the crisis.

Even though civil society organisations (CSOs) have certain benefits in implementing activities in a crisis setting, they played a smaller role than might have expected in response programmes. Many countries saw shrinking civic space which contributed to challenges faced by organisations working to respond to the crisis, particularly among vulnerable populations (ICNL, 2020[101]).

Less COVID-19 specific funding went to NGOs (local and international) compared to all assistance. Overall, assistance for NGOs and CSOs increased slightly in 2020 and 2021, although not as much as that for other channels, such as multilaterals and recipient governments, resulting in a slight decrease in the share of funding channelled through NGOs and CSOs (Figure 5.5). In 2018, 9.1% of all ODA from official providers went to and through NGOs and CSOs, amounting to USD 24.1 billion. In the year before the COVID-19 pandemic, this share was stable (9.05%) even as the volume declined slightly (USD 23.8 billion). In 2020, the share dropped to 8.4% (USD 24.3 billion) and in 2021, declined further as a share of total assistance to 7.6% (USD 25.2 billion). In 2022, ODA to and through CSOs amounted to USD 26.3 billion, a 9% increase from 2018; however, it represented only 7.6% of total ODA and concessional finance.

These data may not fully capture the extent of NGO-related support, as DAC members and other providers indirectly funded NGOs via the use of pooled funds such as CERF and Country-based Pooled Funds (CBPFs). An evaluation conducted for IASC found that such pooled funding was a key source of finance for NGO's, allowing flexibility and adaptation (IAHE, 2022[47]). Studies of crisis support in Nepal (Box 5.16) also illustrate the effective funding of CSOs through multiple channels, including pooled funds, which enabled effective and timely distribution of needed supplies and other assistance to hard-to-reach areas. Likewise, the Kenya case (Box 5.15) had a positive assessment of the involvement of CSOs in the crisis response, not only in service delivery but also at a more strategic level.

Still, many studies found that there was insufficient engagement with NGOs and CSOs. To some extent this may be explained by the urgency of deploying large scale resources quickly, with larger funding flows directed to established agencies and appeals. For example, the Central Emergency Response Fund (CERF) prioritised UN agencies over local actors in its early disbursements in 2020. In the challenging crisis context, local and national organisations also struggled to access flexible funding, despite their frontline roles in delivering aid (IAHE, 2022[47]). Many CSOs and NGOs faced funding bottlenecks, limited absorption capacity and security restrictions that hampered their capacity to receive and deploy large scale funding.

The Active Learning Network for Accountability and Performance in Humanitarian Action's (ALNAP's) synthesis of pandemic-related evaluations found very strong evidence that local CSOs, NGOs and communities played a key role in the pandemic response, but they were largely excluded from decision making and were poorly represented in co-ordination structures (ALNAP, 2024[7]).

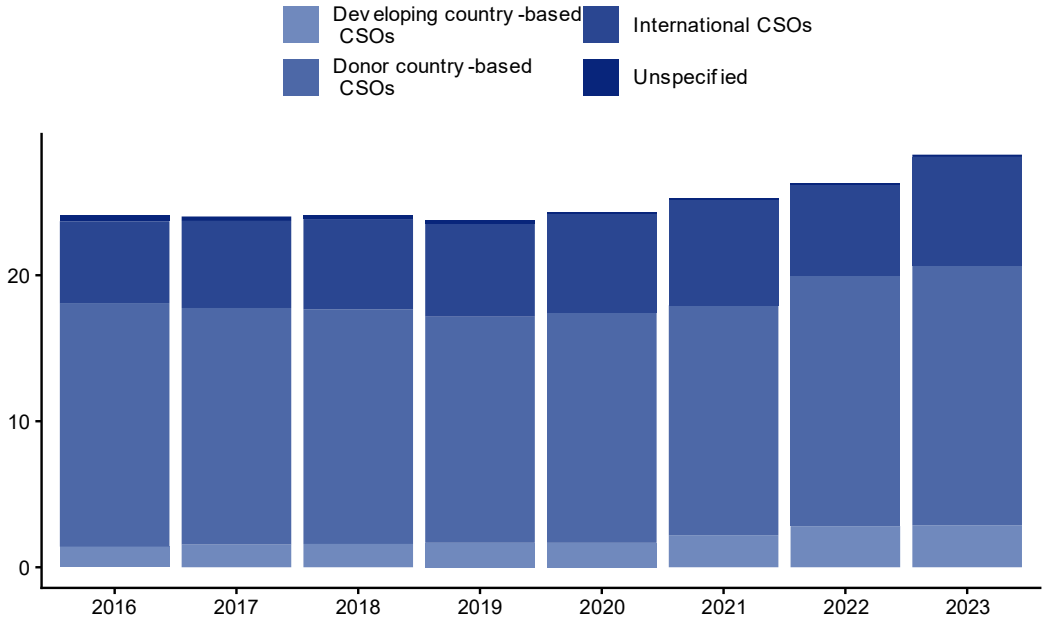
Other evaluations have highlighted the importance of working in partnership with organisations that are familiar with the specific local context and are well-placed to provide an effective response. This strategy was applied for the Health in Common initiative, one of AFD Group's major responses to the COVID-19 pandemic in Africa ((DEval, 2024[57]; AFD, 2024[102])). An evaluation of this project concluded that mobilising the support of long-standing partners or those already on the ground was essential.

The Germany case study (Box 5.7) found that "although the civil society channel is particularly well suited to reaching vulnerable groups, little use was made of it within the [COVID-19 response]" (Römling et al., 2024[103]). The Netherlands also noted that "there was no scale up of funding for regular NGO partnerships, and the vast in-country networks and rapid disbursement capabilities of NGOs may have been left untapped" (OECD/IOB, 2025[70]). The Netherlands noted that administrative factors, for example the ease of contracting with multilaterals, played a role in decision making (OECD/IOB, 2025[70]). From the country perspective, the Burkina Faso case study also found that CSOs were insufficient engaged in the crisis response (Box 5.17).

In short, the balance of evidence shows that CSOs were effective in many contexts in providing health and other needed crisis-related support, though they were perhaps not used as much as they could have been. The funding flows alone are insufficient to understand the contribution of these groups. There are also positive examples of how involving CSOs in crisis response planning at a strategic level.

Figure 5.5. Official development assistance for NGOs and CSOs from all official providers, 2016-2023

All official providers, USD billion disbursements, constant 2023 prices



Source: OECD (2025[6]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Box 5.15. The contribution of civil society to the COVID-19 response in Kenya

Kenya hosts a vibrant civil society sector, and many CSOs were actively engaged in its pandemic response through direct activity and through their involvement in task forces and multidisciplinary committees. For example, the SDG Kenya Forum, which is comprised mainly of CSOs, provided PPE, hygiene kits, food and water to informal settlements, especially those in Kilifi, Kisumu, Mombasa and Nairobi during lockdowns. CSOs also played a key role in community mobilisation, awareness raising, psychosocial support, training, and capacity building. They also contributed to policy frameworks such as the Public Health Rules (for the prevention, control and suppression of COVID-19).

Source: AfDB/IDEV (2022[55]), African Development Bank Group's COVID-19 Response Evaluation - Kenya Case Study, https://idev.afdb.org/sites/default/files/documents/files/Case_study_Kenya_COVID19_Evaluation.pdf.

Box 5.16. Leveraging CSO networks to deliver assistance: The case of Nepal

Nepal's COVID-19 response illustrates how development partners effectively leveraged civil society organisation (CSO) networks to ensure the effective delivery of assistance during the pandemic. The country faced severe pandemic impacts, recording nearly 500 deaths per 100 000 people. With few development partners present in the country, CSO partnerships were particularly valuable.

A limited number of bilateral donors are present in Nepal. According to Finland's Embassy in Kathmandu, out of the three EU Member States with embassies in the country, only Finland and Germany engage in bilateral development co-operation with Nepal. In this context, international partners work closely with CSOs to implement flexible and locally responsive programming.

Finland's crisis approach, for instance, relied on interventions operated via multi-donor funding arrangements and multilateral organisations. Embassy interviews confirmed that this multi-channel strategy proved particularly effective for pandemic-related project adjustments, in part due to robust CSO networks already in place that distributed COVID-19 relief support packages while maintaining implementation timelines despite disruptions.

The CSOs' presence on the ground enabled a targeted response including in remote areas and among vulnerable groups. For example, Islamic Relief's operations in Nepal's Rautahat district allowed the delivery of food vouchers to over 1 700 vulnerable families and additional cash transfers for people unable to work. Simultaneously, the organisation supplied healthcare facilities with critical medical equipment and supplies just as hospitals were reaching capacity and oxygen supplies were dwindling. This showcased how CSO networks could respond rapidly to evolving emergency needs.

Source: Ministry for Foreign Affairs of Finland (2022[45]), "Response of Finnish Development Policy and Cooperation to the COVID-19 pandemic", https://um.fi/documents/384998/0/Final_Report_From+Reactivity+to+Resilience_Assessment+of+the+Response+to+the+Covid-19+Pandemic_web+%281%29.pdf/a815a96a-2813-f9b2-66d8-c997c0ed22f7?t=1650435698559; Islamic Relief Worldwide (2021[104]), "Annual Report and Financial Statements", https://islamic-relief.org/wp-content/uploads/2022/06/IRW-AnnualReport2021-WEB.pdf.

Box 5.17. Missed opportunities for a more effective response in Burkina Faso

Civil society organisations (CSOs) were under-utilised in Burkina Faso's response to COVID-19. There was limited inclusion of CSOs in the initial design processes, but their participation became more prominent in implementation. Notable contributions from CSOs included sensitisation campaigns, community mobilisation and the provision of essential supplies.

The National Youth Council, for example, launched the "Battalion 20-20" initiative, which carried out awareness-raising efforts, produced hydroalcoholic gel and masks, and supported the government's broader response plan.

However, the contributions of CSOs were often fragmented and lacked integration with government efforts. Many operated independently or were inadequately supported, limiting the scale and efficiency of their impact. Discrepancies in communication between government authorities and CSOs occasionally hindered cohesive responses, as seen when crucial public health measures were enacted without CSO input or proper dissemination of information.

While CSOs demonstrated agility and resourcefulness, their limited involvement during the planning stages and their often-isolated initiatives underscored a missed opportunity to fully leverage their potential as partners in a comprehensive and inclusive response strategy.

Source: Government of Burkina Faso (2025[48]), "Évaluation du Plan National de Réponse à la Crise de la Pandémie de COVID-19 du Burkina Faso", https://www.oecd.org/content/dam/oecd/en/toolkits/derec/evaluation-reports/derec/covid19coalition/%C3%89valuation%20du%20Plan%20National%20de%20R%C3%A9ponse%20%C3%A0%20la%20Crise%20de%20la%20Pand%C3%A9mie%20de%20COVID-19%20du%20Burkina%20Faso.pdf.

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Notes

[1] This analysis does not provide a full picture – underrepresenting health spending – because many DAC members focused their COVID-related health spending on support to multilateral efforts, not all of which appear in the sector-based analysis.

[2] This included oxygen plants, liquid medical oxygen tanks, infrastructure for piped medical oxygen to hospital beds and oxygen monitoring devices.

[3] The Nordic Plus group consists of Denmark, Finland, Ireland, the Netherlands, Norway, Sweden and the United Kingdom.

6 Using resources well: The efficiency and timeliness of COVID-19 assistance efforts

The analysis of the efficiency of the international assistance provided during the COVID-19 crisis considers the extent to which partners were successful in managing resources well, including whether response efforts were timely, sufficiently adaptable and cost-effective. It identifies challenges related to staff management and corruption risks.

A huge number of needs rose quickly during the early stages of the COVID-19 crisis, making efficient use of resources and rapid disbursement of funding critical. Flexibility was also needed, especially early on as specific needs were often not well understood, and priorities changed quickly.

This chapter examines crisis support through the lens of efficiency, building on the preceding interconnected analyses of relevance, coherence and effectiveness. It considers the extent to which international assistance was timely, sufficiently flexible and adaptive, and cost-effective. It explores some of the challenges related to timeliness and flexibility, including risks related to staff and partners, and corruption.

COVID-related international assistance was remarkably quick, both in adapting to the crisis and in rolling out new support, though at times this came at a high cost for staff and partners. Many actors quickly allowed programme adjustments and flexibility, such as relaxing procurement process requirements and reducing reporting requests. Key factors that supported a rapid response were working through existing funding relationships; the overall response would certainly have been quicker had there been greater preparedness and readiness. Greater preparedness (and a faster global response overall) would have also reduced costs. Moving quickly called for less focused targeting, which could have trade-offs in terms of meeting the needs of different parts of the population.

While the overall speed of the COVID-19 vaccine roll-out in low- and middle-income countries was too slow – especially in comparison to higher income countries – international assistance played a significant, positive role in enabling the rapid set-up of ACT-A and COVAX and contributed to reducing the delays faced by many countries. Flexibility and adaptability were also high. The approach to flexibility, adaptability and timeliness changed over the course of the pandemic: Over time, the response slowed, while efficiency in delivery increased. Nearly all agencies reported that there was a return to “business as usual”, and that few of the positive new ways of working were maintained after the crisis.

6.1. Timeliness of the crisis response

One of the most frequent observations of international assistance during the crisis was the speed at which co-operation unfolded. Both development and humanitarian actors worked to adapt to the changing needs as the pandemic evolved.

In the early stages, to address immediate needs as quickly as possible, providers and multilateral institutions worked through existing mechanisms and partnerships. At country level this involved close co-ordination with national partners to find practical solutions to move resources quickly, as was seen in Kenya (see Box 6.1) and Bangladesh (Box 6.2).

Compared to “business as usual”, the COVID-19 response was exceptionally fast – both in terms of disbursing new funds and allowing for adjustments to ongoing work – but came at a cost in terms of staff well-being. For example, the European Commission moved agreements through conceptualisation, approval and disbursements at never-before-seen speeds (ADE, 2022[1]). The European Bank for Reconstruction and Development (EBRD) was an early mover (Box 6.3), and the African Development Bank’s (AfDB) Crisis Response Facility (CRF) used a new operating schedule which sped up the approval process for operations.

While it is difficult to judge whether this resulted in support that was “fast enough” to meet needs, findings from multiple evaluations show that international development and humanitarian assistance can be deployed quickly at scale when there is sufficient political will to do so. A political mandate to operate in “crisis mode” and the use of existing partnerships were critical factors in creating the basis for moving quicky. Embedding crisis response measures in existing projects enabled a crisis response that was both efficient, and coherent with strategic goals (DEval, 2024[2]). Sticking to existing programme sectors, focus areas, geographical locations and communities enhanced timeliness as well as relevance by drawing on

established networks and knowledge of the local context (War Child, 2020[3]; Save the Children, 2021[4]; British Red Cross, 2022[5]; Sida, 2021[6]; EBA, 2022[7]; OECD/AfDB, 2025[8]; FAO, 2022[9]).

High-level political commitment played a critical role in the speed of decision making, resource mobilisation, disbursement and logistical arrangements to meet urgent needs. Political leadership and prioritisation had a signalling effect across all layers of institutions and governments, which, in turn, expedited internal processes. Spain showed a good example of this through its "Universal Access Plan: Solidarity in Vaccination", which drove forward its strategy for ensuring universal and equitable access to the COVID-19 vaccines (Government of Spain, 2024[10]). Special emergency funds (which already existed in some UN institutions, including the WHO) were useful instruments to deploy resources quickly as they did not have to be set up as the crisis emerged (UNDS, 2021, p. ix[11]).

Pre-existing mechanisms were re-purposed to increase the efficiency and effectiveness of crisis responses. For example, the Polynesian Health Corridors (PHC) programme, which predated the crisis, was leveraged to manage New Zealand's contribution to the vaccine rollout in six Polynesian countries and Fiji. The programme capitalised on the robust collaboration between the Global Health team at the Ministry of Health and the Health team within the Pacific and Development Group in in the Ministry of Foreign Affairs and Trade (MFAT), which also predated the crisis. Finally, since New Zealand's development co-operation is delivered via a Cabinet mandate, all New Zealand government agencies operated under a shared strategy and guiding principles when engaging with the Pacific.

New and innovative financing mechanisms were established in response to the pandemic, for example, the Solidarity Response Fund (SRF) developed by the World Health Organization (WHO), the UN Foundation and the Swiss Philanthropy Foundation. The SRF operated from March 2020 until the end of 2021, raising nearly USD 257 million. It was designed to mobilise private funding on a global scale to stay ahead of the threat and to provide a nimble, responsive way to direct resources where they were needed most. It relied on the contributions of individuals, corporations, corporate and philanthropic foundations, and non-governmental organisations (NGOs) to provide direct support for WHO and its partners in addressing the pandemic (UNF/WHO, 2021[12]). The SRF filled an immediate funding gap at the onset of the crisis, when UN agencies otherwise experienced an absence of flexible funds. It moved from inception to fund allocation within just three weeks, enabling rapid action ahead of the global pandemic declaration. The first disbursement occurred just weeks after the fund's launch, enabling WHO and the United Nations Children's Fund (UNICEF) to respond immediately to urgent needs (UNF/WHO, 2021[12]; MOPAN, 2022[13]). The COVID-19 Rural Poor Stimulus Facility (another multi-donor initiative) was established to improve the resilience of rural livelihoods within the pandemic context by ensuring timely access to inputs, markets, information and liquidity (IFAD, 2020[14]).

Box 6.1. Efficient funding provisions to Kenya for a rapid COVID-19 response

International development partners, notably the World Bank and the International Monetary Fund (IMF), provided substantial financial support to enhance Kenya's health infrastructure and socio-economic resilience during the COVID-19 pandemic.

The IMF's disbursement of approximately USD 739 million under the Rapid Credit Facility enabled Kenya to address the urgent fiscal needs arising from the pandemic. Concurrently, the World Bank's Kenya COVID-19 Health Emergency Response Project supported the provision of medical supplies, capacity building for health workers, and the establishment of quarantine and isolation centres. This financial assistance was crucial in ensuring that Kenya could respond rapidly and effectively to its fiscal and health challenges during the pandemic.

Source: OECD (2025[8]), "The Development and Humanitarian Response to the COVID-19 Pandemic in Kenya (2020-2022)", https://doi.org/10.1787/21d3dca0-en.

Box 6.2. Partnering to strike the right balance for relevance and timeliness in Bangladesh

The Government of Bangladesh recognised the budgetary constraints faced by development partners early in the pandemic and that mobilising additional resources might take longer than anticipated. Consequently, government officials engaged in dialogue with donors to secure a diverse mix of development assistance through various channels, prioritising the swift mobilisation of resources. This approach evolved as the immediate health emergency subsided, transitioning towards a preference for budget support over grant-based financing in the later stages of the pandemic.

Donors responded positively, with the French Development Agency (AFD) using an adaptive management approach to ensure a relevant response to the country's new and emerging needs, expanding its support beyond infrastructure investments and corporate social responsibility to include health. In November 2020, the Government of Bangladesh urgently sought AFD's financial support for vaccine procurement and later redirected financing from vaccine procurement to the implementation of its Bangladesh Preparedness Response Plan and health system strengthening.

In 2020, the AFD partnered with World Bank to co-finance a social transfer modernisation programme in Bangladesh, which was then restructured to focus on beneficiary targeting; digital payments and data management, to address poverty which had been exacerbated by the COVID-19 pandemic. In 2021, they also initiated a policy-based loan.

Source: OECD (2025[15]), "The Development and Humanitarian Response to the COVID-19 Pandemic in Bangladesh (2020-2022)", https://doi.org/10.1787/c3e42f6f-en.

Box 6.3. The European Bank for Reconstruction and Development's rapid COVID-19 response

The European Bank for Reconstruction and Development (EBRD) was the first international financial institution (IFI) to approve a comprehensive series of response and recovery measures in its Solidarity Package, unveiled on 13 March 2020.

The EBRD quickly rolled out investments and disbursements to clients and countries suffering from the economic shock of the crisis, committing all activity in 2020-2021, worth EUR 21 billion, to help priority regions counter the economic impact of the pandemic. It adapted and scaled up existing instruments and developed new initiatives to provide financing along with rapid advisory and policy support to help businesses and governments combat the economic and societal implications of the virus.

Source: EBRD (2022[16]), "Our response to the Covid-19 pandemic", https://www.ebrd.com/home/what-we-do/focus-areas/our-response-to-the-covid-19-pandemic.html.

6.2. Flexibility and adaptation to meet needs and priorities

International humanitarian and development assistance was adapted flexibly to the crisis context, including by reducing reporting requirements, allowing for no-cost extensions, and other programmatic changes to adjust to local conditions. Unfortunately, most institutions reported that improvements to flexibility and streamlining of systems made in the crisis context were not maintained. Interviewees described a rapid return to "business as usual" as soon as the emergency period had ended.

The Large Ocean / Small Island Developing States (SIDS) case study (European Commision, 2025[17]) found that flexible and adaptive programming supported responsiveness to changing needs in SIDS during the pandemic. Providers adjusted the objectives, scope and methods of evaluations and assessments. Procedures were simplified, allowing for more flexible and responsive management at the country-office level. Funds were repurposed and reallocated from less flexible projects to those that could respond more quickly to evolving needs (European Commision, 2025[17]).

Bilateral donors and philanthropic organisations showcased high levels of agility, particularly in the early stages of the pandemic. Their smaller scale and operational independence allowed them to fill critical gaps quickly, although this was not always sustained as the pandemic's demands increased. EU Member States implemented a range of adaptive strategies, with varying degrees of operational impacts during the pandemic period. Providers commonly simplified key internal processes, which facilitated faster decision making and resource reallocation. Streamlining bureaucratic processes also enabled quicker response strategies. An observed reduction in risk aversion across several providers was likely to have been a factor in enabling such internal adjustments and in reorienting existing development and humanitarian portfolios to address emerging needs.

Programmatic flexibility was demonstrated by donors in Georgia, who exhibited adaptability as they contributed to the government's efforts to recalibrate Georgia's healthcare infrastructure by investing in hospitals and the public health system. This was a priority due to challenges in testing, treating and admitting COVID-19 patients to hospital, without putting them at additional risk. Beyond the provision of financial and in-kind assistance to address the immediate public health emergency, donors also provided technical assistance through forecasting the health impacts of the pandemic; improving vaccine readiness at central, regional, municipal and district levels; and providing research and communication support to improve vaccine delivery and uptake (OECD, 2025[18]).

The multilateral system also demonstrated high levels of flexibility and responsiveness. The Pan American Health Organisation's (PAHO's) response took exceptional measures to repurpose resources, organisational structures and key processes to enable it to respond to the pandemic, especially given its weak financial situation at the onset of the crisis. PAHO simplified and expedited some administrative and financial processes, as well as developing new ones, balancing flexibility with control mechanisms to ensure accountability (PAHO, 2023[19]). Gavi made important decisions to reduce the transaction costs associated with the application, approval and reporting procedures for its grant provision (European Health Group, 2022[20]). COVAX's flexibility, including matching grants and loan buydown facilities, underscored the importance of risk-sharing mechanisms in accelerating funding availability. Philanthropic foundations demonstrated agility by filling critical gaps early in the pandemic, leveraging their ability to take risks and experiment with innovative approaches (OECD, 2020[21]).

The International Labor Organisation's (ILO's) response to COVID-19 highlighted the organisation's swift recognition of the need for budget flexibility and its implementation of innovative and proactive measures to enable a nimble response across all levels, including adjusting regular budget allocations and development co-operation funds (ILO, 2022[22]). There was a strong will to preserve pre-existing programmes, as people already being assisted through existing humanitarian actions were likely to be among those most affected by the pandemic. The Global Humanitarian Response Plan (GHRP) emphasised that funding for existing humanitarian responses should take precedence over new responses. Indeed, a significant proportion of the pandemic response comprised adaptations to pre-existing programmes (IAHE, 2022[23]).

Pre-existing frameworks, such as the Central Emergency Response Fund (CERF), along with pooled funding mechanisms provided immediate and flexible financing, enabling rapid responses to urgent needs. Several organisations and agencies, including the African Development Bank (AfDB), Asian Development Bank (ADB) and Gavi, developed specialised emergency response funds, instruments, and modalities designed to support adaptive, quick and flexible funds. CERF funding was rapidly available with

USD 15 million allocated on 1 March 2020 (before the formal pandemic declaration) to help global efforts to contain the virus, followed by a further USD 80 million later that month. CERF streamlined application and reporting practices to facilitate rapid adjustments, and its disbursement model allowed recipients to deploy resources without waiting for full donor disbursements found (Schwensen and Schiebel Smed, 2023[24]), (Johnson and Kennedy-Chouane, 2021[25]).

Flexible funding practices were also employed by philanthropic organisations – particularly among those that already regularly provided core funding support. The Hewlett Foundation's practice of allocating 70-80% of its grants as flexible support enabled grantees to respond effectively to pandemic challenges (OECD, 2021[26]). The W.K. Kellogg Foundation simplified its reporting requirements, enabling non-profit organisations to focus on urgent pandemic responses while maintaining accountability.

6.3. Challenges to flexibility and timeliness

While there were many positives in how the development and humanitarian assistance adapted to the crisis, it was not without its challenges. Information gaps, a lack of needs analyses, access to populations and limitations to travel meant that agencies were making decisions rapidly, in an environment where there was a very high level of uncertainty. Providers often worked with a "no-regrets" approach, making decisions based on the belief that waiting for more data to become available would potentially increase suffering and risk to life (ALNAP, 2024[27]). This worked well for speed, despite possible risks around targeting.

Furthermore, the rapid mobilisation needed for pandemic responses often led to inefficiencies in distribution and allocation, impacting disbursement rates. For example, the timeliness of interventions was affected by national lockdowns, travel and supply chain constraints, and restricted access to beneficiaries. Evolving and often incomplete information surrounding COVID-19 made it challenging to fully grasp its ramifications and to set objectives. In one case, a provider's long approval processes and strict procurement and granting procedures were a barrier to both timelier assistance and to relevance, as by the time requested support was received, it was no longer a priority. Rather than allowing for adjustments, the funding had to be returning.

As the pandemic progressed, the focus shifted towards sustaining adaptability in response to the dynamic and multi-sectoral challenges posed by the crisis. While initial responses were swift, limitations in flexibility and adaptability became evident as more complex needs emerged. For example, Gavi's risk and programmatic flexibilities were launched early, ensuring the rapid reallocation of resources. However, the delayed rollout of its monitoring, reporting and sustainability framework illustrated how procedural bottlenecks could hinder adaptability when addressing long-term challenges. This trend was not unique to Gavi, as many organisations struggled to balance the urgency of immediate responses with the need for sustained and adaptive interventions. In some cases, assistance patterns failed to align with critical moments in the pandemic. For example, the delays in the delivery of Gavi-funded personal protective equipment (PPE) to several countries, including Pakistan, reflected broader logistical and procedural bottlenecks. Supplies arrived in August and November 2020, months after peak demand during the early pandemic waves (European Health Group, 2022[20]).

While many interventions were timely, significant challenges emerged in addressing the scale and complexity of the crisis. Issues such as supply chain disruptions, uneven co-ordination among stakeholders, and the insufficient localisation of aid were all areas for improvement. Bureaucratic delays, such as prolonged approval processes for reprogramming requests, often hampered the timeliness of funding.

Other factors affecting flexibility and timeliness included:

- Administrative inefficiencies in partner organisations – including implementing organisations that were receiving funding.

- Delayed development of adaptable frameworks: The implementation of new adaptive funding mechanisms often lagged behind immediate needs.
- Fragmented governance structures: Disparate governance and decision-making structures across agencies undermined co-ordinated adaptability. For example, the uneven collaboration among regional development banks highlighted the challenges of aligning funding priorities across diverse institutional mandates. This fragmentation created delays and inefficiencies in reallocating resources to critical areas.
- Capacity constraints in recipient countries: In many cases, the ability to adapt funding was hindered by limited institutional and operational capacity in recipient contexts. For example, challenges in financial absorption and reallocation processes in countries such as Niger delayed the effective use of reprogrammed funds, despite their availability.

Managing duty of care and risks to staff well-being while striving for timeliness

The evaluation finds that the timely delivery of the crisis response came at a high cost in terms of human resources and staff well-being, including the mental health of staff in implementing and funding agencies, as well as local and government partners. Staff were asked to do much more across the board in response to the crisis, and many demonstrated exceptional dedication, while reporting heavy impacts on well-being.

Organisations faced the dual challenge of meeting duty of care obligations for staff, domestically and internationally, and continuing to deliver programmes and international assistance in response to existing and emerging needs. For example, a USAID study described how staff had to deal with both "the effects of the pandemic on their personal lives and the increased pace and overall intensity of work", concluding that staff needed surge capacity and mental health and psychosocial support (USAID, 2024[28]). Interviewees and internal after-action reviews provide numerous examples of exceptionally challenging circumstances including long separations from young children and other vulnerable family members, due to re-patriation or health restrictions.

Decisions by countries to evacuate development staff from many international postings, where in some cases strict travel restrictions prevented repatriation, hampered the ability of bilateral providers to deliver coherent responses with implementing partners and other development agencies (ICAI, 2021[29]; EBA, 2022[30]; Sida, 2021[31]; Ministry of Foreign Affairs of Finland, 2022[32]). Staff departures resulted in increased pressures on the remaining in-country staff. It also led to delays in decision making, hindered engagement with stakeholders in-country and increased reliance on virtual communication methods. Effective communication and co-ordination were challenging without staff on the ground. In contrast, international staff in Cabo Verde, Cambodia and Georgia who remained in post throughout 2020-2021 reported that their communication and co-ordination with both other international partners and country partners intensified (becoming more frequent and less formal, for instance communicating via Signal or WhatsApp rather than through regular in-person meetings), which in turn supported both speed and relevance.

As was the case for many countries, Czechia's Ministry of Foreign Affairs (MFA) took measures to ensure the safety and health of its staff, providing employees with protective equipment and adjusting working conditions. Moreover, the MFA also focused on the mental health of its employees by offering them psychological counselling (OECD/European Observatory on Health Systems and Policies, 2023[33]). Sweden established a Corona Team with oversight of human resources and a duty of care for its staff.

Finland's evaluation of its COVID-19 response found that, even though their initial response to the pandemic effectively prioritised safety and operational continuity, it fell short in fully safeguarding staff well-being over time. An internal survey conducted in March 2021 showed personnel well-being to be declining (from an average of 3.51 to 3.41 out of a possible score of five), with staff experiencing boredom, monotony and concerns about eroding collegiality, especially due to remote working and the move to a new premises.

Despite this, staff continued to push forward with notably the MFA's Employment Satisfaction Barometer during the same period showing an increase in overall satisfaction (rising from 3.74 to 3.81) particularly in management resilience (Ministry of Foreign Affairs of Finland, 2022[32]). This highlighted the need for improved crisis-level preparedness at headquarter (HQ) level, flexible redeployment strategies, continued monitoring of well-being and the retention of pandemic driven innovations and reforms.

An internal survey of International Monetary Fund (IMF) staff (Figure 6.1) revealed significant strains on employee well-being and work life balance due to the workload pressures and changes in the working environment, with the majority of respondents reporting extraordinary levels of stress and disruption in their personal lives. Fewer than half of respondents felt that IMF's reallocation of staff to the departments in greatest need was handled effectively and only 43% of respondents felt that the organisation had meaningfully adjusted relevant human resource (HR) policies and practices to mitigate excessive work-life pressures, highlighting a critical gap for the IMF (IEO/IMF, 2023[34]). Though comparable data are not available, based on interviews and other evaluations, these experiences appear to be typical of staff experiences across most international development agencies and organisations.

A process evaluation of the early crisis responses of Switzerland, Canada and Sweden in Bolivia, identifies useful elements related to staff management, including the interplay between country teams and headquarters, and the importance of open lines of communication with both international and local staff (Box 6.4).

Key drivers of successful crisis management were enabling flexible and context-specific decision making – especially by using local or country-based staff. Another important practice was revisiting expatriation (including for families) and staffing decisions promptly to avoid unnecessary separations and unsustainable workloads. Duty of care that integrated both mental health and material support with realistic workload adjustments that went beyond offering flexible remote work and included actively reducing excessive demands, were most effective in ensuring effective delivery during the crisis.

Box 6.4. Responding to the crisis in Bolivia: Experiences from Switzerland, Canada and Sweden

A process evaluation of three provider agencies (Swiss Agency for Development and Cooperation [SDC]; Global Affairs Canada [GAC]; and the Swedish International Development Cooperation Agency [Sida]) in Bolivia highlighted both commonalities and important differences in the initiatives undertaken to manage human resources and support staff well-being during the crisis. The evaluation found the three embassies "combined a strong headquarter focus on repatriation issues with an active and efficient engagement in the reprogramming process, even within the first months of the pandemic" (Schwensen et al., 2021[35]).

During the first weeks and months of the pandemic outbreak, agency headquarters and ministries of foreign affairs tended to manage staff repatriation using a "one size fits all" approach, with few exceptions. For example, both the Swiss and Swedish embassies faced delays and disputes due to rigid ministry instructions that did not adequately consider the different circumstances faced by local and expatriate employees. At times, these tensions revealed the inadequacy of existing decision-making structures to face a crisis of this scale, resulting in potential gaps in equitable duty of care provision that embassy management was tasked to fill.

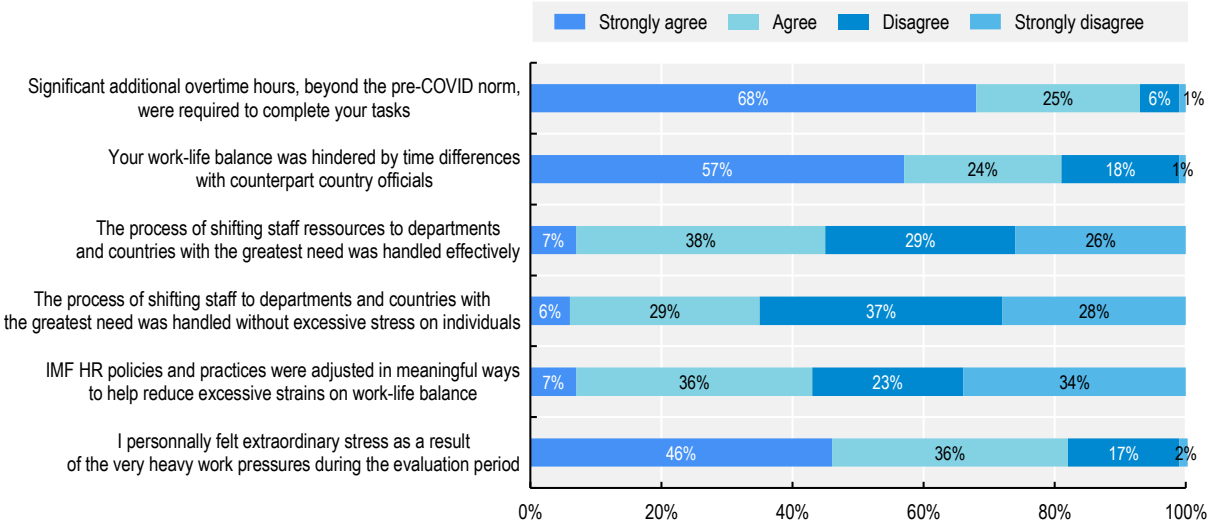
Ultimately, however, the Swiss, Swedish and Canadian embassies in Bolivia were all found to be highly flexible and responsive in their reprogramming processes. They identified practical solutions to managing the heavy workloads arising from both repatriation and reprogramming tasks and introduced different initiatives to increase staff well-being. Local staff were noted as being appreciative of the clear

decisions and communication from management, finding, for example, that maintaining regular routines and new spaces for virtual dialogue useful.

Regular staff surveys conducted by headquarters, the appointment of designated focal points, and virtual social and creative initiatives were also named as effective in providing a supportive work environment during the crisis. These efforts helped surface frustrations early so issues could be addressed and communication lines strengthened.

Source: Schwensen et al. (2021[35]), Process evaluation of three donor agencies' responses to the COVID-19 pandemic in Bolivia during the period March–December 2020, https://www.sida.se/en/about-sida/publications/process-evaluation-of-three-donor-agencies-responses-to-the-covid-19-pandemic-in-bolivia-during-the-period-march-december-2020.

Figure 6.1. Work-related strains and adequacy of IMF response



Note: Excludes the response "not applicable".
Source: IMF (2023[36]), The IMF's Emergency Response to the COVID-19 Pandemic, https://ieo.imf.org/en/Evaluations/Completed/2023-0313-imfs-emergency-response-to-the-covid-19-pandemic.

Managing corruption risks

The pandemic created widespread increases in corruption risk. By mid-2020, the International Monetary Fund, World Bank and Transparency International issued stark warnings about the emergent corruption risks of the pandemic (USAID, 2023[37]). Concern revolved around two drivers of corruption risk: a dramatic increase in public sector spending to respond to the pandemic and its socio-economic impacts; and the suspension or reduced capacity of various corruption detection, reporting and enforcement mechanisms due to lockdowns, other measures and the emergency context in general. The use of emergency procurement creates opportunities for the misuse of funds (IDEV, 2022[38]).

An evaluation of pandemic-related corruption risks noted that USAID health assistance was closely controlled to avoid risks of diversion or corruption, but that this often involved the creation of parallel systems and reduced efficiency and sustainability, notably having no or negative effects on long term systems capacity USAID (USAID, 2023[37]).

It was possible to deliver anti-corruption related assistance during the crisis in ways that were effective both in supporting host country government systems and reducing corruption risks. For example, USAID

health workers in Malawi, embedded within district health offices, identified financial risks created by government personnel shortages. As a result, USAID financed the hiring of auditors to work with the district councils in administering local health clinics. This suggests that such approaches to addressing corruption risks in health activities during emergencies are possible, even if not widespread.

A study by AfDB IDEV in Kenya found that there were 72 reports on the misuse of COVID-19-related funds reported since the outbreak of the pandemic. While the Government of Kenya established a fully operational multi-agency body to monitor COVID-19 expenditures, it has not acted against the public officials implicated in the misuse of the COVID-19 funds at the time of the evaluation. For example, the government's investigation revealed irregular expenditures totalling USD 78 million in the Kenya Medical Supplies Authority (KEMPSA) for which no action has been taken. Similarly, a special audit of COVID-19 funds, required by the loan agreement, has not yet been approved.

6.4. Cost effectiveness of development co-operation and the humanitarian response

The evaluation examined the extent to which the development co-operation and humanitarian assistance were cost effective. Although it was not possible to do a full cost-effectiveness assessment given the scope of the evaluation and the lack of necessary data, it finds that value for money informed decisions about what to support and how, both in terms of general strategies that tended to be principled and made on the basis of limited information – such as pooling funding to the United Nations or providing core funding to key international non-governmental organisations (INGOs) – and the smaller scale programmatic decisions taken later in 2020 and 2021, when more information was available.

Principled support to the multilateral system enabled efficiency while maintaining oversight of the use of funds. Assistance through multilaterals increased to USD 148 billion in 2020, USD 162 billion in 2021 and USD 153 billion in 2022. This reflected the increase of donor contributions to multilaterals as part of their response to the COVID-19 crisis. The IMF, the European Bank for Reconstruction and Development (EBRD) and Gavi saw significant funding increases. The unprecedented scale and speed of funding during the pandemic often outpaced monitoring and evaluation systems, limiting information on the efficacy of efforts to ensure that donor spending was both efficient and impactful (European Health Group, 2022[20]).

Development partners showed a commitment to using resources responsibly and cost-effectively, with some evidence showing that cost-effectiveness improved over time as interventions were adapted to the pandemic context. For example, the World Food Programme's (WFP) cash support programmes in Peru, a country severely impacted by the COVID-19 pandemic, showed increased cost effectiveness from 2020-2022. Investing in strengthening staff capacity in policy advocacy and specialised technical assistance enabled effective engagement with national government institutions and the private sector. This resulted in large-scale benefits such as the mobilisation of important domestic resources in key priority areas (WFP, 2022[39]). All countries struggled to procure high-quality medical equipment in the face of shortages and supply chain disruptions.

PPE was considered key in preventing COVID-19 transmission and protecting healthcare workers. However, the cost-effectiveness of assistance for PPE, such as masks and gloves, was quite mixed. In Bangladesh and Kenya, the COVID-19 response was bolstered by the rapid local production of PPE, which fostered self-reliance and sustainability in cost effective ways as well as building local capacity for future crises (OECD, 2025[15]; OECD/AfDB, 2025[8]). Interviewees in Cambodia, Cabo Verde and Bangladesh reported that donors including China, Japan and Korea provided helpful deliveries of PPE and other equipment, which was possible due to their domestic manufacturing capacities or supplies.

In some cases, in the face of the health emergency, a practical approach to quickly get supplies to where they were needed was prioritised without specific considerations of value-for-money. Based on interviews

and findings from evaluations, this seems to have particularly been the case for bilateral providers who prioritised highly visible and in-kind support, but less so for specialised UN agencies. Medical supplies and PPE were procured and delivered in expensive ways (e.g. shipped from provider countries to partner countries). National and local partners with relatively small budgets were at a disadvantage in procuring supplies (ALNAP, 2020[40]; Brubaker, Day and Huvé, 2021[41]). Furthermore, tying aid (i.e. using a provider's own companies or sources) undermined its cost-effectiveness in some contexts and reflected a prioritisation of political visibility over meeting needs.

Attention to cost effectiveness was demonstrated in some cases as donors targeted support to respond to immediate needs while also building long-term health infrastructure. Many of the facilities and systems that were donated and established for COVID-19 were later adapted to other health challenges, maximising value and resilience over time. For example, the integration of triage systems and guidelines into the healthcare framework, which allowed for the repurposing of facilities to handle non-pandemic health issues, such as Dengue, thus ensuring continued value beyond the initial crisis. Moreover, triage systems, healthcare guidelines and other infrastructure developed during the pandemic have since been integrated into healthcare systems, addressing broader health needs beyond the pandemic. In some cases, the use of digital tools also provided a cost-effective means for efficient implementation. For example, digital systems for vaccine registration and tracking increased efficiency and data accuracy, optimising resource allocation.

Economic analyses regarding the cost-effectiveness of global vaccination efforts during the pandemic are thus far mixed. Early research described the efforts to vaccinate the world as the highest return public investment ever made (Agarwal and Gopinath, 2021[42]), with health, domestic and global economic benefits that vastly exceeded the costs (ALNAP, 2020[40]; Castillo, 2021[43]). However, the efficiency of global allocations was undermined and other research questions the efficiency of pursuing mass COVID-19 vaccinations in low- and middle-income countries given the disease burden and the opportunity costs of resource diversion in achieving this (Bell et al., 2023[44]). In Kenya, the total economic cost of procurement and delivery of COVID-19 vaccines, per person vaccinated with two doses, was estimated to be between USD 29.70 to USD 24.68 for 30% and 100% population coverage respectively, which alone accounts for one-third of the current total annual health expenditure per capita (Orangi et al., 2022[45]; WHO, 2025[46])

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7 Learning from the COVID-19 crisis: Eight key lessons for international co-operation

This chapter identifies and consolidates lessons drawn from the analysis of the overall relevance, coherence, effectiveness and efficiency of international development and humanitarian response to the COVID-19 crisis from 2020-2022. These eight overarching lessons are aimed at ministries and development and humanitarian agencies – and other parts of national and local governments involved in international co-operation – as well as non-governmental organisations, UN organisations and international development banks, with the goal of increasing preparedness and strengthening effectiveness and efficiency in future crisis response efforts. The lessons cover ways of establishing partnerships and working – both before and during a crisis – to respond to emerging needs and ensure long-term resilience. Each general lesson includes a description of the issue and specific suggestions based on the analysis of the practices, policies and behaviours that contributed to more effective crisis responses. It ends with lessons on learning and evaluation.

The COVID-19 crisis triggered an unprecedented global response, bringing together communities, governments, international organisations and development agencies to mobilise, co-ordinate and deploy resources. In many ways, the crisis showed the potential of international co-operation and assistance to combine political decisiveness and technical know-how to respond at speed and scale to reduce human suffering. The analysis presented here also shows that co-operation too often falls short of this promise, and cannot, on its own, compensate for broader failings in international crisis management. There is an urgent need to learn from past failings and scale up best practices.

This chapter outlines eight lessons for development co-operation partners, including providers, implementers, technical partners, governments and communities operating in future crises, as well as improving the efficiency and impact of development co-operation generally. The lessons can be relevant for various international public actions, including advocacy and technical co-operation, as well as work with the private sector. Reflections from partners involved in this exercise have highlighted how these findings may resonate with efforts to improve international co-operation in other areas, including work to combat the climate crisis, which also requires fast and ambitious action at scale.

Lessons were identified through country visits, interviews, document review and an evaluation synthesis, and case studies. Where these lessons were common across multiple sources, a key lesson was developed and refined during learning events in 2025. The lessons focus on generally applicable insights and should be read in tandem with more specific lessons from other evaluations. By understanding and integrating these lessons, the international development community can better prepare for future challenges and strengthen capacities to support the most vulnerable populations worldwide.

Key lessons include the importance of incentivising early action, managing uncertainty, and forming effective partnerships. These lessons highlight how to ensure limited resources are put to best use and underscore the need for international co-operation to work hand in glove with effective country systems (national and local). A successful emergency response – globally and nationally – requires leadership and effective communication across all partners. Future responses must consider the COVID-19 lesson that reacting quickly and flexibly is no substitute for being well prepared with established co-ordination mechanisms and basic planning elements such as capacity assessments in health systems.

7.1. Overall reflections on responding effectively to a global crisis

In 2020, development and humanitarian actors – and the governments and communities they aim to support – were faced with an unprecedented crisis that affected every country and served as a reminder of the interconnectedness between communities and across policy areas. In addition to intensive work to keep existing programmes and projects running – and adjust them to the rapidly changing crisis – the COVID-19 crisis response involved targeted co-operation around preventing infection, disease and death; addressing the economic and social implications of the pandemic and related containment policies; and supporting long-term needs, including strengthening health systems.

The urgency created by the crisis appears to have been a catalyst, enabling flexibility and a “get it done” attitude that drove speed, streamlined certain bureaucratic processes and sharpened focus on what really matters. Development and humanitarian institutions had to balance the requirement to respond swiftly amid high uncertainty, while considering the different mandates, capacities and accountabilities of various stakeholders within the international community. There was a need to balance the ease of working through established partnerships and existing systems and mechanisms with responding to new needs – a balance which many struggled to find.

The evaluation found that many development actors made mistakes that could have been avoided and quickly reverted to old ways, missing the opportunity to transform some of the effective temporary measures into permanent arrangements. Despite many successful individual and joint efforts, geo-political

considerations often outweighed evidence on needs and potential impact, undermining relevance, coherence, effectiveness and efficiency. Incoherence across policy instruments and the lack of robust co-ordination mechanisms to drive resource allocations – including vaccines – was inefficient. Preparedness, including investment in prevention and sound public health systems, was insufficient, undermining the potential for effective action once the crisis broke out.

7.2. Eight lessons from the pandemic response

This section summarises the key lessons for development and humanitarian assistance drawn from the evaluation. Each lesson (summarised in Box 7.1) is accompanied by a brief descriptive paragraph and supportive evidence to help operationalise the lesson.

Box 7.1. Eight lessons for international development co-operation and humanitarian assistance

1. Within development agencies, develop crisis response plans and strategies that **support rapid decision making and co-ordination** across all parts of government – and with partners.
2. Fund quickly in line with **known best practices**, while using available evidence to identify emerging needs (including of vulnerable populations) and **building learning into the crisis response** to manage changing priorities and adjust strategies as needed.
3. Build on **established partnerships** with governments and multilateral institutions to enable rapid deployment of large-scale financial resources, enhancing timeliness, efficiency and effectiveness.
4. Ensure **co-ordination mechanisms and agreements** between funding, implementing and national partners **are in place** in advance of a crisis. Such agreements should enable rapid adjustment of existing programmes, support joint analyses, and facilitate the deployment of funding quickly for the most likely needs and priorities.
5. Align the appropriate financial instruments for crisis response **to country-specific needs and contexts** and prioritise the use of cost-effective tools such as cash transfers and budget support to scale up relevant support to meet these needs.
6. Systematically invest in and **integrate social support systems into national** crisis response plans. At country-level, avoid creating parallel or one-off systems (including oversight mechanisms) and instead fund with the longer term in mind, using the crisis context to strengthen and scale up national health and social protection systems, and increase reach.
7. Strengthen in advance and **prioritise funding through the multilateral system** – while avoiding duplicative bilateral actions – for a co-ordinated, flexible response. Leverage benefits of unearmarked and pooled funding.
8. **Work across government to address incoherent policy actions** that undermine development and humanitarian goals. Reconsider **how national interest is framed and implemented** to ensure that perceived protection of national interest in the short term does not ultimately undermine outcomes for all.

Lesson 1. Managing internal co-ordination and preparedness

Being better prepared for the next global pandemic is essential. Development agencies and ministries need crisis response plans and strategies that support rapid decision making and co-ordination across all parts of government – and with partners. Internal co-ordination mechanisms, including established or new crisis response units with transversal mandates, were crucial for effective communication and

implementing a coherent and quick crisis response. Planning needs to be both adequate and targeted (preparing for realistic threats). Intergovernmental mechanisms – with sufficient clout and clearly defined roles – can play a critical convening role across government. Another key factor was having sufficient political-level support, for example being led by the Prime Minister's Office or mandated by Cabinet. Crisis mechanisms need to support flexibility and investment in ongoing learning and feedback loops.

In contrast, several providers found that different collaborating ministries were guided by different priorities. Combined with occasional ad hoc political decision making, this resulted in strategic uncertainty and incoherence. The internal mechanisms put in place to co-ordinate the response to COVID-19 demonstrated that with strong political commitment, multisectoral responses can be effective, though it is not clear if such approach can be sustained to address more long-term challenges such as poverty.

To ensure better crisis response in the future, it is essential to:

- Establish a specific office or team responsible for institutionally anchoring crisis response programmes and co-ordinating across government, including making decisions, deploying resources, and incorporating and disseminating insights gained from internal and external learning.
- Work across government to act as one in international fora, regional bodies and bilateral relationships.
- Ensure crisis plans give clear guidance on roles, partnerships, channels and co-ordination mechanisms.
- Establish context appropriate staffing models that prioritise local knowledge and know-how and create capacity for continuity and relationships.
- Prepare and plan for managing human resources to enable programme continuity.
- Communicate with and support staff, partners and contractors and address any direct impacts of the crisis on their well-being effectively and thoughtfully, adapting to individual needs and local conditions as they change over time.

Lesson 2. Using evidence and strengthening learning

In the early days of the crisis, there was a clear need to act quickly while ensuring sufficient flexibility to adjust responses as more information becomes available and priorities change. This involved funding quickly in line with known best practices. It also required using available evidence to identify emerging needs, including of vulnerable populations and those particularly at risk in a particular crisis context (such as elderly and immunocompromised people during the COVID-19 pandemic).

Overall, the collective effort showed the need to improve allocation decisions, to provide funding where it is both needed and can make a difference, not just where it is politically expedient. This involves prioritising speed with a "no regrets" funding approach, based on available information (including using evidence from previous experiences and imperfect emerging evidence), combined with proactive learning to adjust as new information arrives. Finding the right balance between strategic planning, timely action and robust monitoring can lead to more relevant, accountable, efficient and impactful responses in future crises.

The pandemic provided useful lessons on the value of carrying out needs assessments using a common framework and involving all relevant partners. These needs assessments and related country planning mechanisms provided useful as ways of focusing and prioritising as well as aligning co-ordinated efforts. UN partners, civil society groups, and national stakeholders also used them effectively to raise attention to and advocate for the needs of vulnerable groups.

Capacities to respond effectively to health emergencies and other crises are not only a question of funding but also require more effective exchange of evidence and learning across countries of all income groups. The risks of knowledge loss following a crisis is high. More systematic approaches to documenting and compiling lessons as a crisis unfolds could enable more effective and efficient support. While many actors

invested in learning and evaluation – including by supporting the COVID-19 Global Evaluation Coalition – there were missed opportunities to draw on lessons from past crises and to capture lessons as they were learned.

To better target international assistance and ensure more effective support:

- Be both adaptable and flexible and build learning into the crisis response to manage changing priorities and adjust strategies as needed. Invest in ongoing learning and course correction to match the right type of support to each context, including managing trade-offs between competing priorities.
- Use multi-phase country-level response plans that both immediate crisis-related needs while maintaining a long-term view and allowing for flexibility as more information becomes available.
- Co-ordinate investment in needs assessments and scenario planning to guide action. Avoid duplicative efforts and support co-ordination, by borrowing or building on other needs assessments (or agreeing to a single crisis assessment that can be used by all partners).
- Set out feasible approaches to monitoring and reporting in crisis response plans. Clearly define responsibilities for planning, management, and evaluation, including integrating monitoring and evaluation approaches and joint scenario analysis from the onset, ensuring they are easy for partners to implement.
- Work to break down silos to capture and share regionally and globally to inform overall crisis-response, as was done with some of the medical elements of the pandemic response.
- Improve the quality and availability of data, particularly results data, which remains limited, and address gaps in data collection on vulnerable groups to enhance the assessment of response effectiveness.

Lesson 3. Working through existing partners and meeting emerging needs

Particularly in the initial phase, a barrier to acting quickly was the time taken to put in place measures or facilities to respond to the pandemic. What worked better was using already established mechanisms – such as emergency funds and co-operation platforms to allow crisis responses to be “slotted in” to existing arrangements.

Building on established partnerships with governments and multilateral institutions were critical to enable rapid deployment of large-scale financial resources, enhancing timeliness, efficiency and effectiveness. Relationships established over years or even decades build confidence between partners. These can be drawn upon during a crisis to overcome barriers and move resources quickly. Making new funding available to existing partners and allowing no-cost extensions or other emergency programme adjustments, provides much needed flexibility to adjust to changes in local conditions (including containment measures).

Emergency declarations related to the pandemic allowed for pragmatic actions, and working around barriers by, for example, streamlining approvals and reducing reporting requirements – both for existing partners and to allow new partners to receive support. In most cases, it was most effective for providers to maintain attention on their existing strategic development co-operation priorities (sectors, policy areas, geographies and target populations), and focus on adjusting ongoing programmes to the crisis, rather than trying to move into new thematic areas or geographies during the crisis. This can involve drawing on established networks and knowledge of local contexts to determine what adjustments in current programming could be made in the immediate term and working with other providers and partners to identify gaps or new needs that are not met through current partnerships.

However, the benefits of staying the course with existing partners must be weighed against addressing crisis-specific needs in different contexts. The approach to funding decisions varied widely, but in many cases was largely driven by geopolitical considerations or historical partnerships and insufficiently informed

by evidence on vulnerability and potential impact. More work is needed to look at the articulation between humanitarian and development streams, which are often operate through distinct channels and institutions, limited the opportunities for flexibility between them.

The evaluation found that capacity was limited to respond to the needs of people who were more vulnerable to the virus itself (the elderly and immunocompromised), and those who were not already targeted in development projects. Future crisis response can work to identify ways to add additional target groups or and adjust existing mechanisms for reaching vulnerable groups to be expanded if needed as new vulnerabilities emerge in a specific context.

Effective partnering for crisis response includes the need to:

- Embed crisis response measures in existing projects and partnerships to enable an efficient crisis response, particularly when looking to deploy large scale funding quickly. This could include contingency lines or emergency funds in budgets, or an option for allowing shifting funding and activities between programme objectives if required.
- Find ways to target those most in need by balancing pre-existing relationships between donors and recipients with evidence-informed and needs-based considerations, as well as options to extend or expand rapid or emergency-response programming as needs change. While relying on existing partners, be careful not to overlook needs and equity implications – and find other ways (including multilateral channels and co-ordination with other providers) to ensure application of the "leaving no one behind" principle.
- Identify newly vulnerable populations and emerging needs which may be less readily identified and harder to meet through existing (or adjusted) programmes.
- Support government efforts – including through technical assistance and knowledge exchange – to establish effective social protection systems that take vulnerabilities into account.
- Explore mechanisms to co-ordinate funding allocations globally (across providers and between countries) to drive greater fairness. The experience with COVAX shows that such mechanisms can work, provided they are sufficiently funded, and bilateral actions align with the joined-up approach.

Lesson 4. Preparing for a co-ordinated, rapid crisis response

Fragmentation and lack of co-ordination have long been flagged as weaknesses in international assistance and a consistent challenge within the global health landscape. Thus, many development actors recognised early in the pandemic that the scale of the crisis would require concerted and improved co-ordination.

Country ownership remains a core tenet of effective development co-operation – a principle that the COVID-19 experience reinforced. Experiences from many countries showed the value of a strong government-led co-ordinating body that both steers the national response and provides a mechanism for co-ordination of international partners. Local actors also play critical roles in delivery and responsiveness. Established or new internal co-ordination mechanisms and crisis response units with transversal mandates helped drive effective communication and rapid decision making. Such entities play a key role for a coherent and quick crisis response while ensuring some level of continuity in core government and health services.

The evaluation shows that the response was more coherent when systems, mechanisms and plans were already in place before the crisis. Co-ordination was most effective in contexts where development and humanitarian actors were already working together with the national government. Where frameworks from past crises, such as in Burkina Faso, Cambodia, Lebanon and Nicaragua, were applied, the effectiveness of the response improved.

Local CSOs, despite playing a crucial role in the response, were often excluded from decision making and co-ordination processes and at times underutilised for reaching impacted populations. Those development

partners that already relied on local and international CSOs were able to use them in the COVID crisis to understand the local impacts of the pandemic and quickly adapt to emerging needs.

The COVID experience also showed that in cases where a government is unwilling or unable to mount an effective response, or is taking measures with which external partners disagree, there is still a role for development partners as trusted advisors, advocates, supporters of civil society and as funders for other institutions – including UN agencies – that may be able to work around and through political barriers to deliver humanitarian and other types of support.

To position themselves to co-ordinate and act quickly:

- Quickly identify suitable existing co-ordination mechanisms – or establish a fit-for-purpose mechanism – with government, UN country teams (UNCTs), funders, technical experts and other stakeholders, and position the national government to steer and provide strong political leadership.
- Involve affected people (if not in the mechanism itself than through representative entities).
- Commit to using co-ordination mechanisms and work together around shared goals and plans, avoiding as much as possible the creation of parallel systems and structures.
- Map possibilities for rapid funding of CSOs, especially local organisations, and identify in advance the funding channels through which these organisations can be reached.
- Find ways to offer guidance and technical suggestions without overstepping local and national authorities' decision making. Make sure that these are resilient to function without the presence of expatriate staff from international partners.

Lesson 5. Aligning funding types with country contexts

The COVID crisis response shows the importance of international development finance using the appropriate financial instruments for country-specific needs and contexts. The use of cost-effective tools including cash transfers and budget support was effective to scale up relevant support to meet these needs. Evidence highlights the importance of having a flexible toolkit of response mechanisms that can be deployed relatively quickly. Greater delegated financial authority in partner countries was useful in this regard.

Knowing which financial instruments and forms of assistance to use in a given context – and understanding the trade-offs involved – is key to an effective and sustainable response. There is no one type of funding that is inherently “good” or “bad” – the role of public sector finance, private sector mobilisation, in-kind aid and other instruments depends on the purpose, timing and funded entities involved. Responses must be tailored to each socioeconomic context.

Cash transfers can also be an effective modality of support in both humanitarian and development settings and were widely used during the pandemic to respond to a range of needs.

Budget support increased markedly during the pandemic and demonstrated value as an effective tool for quickly deploying relevant support to countries, offering flexible funding that empowered recipient governments to determine their own priorities based on needs. This worked effectively when it topped-up existing budget support mechanisms. In the right setting, using budget support is efficient and effective, and can allow the scaling up of social protection or conditional cash transfer mechanisms, a speedy way of getting assistance to those who need it. Budget support had important secondary effects as well, including reinforcing more equitable partnerships and strengthened national systems, which are critical to long term development. Using such modalities ensured more relevant responses as they allowed for some degree of flexibility to changing needs, particularly in a context of high uncertainty. The use of budget support and similar funding mechanisms have decreased since the end of the pandemic.

In-kind support also played a role in the COVID response efforts. The global shortages of health equipment also underscored the importance of investing in preparedness and pre-positioning essential supplies for a more timely and cost-effective response. While nearly every provider studied provided in-kind donations of masks, gloves, testing kits and other supplies, there seems to have been very little co-ordination of these efforts and an over-emphasis on high-visibility bilateral support. This resulted in unnecessary waste and inefficiency. Several countries reported a skewing or redirecting of funding to high-visibility supplies. Furthermore, in adjusting to local contexts, there was a challenge in balancing immediate pandemic needs with longer term priorities, including climate resilience and governance reform efforts, which were put on hold in many countries.

To maximise the positive impacts of funding in different country contexts:

- Improve resilience to future crises by removing barriers to providing unearmarked funds and create smooth pathways for budget support during crises.
- Match finance modalities to contextual factors including a country's debt burden and capacity to absorb financial support, fragility and conflict, and the political environment.
- In countries with strong public financial management, use budget support to get funding to those in need quickly and sustainably.
- Prioritise cash-based assistance over in-kind assistance, and when providing in-kind support look for ways to ensure efficiency and sustainability.
- Use civil society organisations (CSOs) and local non-profit groups to provide context-responsive support to impacted communities, including with a focus on reaching marginalised people.
- Work together to communicate openly and consistently with impacted communities about the crisis and response measures. Ensure clear messaging is delivered via trusted actors, and be sensitive to broader inequalities and power dynamics, which can influence access to information.

Lesson 6. Investing in and using national systems

Across the board, the crisis shone a spotlight on the need to systematically invest in and integrate health and social support systems into national crisis response plans. There were many examples of countries using the crisis context to strengthen, add on to or scale up national health and social protection systems and increase reach. Unfortunately, there were also plenty of cases where international funders created parallel or one-off systems (including oversight mechanisms), which may reduce short-term corruption risks but ultimately weakens national capacities and risks undermining public trust.

Reducing inequalities in health, economic and social contexts, while addressing vulnerability, is not only desirable, but crucial to lessening the impact of a future pandemic for all. Despite challenges in managing competing priorities, governments and development partners were largely successful in adjusting the implementation of programmes and meeting the changing needs of target groups with whom they were already working (e.g. women and girls).

Funding for the health sector – and other social sectors, including education – remains inadequate and under-prioritised, despite the clear evidence even before the COVID pandemic that investment in health was needed to build resilience and preparedness for future pandemics, and that many of the Sustainable Development Goal (SDGs) targets linked to health will not be attained. During the crisis, health funding commitments increased by 73% from 2019 to 2020 (USD 49 billion), reaching a record high in 2022 of USD 59 billion (OECD). By 2022, however, funding to health and social sector spending began to decline.

There were some positive examples of capacity building and workforce development, with international assistance being used for both the recruiting and training of healthcare workers in infection prevention control, diagnostics and case management. The strengthening of health information systems through, for

example, the digitalisation and standardisation of health-related data collection and analysis comprised another part of development co-operation support for health systems that goes beyond the initial response.

The pandemic exposed significant gaps in social protection systems, particularly for those operating outside formal employment structures but also resulted in scaling up and expanding social protection in many contexts. Traditional vulnerability assessments and targeting mechanisms proved inadequate for capturing these emerging vulnerabilities, resulting in delayed and insufficient responses that exacerbated economic insecurity and deepened inequality across affected communities.

Provision of supplies and investments in diagnostic, testing or treatment infrastructure that could be sustained and contribute to the longer-term strengthening of the health systems proved particularly useful and cost-effective. External support for digitalisation processes, including for service delivery mechanisms, social protection, child welfare and critical health services were also successful. Embedding inclusivity into preparedness and response systems was also important for enabling more effective and coherent action. These must be backed up by structures and capacities and mandates to ensure operationalisation.

To prepare for and respond better to future crises:

- Embed crisis response mechanisms into long-term systems to ensure that the response supports – rather than undermines - structural reform.
- International partners should avoid setting up parallel or one-off systems (including oversight mechanisms) to manage programmes that they fund – such as social protection and health system capacity building projects.
- Fund with the longer term in mind, using the crisis context to strengthen and scale up national health and social protection systems, and increase reach.
- In advance of crisis, implement systems for innovation, in particular for digitalisation, which can drive a successful response. During a crisis, work to systematically identify and share promising innovations.
- Use cash transfers and provision of public services for free or at reduced rates to provide blanket support when large parts of the population are in-need during a crisis.
- Preposition medical and humanitarian supplies and cultivate local production sources where appropriate to support quick action to reach households when supply chains are disrupted.
- Invest in improving health systems over time and in ways that support global pandemic preparedness and response goals, as well as national priorities.
- Systematically embed inclusivity, gender equality, human rights, and the principle of leaving no one behind into the design, delivery, monitoring, and financing of preparedness and response systems.

Lesson 7. Strengthening and using the multilateral system

Multilateral channels have many benefits in terms of effectiveness, timeliness and coherence in implementing responses in partner countries. The allocation of resources from and through multilateral actors played a crucial role in shaping fast, coherent and adaptable responses to the COVID-19 pandemic. Bilateral providers relied on the multilateral system and provided core and unearmarked funding for these organisations, contributing to their aim of a coherent nexus response. Providers can usefully adopt this approach in “normal” times, right-sizing the requirements on financial compliance and results monitoring and reporting to manage risks and add value (for learning or accountability) without creating unnecessary burdens.

The crisis showed clearly the importance of investing in the multilateral system as a kind of global insurance to ensure that there is a rapidly usable backbone to support global action when needed. The multilateral system, in particular UN agencies, was key in scaling up co-ordination mechanisms across development

actors, to address the health, socio-economic and humanitarian impacts of the crisis. In total, DAC members provided USD 94 billion to the multilateral system between 2020-2022 (OECD, 2025[1]).

Pooling funding worked well, especially when it was used instead of and not in addition to separate funding channels or existing funding mechanisms. Multistage and core support enable flexibility in the response to an evolving crisis; whereas response programmes that had a short-term and narrow crisis scope lacked sufficient flexibility to meet changing priorities. Earmarked funding should be time-bound and subject to reflection once the crisis has passed to ensure that shifts in or broadening of mandates are intentional and do not contribute to broader fragmentation of the multilateral system.

To support more effective global crisis response:

- Quickly provide unearmarked funding to enable development and humanitarian actors – including implementing agencies – to respond with flexibility and timeliness.
- Use pooling mechanisms to make sufficient resources available for the crisis response, topping up existing pooling funds if possible, or using existing co-ordination platforms to manage new funds.
- At the country level, establish capacities and a clear structure for joint planning and programming.
- Invest in multilateral institutions to ensure they have sufficient capacity, clear mandates and political support to provide necessary leadership, technical guidance and co-ordination.

Lesson 8. Addressing incoherence across policy goals

In a crisis that impacted all, an approach focused on global solidarity and mutually-beneficial assistance was important for garnering support. There were positive examples of aligning national interest with the global public good of responding to the pandemic everywhere and for everyone. The novelty of the virus itself, as well as the sheer global scale and speed of the impacts of COVID-19 meant that decisions were made imperfectly, and that, countries and their development and humanitarian actors had to make trade-offs and difficult decisions. For high income countries, the pandemic impacted on their own populations, and their own health systems and economies were significantly tested. There was, thus, a need to balance the development and humanitarian response with domestic needs and capacity.

International assistance can be complemented – or on the contrary, undermined – by other policy actions by the same governments. Despite many successful individual and joint efforts, actions of provider countries in pursuit of other goals and geo-political considerations often outweighed evidence on needs and potential impact, undermining relevance, coherence, effectiveness and efficiency of international co-operation during the crisis.

The unequal vaccination rates across countries highlighted both the potential of international co-operation and its pitfalls, including the need for a more strategic, holistically joined-up approach using multilateral institutions to ensure equitable distribution. While COVAX and bilateral vaccine donations improved access for low- and middle-income countries and supplied tens of millions of doses, purchase agreements by higher-income countries limited the vaccine supply available to COVAX and ad hoc bilateral distribution undermined the strategic allocation mechanism. Such incoherence in the actions of countries providing development assistance – including procuring doses beyond what their populations required – were at odds with and ultimately undermined the multilateral efforts.

Aligning national policies with humanitarian and development-related objectives accelerates positive dynamics– enhancing efficiency and effectiveness. Policies including commercial interests and intellectual property, border control and migration, asylum and refugee rights, trade and investment, tax, intellectual property, agriculture and fisheries are just some of the areas with critical cross-border impacts.

Political decisions were sometimes poorly aligned with technical co-ordination efforts. In the crisis context, recipient countries found it difficult to decline offers of support – even when those offers were not well-suited to local needs. Future crisis response efforts should aim to better align decision making at all levels.

To address these challenges, providers and partners should:

- Develop tools to better understand the impacts of policy decisions on developing countries.
- Work across government to address incoherent policy actions that undermine development and humanitarian goals.
- Align policy instruments with strategic priorities in long-term national interests. Reconsider how national interest is framed and implemented to ensure that perceived protection of national interest in the short term does not ultimately undermine outcomes for all.
- Work to align bilateral efforts with multilateral co-ordination mechanisms and minimise the extent to which allocations are made unilaterally or driven by donor priorities to the detriment of other considerations including efficiency and coherence.
- Build on the effective work done in rolling out COVID-19 vaccines, especially in supporting national capacities and addressing misinformation, and address vaccine nationalism, procurement and vaccine hoarding, optimal global outcomes will remain out of reach.
- Advocate for equitable access to vaccines, treatments and other needed supplies, and align national procurement strategies to global equity goals.

7.3. Lessons on evaluation, learning and collaboration

Lessons about learning across international development actors have also emerged from this project. The COVID-19 crisis presented many challenges for evaluation – both those working on international co-operation and those supporting national governments in responding to the pandemic. The crisis revealed weaknesses in how evidence is used and communicated. In a context of high uncertainty and rampant disinformation, the role of evidence in informing effective public policies was brought to the fore.

Evidence-based decision-making in an evolving context called for rapid assessments and actionable, timely findings. Evaluators responded by developing and using more real-time and decision maker-oriented approaches that were more closely integrated with programme and funding processes. Evaluators are working to identify challenges and benefits of these approaches and their applicability beyond crisis response as a complementary tool to other types of evaluation.

In addition to the responses of individual evaluation units and networks, the COVID-19 Global Evaluation Coalition emerged as an innovative approach. The Coalition built off previous collaborations including drawing inspiration from the set-up of the Tsunami Evaluation Coalition and the work of the Evaluation of the Implementation of the Paris Declaration Phase 2 in combining donor case studies and country-led partner case studies. It brought together evaluators from across the international development and humanitarian sectors, to co-ordinate and accelerate learning.

The strengths of the approach of the COVID-19 Global Evaluation Coalition included increasing the speed and relevance of evaluative analysis, reducing transaction costs, increasing influence by bringing together partners. Support for country-led evaluations and co-ordination of thematic studies and methodological work across the global evaluation community proved highly valuable. The model of this strategic joint evaluation – a global evaluation looking at overall outcomes – could be further refined and adopted for other topics. Particularly important are lessons about how to accelerate learning by generating evaluations around common questions, and ways to strengthen national ownership through country-led evaluations.

7.4. Future considerations for humanitarian and development co-operation

In addition to the moral imperative to save lives in the future and relieve suffering, there are incentives for all countries to more effectively prevent and respond to global crises. More effective co-operation can improve outcomes for all – both in global health emergencies, and for co-operation to address broader sustainable development goals.

The importance of future planning and pandemic preparedness cannot be understated. However, this needs to be reconciled with the reality that that development and humanitarian co-operation budgets are becoming increasingly constrained. The World Bank and the World Health Organization (WHO) estimate that an additional USD 10.5 billion per year in international financing will be required to fund a fit-for purpose pandemic preparedness and response architecture, with most gaps found in low-income countries and lower-middle-income countries (WHO/World Bank, 2022[2]).

There have been positive moves since the pandemic to support pandemic response in the future:

- The development of a pandemic preparedness and response accord by WHO Member States is a positive step in helping ensure communities, governments and all sectors of society are better prepared and protected in the event of a future pandemic (WHO, 2025[3]). However, there have been delays in reaching an agreement.
- The creation of the Pandemic Fund, a multilateral financing mechanism dedicated to strengthening critical pandemic prevention, preparedness and response capacities, and capabilities of low- and middle-income countries, is also a positive step forward in ensuring readiness and the availability of funds when required by the next pandemic (The Pandemic Fund, 2024[4]).

Looking to future crises, transparent needs assessment frameworks – coupled with dedicated emergency funding windows accessible to all affected countries, regardless of existing relationships – that serve an overall steering function for allocation decisions, are essential to upholding the fundamental humanitarian principle that aid should reach those most in need and that health and life have the right to be protected.

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Annex A. COVID-19 Global Evaluation Coalition

The COVID-19 Global Evaluation Coalition is an independent collaborative project. The Coalition is made up of country development evaluation units, UN agencies and multilateral organisations. The Coalition provides credible evidence to inform international co-operation supporting non-clinical responses to and recovery from the COVID-19 pandemic in developing countries - helping to ensure that lessons are learned and that the global development community delivers on its promises. The Coalition will support and communicate both individual participants' evaluations, and joint work involving multiple participants. This collaborative approach will maximise synergies and learning, while reducing duplication of effort in evaluating different elements of the COVID-19 pandemic response.

Participants and steering group

The Coalition is made up of the central, independent evaluation units (or other suitable research or accountability entity) from 35 countries (both OECD members and other countries) and multilateral institutions. The role of Coalition participants is to provide input and data, such as information on the COVID-19 response of their respective institutions; monitoring, evaluation and results data; and evaluation findings. Participants are expected to provide timely feedback on Coalition work and to support quality by reviewing draft reports. Participants take the lead in linking with evaluation users/audiences, identifying learning and accountability needs to ensure policy relevance. Likewise, they are expected to collaborate, sharing information and adjusting work plans to increase coherence.

Table A.1. Participants in the COVID-19 Global Evaluation Coalition and Core Group

International Organisations	Countries
African Development Bank	Australia
ALNAP	Bangladesh
Asian Development Bank	Belgium
Asian Infrastructure Investment Bank	Benin
CABEI	Burkina Faso
CEPI	Cambodia
Council of Europe	Canada
European Bank for Reconstruction and Development (EBRD)	Cabo Verde
FAO	Colombia
GAVI	Czechia
Global Environment Facility (GEF)	Denmark
IADB	European Commission
ILO	Finland
IMF	France
International Federation of Red Cross and Red Crescent Societies (IFRC)	Gabon
IOM	Germany
Islamic Development Bank	Ghana
New Development Bank (NDB)	Iceland
OHCHR	Ireland
UNESCO	Italy
UNDP	Japan
UNFPA	Luxembourg

International Organisations	Countries
UNICEF	Malawi
UNIDO	Mexico
UNOCT	Netherlands
UN ECA	New Zealand
UN Women	Norway
UNHCR	South Africa
WFP	Spain
World Bank Independent Evaluation Group	Sweden
WHO	Switzerland
	Togo
	Uganda
	United Kingdom
	United States

Table A.2. Steering Group of the Strategic Joint Evaluation

Name	Country or International Organisation
Winston ALLEN	Agency Evaluation Officer, Bureau for Policy, Planning and Learning, USAID
Kevin ANDREWS	Foreign, Commonwealth and Development Office (FCDO), UK
Angelina BAZUGBA	Director, National Transformational Leadership Institute, University of Juba, South Sudan
Eva Jakobsen BROEGAARD	Chief Adviser - Evaluation, Learning & Quality, Ministry of Foreign Affairs of Denmark
Alexandra CHAMBEL and Michael OHIARLAITHE	Senior Evaluation Officer, WFP
Jenny GOLD and Stephen PORTER	Senior Evaluation Officer, World Bank
Ivo HOOGHE	Evaluation Coordinator, Special Evaluation Office, Belgium
Richard JONES	Senior Evaluation Advisor, UNDP
Frank KIRWAN, Patrick EMPEY, and Siobhán MCGEE	Development Specialist, Evaluation and Audit Unit, Department of Foreign Affairs, Ireland
Ida LINDKVIST	Senior Advisor, NORAD
Timothy LUBANGA	Office of the Prime Minister, Uganda (TBC)
David MAKHADO	Chief Director for Research and Knowledge Management, Department of Planning Monitoring and Evaluation, South Africa
Isabelle MERCIER	Director, Evaluation, Global Affairs Canada
Leslie MORELAND	Senior Programme Officer, Gavi
Nana OPARE DJAN	Director General, Monitoring and Evaluation Division, National Development Planning Commission, Ghana
Amélie zu Eulenburg	DEval, Germany
Magdalena Orth	DEval, Germany
Cornelia Römling	DEval, Germany
Anna Lorenza PIGAZZINI	European Commission
Ilona Mattila, Sanna PULKKINEN	Senior Evaluation Specialist, Ministry for Foreign Affairs of Finland
Véronique SALZE-LOZAC'H	Chief Evaluator, European Bank for Reconstruction and Development (EBRD)
Anand SIVASANKARA KURUP and Riccardo POLASTRO	Evaluation Officer, World Health Organization (WHO)
Carlos TARAZONA	Senior Evaluation Officer, Food and Agriculture Organization (FAO)
Albert TUYISHIME	Medical doctor, Head of HIV/AIDS, Diseases Prevention and Control Department, Rwanda Biomedical
Patricia VIDAL	Evaluation Officer, International Labour Organization (ILO)
Ndadilnasiya Endie WAZIRI	National Coordinator, African Field Epidemiology Network, Nigeria

Annex B. Methodology

Scope of the evaluation

The evaluation assesses the collective international development and humanitarian assistance response in official development assistance (ODA) eligible countries, covering the period 1 January 2020 to 31 December 2022, the main phase of the pandemic response. The term "collective response" is used throughout this report to refer to the entirety of actions undertaken by development and humanitarian actors including bilateral development agencies (hereafter referred to as "bilateral providers") – both DAC members and others – United Nations agencies, multilateral institutions and non-governmental actors, in responding to the COVID-19 pandemic in partner countries.

Its scope includes all development and humanitarian co-operation including ODA (i.e. grants and concessional loans) and other official flows (i.e. non-concessional loans and financing) that were provided, including bilateral and triangular co-operation, in-kind support and other concessional finance, to create a full picture of the response. There are three broad categories of assistance considered within the scope of this evaluation: 1) all existing assistance prior to the pandemic; 2) new COVID-19-specific funding during the pandemic; and 3) all assistance during the pandemic including non-COVID-19-related.

Trends related to development assistance prior to and after the COVID-19 pandemic are analysed using official development finance (ODF) data (i.e. total funding including ODA and other official flows), from 2016-2023, along with data on private flows available in the OECD's Creditor Reporting System (CRS), as ODF gives a more complete picture, particularly at country level. All trends in ODA from 2020-2022 are considered to be related to or influenced by the COVID-19 pandemic and are therefore relevant to this study. ODA specifically tagged as COVID-19-related in the CRS database is used in case studies and in sector flows to highlight differences between COVID-19 funds and overall assistance, thus providing a better understanding of the international response. Case studies and DAC peer reviews were used to complement the analysis and explore factors underpinning provider decisions in how they responded.

This was not an evaluation of the performance of partner countries' own responses to the pandemic. The case studies provided by ODA partner countries have been used in this report only to gain insight into the dynamics between national governments and international development and humanitarian providers.

The term "partner countries" is used throughout the report to refer to countries and territories receiving assistance (based on those that were ODA-eligible in 2020-2022). The term "provider" is used to denote the country or entity that supplied funding or other forms of assistance.

The analysis considers all support for equitable access to COVID-19 vaccines and vaccination rollouts including contributions to the Access to COVID-19 Tools Accelerator (ACT-A), manufacturing and donations of COVID-19 vaccine doses, and support to address issues related to vaccine manufacturing and supply, delivery, health system capacities, communication, and combating mis- or disinformation.

Design of the evaluation and its approach

The evaluation was designed to engage the intended users – including humanitarian and development agencies, national governments and implementing partners – through the Evaluation Steering Committee and via the OECD's Development Assistance Committee (DAC).

This evaluation was structured to complement existing evaluative work, drawing on the important work of the Independent Panel for Pandemic Preparedness and Response report, *COVID-19: Make it the Last Pandemic*, presented to the World Health Assembly in May 2021 (The Independent Panel, 2021[1]).

Other significant international evaluations of relevance include those undertaken by the:

- Inter-Agency Evaluation of the COVID-19 Humanitarian Response (IAHE, 2022[2]),
- the System-Wide Evaluation of the UN Development System Response to COVID-19 (UNSDG, 2022[3]),
- The World Bank's Early Support to Addressing COVID-19 Health and Social Response (An Early-Stage Evaluation) (World Bank, 2022[4])
- International Monetary Fund (IMF) responses (IMF/IEO, 2023[5])

In addition, MOPAN's Assessment of the Multilateral System and COVID-19 (MOPAN, 2022[6]) and DAC peer reviews (OECD, 2025) provided valuable inputs.

Studies focused on COVID-19 vaccines and equitable access that informed this evaluation include:

- an evaluation of COVAX by Gavi (ITAD, 2023[7])
- WHO's ACT-Accelerator Strategic Review (WHO, 2022[8])
- the Evaluation of CEPI's COVID-19 Vaccine Development Agreements (CEPI, 2022[9])
- the Evaluation of Gavi's Response to COVID-19 (Euro Health Group, 2022[10])
- real-time assessments of UNICEF's support to the COVID-19 vaccine roll out and immunisation programme strengthening (UNICEF, 2021[11]).

The analysis looks at programmatic and policy responses using the evaluation criteria of relevance, coherence, efficiency and effectiveness, along with a set of related evaluation questions. The policy and programmatic intentions of the providers are ordered under these criteria, making it easier to address the findings at a higher level, rather than looking at individual policy and programmatic intentions in isolation.

Further detail on the overall evaluation approach, design, evaluation questions and sampling of country case studies are outlined in the inception report (Smith-Kouassi, 2023[12]).

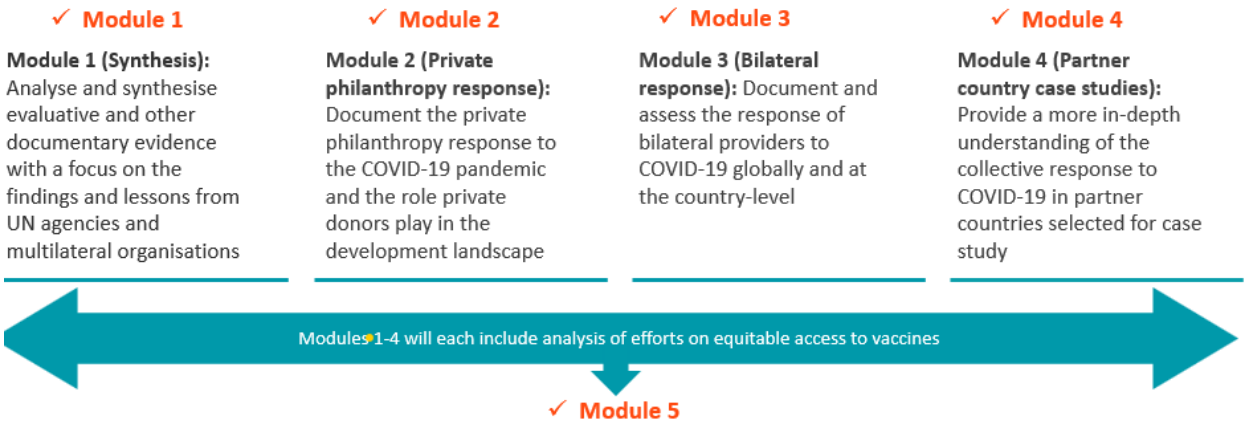
The IOD PARC evaluation team refined the evaluation's design to ensure it was feasible, taking into account the data available and the work that had already been undertaken. This included moving away from the use of indicators alongside the criteria and questions outlined in the original evaluation framework, and minor refinements to the evaluation questions. Planned case studies on Czechia, Mozambique, Nicaragua and Saudi Arabia were dropped or scaled back due to resource constraints.

The key questions used to guide the Module 5 final evaluation report are outlined below in Table B.1.

Table B.1. Evaluation questions

	Evaluation questions	Sub-questions
Descriptive	Q1. How did national governments, and development and humanitarian actors respond to the COVID-19 pandemic?	Q1.1. What were the identified needs and priorities of partner countries in addressing COVID-19?
		Q1.2. Who funded the international response to the COVID-19 pandemic, what was funded, and where were efforts focused?
		Q1.3. How and where did international development and humanitarian actors support access to vaccines and vaccination rollouts?
Relevance	Q2. To what extent did COVID-19 support meet partner country needs and priorities?	Q2.1. To what extent was funding and programming responsive to partner country needs and priorities, including those of the most vulnerable?
		Q2.2. To what extent were providers flexible and adaptive in responding to changing needs and priorities as the pandemic evolved?
Coherence	Q3. To what extent did responses align to ensure coherent approaches at global and country levels?	Q3.1. To what extent, and in what ways, was the collective response coherent at global level? At country level?
		Q3.2. To what extent were efforts focused on equitable access to vaccines, and vaccinations co-ordinated and aligned?
Effectiveness	Q4. What are the early results of the collective response to COVID-19?	Q4.1. To what extent did DAC members deliver on joint commitments regarding support for COVID-19 responses and equitable access to vaccines in partner countries?
		Q4.2. To what extent, and in what ways, did development co-operation and humanitarian assistance contribute to alleviating the immediate public health crisis stemming from the COVID-19 pandemic?
		Q4.3. To what extent, and in what ways, did development co-operation and humanitarian assistance contribute to interventions alleviating the secondary social and economic effects of the crisis?
		Q4.4. To what extent, and in what ways, did vaccine-related support result in equitable access and greater coverage?
		Q4.5 What were the unintended effects of the development and humanitarian support provided for COVID-19 response efforts?
Efficiency	Q5. To what extent were funding and programming decisions and interventions timely and informed?	Q5.1. To what extent were providers successful in mobilising timely and flexible funding to respond to COVID-19?
		Q5.2. To what extent can the different dimensions of the development co-operation and humanitarian response be considered good value for money?
Forward looking	Q6. What good practices, innovations and lessons learned emerged from the collective response to COVID-19?	Q6.1. What good practices and innovations emerged that can inform ongoing or future responses?
		Q6.2. What are the key lessons learned and how can these inform future co-ordination and crisis preparedness?

Figure B.1. Evaluation modules



The evaluation design included a modular and case-based approach, including both partner and provider case studies. The design reflects the global scope of the pandemic, the extent of evaluative work already available, and the range of actors involved. Modules 1-4 gathered *evidence* to answer the six overarching evaluation questions (and sixteen sub-questions) outlined in Table B.1 above.

The evaluation includes case studies of assistance received during 2020-2022 in Bangladesh, Burkina Faso, Cabo Verde, Cambodia, Georgia, Kenya, Lebanon, Nicaragua and the Large Ocean States/Small Island Developing States (SIDS) group. Partner country case studies document country-specific contextual information, detail the collective response to COVID-19 in partner countries and the COVID-19 responses of national governments. They examine alignment with national strategies and priorities, and coherence across development partners and with other sustainable development efforts.

These cases were complemented by in-depth analysis of provider experiences, including the international assistance of the People's Republic of China (hereafter 'China'), Germany, Mexico, the Netherlands, New Zealand, Saudi Arabia, South Africa, Spain, and the United States. Provider studies look at international co-operation and humanitarian assistance of from the provider government in 2020-2022. They included an analysis of data from the OECD CRS database and from publicly available reports and websites on assistance. Experience of other countries and providers were included through the Module 1 synthesis and the global analysis.

This evaluation report (Module 5) synthesises and triangulates evidence from each of the previous modules. The consolidated report considers the global-level data and draws on the previous modules through a documentary review of approximately 130 documents, along with 12 additional key informant interviews, to generate findings and draw conclusions about the collective response.

Management and conduct

The inception phase of the evaluation was carried out by Organisation for Economic Cooperation and Development (OECD) from November 2022 to the completion of the final inception report in June 2023, with data collection underway until October 2024. Module 1 was completed by the Nordic Consulting Group in early 2023; Module 2 was completed by the OECD in 2023; and Modules 3 and 4 were led by a range of teams made up of OECD staff, COVID-19 Coalition participant evaluation units and contracted consultants.

The OECD conducted the case studies of Bangladesh, Cabo Verde, Cambodia, Georgia and Nicaragua. Burkina Faso carried out its own country-led evaluation with support from the OECD and the Global Evaluation Initiative (GEI). The African Development Bank IDEV carried out the Kenya case. Evaluation Department at Global Affairs Canada carried out the Lebanon case. The EC DG INTPA commissioned the SIDS group case, and the study was completed by Particip/IRMA. The OECD and IOB Netherlands jointly carried out the case study of the Netherlands. The ISDB supported the Saudi Arabia case. The Mexico case was conducted by AMEXCID and the OECD. The countries' own reports were used for analysis of the international assistance provided by China, Germany, New Zealand, South Africa, Spain and the United States.

Responsibility for completing the evaluation (Module 5) was passed on to an independent evaluation team from IOD PARC in March 2024. IOD PARC is an independent consulting company specialising in international development and performance assessment. IOD PARC's key responsibilities included support to complete provider and partner case studies, supplementary data collection and analysis, quantitative analysis of CRS data, and the development of this Module 5 evaluation report. The report was finalised by the OECD, with input and validation from the evaluation Steering Group (Annex A).

Data collection and analysis

In addition to the document reviews and interviews conducted for the individual case studies, a further twenty interviews were conducted by IOD Parc and the OECD. An opinion survey, designed and administered by DEval and the OECD was circulated to more than 600 stakeholders. There was a limited response from stakeholders outside German development co-operation, but the analysis of German responses and qualitative data in the other survey responses was used to inform the analysis and findings.

Case studies included extensive document reviews, including available evaluation literature and interviews with key national and international stakeholders working in the country in 2020-22. Country visits and interviews were used for Bangladesh, Burkina Faso, Cabo Verde and Cambodia. The Kenya case study builds on a country evaluation by the Independent Development Evaluation (IDEV) of the African Development Bank (AfDB), which included extensive document review, quantitative data and a country visit. Resource constraints in Lebanon meant that the team was only able to carry out a handful of interviews in the country, relying primarily on secondary sources.

To analyse the data across the four modules, the evaluation team developed an expansive qualitative coding framework, which was based on the six evaluation questions and 16 sub-questions. They analysed each document the data using a coding and analysis software tool (MAXQDA). The analysis was iterative, with additional codes being identified as the analysis progressed (i.e. use of budget support, PPE etc.). The analysis used the lenses of gender, equity, human rights and inclusion, where possible. Evaluator judgement then discerned trends and themes from across the coded data to develop preliminary findings and the report narrative.

Data were triangulated through the cross-refencing of data sources, triangulation through team analysis and team "sense-making" sessions and validation of findings through the commenting process with the evaluation manager, quality assurance lead, and Steering Committee. The provider and partner case studies are used in this report to provide illustrative and descriptive examples supporting the key findings emerging from the aggregated analysis to triangulate findings and to inform lessons.

The evaluation team presented the preliminary findings in November 2024 to OECD colleagues and the Steering Committee for validation before drafting the main report. It was then quality assured ahead of submission and revised and finalised in April 2025, following feedback from OECD and Steering Committee colleagues.

Limitations

Key limitations identified and the ways these were managed, were as follows.

- Resource constraints – including numerous staffing challenges in the evaluation team – meant that only a limited number of interviews and country visits could be conducted, with much of the work relying on data collected by partners and presented in their evaluation reports. It is expected that this led to some skewing of the data, either positively or negatively.
- National actions were largely out of scope, though the policies and response programmes were the main drivers of overall pandemic outcomes.
- There was a significant amount of variation across individual institutions, countries and even time periods (from early 2020 to the end of the evaluation period in 2022, by which time many actors had shifted out of crisis mode) in terms of reporting on activities and strategies.
- Evaluations were available for a fraction of the strategies, programmes, projects and institutions involved in international co-operation during the crisis response. As a result, the pool is slightly skewed towards institutions that were more active during the crisis response and looked primarily at activities that were funded and implemented, with little analysis of opportunities that were missed or actions not taken due to the crisis or institutional failings. To address this imbalance, interviews were used to explore decision making and identify barriers to action.
- Many actors were involved in producing the case studies, which meant that there were differences in approaches and focus, and the voluntary nature of participation inevitably resulted in uneven coverage of some providers and agencies.
- The volume of information available means that the report did not fully capture the full wealth of information, insights and conclusions of evaluation reports carried out on the COVID-19 response globally. To address this limitation, the final report focuses on providing useful lessons that can inform responses to future crises.
- It should also be noted that there was some level of “COVID fatigue”, especially in 2022 when the bulk of the case study work took place. Many stakeholders wanted to move on from the pandemic, which they described as a difficult or even traumatic period. However, in 2024-2025, perhaps with the benefit of some distance, many participants reported a renewed interest in drawing lessons, as well as an increase in public debate and discussions of the response as countries sought to incorporate lessons into a changing development landscape. This limitation was managed by focusing on lessons applicable to future co-operation, relevant in the current context.

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Annex C. Additional data and charts

Support by region

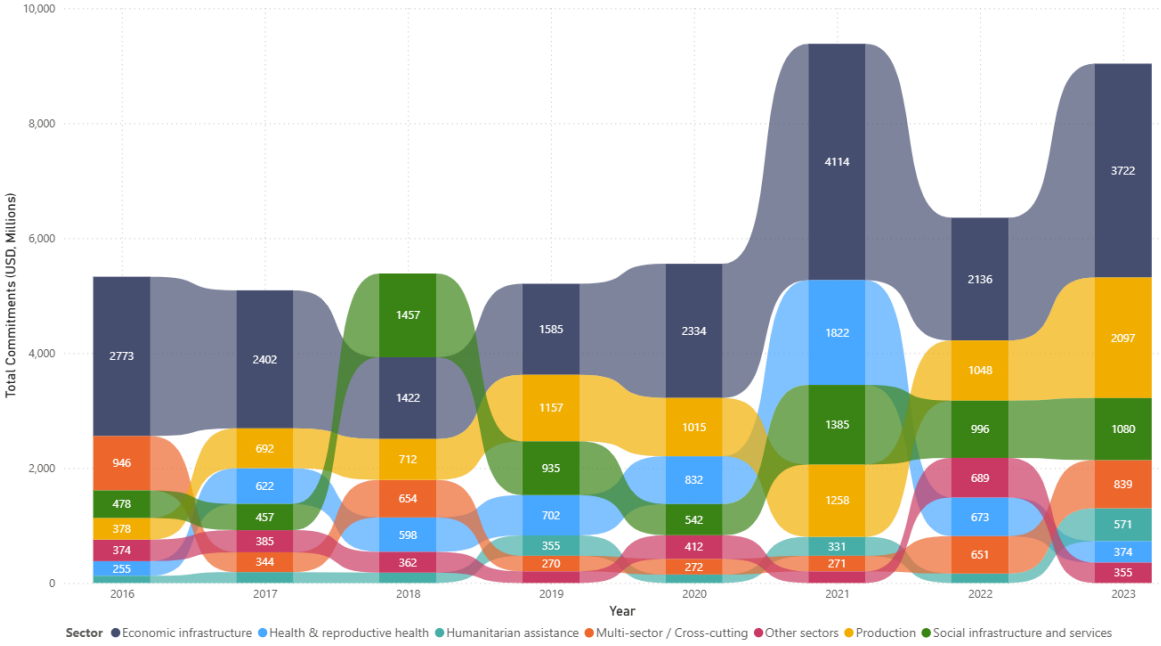
In 2016, the regions receiving the most assistance were Asia (USD 99.7 billion) and Africa (USD 86.2 billion). Funding not tagged to a specific region (USD 50.3 billion) was also significant. These three categories accounted for 81.2% of the total official development assistance (ODA). This trend continued during the pandemic; however, by 2022, the share of assistance to Africa and Asia had dropped slightly, as funding to Europe and regional areas rose. Within the assistance allocated to COVID-19 specifically, the regions receiving the highest levels of ODA were, again, Africa and Asia, with a large amount of regional and unspecified funding.

While all regions saw an increase in per capita assistance in the first year of the pandemic, by 2022, per capita funding had declined for the Americas, Asia, and Oceania. Regional and unspecified assistance (which makes up a small share) rose slightly in 2020 and 2021 and then increased significantly in 2022 mainly driven by vaccine rollouts and the Ukraine response.

Prior to the pandemic, Europe and Small Island Developing States (SIDS) received the highest amounts of assistance per capita, a trend that continued into 2020. Both groups typically exceed USD 100 of assistance per capita. Towards the end of the pandemic, the start of Russia's full-scale war of aggression against Ukraine resulted in an even more significant jump in funding, with a three-fold increase in assistance to Europe from 2020-2022 (OECD, 2024[1]). In contrast, assistance to Africa, Asia and Oceania remained relatively constant.

Figure C.1. Official development finance to Africa, by sector, 2016-2023

USD million commitments, constant 2023 prices

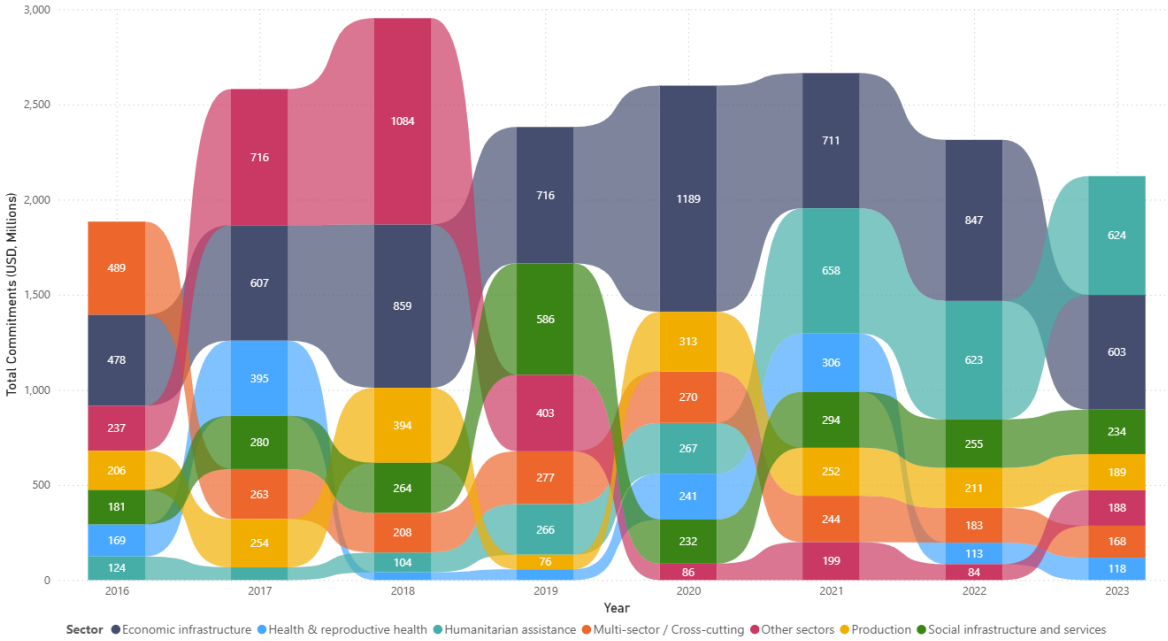


Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.

Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.2. Official development finance to Americas, by sector, 2016-2023

USD million commitments, constant 2023 prices

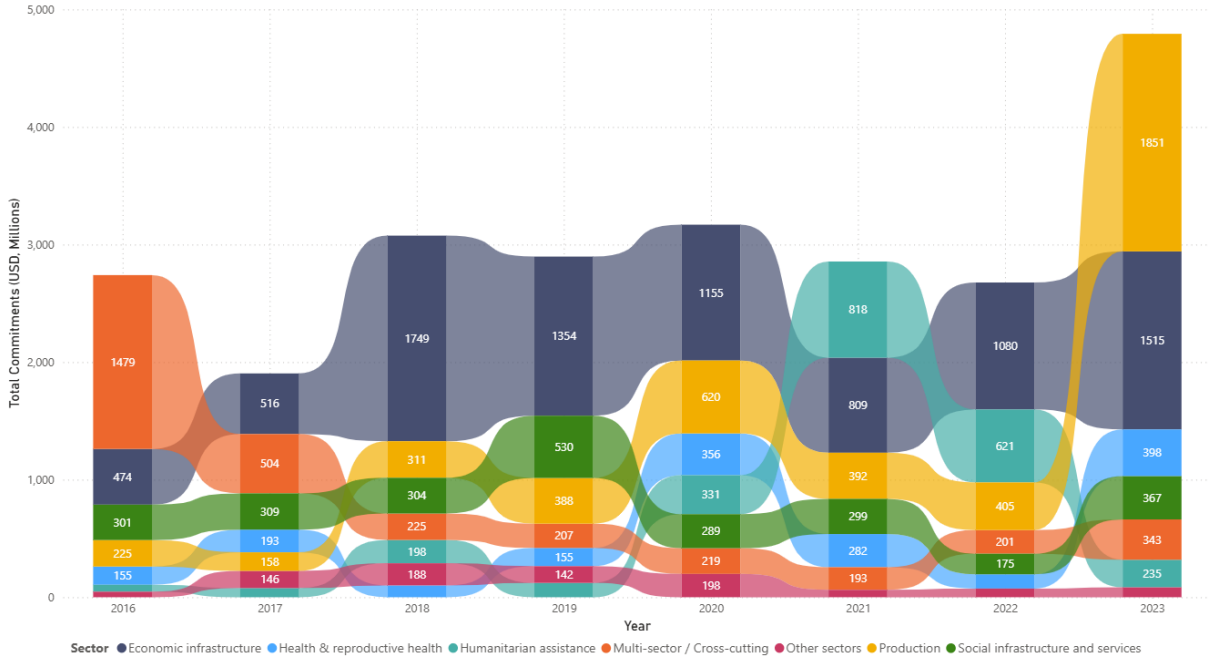


Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.

Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.3. Official development finance to Asia, by sector, 2016-2023

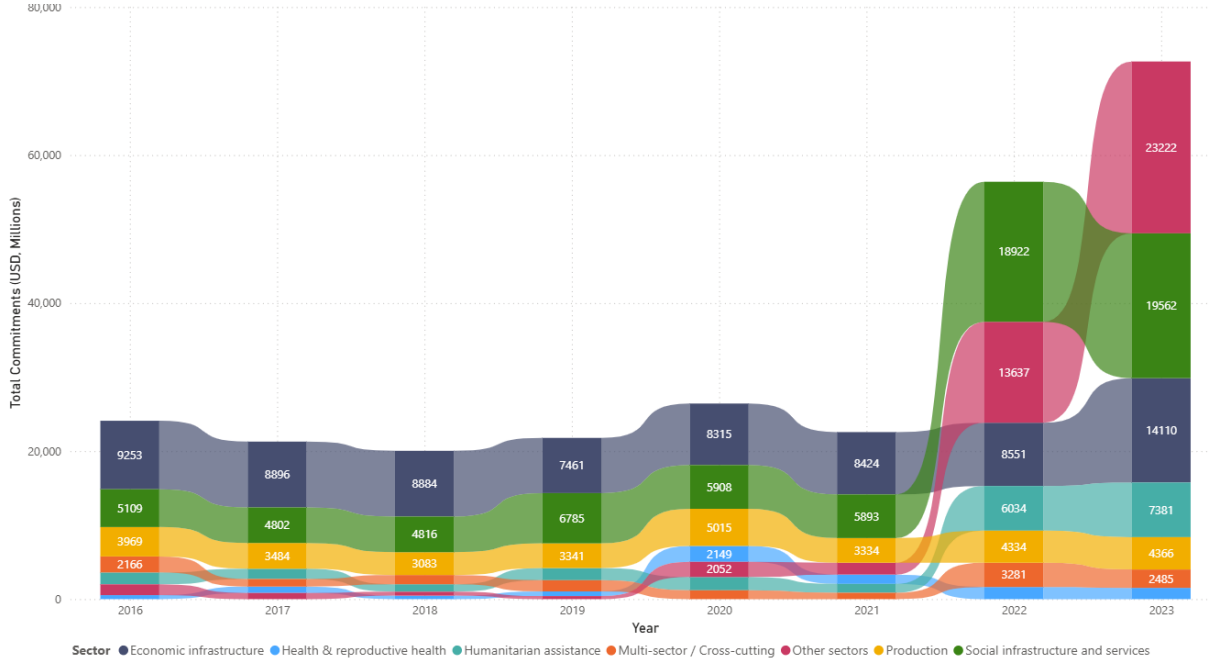
USD million commitments, constant 2023 prices



Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.4. Official development finance to Europe, by sector, 2016-2023

USD million commitments, constant 2023 prices



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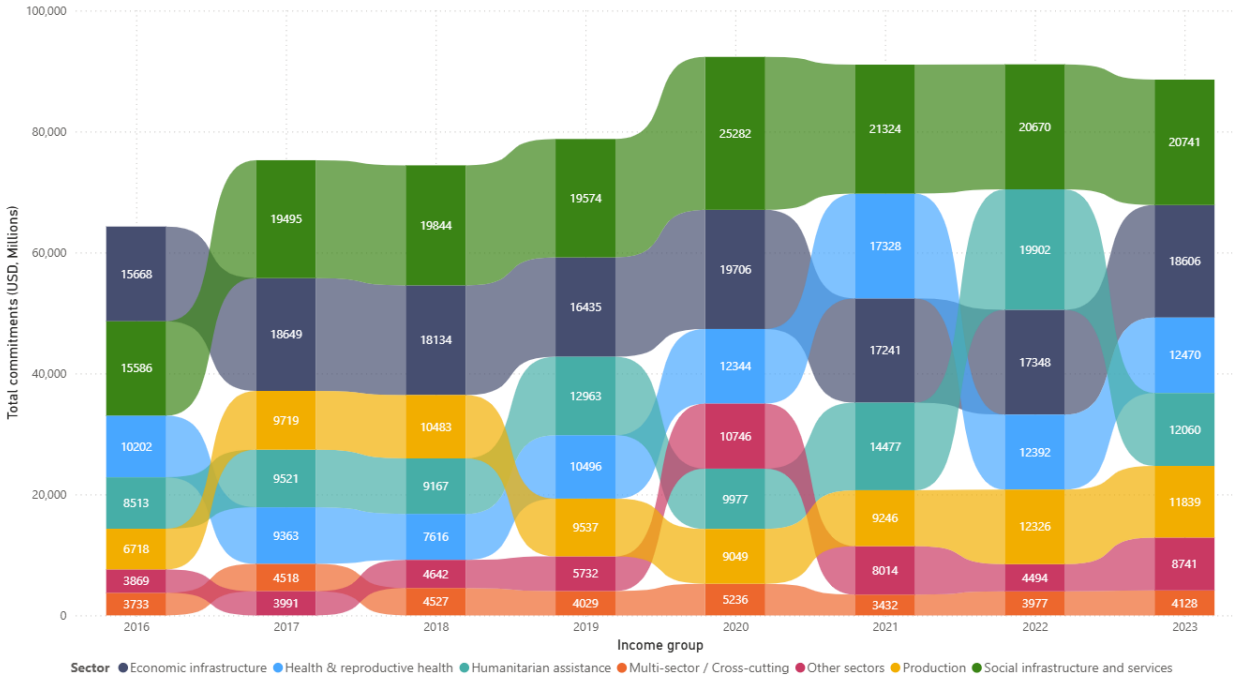
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Support by income group

Albeit with large levels of variation within countries, there are some discernible trends in funding strategies by sector within different income groups during the pandemic. Notably, health funding to least developed countries rose significantly in 2020-2021 (before reverting to near pre-pandemic levels in 2022). Both the total proportion of health funding and the increase are less marked in middle-income countries. Likewise for "other sectors", which captures budget support and other similar types of broad support.

Figure C.5. Official development finance to least developed countries, by sector, 2016-2023

USD million commitments, constant 2023 prices



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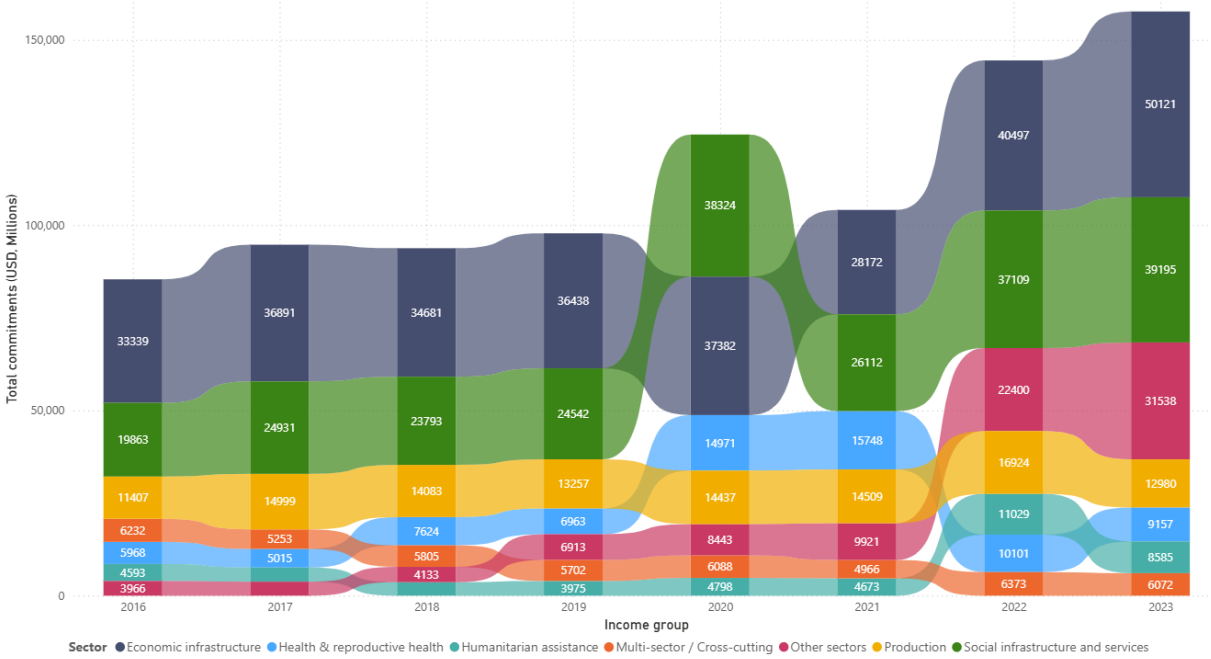
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.6. Official development finance to lower-middle-income countries, by sector, 2016-2023

USD million commitments, constant 2023 prices



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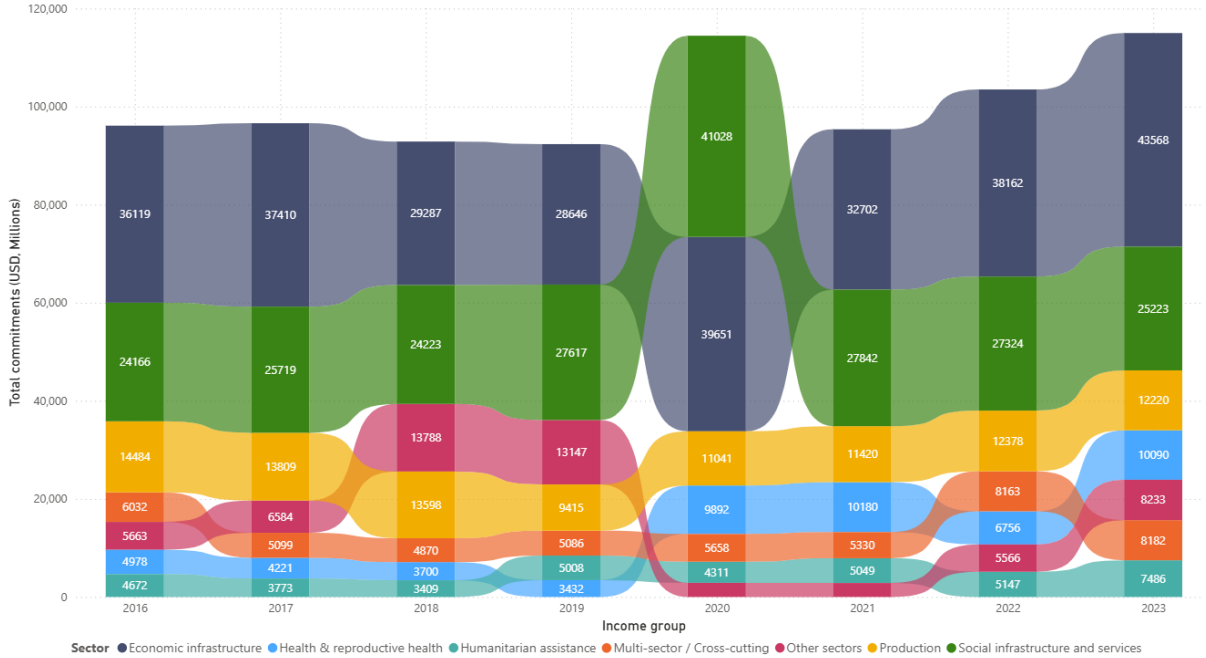
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.7. Official development finance to upper-middle-income countries, by sector, 2016-2023

USD million commitments, constant 2023 prices



Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.

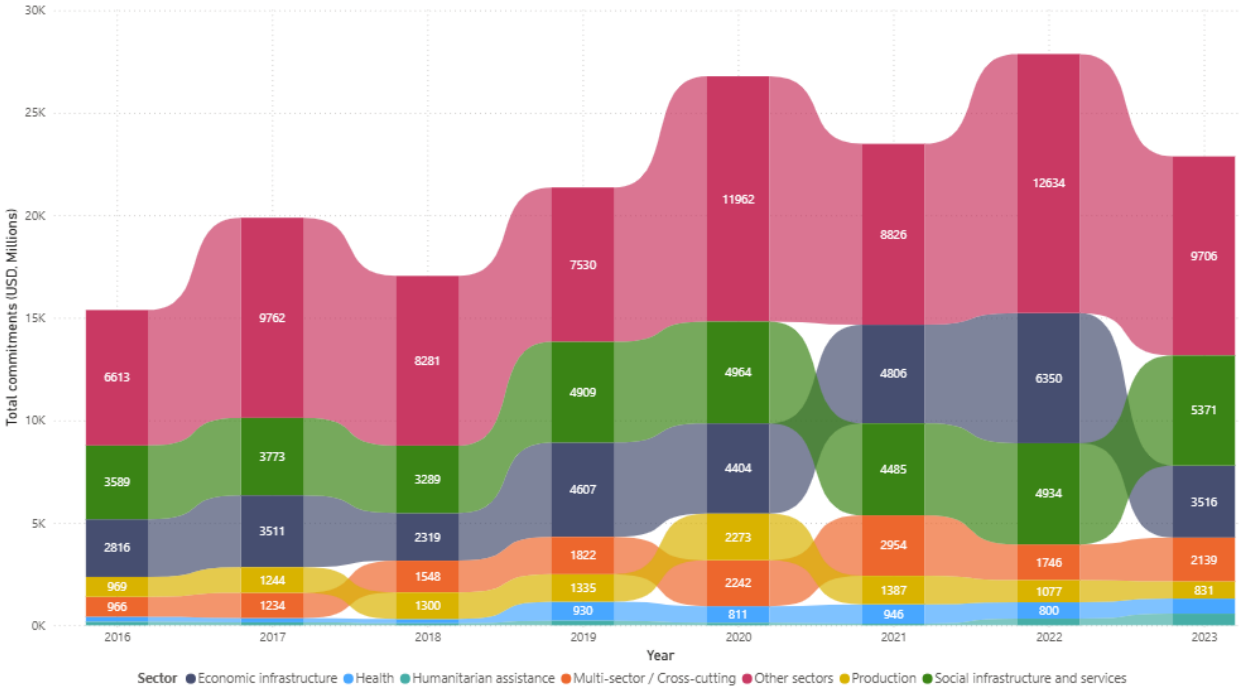
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Provider funding by sector

The sectoral focus of select providers (including all case studies that report to the OECD) remained stable in most cases, though nearly all increased health sector funding in 2020. Several also show increases in multi-sector funding, including budget support or other types of cross-cutting support, and others increased social sector funding.

Figure C.8. Official development finance from France, by sector, 2016-2023

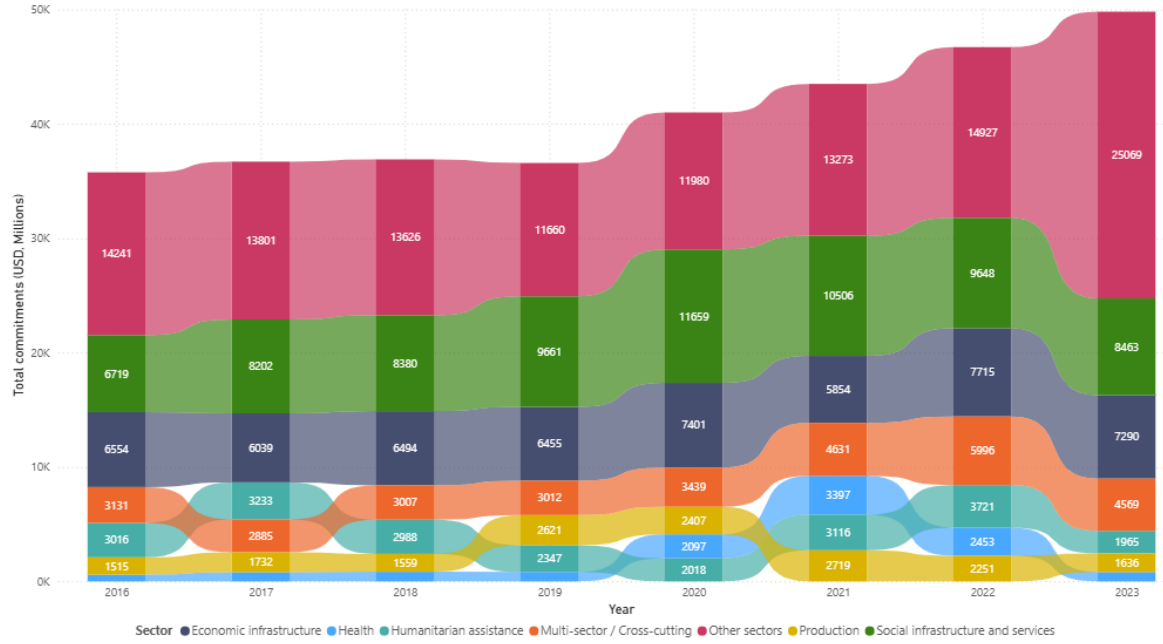
USD million commitments, constant 2023 prices



Note: Includes DAC, non-DAC, multilateral and foundations financing. “Social infrastructure and services” includes education, population policies, governance, and water and sanitation. “Economic infrastructure” includes transport, energy, communications, banking and financial services, and business. For providers, “other sectors” includes general budget support and debt actions, as well as in-donor refugee costs, administration costs, and other programmes, making it the largest category.
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.9. Official development finance from Germany, by sector, 2016-2023

USD million commitments, constant 2023 prices

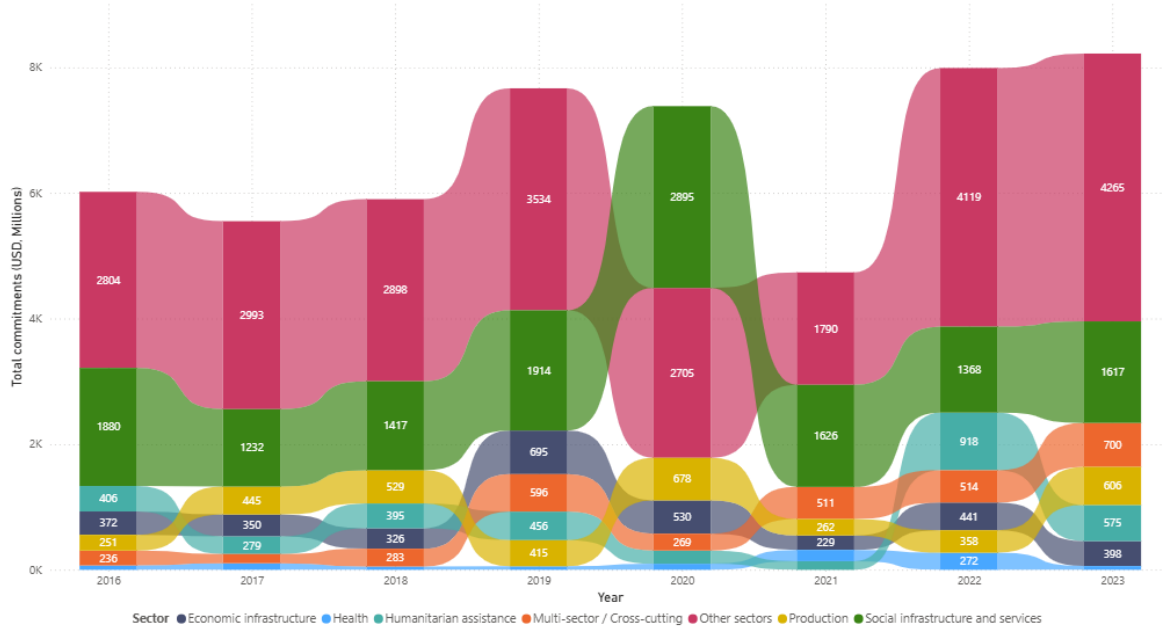


Note: Includes DAC, non-DAC, multilateral and foundations financing. “Social infrastructure and services” includes education, population policies, governance, and water and sanitation. “Economic infrastructure” includes transport, energy, communications, banking and financial services, and business. For providers, “other sectors” includes general budget support and debt actions, as well as in-donor refugee costs, administration costs, and other programmes, making it the largest category.

Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.10. Official development finance from the Netherlands, by sector, 2016-2023

USD million commitments, constant 2023 prices

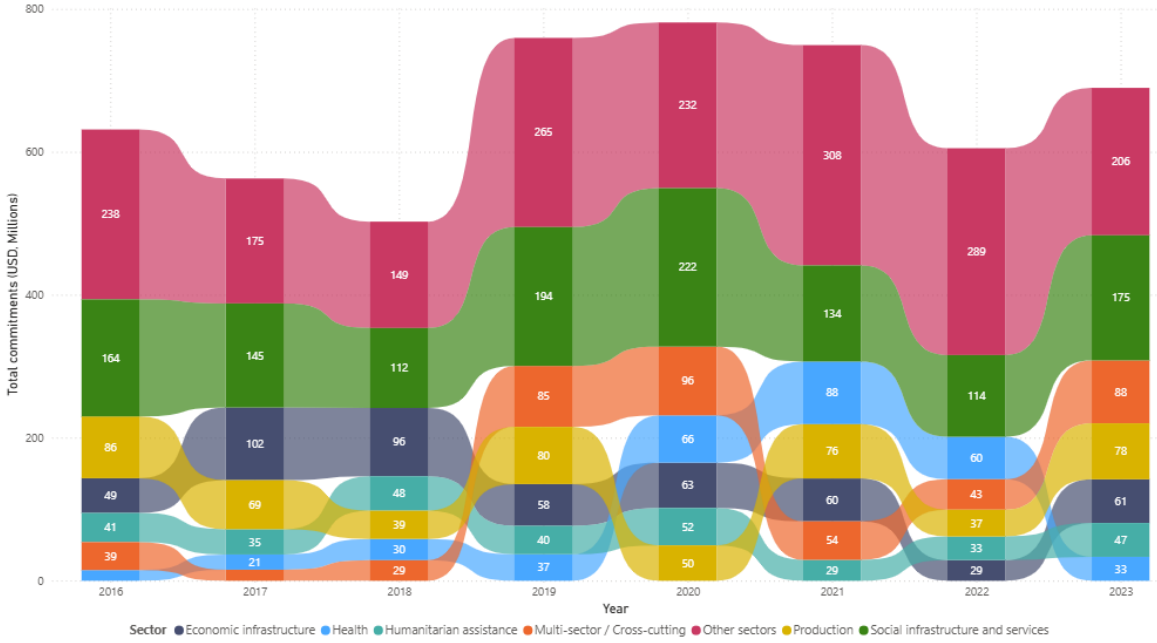


Note: Includes DAC, non-DAC, multilateral and foundations financing. “Social infrastructure and services” includes education, population policies, governance, and water and sanitation. “Economic infrastructure” includes transport, energy, communications, banking and financial services, and business. For providers, “other sectors” includes general budget support and debt actions, as well as in-donor refugee costs, administration costs, and other programmes, making it the largest category.

Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.11. Official development finance from New Zealand, by sector, 2016-2023

USD million commitments, constant 2023 prices

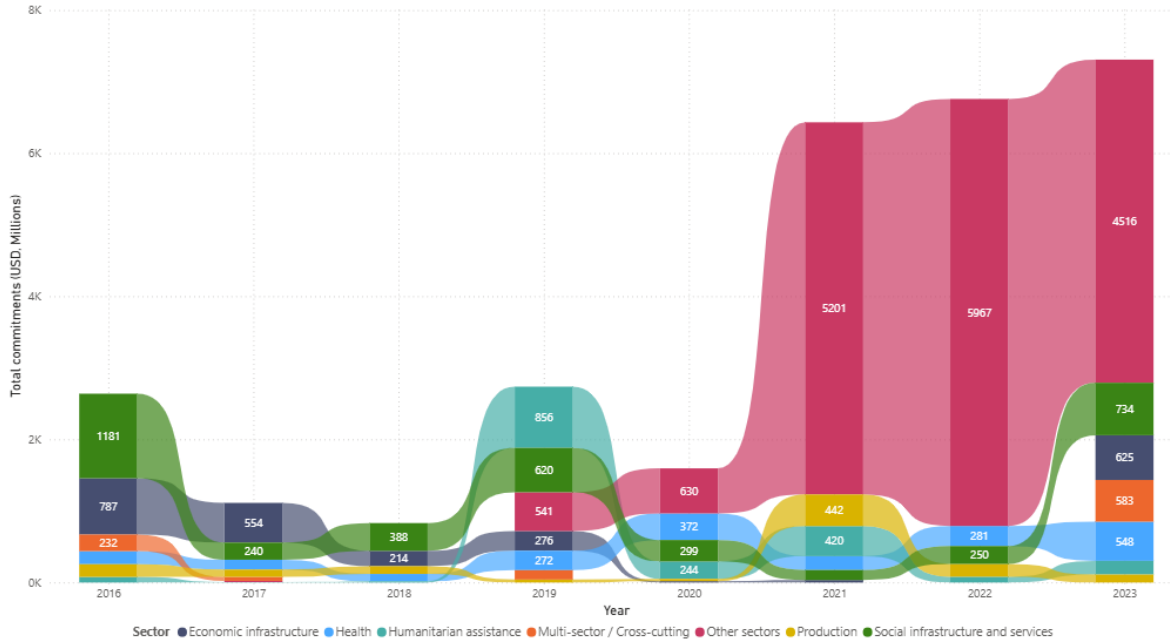


Note: Includes DAC, non-DAC, multilateral and foundations financing. “Social infrastructure and services” includes education, population policies, governance, and water and sanitation. “Economic infrastructure” includes transport, energy, communications, banking and financial services, and business. For providers, “other sectors” includes general budget support and debt actions, as well as in-donor refugee costs, administration costs, and other programmes, making it the largest category.

Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.12. Official development finance from Saudi Arabia, by sector, 2016-2023

USD million commitments, constant 2023 prices

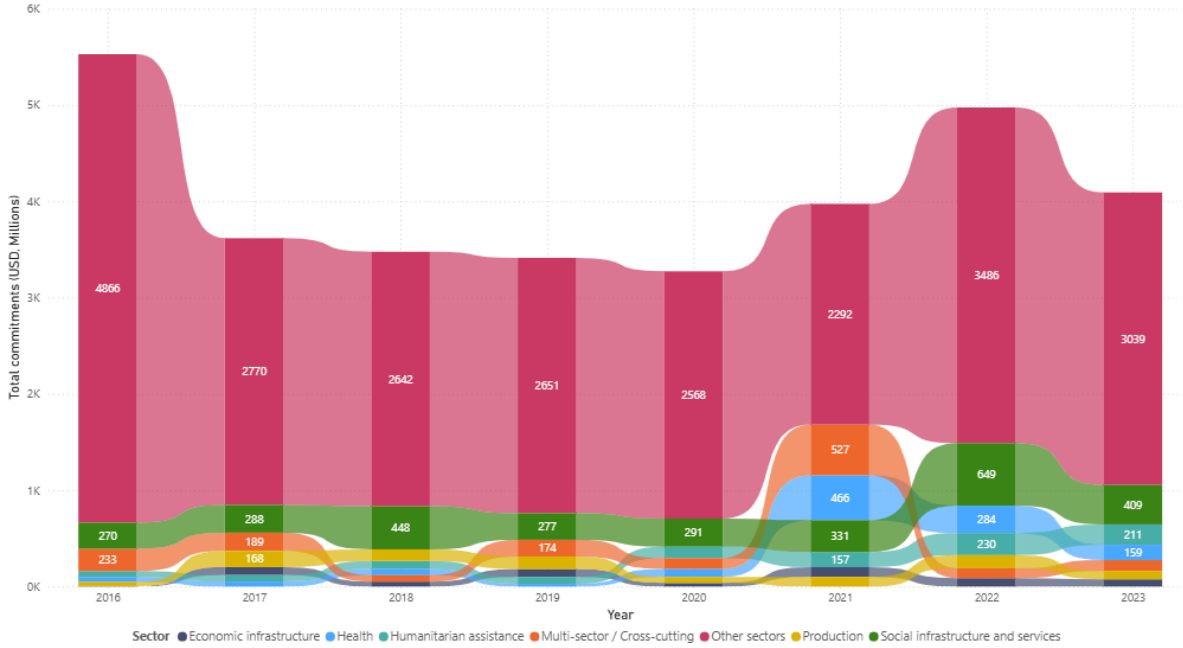


Note: Includes DAC, non-DAC, multilateral and foundations financing. “Social infrastructure and services” includes education, population policies, governance, and water and sanitation. “Economic infrastructure” includes transport, energy, communications, banking and financial services, and business. For providers, “other sectors” includes general budget support and debt actions, as well as in-donor refugee costs, administration costs, and other programmes, making it the largest category.

Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.13. Official development finance from Spain, by sector, 2016-2023

USD million commitments, constant 2023 prices

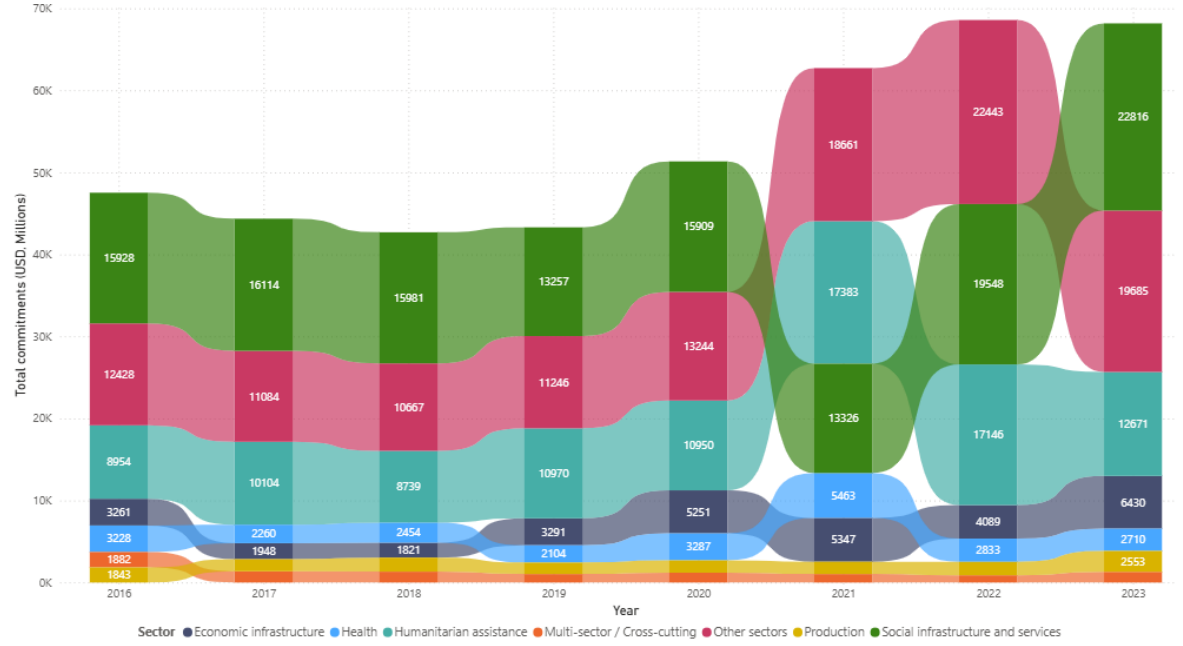


Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, and water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. For providers, "other sectors" includes general budget support and debt actions, as well as in-donor refugee costs, administration costs, and other programmes, making it the largest category.

Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.14. Official development finance from the United States, by sector, 2016-2023

USD million commitments, constant 2023 prices



Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, and water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. For providers, "other sectors" includes general budget support and debt actions, as well as in-donor refugee costs, administration costs, and other programmes, making it the largest category.

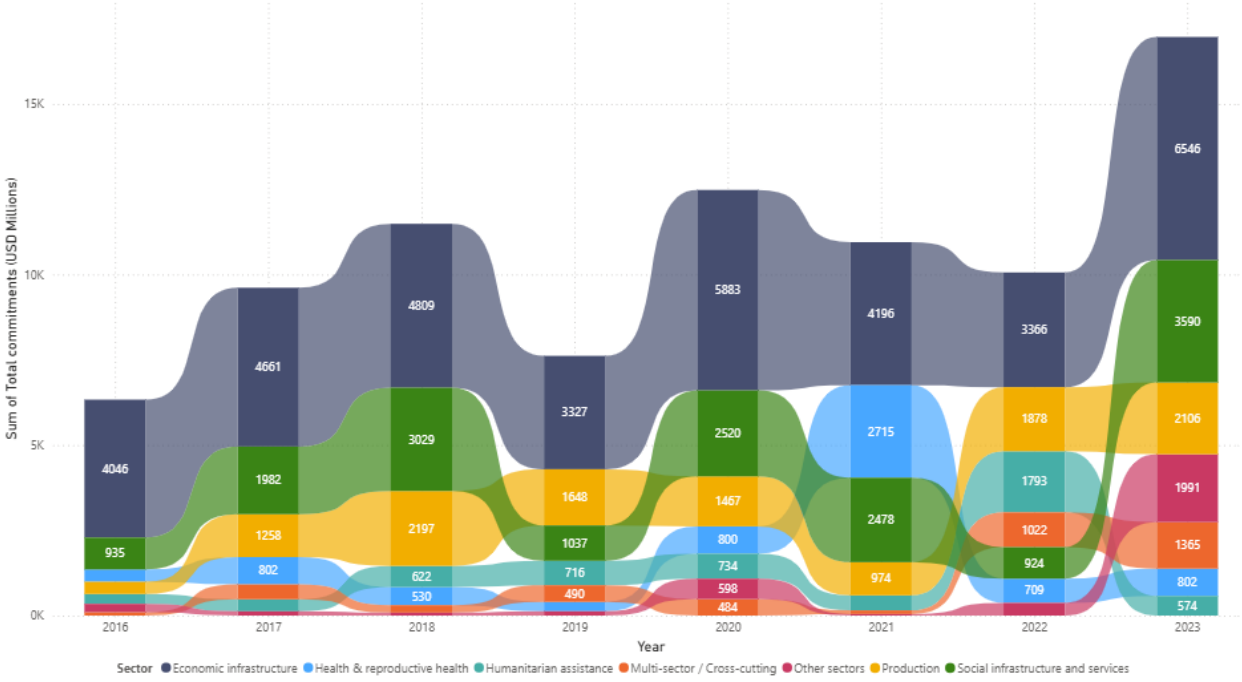
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Support to recipient countries by sector

Comparison of in-coming development finance shows wide variation across countries, both in the overall sectoral split, and the changes related to the pandemic crisis, or other factors such as natural disasters or humanitarian crises.

Figure C.15. Official development finance to Bangladesh, by sector, 2016-2023

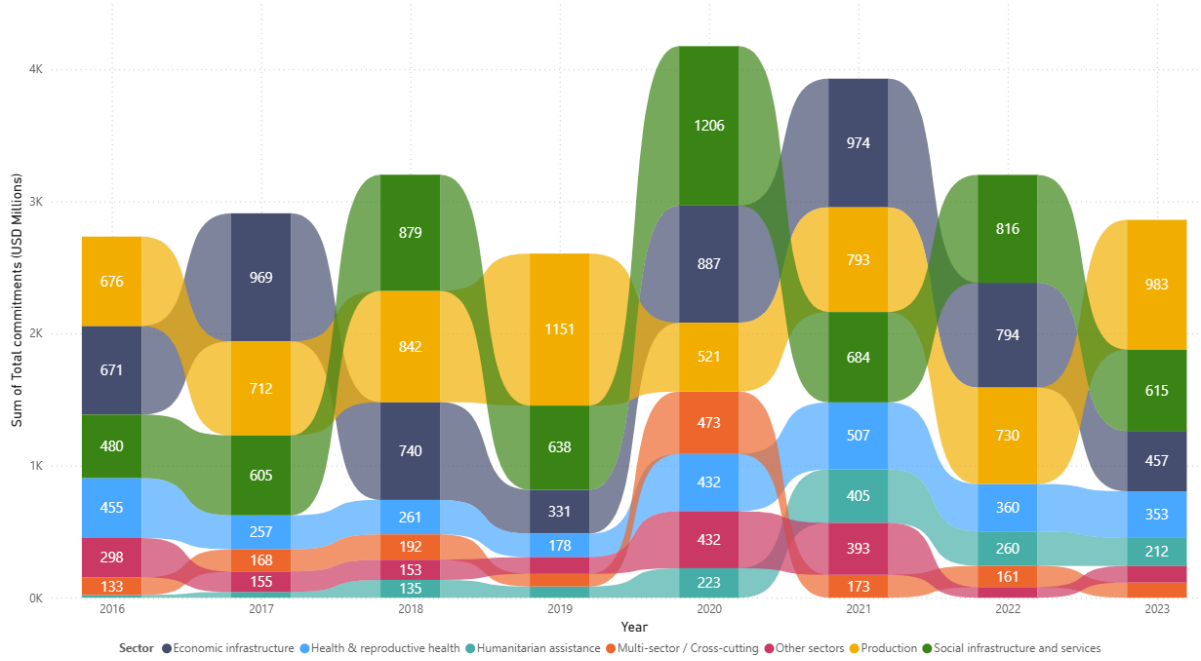
USD billion commitments, 2023 prices



Note: Includes DAC, non-DAC, multilateral and foundations financing. “Social infrastructure and services” includes education, population policies, governance, water and sanitation. “Economic infrastructure” includes transport, energy, communications, banking and financial services, and business. “Other sectors” includes general budget support as well as debt rescheduling.
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.16. Official development finance to Burkina Faso, by sector, 2016-2023

USD million commitments, 2023 prices

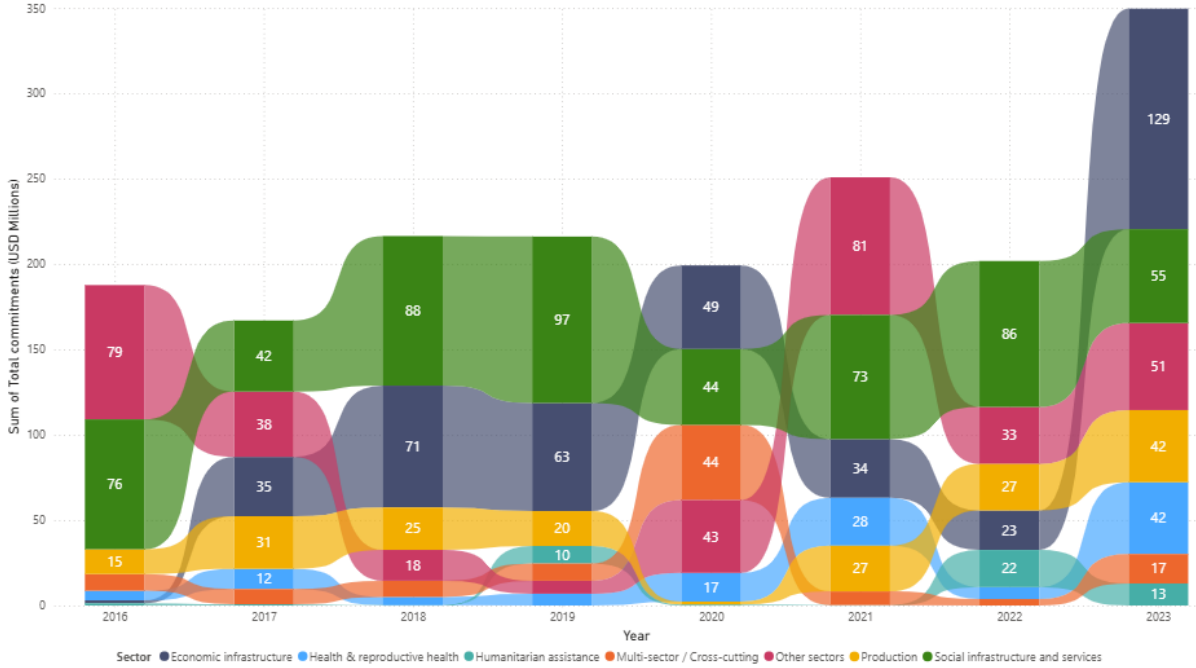


Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.

Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.17. Official development finance to Cabo Verde, by sector, 2016-2023

USD million commitments, 2023 prices



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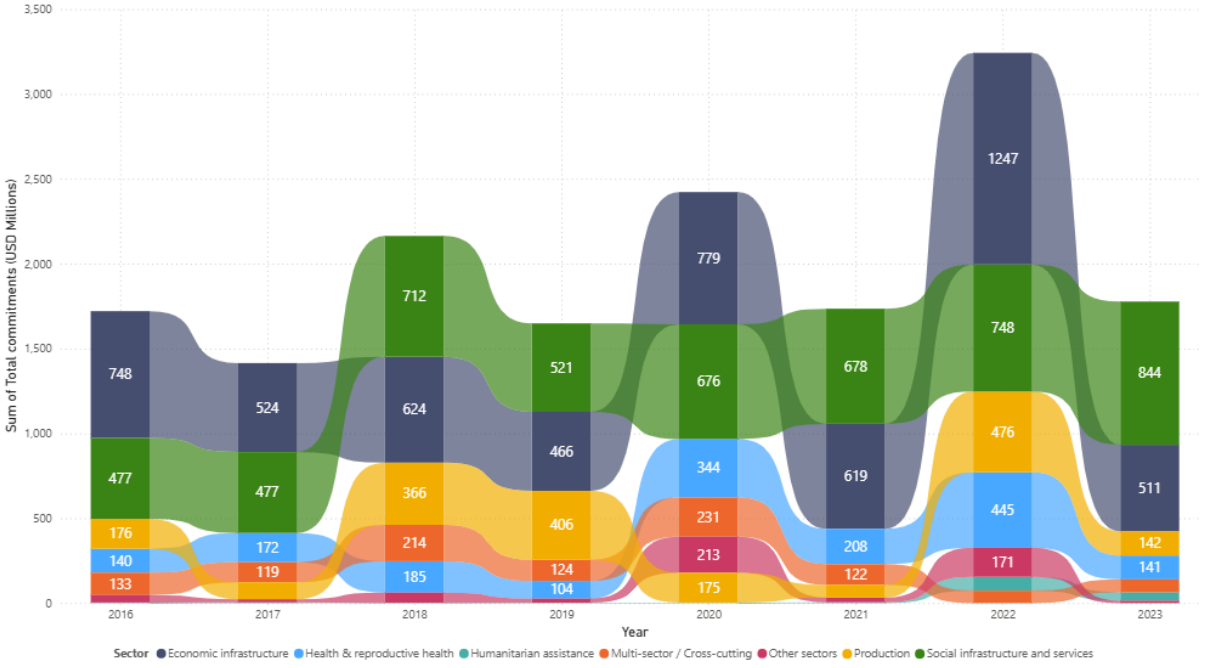
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.18. Official development finance to Cambodia, by sector, 2016-2023

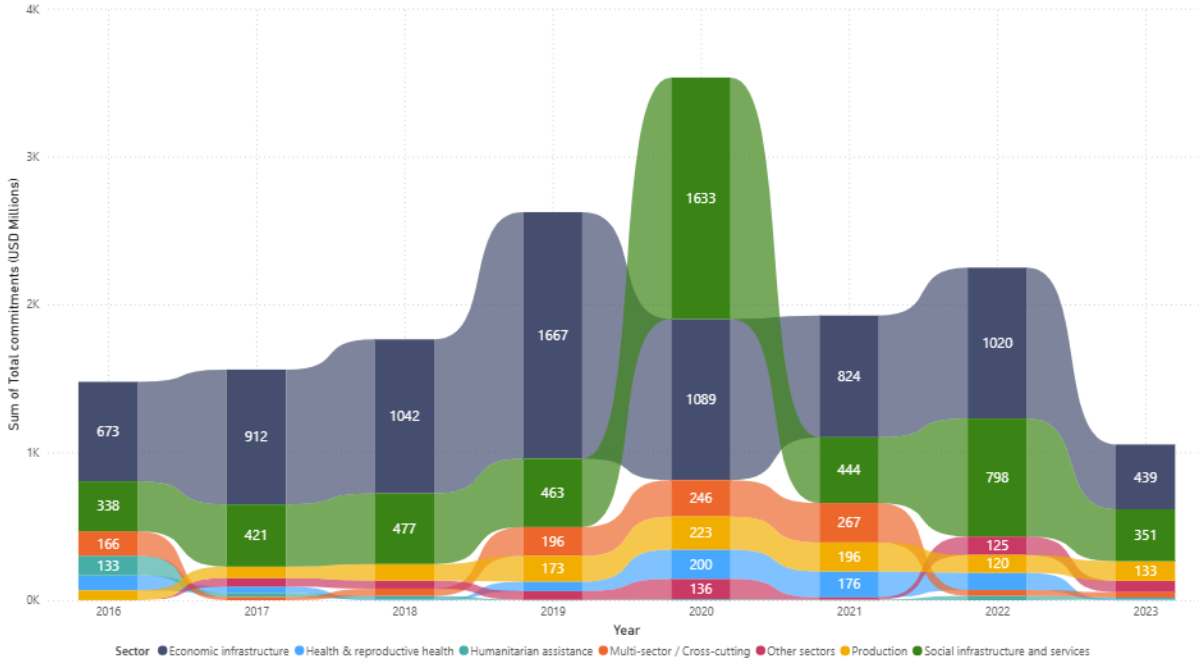
USD million commitments, 2023 prices



Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

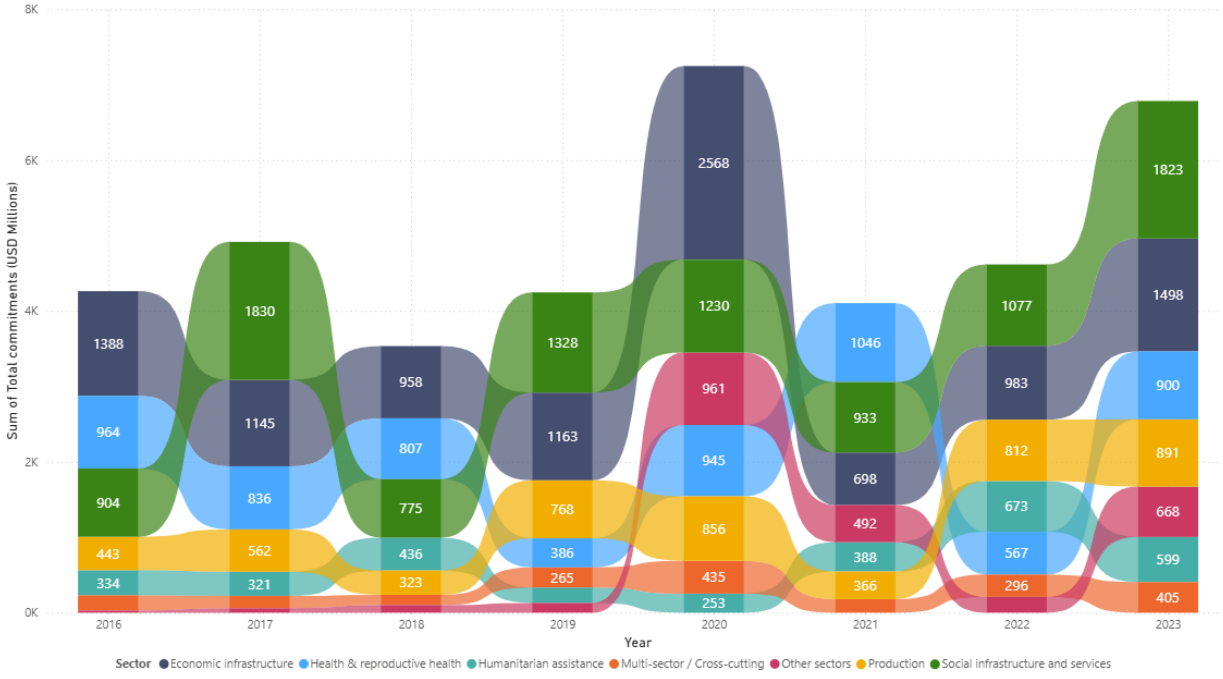
Figure C.19. Official development finance to Georgia, by sector, 2016-2023

USD million commitments, 2023 prices



Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

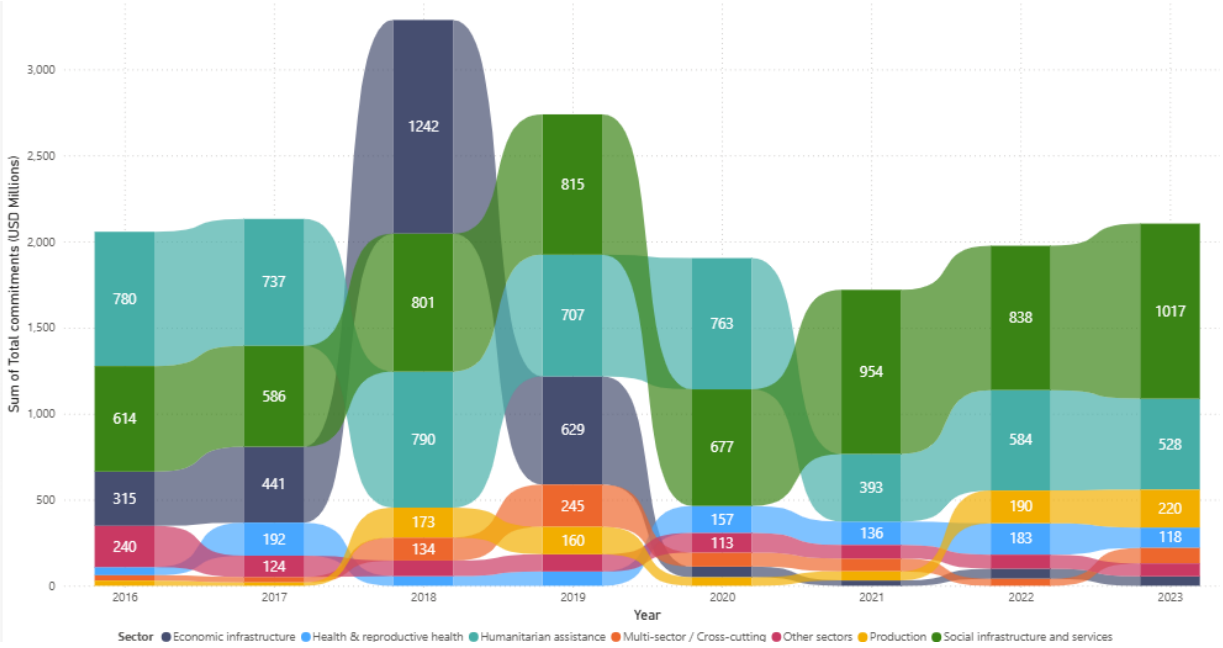
Figure C.20. Official development finance to Kenya, by sector, 2016-2023



Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

Figure C.21. Volume of official development finance to Lebanon, by sector, 2016-2023

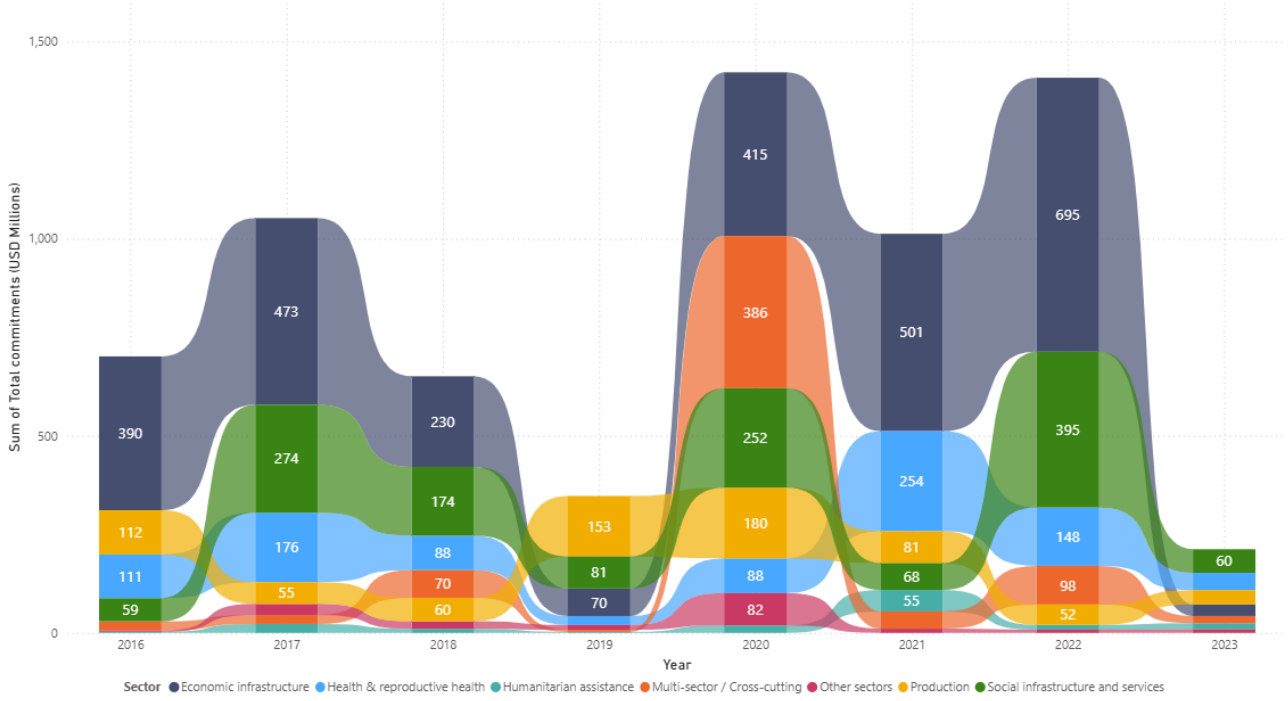
USD million commitments, 2023 prices



Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), hhttp://data-explorer.oecd.org/s/52.

Figure C.22. Official development finance to Nicaragua, by sector, 2016-2023

USD million commitments, 2023 prices



Note: Includes DAC, non-DAC, multilateral and foundations financing. "Social infrastructure and services" includes education, population policies, governance, water and sanitation. "Economic infrastructure" includes transport, energy, communications, banking and financial services, and business. "Other sectors" includes general budget support as well as debt rescheduling.
Source: OECD (2025[2]), OECD Data Explorer, Creditor Reporting System (flows) (Database), http://data-explorer.oecd.org/s/52.

References

OECD (2025), *OECD Data Explorer, Creditor Reporting System (flows) (Database)*, http://data-explorer.oecd.org/s/52 (accessed on 8 August 2025). [2]

OECD (2024), *OECD CRS Data*, https://www.oecd.org/en/data/datasets/oecd-DE.html. [1]

Strategic Joint Evaluation of the Collective International Development and Humanitarian Assistance Response to the COVID-19 Pandemic

This Strategic Joint Evaluation examines how international development and humanitarian actors responded collectively to the COVID-19 pandemic between 2020 and 2022. Drawing on evidence from over 60 organisations and a wide range of country and provider case studies, it sheds light on the relevance, coherence, effectiveness and efficiency of the global response. The evaluation reveals that while the pandemic placed immense pressure on global systems, it also spurred unprecedented levels of co-operation, innovation and resource mobilisation. It highlights the importance of flexibility, local leadership and timely support, while also noting where incoherence and missed opportunities limited impact. This report offers a system-wide perspective – one of the few of its kind – capturing critical lessons to strengthen future responses to global crises. It is a valuable resource for policymakers, development professionals, humanitarian actors, and anyone seeking to understand how the international community can act more effectively in times of emergency.

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