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Highlights from the Report of the External Evaluation of PAHO's Response to COVID-19

The Americas was one of the regions most affected by the COVID-19 pandemic. By mid-January 2020, the Pan American Health Organization (PAHO) activated an organization-wide response to support all its Member States in accordance with the COVID-19 Strategic Preparedness, and Response Plan (SPRP) of the World Health Organization (WHO). On 5 March 2020, PAHO launched its COVID-19 Response Strategy and Donor Appeal to support COVID-19 preparedness and response efforts in the Americas, followed by its Regional COVID-19 Response Strategy (2021).

The Director of PAHO and the Executive Management team included the evaluation of PAHO's response to the COVID-19 pandemic (EPRC) in the corporate evaluation workplan for 2022-2023. The aim was to provide an objective and independent assessment of PAHO's overall performance during the response, from January 2020 to August 2022. The evaluation served accountability and organizational learning purposes and is focused on the operations undertaken by the PAHO Secretariat across its four subregions - the Caribbean (CRB), Central America (CAM), South America (SAM), and North America (NAM) - and in 35 Member States.

Key Findings

1. **PAHO was the only regional organization with the mandate, institutional capacity, and technical expertise to encourage a regional response at the highest political level.** PAHO supported the continuity of Member States essential functions beyond the health sector ("whole-of-government" approach) while supporting health systems.

2. **PAHO's response to the pandemic was aligned with the National Response Plans.** This was thanks to PAHO's mandate, close collaboration with most Ministries of Health (MoHs) in the Region, experience and technical expertise in emergency preparedness and response, early activation of the Incident Management System (IMS), and integration into national emergency operations centers.

3. **Close coordination between PAHO and MoHs enabled, to some extent, the identification of needs informed by evidence and science;** however, the scarcity of quality and disaggregated indicators needed for targeted and effective priority-setting hindered a more accurate assessment of national needs.

4. **PAHO planned for an equitable response to reduce barriers for vulnerable groups and underserved areas.** Nevertheless, PAHO's advocacy and other actions were challenged by the overwhelming health emergency, protracted inequities in the Region, and limited access to additional resources, especially vaccines and mental health services.

5. **PAHO was able to adapt its response at programmatic and organizational levels during the various phases of the pandemic response,** enabling the organization to operate in an unprecedented context with ever-changing health challenges, and emerging priority needs, such as the 'infodemic' control and the development of digital health.

6. **PAHO implemented actions to support the MoHs to cover all pillars of WHO/PAHO's COVID-19 SPRP,** aalthough with varying intensity and considering national contexts and resources allocated to each pillar. There is broad recognition of the quality of PAHO's technical assistance in supporting government counterparts to develop national crisis management plans. One of the most successful actions implemented by PAHO were immediate activities to strengthen the regional capacity of surveillance systems and to adopt innovative tools for outbreak investigation. Support to operations, logistics, and supply chains were the other areas where PAHO performance was better as compared to other pillars. PAHO provided support to prepare the COVID-19 National Vaccination Development Plans and strategies linked to financing the procurement of vaccines, but delays and unpredictability of vaccine procurement impacted the relationships between PAHO and some MoHs.

7. **PAHO's response to the COVID-19 pandemic was affected by critical financial and human resource constraints, internal bureaucracy, and some shortcomings in communicationbetween PAHO Headquarters (HQ) and Country Offices.** Other factors that affected PAHO's capacity to respond included the centralization of decisions in WHO HQ affecting the Americas Region, the dependence on the COVID-19 Vaccine Global Access (COVAX) mechanism, and the politicization of the response in the Americas,together with the infodemics and the heterogeneity of health systems in the Region.

8. **PAHO simplified and expedited some administrative and financial processes, developed new ones, and balanced these with control mechanisms for accountability.** PAHO's administrative rigidity, however, affected efficient service delivery to Member States leading to missed opportunities for funding, dissatisfaction among some donors and partners, difficulties in recruiting personnel, and delays in signing agreements.

9. **PAHO's unique and specialized regional mandate was a key factor for obtaining financial, political, and institutional support;** this was crucial in providing technical cooperation and facilitating access to vaccines. With additional funding related to COVID-19, PAHO's procurement function evolved to play a strategic role, providing critical support to Member States.

10. **PAHO's regular programs were affected during thepandemic by operational, human resource, and financial constraints.** Internally, PAHO personnel from regular programs were assigned to support the pandemic response.

11. **PAHO's achievements during the pandemic were due to the commitment and professionalism of its personnel, though at a high personal cost.** Teleworking did not negatively affect work productivity, but the response did lead to a significant increase in workload. The health and well-being measures provided by PAHO were not available to all personnel nor were they sufficient to support personnel's mental health.

12. **PAHO's coordination role within United Nations Country Teams was overall considered to be useful.** In particular, the joint work through the United Nations Humanitarian Response Depot (UNHRD) in Panama, significantly reinforced regional logistic and distribution capacities.

13. Some measures supported by PAHO during the pandemic had the potential to strengthen health systems and to be applied to non-emergency periods and programs (e.g., investmentsin laboratories which were key in facilitating an evidence-based response to COVID-19).

14. MoHs adopted most PAHO recommendations, although essential public health decisions by some Member States were not always aligned with the scientific evidence offered by PAHO.

Conclusions

Strategic Dimension

1. PAHO consolidated its position as the reference agency in health in the Region. It provided consistent and sustained technical and logistical support to MoHs, despite internal and external factors that constrained PAHO's operations and compromised trust in the organization in critical moments of the response.

Operational Dimension

2. At the onset of the pandemic, PAHO's institutional response was timely, but bureaucratic processes and limited resources affected its implementation capacity and efficiency. PAHO's performance during the pandemic yielded mixed results, with an overall positive balance in technical cooperation and more limited results in institutional and social spheres.

3. PAHO had the ability to innovate and to integrate the learnings acquired throughout the pandemic response ("learning-by-doing") in key areas to adapt and transform how it worked institutionally and technically and evolve as an organization.

4. PAHO contributed to addressing some digital gaps in the Region, supporting the digital transformation of the health sector at the country level, and strengthening its own digital transformation policy.

5. The equity principle was at the center of the PAHO COVID- 19 SPRP. However, its practical application was limited due to the protracted and preexisting barriers that hampered access to COVID-19 diagnoses,treatment, and vaccines. In many cases, efforts were insufficient to mitigate the differential impact of the pandemic on women and vulnerable groups.

6. The planning and monitoring system for the response to COVID-19 was not designed to assess organizational performance during the pandemic. Although PAHO's contribution to the pandemic response has been extensively documented, assessing its broader effects is challenging and seems to vary significantly depending on the modalities of cooperation, the pillars of the SPRP, and the different subregional and national realities.

Organizational Dimension

7. The early activation of PAHO's IMS effectively provided support and strategic guidance to the Region and Member States and contributed to the coordination of national response activities. However, the co-optation of professionals from other units and the long-term operation of the IMS generated organizational imbalances.

8. PAHO expanded the existing remote working modality to enable the continuity of operations while aiming to protect its personnel and their families. However, this decision put PAHO personnel at the Country Office level in a difficult situation. They needed to continue working face-to-face with their in-country national counterparts to provide consistent technical cooperation ("teleworking paradox").

9. PAHO's achievements during the pandemic were due to the commitment and professionalism of its personnel who, despite PAHO's investments in duty of care measures, experienced mental and physical health issues. Some PAHO personnel did notconsider emergency response as part of their contractual responsibilities, which generated inequal workloads and internal imbalances.

Recommendations

PAHO should:

1. Review and update its **governance** for use during a large-scale public health emergency and engage Member States in conceiving a "PAHO of the future" in a post-COVID-19 era.

2. Encourage the creation of a specialized regional mechanism for convening an **independent scientific advisory group** for responding to complex public health emergencies.

3. Diversify its funding model to fit its purpose during normal and crisis times, building on successful strategies employed during the pandemic and ensure that adequate means are available to consistently support MoHs in emergency preparedness andresponse to large-scale crises.

4. Mainstream **evidence-based gender and equity approaches** to pandemic preparedness, response, and recovery actions.

5. Design and develop a **specific organizational model** to allow the organization to operate on a sustained basis during long-term public health emergencies, based on the vast experience of the IMS.

6. Capitalize on new technologies and approaches adopted during the pandemic to **develop new ways of increasing cooperation with the MoHs,** address the digital gap, and promote technological transformation.

7. Comprehensively **review management procedures and tools** as well as internal **communication mechanisms** for use during times of crisis.

8. Reinforce the organizational capacity to deploy specialized personnel for emergency response; review and **update the hiring and duty-of-care policies, and remuneration schemes** (based on performance and extra workload) during public health emergencies.

The evaluation was conducted from June to December 2022 by an external independent team of evaluation, public health and epidemiology experts, and senior advisors. The evaluation was managed by the Planning, Budget and Evaluation (PBE) Department in line with PAHO's Evaluation Policy and international standards. The evaluation used mixed methods to collect and to triangulate data from multiple sources, used extensive desk review including more than 100 documents, conducted 112 semi-structured key informant interviews, and two online surveys answered by nearly a thousand PAHO personnel. In-depth country/subregion analysis was conducted in Mexico, Brazil, Barbados, Guatemala, Peru, Haiti, as well as in the Panama regional logistic hub, and in Barbados as a subregional office.

Contact

For further information please contact **evaluation@paho.org** at the Planning, Budget, and Evaluation Department (PBE).

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